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AGEING AND ALIENISM:  
EXPERIENCES OF OLDER PEOPLE WITHIN  
OTAGO'S ASYLUMS, 1863-1898

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## Abstract

From the 1850s, the expanding provincial centres of New Zealand were forced to address two overlapping social questions: first, how to support and meet the needs of increasing numbers of older people in the community, and, secondly, how to provide socially coordinated care for individuals with mental ill-health. These dual challenges were even more pressing because the settler communities lacked, at least initially, the budgetary resources and established support networks needed to care for people affected by advanced old age, mental ill-health, or a combination of both.

This thesis focussed on personal and social dimensions of ageing and mental ‘ill-health’ in the population of colonial Otago and Southland. The analysis was based on admission documents and case records for 55 older people resident in the Dunedin Lunatic Asylum and Seacliff for the period 1863 to 1898 inclusive. This analysis examined five principal themes: (i) social contexts of older people with mental ill-health both within and outside the asylum system; (ii) the process of committal and pathway to admission; (iii) how characteristics and behaviours of older people within the asylum system were framed within alienist paradigms; (iv) the fate of older people in asylumdom; (v) the social options and alternatives for care of older people with mental disorders in nineteenth century New Zealand, including international comparisons.

In general, the asylum records from nineteenth century Otago indicated prolonged periods of admission for older patients with little evidence of ‘recovery’ and discharge. This challenged the earlier assumptions that episodes of asylum care might be limited and followed by a return to relatively independent life. Colonial perspectives on care for older people related to the prevailing attitudes and priorities of the wider community, but also reflected the financial or personal capacity of individuals or their families to manage the complexities of mental disorders.

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## List of Abbreviations

AJHR: Appendices to the Journals of the House of Representatives

ANZ DRO: Archives New Zealand - Dunedin Regional Office

GPI: General paralysis of the insane

NZPD: New Zealand Parliamentary Debates

# Ageing, Mental Ill-health and Contexts of Care in Nineteenth Century New Zealand: Introduction and Historiography

## *Objectives and Chapter Outline*

This project explored an important nexus of two emerging social issues in colonial New Zealand by focussing on the experiences of older people who were also considered to be affected by serious ‘disorders of the mind.’ This research explored dimensions of asylum-based care for older people diagnosed with various kinds of mental illness, with a specific focus on the situation in Otago and Southland for the period 1863-1898. These emerging provincial centres experienced substantial shifts in the provision of institutional care for those with mental illness across this period. From the 1870s, local and national authorities were also forced to accommodate the needs of increasing numbers of older people in the community. This analysis is based on the experiences and journeys for committal, admission, inpatient care, discharge or death within the asylum system for a cohort of older people in Otago and Southland.

The study population included two groups recorded as being asylum residents between 1863 and 1898: those who were either aged 60 years or more at time of first admission (‘admitted older’), and those who attained this age while an asylum inpatient or upon re-admission at Dunedin and/or Seacliff (‘transitioned older’) in the specified period. Five principal themes were assessed: (i) social contexts of older people with mental ill-health both within and outside the asylum system; (ii) the process of committal and pathways to admission; (iii) how characteristics and behaviours of older people within the asylum system were framed within alienist paradigms; (iv) the fate of older people in asylumdom; (iv) the social options and alternatives for care of older people with mental disorders in nineteenth century New Zealand, including international comparisons.

The overall structure of the thesis is as follows. The first part of the Literature Review provides the wider historical context for wellbeing and welfare of older people in nineteenth century New Zealand, including a review of the historiography relating to ageing, demographic patterns and social supports relevant to people over 60 years of age. This Review will also examine the national context, with the support options more specifically relevant to Otago and Southland to be discussed in Chapter 5 (see below). The second part of the Literature review will focus on the historiography on mental illness and its management in New Zealand from the 1840s,

with a particular emphasis on the perceived challenge of ‘lunacy’ and the emergence of an asylum system. In the following section on primary and secondary sources, an overview is provided of the strategies used for identifying the relevant material, including the range of archival material used to support the analyses. Analysis of these records employed both quantitative and qualitative approaches, which are briefly described.

In brief, Chapter 1 presents four diverse case studies and explores the personal and social context of their lives both within and outside the asylum. This Chapter also reviews the broader demographic trends that influenced the pattern of admissions into Otago’s asylums. Chapter 2 examines the medico-legal processes of committal and asylum admission, including the transition towards becoming an officially defined asylum ‘patient.’ Chapter 3 reviews how distinctive ‘clinical communities’ became established within Otago’s early asylums, and how these hierarchical structures within these institutions influenced the management of older patients. The classifications and explanations for the mental disorders affecting the study population of older individuals will also be compared with the prevailing nineteenth century alienist paradigms. Chapter 4 explores the longer-term personal fate of older people in asylumdom, including the complex pathways towards death or discharge. The rationale and implementation of therapeutic decisions relating to older people will also be described. In Chapter 5, the historical evidence will be used as basis to examine the place of the asylum within the wider social options and alternatives for care in nineteenth century New Zealand. The ‘welfare’ options that evolved in Otago and Southland will be discussed in depth. The evolution of care for older people with mental ill-health in colonial New Zealand will then be compared with contemporaneous responses and challenges Britain and the Empire, North America, and other industrialised countries. At the end of the thesis, four Appendices provide more detailed summary data and basic statistical analysis of the study population.

### *Background and Academic Perspective of the Researcher*

I am (as of 2022) a Professor of Epidemiology at the School of Population and Global Health, The University of Western Australia (UWA). I am a medical graduate (MBCChB, *Auckland* 1992) and registered medical practitioner (Canberra, ACT, 1994) and during the 1990s I gained health research experience concurrently with my ongoing practice at hospitals and community medical clinics.

In 2007 I completed a PhD in Population Health and Epidemiology (University of Otago, New Zealand, 2007). My experiences in epidemiological research and teaching continued with my appointment at the School of Population and Global Health at the UWA in March 2003. For the past 15 years I have been the main coordinator for *Plagues, Pox and Pandemics; A History of Death and Disease* an innovative multidisciplinary undergraduate course co-taught with History in the School of Humanities, which is dedicated to both providing the educational framework for understanding the interconnections between history, medicine and population health.

In this thesis, my focus is partially directed towards the history of medicine, with an emphasis on mental health. The research themes also encompass the broader historical dimensions of ageing, health systems and policies, and past forms of welfare provision. My previous research and clinical experience provided the foundations for this multidisciplinary approach to the questions of how older people with mental illness were assessed and managed in previous eras. Completion of this Master's thesis also provided me with a unique opportunity to explore the lives of older individuals 'beyond the asylum,' and to assess how their personal journeys were affected both by ill-health and the social responses to their circumstances in the context of nineteenth century New Zealand.

### *Definitions of 'Old Age' Used in this Research Project*

In recent decades, historians have focussed on past experiences and understandings of 'old age' and examined how health and social dimensions of ageing may vary across different eras and cultural milieux. However, there is no generally accepted definition or established milestone for 'old age.' The concept of old age itself is not fixed in historical time and is contested both within and across discipline areas. As a leading social historian Pat Thane has noted: "Old age is defined chronologically, functionally or culturally," where 'functional' old age is reached when an individual can no longer fully perform "the tasks expected of [them], such as paid work" and 'cultural' old age is considered in relation to the norms of the society.<sup>1</sup>

In this thesis, the term will be used to refer to the stage of life at or over 60 years of age, and correspondingly, the term 'older people' will be used here to refer to individuals in this age group. There are historical precedents to the use of the 60 year milestone, including various medieval legislative texts which considered this as an age which allowed exemption from some taxes and military and other civic obligations;<sup>2,3</sup> in later centuries, reaching around 60 years of

age was a factor in eligibility for Poor Law pensions in England. As Paul Johnson notes, these kinds of age thresholds have “remarkably deep historical roots,”<sup>4</sup> but their persistence could often lead to a popular belief that such cut-offs were an “immutable” indicator of old age.<sup>5</sup> In academic contexts, this ‘cut-off’ of 60 years has also been used in other historical analyses of mental health in older people during the Victorian era.<sup>6</sup> A potential ‘bio-medical’ rationale for using a threshold age of 60 years is that the incidence of organic brain disorders, such as common types of dementia, tend to significantly increase in frequency after this age. Connections between changes in mental function and transitions into advanced age have in fact been described for millennia, including by classical authors such as Aulus Cornelius Celsus (first century CE) and Galen (130 – c.210 CE).<sup>7</sup>

### *Health and Welfare of Ageing Populations in Nineteenth Century New Zealand*

In order to provide the context for wellbeing and welfare of older people in nineteenth century New Zealand, this first section of the Literature Review will examine the historical evidence and historiography relating to ageing, demographic patterns and social supports relevant to settlers at or over 60 years of age. The experiences of older Māori in this period follow a distinctive socio-cultural and demographic pathway through the nineteenth century and will not be reviewed in detail here. The second part of the Literature Review will summarise the socio-political and medical responses to the issue of mental ill-health in New Zealand communities across the same period.

In his 1998 book *A World Without Welfare: New Zealand's Colonial Experiment*, David Thomson highlighted the distinctive approach to ‘welfare’ that had evolved in colonial New Zealand.<sup>8</sup> In terms of care for older people, there were initially few local equivalents to the charitable foundations (often coordinated through parishes), workhouses, and county asylums that provided ‘care’ - although usually only at subsistence level - in Great Britain and other Western European and North American nations. The English Poor Laws - or their less formalised Scottish equivalents - were not directly transferred to colonial New Zealand context, although there was similar emphasis on the supposed virtues of “[s]elf-help, independence, opposition to compulsory public support, and the lauding of voluntary effort”<sup>9</sup> that were being encouraged by British governments in the mid- to late-nineteenth century.<sup>10</sup> One of the first legislative measures that sought to address the issue of population ‘welfare’ was introduced in the Crown Colony era (1840-52). The *Destitute Persons Ordinance*, passed in 1846, placed

demands on family members (a specified group of near relatives) to provide for older people who were no longer able to support themselves by their own labour.<sup>11</sup> Thomson argues that many of the fundamental aspects of this law remained in force until the end of the nineteenth century, after which there was shift to modest state-based support through old age pensions (from 1898).<sup>12</sup>

From 1852, the various Provincial administrations across New Zealand offered a limited and rather haphazard distribution of ‘charitable aid’ used to provide basic relief (often involving short-term assistance to impoverished individuals) and to perform other social functions, such as building hospitals and asylums.<sup>13</sup> ‘Charitable aid’ usually referred to support from the local authorities or government and was seen as distinct from “wholly voluntary or religious philanthropy.”<sup>14</sup> Margaret Tennant argues the term also allowed the government to evade any reference to a ‘Poor Law’ (along English lines), which many colonists were opposed to introducing in New Zealand.<sup>15</sup> In Otago, for example, in 1864-5 year, the Provincial Council allocated £1500 in charitable aid for relief for destitute persons in Dunedin, plus another £2500 to cover out-of-work populations in the goldfields.<sup>16</sup> The Council also committed to the construction of a new hospital in Dunedin as well as smaller hospitals across the main goldfields.<sup>17</sup> By 1867-8, support for various ‘welfare-related’ activities - including relief for the destitute and operation of the hospital and asylum – was equivalent to approximately 5% of total Provincial spending for Otago and Southland.<sup>18</sup>

A system of ‘outdoor relief’ – that is, provision of various kinds of support offered in the recipient’s own home - was also introduced in New Zealand. Depending on the location (such as urban versus rural) and the individual’s social situation, these forms of relief could include “food rations, rent supplements, firewood, free medical attendance, burial costs” or relatively small and often temporary cash payments.<sup>19</sup> In the 1880s and 1890s, however, there was a growing preference for ‘indoor relief’ (that is, within institutions) versus the ‘outdoor’ option, possibly for ease of administration, with funds directed to a specific organisation rather than being distributed by agents or officials in the community. According to Thomson, the threat of institutionalisation also acted as a disincentive for needy people seeking help, thereby saving money.<sup>20</sup> Across New Zealand, a number of religious and other benevolent charities were established in the mid- to late nineteenth century, including the Salvation Army or various organisations affiliated with, for example, the Presbyterian or Roman Catholic Church. However, welfare needs of older people were well down the list of priorities, after relief for orphaned children, women with young families who had lost spousal support (such as through

partner death, separation, infirmity or imprisonment), unemployed men requiring temporary assistance, and (ex-)prisoners.<sup>21</sup>

Margaret Tennant has explored the social alternatives available to support older and indigent New Zealanders in the nineteenth century, especially during the 1880s and 1890s. In terms of residential care, options included a range of ‘homes,’ refuges and depots of varying quality. In Auckland, for example, the Old Men's Refuge was situated on the public hospital grounds and had originally been used as a lunatic asylum. The poor quality of the site and the substandard building had been acknowledged at the time: a review in 1877 found the refuge to be dilapidated and bug-infested.<sup>22</sup> By 1886 the Auckland Hospital and Charitable Aid Board discussed whether the Refuge should be vacated or turned into a fowl-house.<sup>23</sup> In contrast, the Thames Refuge - which was operated as part of the hospital - was (in 1883) reported to be clean and well-furnished, with good quality food provided to its 12 residents.<sup>24</sup> Other options for the unsupported or “homeless elderly” included relocation into cottages (where the older person was often provided with food and tobacco) or boarding houses.<sup>25</sup> The Armagh Street Depot in Christchurch was a casual lodging house that provided shelter for a few nights but not permanent accommodation; some of those not permitted to stay resorted to sleeping in city parks or on the river banks.<sup>26</sup> Institutions for older people could be unsettling and even violent environments in which to reside. Tennant concluded that these “early institutions were often turbulent places which...functioned in a simmering state of hostility between management and inmates,” characterised by the “sheer fractiousness and perversity of the inmates, and the often domineering and inflexible response of the institutions’ management.”<sup>27</sup>

The welfare demands of New Zealand’s ageing population shifted substantially in the last decades of the nineteenth century.<sup>28</sup> As Brian Heenan notes, the non-Maori population was affected by “a strong pulse of demographic ageing” during this period. From 1874 - 1901, the proportion of New Zealanders aged 60 years or older increased from 2.3 to 6.7%, a pattern that was accompanied by a sharp decline in the proportion of children younger than 15 years across the same time period.<sup>29</sup> Demographer Ian Pool also notes that average life expectancies at birth for non-Māori males and females also steadily increased from the 1870s, rising from around 48 years for males and 52 for females in that decade to 55 for males and 58 for females by 1891.<sup>30</sup> There were regional variations in these demographic changes, with Central Otago and the West Coast experiencing more marked ageing of the population who had participated in earlier large-scale immigration, such as during the gold-rush period (principally in the 1860s-70s). For example, in the year of 1861, Otago alone “absorbed over 87% of immigrants to New

Zealand.”<sup>31</sup> Heenan also notes that a large proportion of male immigrants, especially in rural parts of the South Island where they predominated numerically over female immigrants, “never married and very often existed alone, many without family support.”<sup>32</sup> The resources and employment opportunities of (often landless) older people were also challenged by geographical isolation and the protracted global economic downturn spanning the 1880s and early 1890s. Many older men and – in increasing numbers – women were squeezed out of the labour market or were forced to seek casualised work (such as gardening) to avoid complete destitution.<sup>33</sup> Expectations about saving for old age were increasingly unrealistic during this period of highly interrupted employment.<sup>34</sup>

By the 1880s, many of New Zealand’s hospitals and charitable organisations found themselves caring for increasing numbers of the ‘old and infirm.’<sup>35</sup> One of the key figures involved assessing hospital expenditure and operations in this period was Dr George Wallington Grabham. Grabham, who trained in London and worked as the Medical Superintendent at Earlswood Idiot Asylum in Surrey for 12 years, was appointed Inspector of Asylums and Hospitals for New Zealand in 1882. Grabham was also involved in drafting *Hospitals and Charitable Institutions Act* in 1885, as will be discussed below.<sup>36</sup> During the period of his Inspectorate, Grabham reported on the high numbers of older and often so-called ‘incurable’ patients on the general hospital wards, which in some locations had reached such a degree that the ‘curable’ patients could not even be admitted and accommodated. He argued that use of hospital beds for so-called ‘refuge cases’ was also an expensive option compared to other forms of care.<sup>37</sup> In his opinion, some New Zealand hospitals were too accommodating, with the “provision of free board and medical attendance during illness for those who ought to be able to pay for them”; as a result, long-stay patients had now come to resemble “the permanent pauper inhabitants of an English union workhouse.”<sup>38</sup> In response to this challenge, Grabham sought to expand the capacity of refuges (or construct new ones) to divert older ‘incurable’ patients from hospital wards.<sup>39</sup>

In relation to welfare legislation, one of the main milestones in this period was the *Hospital and Charitable Institutions Act* of 1885. Margaret Tennant has suggested that the Act, by establishing a national network of hospitals and charitable relief, to some degree “confirmed that responsibility for the sick and poor was a charge upon all parts of the country and all sections of the community.”<sup>40</sup> Kay Saville-Smith has suggested that the 1885 Act represented an initial step towards “State intervention” in the lives of older New Zealanders (whereas, for example, the earlier *Destitute Persons Act* had focussed on the specific social issue of the

‘destitute’ as opposed to older people). The societal transition from younger ‘pioneers’ to more established ‘settlers’ was accompanied by a gradual shift in policy towards more publicly-funded income support and various kinds of institutional care (such as homes and asylums) for older people.<sup>41</sup> More generally, US historian Carole Haber has argued that many late nineteenth century welfare reforms increasingly focussed the issue of “needy senescence,” with the “lack of material goods and a suitable family network” for many older people seen as predictive of prolonged periods of indigence and dependence.<sup>42</sup>

In practical terms, the 1885 Act therefore provided “a conduit for government subsidies to the voluntary sector.”<sup>43</sup> Local boards would be responsible for managing hospitals and the distribution of ‘charitable relief’: a combination of “voluntary contributions, local rates, and government subsidies.”<sup>44</sup> This relief was often delivered through the hospital administrative structure, although the boards usually separated out their duties to the ‘poor’ as opposed to their role in providing medical care.<sup>45</sup> However, an unintended consequence of this arrangement, to be discussed in a later chapter, was that local authorities sought to reduce their own expenditure by shifting older people into lunatic asylums (which were largely funded by the central government) and away from other institutions, such as homes and refuges for the ‘aged poor’ (for which local authorities were still required to provide half of the funding).<sup>46</sup>

In 1886, Duncan MacGregor (1843–1906) was appointed national Inspector-General of Asylums, Hospitals and Charitable Institutions.<sup>47</sup> MacGregor, an imposing man described as “tall” and “immensely built,” did not hesitate to convey his strong opinions on social policy and the management of public institutions.<sup>48</sup> As Michael Belgrave notes, MacGregor was firmly opposed to any form of ‘pauperism’ or other kinds of widespread social ‘dependency’ becoming established in New Zealand society.<sup>49</sup> MacGregor feared the escalating financial burden on the government if it moved to replace the functions of charitable organisations, including support for older people. His often unforgiving views even extended to opposing uncontrolled migration and limiting the opportunities for procreation of the “unfit” and “degenerate” sections of society,<sup>50</sup> which he described as “a swarm of parasitical organisms.”<sup>51</sup> Many of MacGregor’s opinions were also mirrored by the politician Robert Stout, Premier from 1884 to 1887, a period during which he had supported Macgregor’s appointment as Inspector-General.<sup>52</sup> However, as Belgrave argues, MacGregor’s views on restricted state support were gradually being superseded by more active government policies, which – although still highly parsimonious by modern standards – started to more directly respond to the complex welfare needs of a growing population.<sup>53</sup>

The passage of the 1898 *Old Age Pensions Act* was another major turning point in New Zealand's approach to welfare for older people, marking a transition from charitable support towards a state scheme supported by taxation (as opposed to relying on personal contribution or charitable donation) and with eligibility defined by statute. However, as discussed by Gaynor Whyte, entitlement to a partial or full pension for those age at or above 65 years was relatively restricted.<sup>54</sup> Older people were forced to meet a number of requirements before they could access the scheme, including means-testing based on income and assets.<sup>55</sup> (Two notable exceptions were those receiving war pensions from Britain and superannuated colonial civil servants, but these groups constituted only a small fraction of New Zealand society.<sup>56</sup>) There was also a moral component to successful procurement of a pension: applicants were required to demonstrate their "good moral character" and provide assurances or evidence that they had lead a "sober and reputable life" in the preceding five year period.<sup>57</sup> Compared to the situation in Australia and Britain, old age pensions in New Zealand were in fact lower in value relative to wages and less frequently made available.<sup>58</sup>

### *Managing Mental Ill-Health in Nineteenth Century New Zealand: Socio-political and Institutional Contexts*

The next section of the Literature Review will focus on the social and political contexts of managing 'lunacy' in nineteenth century New Zealand, including the emergence of the asylum system. The evolution of mental health services in the nineteenth century accompanied, often in a sporadic manner, the expansion of settler communities. Prior to the 1860s, and in the absence of any other realistic options, individuals diagnosed with a mental disorder were often managed by family members or even close friends. Actions and behaviours that threatened law and order could come to attention of the constabulary, and in some cases resulted in sentencing and imprisonment of people with mental illness.<sup>59</sup> Ultimately, family-centred management was not always feasible or available, especially for those with severe or chronic psychiatric illnesses, and therefore various community alternatives were considered.

Detailed analyses of the early care of people with mental disorders, and the development of the asylum system in nineteenth century New Zealand, have been provided by historians such as Angela McCarthy and Warwick Brunton. Brunton notes that the management of 'lunacy' in colonial New Zealand was strongly influenced by socio-political and scientific developments in Britain.<sup>60</sup> Medical connections between New Zealand and the 'home country' were

maintained through affiliations with British professional bodies - such as the royal medical colleges - as well as “journals, organised recruitment of specialist medical and nursing staff, and study tours.”<sup>61</sup> Ideas and innovations were also drawn from other parts of the British Empire (especially Australia, including through various professional associations, as well as Canada),<sup>62</sup> major European centres (notably France), and the United States.<sup>63</sup>

New Zealand’s first mental health legislation, the *Lunatics Ordinance* (1846), was principally directed at individuals with mental health disorders who were a threat to public safety or themselves.<sup>64</sup> This Ordinance, which was closely based on existing legislation developed in New South Wales (1843) and South Australia (1844),<sup>65</sup> allowed for transfer of the lunatic to a gaol, house of correction, or public hospital until they could be transferred to a “public colonial lunatic asylum.”<sup>66</sup> Brunton has noted that the term ‘lunatic asylum’ in colonial settings at the time was “often not strictly defined” and might in reality refer to “a few designated cells that were a ‘mere adjunct’ to a gaol, hospital or poorhouse” or even to converted buildings, such as “old barracks” or “prisons.”<sup>67</sup> Smaller “first generation” asylums – many of which were intended to be temporary – were established in New Zealand’s provinces, starting in Wellington (at Karori in 1854) and Auckland (as an annexe to the main hospital).<sup>68</sup> Proposals to build a centralised lunatic asylum to serve the colony were rejected by parliament in 1858 and 1861, and a network of provincial asylums developed instead. The first buildings provisionally used as asylums tended to be relatively small and constructed of timber.<sup>69</sup>

Brunton has also examined the further legislative reforms and more extensive development of the asylum network between 1867 to 1876.<sup>70</sup> This included implementation of the *Lunatics Act* (1868), in which New Zealand adopted many of the “recent alterations and improvements” in legislation that had been introduced in Britain and “the neighbouring Colonies” (here referring especially to introduction of the revised Acts in Victoria).<sup>71</sup> The *Lunatics Act* of 1868 also required that costs of patient care were “to be met by the Province where the lunatic resided.”<sup>72</sup> However, under the system of provincial control, many of these initiatives were not well-coordinated across the colony. The South Island provinces, drawing on the profits of gold mining, could afford to spend more on asylum staffing and buildings than those in the North Island.<sup>73</sup> The year 1876 was a pivotal one for the management of New Zealand’s asylum system, with the end of direct provincial control and its replacement with centralised administration and funding for care.<sup>74</sup> The Department of Lunatic Asylums was established to coordinate the operation of asylums and advise on relevant policy and legislation.<sup>75</sup> In 1876, Frederick W. A. Skae, a Scottish alienist from a prestigious medical family<sup>76</sup> and former

Medical Superintendent for the Stirling District Lunatic Asylum, was appointed New Zealand's first Inspector of Lunatic Asylums. He was succeeded by George Wallington Grabham (1882-86) and then Duncan MacGregor (1886-1906), whose careers were briefly discussed in the previous section.<sup>77</sup> Under the *Lunatics Act* of 1882, the formal process of certification and committal proceedings required involvement of Resident Magistrate and the assistance of two medical practitioners to record the diagnosis of a mental disorder. The Act also stipulated requirements for the regular inspections of asylums.<sup>78</sup>

Recent publications – including by Catharine Coleborne and Angela McCarthy – have evaluated the broader social contexts and impacts of ‘insanity’ in nineteenth century New Zealand, including the relationships between the immigration and asylum admission in the 1850s–1890s.<sup>79,80</sup> Coleborne has noted that 45% patients in the Auckland Lunatic Asylum were born outside New Zealand, principally from England, Ireland and Scotland. She argues that immigrants faced multiple challenges as they attempted to establish their new lives. Although historical records are often silent on the frequency of mental illness, there is evidence suggesting significant levels of mental breakdown, excessive alcohol use, ‘lunacy’ and suicide amongst colonial settlers.<sup>81</sup> Coleborne suggested that “[b]oth loneliness and chaos characterized these new places...Migrants could become dissatisfied and broken by their poor luck.”<sup>82</sup> McCarthy explored the evidence for the assumed role of social disconnectedness on insanity. She notes that although previous studies emphasised a high degree of isolation amongst settlers, other research has demonstrated a high degree of interaction and enduring kinship ties.<sup>83</sup>

In late nineteenth century New Zealand, migrants also suffered from increasing stigmatisation as a result of prevailing views that unwanted lunatics were being deliberately being sent to the colonies as way of ‘offloading’ them from Britain.<sup>84</sup> In Otago, for example, official appointees such as Provincial Surgeon Edward Hulme and Duncan MacGregor (referred to above) expressed their concern that the Province – and indeed New Zealand more generally – was being flooded with “lunatics” from Britain (especially Scotland); all of the ‘incurable’ Scandinavians ending up in asylums were also creating alarm amongst the authorities.<sup>85</sup> In 1874 Edward Hulme noted that up to a third of women being admitted to the Dunedin Lunatic Asylum were recent arrivals to New Zealand, who had not long left the ship or immigration barracks.<sup>86</sup> An example of the disapproval directed towards some migrant groups is demonstrated by John Torrance, initially appointed by the provincial government as Chaplain of the Dunedin Hospital, Gaol and Lunatic Asylum in the 1860s-70s, before he took on the role

as chaplain at Seacliff asylum. Torrance wrote a detailed description of the asylum in 1890, and - in his review - he also criticised the British policy of unregulated immigration to New Zealand. As a result of this influx of people who were “from their mental calibre, unfitted for colonial life,” Torrance argued that:

the number of men absolutely adrift in the colony is appalling, and in many instances they find their way into asylums, where they are cared for, or prematurely and as strangers end their lives in the hospitals or benevolent institutions, with none of their kith or kin present to cheer them in their last days and hours, and with no one save the Chaplain or other minister to follow their remains to the cemetery.<sup>87</sup>

Catharine Coleborne and Bronwyn Labrum have examined the gendered history of insanity and the role of asylums in New Zealand<sup>88</sup>. In her analysis of patient experiences of the Auckland Lunatic Asylum between 1870 and 1910, Labrum noted that female patients with mental disorders were often judged in relation to prevailing “notions of respectability” and to their “performance in the roles of wife, mother, and housewife, and in their behaviour as women.”<sup>89</sup> Case records also indicate that some form of “domestic crisis” (where “abnormal behaviour and delusions associated with insanity played havoc with family life”<sup>90</sup>) or “economic distress” were more often referred to as a trigger for committal amongst female patients compared with male patients. Catharine Coleborne’s work on the history of mental illness in the New Zealand and Australian context has also emphasised importance of the family experience of having a relative diagnosed with ‘insanity.’<sup>91</sup> This extended to families visiting the asylum itself and their interactions with the patients and staff within the institutional context.<sup>92</sup>

With specific reference to the history of Otago and Southland, in the decades before a separate asylum was established, those diagnosed with severe mental illness in Otago were placed in Dunedin’s small general hospital - which was until 1866 situated on the northwest corner of the Octagon - or in some cases were kept in the Gaol.<sup>93</sup> The first public patient admitted to Dunedin’s general hospital in July 1852 was Andrew Doig, a prisoner with a mental disorder; Doig was placed in isolation.<sup>94</sup> Robert Williams, the Colonial Surgeon from 1853 to 1857, was responsible for attending public patients in the hospital and prisoners at the Gaol, as well conducting home visits and running his own private practice.<sup>95</sup> Based on the records of 1856, a total of 15 patients were treated at Dunedin hospital for that year, including one private lunatic patient and two ‘pauper lunatics.’<sup>96</sup> Henry Monson, Dunedin’s Gaoler from 1851-61, had a

reputation for his relatively humane approach to ‘lunatics’ who found themselves incarcerated: in his journal he declared his belief in “treating everyone as a human being, as a man, and as a [C]hristian.”<sup>97</sup> In the decades before the colony’s large asylums were built, it was also permitted for relatives, guardians, or friends to provide “out-of-hospital compulsory care,” even for patients who had been certified.<sup>98</sup> By the 1860s, Otago’s Provincial Surgeon Edward Hulme - who had studied at the Royal College of Surgeons in London and advanced his training in the famous Salpêtrière asylum in Paris<sup>99</sup> - was advocating for a “proper place” or “model Institution” for those with mental illness, where they could be cared for by a “properly qualified specialist.”<sup>100</sup>

The region’s first public institution for the treatment of mental disorders was the Dunedin Lunatic Asylum, established in 1863 by the (then) Provincial government.<sup>101</sup> Jeremy Bloomfield has provided an overview of the development and operation of the asylum for the period 1863-1876.<sup>102</sup> Although Edward Hulme had recommended that any new facility should accommodate 70 patients, the so-called ‘Temporary’ Lunatic Asylum was in fact initially designed for only for 21 patients.<sup>103</sup> Hulme was highly critical of the finished building, with its limited size, enclosed and muddy recreation yards, and low walls - over which the first male patient quickly escaped.<sup>104</sup> Within a year of opening, the asylum already housed 32 people.<sup>105</sup> Responsibility for the operation of the asylum was shared between a keeper (or superintendent) and a visiting medical officer.<sup>106</sup> Robert Drysdale was appointed as the first asylum Keeper (or superintendent), but left the position within a year amidst accusations of mistreatment and assault of patients.<sup>107</sup> In 1864, James Hume was appointed as Keeper and Superintendent of the asylum on £120 per year (increased to £350 by 1870), and his wife, Mary, took on the role of Matron on £60 per year (increased to £100 by 1870). Provincial Surgeons had the legal authority to visit asylums, but in the first decades formal reviews and strict inspections appear to have been uncommon in many centres.<sup>108</sup> The pivotal role of individuals such as James Hume and Edward Hulme in the operation of the asylum will be discussed more fully in Chapter 3.

In physical terms, Dunedin’s main asylum was initially comprised of long one-storey wooden buildings that enclosed exercise yards, but numerous further extensions were added over subsequent years.<sup>109</sup> The patients themselves were enlisted to help level the grounds around the asylum, and also were also involved in gardening (allowing the asylum to achieve self-sufficiency in vegetables by 1870, with surplus produce also sent to the main Hospital and Gaol), baking bread, as well as the construction of new facilities, such as the installation of a

large brick water tank.<sup>110</sup> Services and care within the asylum showed a degree of social stratification. Poorer patients were placed in the East House with fewer attendants, whereas fee-paying patients in the West House or nearby Park House (in fact part of the Hume family home and usually housing around four patients paying fees of £50 a year) were offered greater comfort, superior food, and higher numbers of staff per patient.<sup>111</sup> To meet the growing demand for fully private care in Otago, Ashburn Hall - a small separate asylum for fee-paying patients - opened in 1882.<sup>112</sup>

There were marked demographic shifts in Dunedin's overall asylum population even in the first years of its operation. The proportion of younger men in the asylum declined between 1863 and 1876: 77% down to 40%, respectively. In contrast, the proportion of married women (across all ages) increased from 9% to 34% of patients over the same period.<sup>113</sup> Overall patient numbers also steadily increased in the Dunedin Lunatic Asylum - from 27 in 1863 to around 250 by the end of the subsequent decade<sup>114</sup> - and the costs of operation also rose - from £1700 in the mid-1860s to £5 000 in 1876.<sup>115</sup> Despite ongoing additions and renovations to the original structures, it became apparent that a larger and more permanent institution would be required. Basic water and sanitation problems – including insufficient water supplies, pipe ruptures, and overloaded cesspools – persisted into the early 1870s, when the asylum was finally connected to the Dunedin Water Works.<sup>116</sup> In the mid-1870s, Provincial asylum inspector Duncan MacGregor complained of the unsuitability of the existing facilities, especially for such “a wealthy and enlightened province” as Otago.<sup>117</sup> By 1877, the (now centralised) New Zealand government supported the development of the “farm asylum” at Seacliff, at a relatively isolated coastal location around 20 miles north of Dunedin.<sup>118</sup> The asylum site (which had originally been reserved by the Otago Provincial Government) became more accessible in 1878 with the extension of the northern railway line up to Waikouaiti.<sup>119</sup>

By 1884, the main block of the new asylum at Seacliff - constructed in a dramatic and imposing Scottish baronial style reminiscent of Balmoral, and at that time the largest public building in New Zealand - was completed, and all patients from the original Dunedin Asylum had been relocated.<sup>120</sup> Dr George Grabham, Inspector of Asylums and Hospitals for New Zealand from 1882-6, described the new hospital as “palatial looking” but “cold and ill-planned.”<sup>121</sup> The health care pioneer Frederic Truby King was appointed the Medical Superintendent of Seacliff Lunatic Asylum from 1889 to 1921. Cheryl Caldwell provided an overview of King's administration of Seacliff Asylum, during which time he implemented a number of reforms, including modifications to the buildings and grounds (to provide more light and space), as well

the introduction of dietary changes and work activities as part of a broader therapeutic approach.<sup>122</sup> The institutional characteristics of Seacliff and the influence of individuals such as King will be examined in greater depth in Chapters 3 and 4.

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### *Introduction and Historiography: Notes*

<sup>1</sup> Pat Thane, "Social Histories of Old Age and Aging," *Journal of Social History* 37, no.1 (2003): 98.

<sup>2</sup> Margaret Pelling and Richard Smith, eds., *Life, Death, and the Elderly: Historical Perspectives* (London: Routledge, 1991), 6.

<sup>3</sup> Thane, "Social Histories of Old Age and Aging," 97.

<sup>4</sup> Paul Johnson and Pat Thane, eds., *Old Age from Antiquity to Post-Modernity* (London; New York: Routledge, 1998), 3.

<sup>5</sup> *Ibid*, 123.

<sup>6</sup> For example: Graeme Yorston and Camilla Haw, "Old and Mad in Victorian Oxford: A Study of Patients Aged 60 and over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century," *History of Psychiatry* 16, no. 64 (2005): 413.

<sup>7</sup> Francois Boller and Margaret Forbes, "History of Dementia and Dementia in History: An Overview," *Journal of Neurological Science* 158, no.2 (1998):126.

<sup>8</sup> David Thomson, *A World Without Welfare: New Zealand's Colonial Experiment* (Auckland University Press with Bridget Williams Books Auckland, 1998).

<sup>9</sup> *Ibid*, 17.

<sup>10</sup> *Ibid*, 17.

<sup>11</sup> David Thomson, "Old Age in the New World: New Zealand's Colonial Welfare Experiment," in *Old Age from Antiquity to Post-Modernity*, ed. Paul Johnson and Pat Thane (London; New York: Routledge, 1998), 147.

<sup>12</sup> *Ibid*, 149.

<sup>13</sup> *Ibid*, 150.

<sup>14</sup> Margaret Tennant, *Paupers and Providers: Charitable Aid in New Zealand* (Wellington: Allen Unwin, 1989), 2.

<sup>15</sup> *Ibid*, 2.

<sup>16</sup> A further £1500 was set aside for pauper burials. John Angus, *A History of the Otago Hospital Board and its Predecessors* (Dunedin: The Otago Hospital Board, 1984), 54.

<sup>17</sup> Thomson, *A World Without Welfare*, 85.

<sup>18</sup> *Ibid*, 137.

<sup>19</sup> *Ibid*, 84.

<sup>20</sup> *Ibid*, 93.

<sup>21</sup> *Ibid*, 137.

<sup>22</sup> Michael Chilton, "The Genesis of the Welfare State: A Study of Hospitals and Charitable Aid in New Zealand, 1877-92" (MA., University of Canterbury, 1968), 57.

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- <sup>23</sup> The newly constructed Costley Home for the Aged Poor replaced the Auckland Old Men's and Old Women's Refuges in 1890. See: Margaret Tennant, "Elderly Indigents and Old Men's Homes," *New Zealand Journal of History* 17, no.1 (April 1983): 7-8.
- <sup>24</sup> Chilton, "The Genesis of the Welfare State," 58.
- <sup>25</sup> Tennant, "Elderly Indigents and Old Men's Homes," 4.
- <sup>26</sup> Chilton, "The Genesis of the Welfare State," 57.
- <sup>27</sup> Tennant, "Elderly Indigents and Old Men's Homes," 14.
- <sup>28</sup> John Bryant, *The Ageing of the New Zealand Population, 1881-2051*. *New Zealand Treasury Working Paper, No. 03/27* (Wellington: New Zealand Government, 2003), 21.
- <sup>29</sup> Brian Heenan, "Population Ageing Among Non-Maori New Zealanders in Later Victorian Times," *New Zealand Journal of History* 35, no.2 (2001): 179.
- <sup>30</sup> Ian Pool and Jit Cheung, "Why Were New Zealand Levels of Life Expectation so High at the Dawn of the Twentieth Century?" *Genus* 61, no. 2 (2005): 15.
- <sup>31</sup> Heenan, "Population Ageing Among Non-Maori New Zealanders," 196.
- <sup>32</sup> *Ibid*, 179.
- <sup>33</sup> Thomson, *A World Without Welfare*, 131.
- <sup>34</sup> *Ibid*, 159.
- <sup>35</sup> Chilton, "The Genesis of the Welfare State," 58.
- <sup>36</sup> Grabham resigned in 1886 and returned to practice in England. See: Rex Earl Wright-St Claire and Elizabeth Wright-St Clair, *Historia Nunc Vivat: Medical Practitioners in New Zealand, 1840 to 1930* (Christchurch, NZ: Cotter Medical History Trust, 2013), 160.
- <sup>37</sup> Appendix to the Journals of the House of Representatives (AJHR), *Report on Hospitals in New Zealand*, 1883, Session I, H-03a, ii.
- <sup>38</sup> *Ibid*.
- <sup>39</sup> AJHR, *Report on Hospitals in New Zealand*, 1883, Session I, H-03a, ii.
- <sup>40</sup> Margaret Tennant, "Mixed Economy or Moving Frontier: Welfare, the Voluntary Sector and Government," in *Past Judgement: Social Policy in New Zealand History*, eds. Bronwyn Dalley and Margaret Tennant (Dunedin: Otago University Press, 2004), Kindle.
- <sup>41</sup> Saville-Smith, "The State and the Social Construction of Aging," 83.
- <sup>42</sup> Carole Haber, *Beyond Sixty-Five: The Dilemma of Old Age in America's Past* (Cambridge: Cambridge University Press, 1983), 41.
- <sup>43</sup> *Ibid*.
- <sup>44</sup> Margaret Tennant, "Duncan MacGregor and Charitable Aid Administration 1886-1896," *New Zealand Journal of History* 13, no.1 (April 1979): 34.
- <sup>45</sup> Kay Saville-Smith, "The State and the Social Construction of Aging," in *New Zealand's Ageing Society: The Implications*, ed. Peggy Koopman-Boyden (Wellington: Daphne Brassell Associates Press, 1993), 82.
- <sup>46</sup> Angela McCarthy, "Connections and Divergences: Lunatic Asylums in New Zealand and the Homelands before 1910," *Health & History* 14, no.1 (2012): 27.
- <sup>47</sup> Tennant, *Paupers and Providers*, 40.
- <sup>48</sup> Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke: Palgrave Macmillan, 2010), 36.
- <sup>49</sup> Michael Belgrave, "Needs and the State: Evolving Social Policy in New Zealand," in *Past Judgement: Social Policy in New Zealand History*, eds. Bronwyn Dalley and Margaret Tennant. (Dunedin: Otago University Press, 2004), Kindle.
- <sup>50</sup> Discussed in: Thomson, *A World Without Welfare*, 102.
- <sup>51</sup> Discussed in: Tennant, *Paupers and Providers*, 46.

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- <sup>52</sup> Tennant, *Paupers and Providers*, 23. In reality, the role allowed for a high degree of direct influence over asylum operations but only general oversight of over hospitals and charitable institutions, where most of the actual decision-making and implementation occurred at the local level. See: Tennant, *Paupers and Providers*, 40.
- <sup>53</sup> Belgrave, “Needs and the State,” Kindle.
- <sup>54</sup> Gaynor Whyte, “Beyond the Statute: Administration of Old-age Pensions to 1938,” in *Past Judgement: Social Policy in New Zealand History*, ed. Bronwyn Dalley and Margaret Tennant. (Dunedin: Otago University Press, 2004), Kindle.
- <sup>55</sup> Gaynor Whyte, “Beyond the Statute,” Kindle.
- <sup>56</sup> Thomson, “Old Age in the New World,” 160.
- <sup>57</sup> Thomson, *A World Without Welfare*, 162.
- <sup>58</sup> *Ibid*, 163.
- <sup>59</sup> Warwick Brunton, “The Scottish Influence on New Zealand Psychiatry before World War II,” *Immigrants & Minorities* 29, no. 3 (2011): 311.
- <sup>60</sup> Warwick Brunton, “Out of the Shadows: Some Historical Underpinnings of Mental Health Policy,” in *Past Judgement: Social Policy in New Zealand History*, eds. Bronwyn Dalley and Margaret Tennant. (Dunedin: Otago University Press, 2004), Kindle.
- <sup>61</sup> *Ibid*.
- <sup>62</sup> Warwick Brunton, “‘At Variance with the Most Elementary Principles’: The State of British Colonial Lunatic Asylums in 1863,” *History of Psychiatry* 26, no.2 (2015): 160.
- <sup>63</sup> Such as through the influential 1872 report of Dr. Edward Paley, Inspector-General of Lunatic Asylums in Victoria, and the writings of Dr. Frederic Norton Manning, Inspector of Asylums in New South Wales and one of Australia’s most prominent alienists of the nineteenth century. Discussed in: Maree Dawson, “Halting the ‘Sad Degenerationist Parade’: Medical Concerns About Heredity and Racial Degeneracy in New Zealand Psychiatry, 1853-99,” *Health & History* 14, no.1 (2012): 43.
- <sup>64</sup> Warwick Brunton, “A Choice of Difficulties: National Mental Health Policy in New Zealand, 1840-1947” (PhD diss., University of Otago, 2001), 60.
- <sup>65</sup> Brunton, “At Variance with the Most Elementary Principles,” 156.
- <sup>66</sup> Warwick Brunton, “The Place of Public Inquiries in Shaping New Zealand’s National Mental Health Policy 1858-1996,” *Australia & New Zealand Health Policy* 2, no. 24 (2005): 4.
- <sup>67</sup> Brunton, “At Variance with the Most Elementary Principles,” 153.
- <sup>68</sup> McCarthy, “Connections and Divergences,” 19.
- <sup>69</sup> Brunton, “The Scottish Influence on New Zealand Psychiatry,” 312.
- <sup>70</sup> Brunton, “At Variance with the Most Elementary Principles,” 158.
- <sup>71</sup> NZPD [New Zealand Parliamentary Debates] (20 August 1867). Discussed in: Brunton, “At Variance with the Most Elementary Principles,” 158.
- <sup>72</sup> McCarthy, “Connections and Divergences,” 20.
- <sup>73</sup> Brunton, “The Scottish Influence on New Zealand Psychiatry,” 317.
- <sup>74</sup> In 1878, the average cost per patient in Dunedin was estimated at £23 9s 3d. Discussed in McCarthy, “Connections and Divergences,” 31.
- <sup>75</sup> Brunton, “The Scottish Influence on New Zealand Psychiatry,” 318.
- <sup>76</sup> His father, David Skae (1814 –1873), was one of the leaders of psychiatry in Scotland and Physician Superintendent of the Royal Edinburgh Asylum.
- <sup>77</sup> Brunton, “The Scottish Influence on New Zealand Psychiatry,” 319.
- <sup>78</sup> *Lunatics Act* 1882 (New Zealand), No 34, s 19-23.

- <sup>79</sup> Angela McCarthy, "Migration and Madness in New Zealand's Asylums, 1863–1910," in *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*. eds. Angela McCarthy and Catharine Coleborne (Florence: Taylor & Francis Group, 2011).
- <sup>80</sup> Catharine Coleborne, "Immigrants, Mental Health and Social Institutions: Melbourne and Auckland, 1850s–1890s," in *Insanity, Identity and Empire: Immigrants and Institutional Confinement in Australia and New Zealand, 1873–1910*, eds. Coleborne, Catharine, Andrew Thompson, and John MacKenzie (Manchester: Manchester University Press, 2015), 53.
- <sup>81</sup> Catharine Coleborne, "Insanity in the 'Age of Mobility': Melbourne and Auckland, 1850s–1880s," in *Insanity, Identity and Empire: Immigrants and Institutional Confinement in Australia and New Zealand, 1873–1910*, eds. Catharine Coleborne, Andrew Thompson, and John MacKenzie (Manchester: Manchester University Press, 2015), 40.
- <sup>82</sup> Catharine Coleborne, "Mobility Stopped in Its Tracks: Institutional Narratives and the Mobile in the Australian and New Zealand Colonial World, 1870s–1900s," *Transfers* 5, no. 3 (2015): 92.
- <sup>83</sup> McCarthy, "Migration and Madness in New Zealand's Asylums, 1863–1910," 66.
- <sup>84</sup> Coleborne, "Immigrants, Mental Health and Social Institutions," 69.
- <sup>85</sup> *Ibid*, 28.
- <sup>86</sup> Jeremy Bloomfield, "Dunedin Lunatic Asylum 1863-1876" in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, ed. Barbara Brookes (Dunedin: University of Otago Press, 2001), 28.
- <sup>87</sup> John Ainslie Torrance's "Public Institutions" in *Picturesque Dunedin, or Dunedin and its Neighbourhood in 1890 – With a Short Historical Account of the City and its Principal Institutions*, ed. Alexander Bathgate (Dunedin: Mills, Dick & Co., 1890), 73.
- <sup>88</sup> Bronwyn Labrum, "Looking Beyond the Asylum - Gender and the Process of Committal in Auckland, 1870-1910," *New Zealand Journal of History* 26, no. 2 (1992): 125–44.
- <sup>89</sup> *Ibid*, 144.
- <sup>90</sup> *Ibid*, 141.
- <sup>91</sup> Discussed in: Catharine Coleborne, "Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, C. 1880-1910," *Social History of Medicine* 19, no.3 (2006): 425.
- <sup>92</sup> Catharine Coleborne, "Challenging institutional hegemony: family visitors to hospitals for the insane in Australia and New Zealand, 1880–1910," in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, eds. Graham Mooney, Jonathan Reinartz, Clio Medica/The Wellcome Series in the History of Medicine. (Amsterdam: Rodopi, 2009), 303.
- <sup>93</sup> Jeremy Bloomfield, "Dunedin Lunatic Asylum," 22.
- <sup>94</sup> Angus, *History of the Otago Hospital Board*, 20.
- <sup>95</sup> *Ibid*, 20.
- <sup>96</sup> *Ibid*, 23.
- <sup>97</sup> Discussed in: Warwick Brunton, "A Choice of Difficulties," 66.
- <sup>98</sup> Anthony O'Brien and Robert Kydd, "Compulsory Community Care in New Zealand Mental Health Legislation 1846-1992," *SAGE Open* (2013): 2.
- <sup>99</sup> Erik Olssen, *A History of Otago* (Dunedin, N.Z.: J. McIndoe, 1984), 85.
- <sup>100</sup> Discussed in: Brunton, "The Scottish Influence on New Zealand Psychiatry," 314.
- <sup>101</sup> An account of the period is provided by William Lauder Lindsay (1829–1880), a leading physician and alienist who trained in Edinburgh (graduated with an MD in 1852). He travelled to New Zealand in 1861-2 and provided advice on its management of patients with mental illness. See: William Lauder Lindsay, "Suggestions for the Proper Supervision of the Insane and of Lunatic Asylums in the British Colonies," *British and Foreign Medico-Chirurgical Review* 44 (1869): 480–494; William Lauder Lindsay, "Lunacy legislation in New Zealand," *Journal of Mental Science* 18, no. 84 (1873): 498–521.
- <sup>102</sup> Bloomfield, "Dunedin Lunatic Asylum," 21-33.
- <sup>103</sup> Angus, *History of the Otago Hospital Board*, 47.

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- <sup>104</sup> Ibid, 47.
- <sup>105</sup> Olssen, *A History of Otago*, 85.
- <sup>106</sup> Brunton, "At Variance with the Most Elementary Principles," 154.
- <sup>107</sup> Angus, *History of the Otago Hospital Board*, 28. Additional details on asylum staff were provided in Torrance, "Public Institutions," 65.
- <sup>108</sup> Brunton, "At Variance with the Most Elementary Principles," 155.
- <sup>109</sup> Bloomfield, "Dunedin Lunatic Asylum," 22.
- <sup>110</sup> Ibid, 30.
- <sup>111</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 316.
- <sup>112</sup> Aspects of patients' experiences in Ashburn Hall are explored by Elspeth Knewstubb, "Respectability, Religion and Psychiatry in New Zealand: A Case Study of Ashburn Hall, Dunedin, 1882-1910" (Master of Arts in History, University of Otago, 2011), 4.
- <sup>113</sup> Olssen, *A History of Otago*, 86.
- <sup>114</sup> AJHR, *Annual Report on Lunatic Asylums of New Zealand*, 1878, H-10, 1.
- <sup>115</sup> Angus, *History of the Otago Hospital Board*, 50.
- <sup>116</sup> Bloomfield, "Dunedin Lunatic Asylum," 25.
- <sup>117</sup> Ibid, 23.
- <sup>118</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 308.
- <sup>119</sup> Brunton, "A Choice of Difficulties," 240.
- <sup>120</sup> Ibid, 241.
- <sup>121</sup> Discussed in: Warwick Brunton, "Out of the Shadows," Kindle.
- <sup>122</sup> Cheryl Caldwell, "Truby King and Seacliff Asylum, 1889-1907" in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, ed. Barbara Brookes (Dunedin: University of Otago Press, 2001), 35-48.

## Primary and Secondary Sources / Analytical Approaches

### *Identification and Selection of Primary and Secondary Sources*

The first stage of this project involved a literature search of humanities, medical and health-related databases using combinations of keywords relating to the history of mental illness in older people, including use of broad terms such as ‘nineteenth century’, ‘1800s,’ or the ‘Victorian era.’ The literature search encompassed general and more specific medical terms in connection with references to or synonyms for ‘old age,’ ‘older people,’ or ‘elderly.’ This search initially focussed on the range of care and support available to all people diagnosed as having mental disorders within the New Zealand context. Further subanalyses were then conducted on classifications of psychiatric or mental disorders of older people and the history of care of older people, including leading clinical theories and approaches to care in the nineteenth century. A preliminary thematic analysis was conducted based on the collection of secondary sources. This process generated a list of the prevailing concepts, terminologies and range of management options for mental disorders in older people, especially for the time period from 1850 to 1900. Based on the literature on psychopathology and mental disorders in the nineteenth century, a brief glossary was compiled containing relevant diagnostic indicators and classification systems.

The primary sources relevant to this analysis of asylum care of older people with mental disorders included: (i) Committal papers; (ii) Admission documents; (iii) Case notes; (iv) Discharge documents; (v) Mortality records while the patient was admitted in the institution. The range of archival resources that pertained to this project were initially identified by a review of Archway, Archives New Zealand’s system for documenting government records. These are summarised in the next Chapter (*Table 1*). A preliminary review assessed which of the archival material is accessible online, including electronic or scanned records and reports.

Table 1. Archival sources used for this research project

Archival material/ Reference number	Years of holdings	Description	Availability
<b>1. Primary material relating to Dunedin Lunatic Asylum</b>			
<b>Dunedin Lunatic Asylum Provincial Surgeon's Daily Reports</b> Archives NZ reference: Series; DAHI <b>19825</b> D264/1/b; DAHI <b>19825</b> D264/1/c; DAHI <b>19825</b> D264/1/d; DAHI <b>20243</b> D264/35/c	c.1862–1912	Written by the Provincial Surgeon regarding his visits to the Dunedin Lunatic Asylum	Open access; Archives NZ, Dunedin Regional Office
<b>Dunedin Lunatic Asylum Register of Patients</b> Archives NZ reference: Series; DAHI <b>20104</b> D264/93	1863 - 1868	Patients admitted to the Dunedin Lunatic Asylum	Open access; Archives NZ, Dunedin Regional Office
<b>Dunedin Lunatic Asylum Keeper's Journal</b> Archives NZ reference: Series; <b>19827</b>	1863 – 1867	Recorded the daily events at the Dunedin Lunatic Asylum	Open access; Archives NZ, Dunedin Regional Office
<b>2. Primary material relating to both the Dunedin Lunatic Asylum and Seacliff Lunatic Asylum</b>			
<b>Seacliff Mental Hospital Statutory Admission Papers</b> Archives NZ reference: Series; DAHI <b>19850</b> D266	c.1862–1912	Statutory papers related to the committal, admission, and discharge of patients to the Dunedin Lunatic Asylum and Seacliff Lunatic Asylum <sup>1</sup>	Open access; Archives NZ, Dunedin Regional Office
<b>Index to Seacliff Mental Hospital Patient Admission Registers</b> Archives NZ reference: Series; DAHI <b>20103</b> D264/91	c.1863- 1920	Indexes providing access to the Seacliff Lunatic Asylum / Mental Hospital Patient registers	Open access; Archives NZ, Dunedin Regional Office
<b>Seacliff Mental Hospital Medical Casebooks</b> Archives NZ Reference: Series; DAHI <b>19956</b> D265 or D264	c.1863–1916	Details of patient admission, medical history and treatment given while held at the Dunedin Lunatic Asylum or Seacliff Lunatic Asylum. The Medical Casebooks also contain biographical details about the individual, a psychiatric assessment, and a questionnaire completed by the patient's relatives describing their life history, behaviour, and related issues. Some Medical Casebooks included photographs of patients.	Open access; Archives NZ, Dunedin Regional Office
<b>Seacliff Mental Hospital Registers of Discharges, Removals and Deaths</b> Archives NZ Reference: Series; DAHI <b>19990</b> D264	1868 - 1922	Recorded the discharge, removal or death of patients at the Dunedin Lunatic Asylum or Seacliff Lunatic Asylum	Open access; Archives NZ, Dunedin Regional Office

Following correspondence with the Southern District Health Board, an approval letter was obtained for review of the case records from the Dunedin Lunatic Asylum and Seacliff Asylum

for the purpose of the specified historical research. Permission was granted from the Psychiatric Records Department on 18 October 2019 on condition that that the case review process complied with the 100-year restriction on patient information, and that the privacy and confidentiality of the information was ensured.

A sequential sample of 55 patients in the specified age group was selected for patients present in the Dunedin Lunatic Asylum and/or Seacliff Asylum in any of the years from 1863 to 1898. It was decided that details would not be sought on all patients at or over 60 years of age in the time period given the number of in-depth case reviews that would be required and difficulties in achieving this task within the limited timeframe of a Master's project. Inclusion criteria for individuals identified in the records were as follows: (i) confirmed age of 60 years or over at any time during their admission; (ii) date(s) of admission(s) able to be confirmed; (iii) admission records were available to confirm symptoms or diagnosis used to justify admission into the asylum.

Because of travel restrictions in place due to COVID-19, it was not possible for the investigator (AC) to personally travel from his home in Western Australia to Dunedin for review of historical material during the study period (2020-2021). Archivists at the Dunedin Regional Office of Archives NZ and a trained postdoctoral research assistant based in Dunedin were therefore contracted to retrieve and scan the primary source materials outlined in *Table 1* above. The scanned material was then electronically submitted to the investigator (AC) in Western Australia.

The primary source material related to the Dunedin Lunatic Asylum and the first decades of operation of the Seacliff Asylum. Where recorded and available, the following socio-demographic and clinical information was obtained through the process of archival review: (i) Full name; (ii) Age; (iii) Gender; (iv) Country of birth; (v) Place of residence; (vi) Occupation; (vii) Religious affiliation; (viii) Marital status; (ix) Next of kin; (x) Primary/principal diagnosis (reason for admission); (xi) Any secondary diagnoses; (xii) Reported or alleged causation of illness or other exacerbatory factors; (xiii) Admission date(s); (ix) Predominant symptoms / clinical observations during admission; (x) Treatments used; (xi) Discharge date(s) or date deceased; (xii) Cause of death (where relevant).

For the purpose of this research project, all patient names, dates of birth and other specific identifiers were removed, and individuals were assigned random alphanumeric codes. The analytical stage of this project drew on the data and historical themes identified from secondary

and primary sources to conduct an integrative review and draw final conclusions on the patterns of institutional care for older patients (who were 60+ years either at time of first admission, or who ‘attained’ the age of 60 as an existing inpatient or upon re-admission) with mental disorders in this period. Detailed textual analyses of the primary sources were used to evaluate the following social and clinical aspects of patients who were admitted into the asylum: (i) social contexts of the older person’s life outside and within the asylum setting; (ii) descriptors of the older person’s health and personal situation as described during committal, admission and initial diagnosis for older patients; (iii) clinical perspectives and understandings on patient prognosis or the goals of asylum care; (iv) any references to options for - and efficacy of - therapies for these patients; (v) the general experiences and progression of the older individual in the asylum system. As presented in the **Appendices A - D**, statistical approaches were used to generate summaries of the patient frequencies by age, gender, occupational history, marital status and other relevant demographic factors.

### *Use of Asylum Records in Historical Analysis: Issues and Approaches*

In his study of Gartnavel Royal Asylum in Glasgow, Jonathan Andrews (1998) observed in “case notes constitute an especially important and extensive resource” to guide historical analysis of “the changing nature of the experience of the insane in asylums since 1800.”<sup>2</sup> These include “insights into medical treatment and practice...[and] illumination of the inner environment of the hospital or asylum.”<sup>3</sup> Documented patient and staff interactions within the asylum system capture aspects of past lives that may not have otherwise been available in the historical record. However, it is acknowledged that there are significant limitations in the use and interpretation of such medical archival material. Andrews also emphasised that case notes are “not written for historians” and cannot be considered as comprehensive accounts of all patient experiences within the asylum. Case notes primarily served clinical and administrative functions to support the basic maintenance and management of patients within a particular institution setting.<sup>4</sup> Asylum records were also used for official purposes to monitor basic levels of care and compliance with standards: for example, in Britain, these included regular reviews by Lunacy Commissioners from the 1850s, as required by legislation.

Omissions, errors and inconsistencies in terminology and case details are also likely to arise in any patient records. As Angela McCarthy noted in her analysis of New Zealand asylum histories, “record keeping was not uniformly undertaken”; furthermore, casebooks were “not

standardised across all the asylums” and “changed over time.”<sup>5</sup> From the 1870s, some alienists (such as Thomas Clouston in Edinburgh) had promoted the use of more systematic case records and classification systems, partly in order to advance the scientific study of insanity. However, many asylum superintendents and physicians resisted these externally imposed ‘structures’ and continued to record their case notes (or not) according to their own preferences.<sup>6</sup>

One of the major constraints in following patients over time using the Dunedin Lunatic Asylum and Seacliff archives is that the sets of casebooks were incomplete and interrupted across a number of years. In some instances, the only detailed patient descriptions are contained within clinical summaries prepared years after first admission. These summaries have been carried over from earlier material that is no longer accessible. As also noted by McCarthy, these later casebooks cannot be used to provide a continuous record of entry into the asylum because they omit some patients who were admitted in earlier years but then either died or were discharged.<sup>7</sup> For this project, the asylum casebooks were - wherever possible - supplemented by other records, such as admission records, in order to identify earlier patients who may have been “lost” in later summaries. A further online search through Archway (online database for records held at Archives New Zealand) was also conducted to independently check the years of patient admission(s) and discharge(s) or death as recorded in regional health board and relevant legal documents.

In any discussion of historical perspectives of old age and disorders of the mind, it must be acknowledged that a range of different clinical descriptions and terms were applied to older people in asylum care. The clinical terminology in asylum case notes - although appearing somewhat familiar to modern readers - may not fully correspond to current understandings or usage of the descriptive term. As noted by medical historian Günter Risse, for each historical period, “cultural norms, contemporary scientific knowledge, and technological methods [have] decisively shaped our understanding of disease concepts and causality.”<sup>8</sup> One of the leading historians of psychiatry, German Berrios, has also explored the challenges of interpreting descriptions of mental disorders across different time periods.<sup>9</sup> A strict “epistemic” view would imply that comparisons between time periods are highly challenging, because the events only have meaning and value within their own time period.<sup>10</sup> For example, it cannot be assumed that terms such as ‘mania’ have an invariant meaning across different time periods and cultural milieux.<sup>11</sup> Prior to the nineteenth century the term ‘mania’ was often applied more generally to a state of insanity.<sup>12</sup> The specific association of ‘mania’ with markedly elevated mood (more consistent with modern usage) only became established later in the nineteenth century.<sup>13</sup>

More generally, one of the major limitations arising from privileging asylum notes is that it creates a restricted perspective of the experience of mental illness and its management in nineteenth century society. Such records may draw on the accounts of the individual with ill-health, their family members and other witnesses to the patient's illness, but the scope and type of information presented (or omitted) also reflects the personal, socio-cultural and scientific perspectives of the principal health providers and administrators. As Angela McCarthy notes, records of the patients' own experiences and clinical journeys may be "silenced, obscured or invisible because of the power relations of the institutions themselves."<sup>14</sup> Medical records represent summaries of the patient's condition, treatment and predicted outcomes that have been 'filtered' by health providers – such as physicians, superintendents, and attendants – and are 'constructed' using the prevailing terminologies of health professions.<sup>15</sup> Laurence Ray notes that it is challenging to make inferences on "patients' actual motivations or conceptions of their situation except insofar views are mediated through the case notes."<sup>16</sup> Akihito Suzuki has suggested that the alienist and patient are in effect engaged in "a contest for interpretative authority over the act of decoding and defining disease."<sup>17</sup> Suzuki in fact went further in noting that the communication between people with mental disorders and medical professionals in fact often formed a "triad," with "accounts of the [patient's] disease being normally given to the doctor by the third party" (usually the patients' family members, friends or neighbours).<sup>18</sup> Even here, as noted by Catharine Coleborne, there could be contrasts between the 'language' describing mental disorder (and its possible causes) used by affected family members versus the formalised clinical descriptions of mental illness used in asylums.<sup>19</sup>

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### *Primary and Secondary Sources / Analytical Approaches: Notes*

<sup>1</sup> Between 1862 and 1868 these files only contained a Warrant of Commitment, and sometimes an Inventory of Money and Property, or letters from medical staff. Under the Lunatics Act 1868, the admission of an individual into a mental institution became more regulated and required the following papers: (i) Notice of Admission; (ii) Order for Reception of a Lunatic into an Asylum; (iii) Certificate that a Person is a Lunatic and a Proper Person to be Detained under Care and Treatment. Other documents that could also be included with these admission papers included: (i) Inventory of Money and Property (Police Document); (ii) Letters; (iii) Copies of Death Certificates; (iv) Certificate of Discharge.

<sup>2</sup> Jonathan Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," *Social History of Medicine* 11, no.2 (1998): 255.

<sup>3</sup> *Ibid*, 255.

<sup>4</sup> *Ibid*, 266.

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- <sup>5</sup> Angela McCarthy, Catharine Coleborne, Maree O'Connor and Elspeth Knewstubb. "Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health," *Medical History* 61, no. 3 (2017): 365.
- <sup>6</sup> Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum," 260.
- <sup>7</sup> McCarthy, "Lives in the Asylum Record," 366.
- <sup>8</sup> Guenter Risse, "Cause of Death as a Historical Problem," *Continuity and Change* 12 (1997): 178.
- <sup>9</sup> German Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996), 2.
- <sup>10</sup> *Ibid*, 2.
- <sup>11</sup> *Ibid*, 11.
- <sup>12</sup> *Ibid*, 298.
- <sup>13</sup> Edwin Wallace and John Gach, *History of Psychiatry and Medical Psychology* (New York: Springer, 2007), 367.
- <sup>14</sup> McCarthy, "Lives in the Asylum Record," 359.
- <sup>15</sup> Emma Spooner, "'The Mind is Thoroughly Unhinged': Reading the Auckland Asylum Archive, New Zealand, 1900-1910," *Health and History* 7, no. 2 (2005): 64.
- <sup>16</sup> Laurence Ray, "Models of Madness in Victorian Asylum Practice," *European Journal of Sociology* 22, no. 2 (1981): 237.
- <sup>17</sup> Akihito Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century," in *Insanity, Institutions and Society, 1800-1914*, ed. Bill Forsythe and Joseph Melling, Joseph (London: Taylor and Francis, 2013), 116.
- <sup>18</sup> *Ibid*, 116.
- <sup>19</sup> Catharine Coleborne, "'His Brain Was Wrong, His Mind Astray': Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880s-1910," *Journal of Family History* 31, no. 1 (2006): 48.

## Chapter 1. Lives of Older People Outside and Within Asylumdom

### *Ageing and Mental Ill-Health in Nineteenth Century Otago: Personal Journeys and Social Consequences*

The 55 individuals assessed in this project followed diverse life journeys before their first encounters with the asylum system in Otago, and their months or years as asylum residents were also complex. The range of recorded experiences of life “outside” and within asylums are illustrated by the four personal accounts below, based on available records.

- P.B.:

P.B. was born in County Antrim, Northern Ireland, in 1817. Her religious affiliation was listed as Anglican.<sup>1</sup> Online genealogical records<sup>2</sup> indicate that she married and emigrated to New Zealand aboard the SS *Canterbury* and arrived in Port Chalmers in 1880. At the time of her asylum admission in 1883, P.B. was married but separated from her (second) husband, whom she described “a drunken worthless fellow” that she had not seen “for years.” P.B. had four living sons also in Otago at the time of her admission.<sup>3</sup>

At the age of 66, P.B. - then listed as a resident of Dunedin - was arrested on 19 March 1883 for “Lunacy” and transferred to the Seacliff Asylum.<sup>4</sup> At the time of her admission, she was formally diagnosed with “delusions” and “senile dementia.” She believed that her “second husband” (although long separated) was “trying to murder her youngest son by her first husband” and “employs multitudes to do the same.”<sup>5</sup> Subsequent clinical notes reported that she continued to be affected by enduring delusions for many years, which later shifted to a belief “that a son who was drowned many years since is still alive and imprisoned somewhere or other.” Clinical notes for the remainder of 1883 and 1884 reported that otherwise her “general health [was] very good.”

In 1896, the administrators at Seacliff Asylum actively sought financial contributions to care of P.B. from her four living sons.<sup>6</sup> In August 1896, one of her sons, H., a fisherman at Port Chalmers was sent a request from the asylum for 2/- and sixpence towards support of his mother. However H. responded that he “cannot pay even that amount of money” because of “the scarcity of fish” in the previous year. Another son, J., of Mornington had “steady work” and “property.” J. had offered 2/- a week but failed to pay, and Seacliff asylum initiated prosecution proceedings. P.B.’s third living son, A., of Ravensbourne was a described as a

hawker. He was married with seven children, and - on the basis of his family commitments - A. could not offer to pay. Her fourth son, R., owned a hotel in the town of Lawrence. He was approached by Seacliff asylum and appears to have made some regular payments in 1896.

The clinical notes in December 1901 reported that P.B. has exhibited “No mental change” but had experienced “several attacks of syncope [fainting].” Even at this stage, 18 years after her first admission, it was noted that she is “always wanting to get away to her son, whom she can hear calling for her.” P.B. remained in the asylum until her death in October 1904 from a “paralytic stroke.” She was 87 years old.<sup>7</sup>

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- P.C.:

In May 1875, a reference to P.C., a resident of Oamaru, appeared in a regional newspaper relating to a charge of assault. The court proceedings indicate that P.C. repeatedly struck his wife, M., and then locked her out of the house. M. told the court that her husband had not worked for eight months, and had not given her any money to support herself and family (of four children) during that time. M. had been forced to take in washing to provide an income.<sup>8</sup> She also noted that her husband was repeatedly drunk, that he often walked the streets, and was recently observed falling to his knees in the middle of kitchen and starting to pray. The magistrate sentenced P.C. to six weeks’ imprisonment in Dunedin Gaol.

In September 1876, P.C. (at the age of 42) was brought before the Resident Magistrate and then admitted into the Dunedin Lunatic Asylum. His clinical diagnosis at this time was “the first stage of general paralysis”<sup>9</sup> (of the insane; that is, neurosyphilis). Witness accounts noted that P.C. “lies in bed all day and wanders about at night” with no clothing on. His mother, who lived with the family, had died the Friday prior to his committal after being roughly handled by P.C. He had also been seen hurling “his children around like they were logs of wood,” including his six-month old child, who was being thrown “as if he wished to kill it.”<sup>10</sup> A doctor’s examination revealed P.C. to be “weak and sluggish,” of “unclean appearance,” and affected by “hallucinations and illusions,” including that the perception that “there is someone inside him laughing.”<sup>11</sup>

Although at the time of his admission, P.C. had been diagnosed “general paralysis,” which was often a progressive disorder that shortens life expectancy. This conclusion may perhaps be considered less likely given that asylum notes of 1893 indicated that P.C. was still alive, and

in fact described as a “well built and well nourished man.”<sup>12</sup> However, he was “unable to converse rationally,” and his condition at this stage was defined simply as “dementia.” There was “no mental change” reported in 1897. A review in March 1904 indicated that he was “silent old chap” who “was quite deaf.”<sup>13</sup> He was also described as “a good worker.” In 1913, at the age of 80, P.C. died from “valvular disease of the heart.”

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- M.A.:

M.A., a resident of Invercargill, was described in his clinical notes as a “native of Barbados,”<sup>14</sup> although the death notice identified him as a “native of Jamaica.”<sup>15</sup> His religious affiliation was Anglican. He had previously worked as a fisherman based at Horseshoe Bay on Stewart Island.

M.A. was admitted to Dunedin Lunatic Asylum in February 1884 at the age of 73. He had suffered from a “paralytic seizure” which left him “quite imbecile and unable to speak”; furthermore, he could “not understand anything said to him.” He was described as having “almost complete absence of mind.”<sup>16</sup> The notes reported that his son J. “has taken care of him for the last eleven months.” It was reported that M.A. “wanders from home if left alone” and he was “lost in bush for 5 days and very nearly perished.” According to the asylum notes, he was considered “incurable” with “dementia of old age” and “paralysis of speech.” M.A. was transferred to Seacliff in March 1884. He died in May 1884 from “debility of old age.”

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- W.D.:

W.D., a woman from Dunedin, had two recorded asylum admissions. Her first admission was in January 1867 at the age of 49, and she remained there for two years. The clinical notes report that she was affected by “delusions” in which she “fancies she has a great quantity of money” left in a charity school in Liverpool. In May 1867, she escaped from the Asylum but was “retaken in an hour.”

W.D. was admitted a second time from 1870 to her death in 1887. Prior to W.D.’s second admission in September 1870, she was detained in the Dunedin Police Depot. The initial medical examination required for committal was conducted by Edward Hulme and Robert Burns (their roles will be discussed in Chapter 3). It was noted that W.D.’s neighbours were

“afraid of violence to their children” arising from her disordered mental state.<sup>17</sup> W.D. claimed that “people are robbing her.” Burns, one of the committing doctors wrote that “Constable O'Donnell informs me that [W.D.] talks of owning several houses and street cabs which he knows to be a delusion.” She was diagnosed with “delusional insanity.”<sup>18</sup> The notice of admission to the asylum was signed by the Keeper James Hume and medical officer E.W.Alexander (their roles will also be discussed in Chapter 3).<sup>19</sup>

W.D. turned 60 in 1878. The notes for 1882 described: “An elderly woman. Has been in the asylum long prior to my coming. Is a quiet inoffensive woman but full of delusions.”<sup>20</sup> Later in 1882 she was “was seized with a fit in afternoon and on regaining consciousness in half an hour was found to have paralysis on left side.” In June 1885, a letter was sent to the Medical Superintendent of Seacliff from W.D.’s brother requesting a short report on his sister.

In December 1887, W.D. died of “apoplexy” at the age of 70.

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These four summaries indicate the diverse social and demographic backgrounds of older people who were to ultimately experience life within Otago’s asylums. Historians Paul Johnson and Pat Thane have explore various historical understandings of ageing, including in relation to the following personal and social dimensions: (i) *Participation*, including active involvement of older people in civil society, household and communal activities and the labour market; (ii) *Well-being*, including its physical, mental and socio-economic aspects; and (iii) *Status*, referring to the person’s social position as determined by political, legal, cultural and medical norms and customs.<sup>21</sup> These themes will be used to examine the experiences of older people outside and within the asylum system, drawing on the four life accounts above.

In relation to participation, these personal accounts indicate the abrupt transition away from active involvement in the everyday activities of the household and the community. The onset of mental ill-health itself could represent a profound loss of autonomy, a problem that could be further amplified by removal to an asylum. P.B., who was diagnosed with both “delusions” and “senile dementia,” would in all likelihood have experienced a loss in independence from her progressive mental ill-health even before her arrest. With her committal in 1883 (aged 66), P.B.’s external contact with the ‘outside world’ (including her four sons) would have been subject to institutional regulations and reliant on medical approval. The geographical

remoteness of Seacliff would have also uncoupled the individual from familiar community activities and support networks.<sup>22</sup>

There is compelling evidence from these accounts that the onset of mental illness in older people could impact on all aspects of individual wellbeing. In the case of M.A., his mental state (“almost complete absence of mind”) had even resulted in a direct threat to his life: it was noted that he was likely to wander from home, and in the preceding months had been “lost in bush for 5 days and very nearly perished.” The impacts of institutionalisation on different aspects of well-being were complex. Although these individuals entered a nominally therapeutic environment of the asylum, it was by no means certain that they would experience improvements in their mental state. The limited progress toward recovery and independence, and paucity of effective therapeutic options, were demonstrated by the experiences of W.D. She was admitted twice: first from 1867-9 with “delusions” and then second time from 1870 to her death in 1887. At the age of 64 (in 1878), it was noted by the treating physician that W.D. had “been in the asylum long prior to my coming” and that even at this stage she was still “full of delusions.” A reasonable level of physical health could co-exist with ongoing psychiatric problems. For P.B., her delusions – especially those relating to the fate of her youngest son – persisted for at least 18 years after her admission, although it was noted that her “general health [was] very good” until she started experiencing fainting spells in her mid-eighties.

In terms of status, these four individuals underwent substantial transitions in their social position within the established norms of the era, both as a result of their underlying disorder but also because of admission to an asylum. To some extent, familiar social markers - including professional roles and possessions denoting wealth and position - could also be removed or blurred within the “anonymising” asylum context. As Coleborne notes, asylums in both New Zealand and Australia often “housed a large cross-section of society.”<sup>23</sup> The status of the older person within the traditional family structure was potentially undermined, and was often accompanied by a change in social roles from a more senior member of the household to a person now ‘in need’ and potentially subject to the decisions of state authorities and medical professionals.<sup>24</sup> The act of certification and admission also represents a change in legal status, which creates a restricted role for people with mental disorders unlike that associated with the management of most physical disorders.<sup>25</sup> An important measure was status in older age is ongoing ownership or control of property.<sup>26</sup> Direct control of these assets was essentially diminished in socio-legal sense with the diagnosis of ‘insanity’ and in a direct physical sense

with admission into an institution that was in many ways disconnected from wider interaction with the outside.

Medico-legal and diagnostic labels such “lunacy,” “delusions” and “senile dementia” could result in some suspension of personal responsibility - but also of personal rights. For example, for both W.D. and P.C., accounts by neighbours and other witnesses suggest that these individuals both posed an actual or potential risk to members of their own family or other people in the community. P.C. was accused of assaulting his wife, placing his children at risk, and roughly treating his mother, perhaps even contributing to her death. Public awareness (including through accounts in the newspapers) of such violent threats or acts directed towards vulnerable family members would have permanently diminished his social standing within his community. From a legal perspective, the uncontrolled behaviour by P.C. would also have demonstrated that he was no longer mentally competent to care for or make responsible decisions for his four children. Ultimately, P.C.’s opportunities for an ongoing relationship (personal or legal) with members of his family were largely curtailed: he was destined to remain in the asylum from the time of his admission at the age of 42 until his death at 80.

### *Socio-demographic Dimensions*

A summary of socio-demographic characteristics for the entire study population is provided in **Appendix A**. This sample of 55 patients was not obtained through a fully randomised process and is intended to be illustrative but not comprehensive or representative of the entire population of older people in the asylum over this period. To place the study population in a wider context, the overall numbers and proportions of older patients can be ascertained from official Reports on Lunatic Asylums. For example, in 1885 (on 31 December) the number of Seacliff patients over 60 years of age was 16 out of a total of 450 (4%).<sup>27</sup> Ten years later, this absolute number and overall proportion over 60 years of age had increased to 89 out of a total of 561 (16%).<sup>28</sup>

It can be concluded from the limited sample in this study that there were two discrete categories of ‘older’ patients in the asylum: those aged 60+ years at time of asylum admission, and those who ‘attained’ the age of 60 as an existing asylum inpatient or upon re-admission in the period 1863-93. Of those patients aged 60+ years at time of first admission, the mean age at admission was 67 years, compared with 42 years for patients who attained the age of 60. With reference to the four personal accounts above, P.C. provides an example of a patient who ‘transitioned

older': he was admitted at the age of 42 assumed to be in "the first stage of general paralysis." He was later diagnosed with later "dementia," and remained in the asylum, apparently in reasonable physical health (apart from deafness), until his death at the age of 80. This contrasts with the experience of M.A., admitted to Dunedin Lunatic Asylum at the age of 73, diagnosed with "dementia of old age" and "paralytic seizure" that left him unable to communicate; within a few months of his admission M.A. had died. Comparing these two experiences, in the case of P.C., the impact of the mental disorder - and the subsequent placement within the asylum - must be considered over an extended period that encompasses at least half of his entire lifespan. For M.A., the recorded illness and period of institutional care are far more 'compressed' towards the last stages of his life; in fact, it might be argued that the asylum was principally providing a setting for end-of-life care.

Although this study population was not selected in a completely randomised way, the observed gender imbalance (80.0% male) is generally consistent with other sources covering this period. The 1870 *Report on Lunatic Asylums in New Zealand* noted that the daily average number of patients under care in the Dunedin Lunatic Asylum was 105, of which around three-quarters were male.<sup>29</sup> Bloomfield also highlights changes in relative gender frequencies, with higher proportions of younger males in the Dunedin Lunatic Asylum in the years between 1863 and 1876.<sup>30</sup> At Seacliff, summaries from the Reports on Lunatic Asylums indicated that in 1885 (on 31 December) the percentage of male patients at Seacliff across all ages was 65%; for those patients over 60 years of age, 10 of the 16 were male (63%).<sup>31</sup> By 1895, the percentage of male patients across all ages had fallen marginally to 62%; for those patients over 60 years of age, 57 of the 89 were male (64%).<sup>32</sup> Demographic trends from 1850 may partially account for the distinctive gender pattern of asylums admissions. Many of the earlier migrants to Otago and Southland were male, and the gender imbalances became less pronounced only in the early twentieth century. Across the general population, males (for all age groups) comprised 60% of the roughly 70 000 people in Otago and Southland in 1871.<sup>33</sup> By 1891, the census summary for Otago indicates that males and females had become more evenly matched for those under the age of 35, but across older age groups, males could still exceed females by up a factor of two or more.<sup>34</sup>

Compared to female migrants in the colonial period, it is likely that some male subpopulations could not draw on equivalent levels of social support. The younger men who migrated to New Zealand across these early decades of settlement often remained unmarried and most were not accompanied by parents or other relatives.<sup>35</sup> As Barbara Brookes notes, in colonial New

Zealand “[m]arriage protected men from committal [to asylums],” and such men were less likely to engage in jobs (such as mining, rabbiting, gum-digging, and labouring on isolated farms) with limited opportunities for sustained human contact.<sup>36</sup> This pattern of ‘solitary life’ may have increased their risk of developing mental illness, acted to increase their reliance on institutional care when they did become unwell, or reduced the likelihood of successful discharge back into the community. Asylum inspectors even referred to “colonial insanity,” which was attributed to the lack of emotional support or “sympathy” from the “isolation of individuals and families” in settler societies.<sup>37</sup> From the 1870s, population trends start to shift with assisted migration programs that resulted in greater numbers of families travelling together<sup>38</sup>; an alternative was ‘chain’ migration involving a succession of family members shifting to New Zealand over time.<sup>39</sup> For example, as referred to above, P.B., originally from Northern Ireland, had arrived in Dunedin in 1880 and been committed to the asylum in 1883. She had four sons who were also residing in Otago, and a second husband who was apparently now absent.

Prior to admission, around a third of the 55 individuals in this study were resident in the city of Dunedin and environs, with Invercargill and Oamaru the next most common locations. The most frequently recorded regions and countries of birth were Scotland, England and Ireland, which is consistent with the general settlement pattern of Otago, which attracted large number of migrants from Scotland. From the four personal accounts above, M.A.’s background was more unusual in that he was born in the Caribbean, and he had previously lived and worked as a fisherman on Stewart Island before coming to Invercargill. The study population encompassed a wide range of occupations. Various kinds of “labourer,” “miner,” “carpenter” and “farmer” were the most commonly recorded categories for men. For women, no occupation was specified for the majority, but “domestic duties” and “washerwoman” were amongst those which were identified. The experience of P.C. demonstrates the profound consequences of mental illness on capacity for employment: as his wife M. noted, P.C. had not worked for eight months (it was stated that he “lies in bed all day and wanders about at night”) and was repeatedly drunk; P.C. had also spent time in prison before being committed.

For many patients, entry into the asylum also represented a departure from the labour market and an end to financial self-determination. In settler societies, the capacity for self-support and autonomy was not only expected but usually also necessary for basic survival,<sup>40</sup> although many of those in physically demanding jobs were in fact not able to continue with high levels of arduous work over 55 or even 45 years of age.<sup>41</sup> Kay Saville-Smith argues that ‘independence’

was seen as a state connected to having paid work; ‘dependence’ implied exclusion from this state.<sup>42</sup> As Catharine Coleborne has noted, “institutional confinement curtailed the mobility of some immigrants and settlers.”<sup>43</sup> She argues that the migrants’ preconceptions and “ideas about “settling” and life in the colonies” could end up being “disturbed and fragmented by mental illness, showing that hopeful mobility was sometimes dashed by the difficulty of sickness or injury.”<sup>44</sup> In a colonial setting often bound by a strong ethos of self-reliance,<sup>45</sup> the emergence of a severe mental illness could force affected individuals into a state of tenuous employment and even destitution, thereby also affecting their ability to establish enduring social foundations.

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## *Chapter 1: Notes*

<sup>1</sup> Archives New Zealand Dunedin Regional Office (ANZ DRO), “Seacliff Mental Hospital Medical Casebooks,” 547.

<sup>2</sup> WikiTree. (Accessed 31/12/21.)

<sup>3</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>4</sup> Ibid.

<sup>5</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 243.

<sup>6</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>7</sup> Ibid.

<sup>8</sup> *North Otago Times*, 1875, Papers Past <https://paperspast.natlib.govt.nz/newspapers> [Accessed 2/1/2022.] Full newspaper reference omitted to prevent identification of the individual.

<sup>9</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>10</sup> *North Otago Times*, 1876, Papers Past. <https://paperspast.natlib.govt.nz/newspapers> [Accessed 2/1/2022.] Full newspaper reference omitted to prevent identification of the individual.

<sup>11</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>12</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 111.

<sup>13</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 111.

<sup>14</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 622.

<sup>15</sup> *Southland Times*, 1884, Papers Past. <https://paperspast.natlib.govt.nz/newspapers> [Accessed 2/1/2022.] Full newspaper reference omitted to prevent identification of the individual.

<sup>16</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 523.

<sup>21</sup> Johnson, *Old Age from Antiquity to Post-modernity*, 5-16.

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- <sup>22</sup> Ibid, 10.
- <sup>23</sup> Coleborne, *Madness in the Family*, 3.
- <sup>24</sup> Haber, *Beyond Sixty-Five*, 29.
- <sup>25</sup> Roy Porter, "Madness and its Institutions," in *Medicine in Society*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 278.
- <sup>26</sup> Thane, "Social Histories of Old Age and Aging," 99.
- <sup>27</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1886, Session I, H-06, 17.
- <sup>28</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1896, Session I, H-07, 14.
- <sup>29</sup> AJHR, *Report on Lunatic Asylums in New Zealand*, 1870, Session I, D-29, 12.
- <sup>30</sup> Bloomfield, "Dunedin Lunatic Asylum," 22.
- <sup>31</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1886, Session I, H-06, 17.
- <sup>32</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1896, Session I, H-07, 14.
- <sup>33</sup> Olssen, *A History of Otago*, 71.
- <sup>34</sup> "Results of a Census of the Colony Of New Zealand 5th April, 1891," Statistics New Zealand, (Accessed 9/12/2021), [https://www3.stats.govt.nz/historic\\_publications/1891-census/1891-results-census/1891-results-census.html#d50e166710](https://www3.stats.govt.nz/historic_publications/1891-census/1891-results-census/1891-results-census.html#d50e166710)
- <sup>35</sup> Ian Pool, Arunachalam Dharmalingam and Janet Sceats, *The New Zealand Family from 1840: a Demographic History* (Auckland: Auckland University Press, 2007), 74.
- <sup>36</sup> Barbara Brookes, "Men and Madness in New Zealand, 1890–1916," in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994*, eds. Linda Bryder and Derek Dow (Auckland: Pyramid Press, 1995), 205.
- <sup>37</sup> Coleborne, "Families, Patients and Emotions," 429.
- <sup>38</sup> Ibid, 430.
- <sup>39</sup> Thomson, *A World Without Welfare*, 143.
- <sup>40</sup> Thane, "Social Histories of Old Age and Aging," 101.
- <sup>41</sup> Thomson, *A World Without Welfare*, 131.
- <sup>42</sup> Saville-Smith, "The State and the Social Construction of Aging," 79.
- <sup>43</sup> Coleborne, "Insanity in the 'age of mobility' ", 42.
- <sup>44</sup> Coleborne, "Mobility Stopped in Its Tracks," 95.
- <sup>45</sup> Catharine Coleborne, "White Men and Weak Masculinity: Men in the Public Asylums in Victoria, Australia, and New Zealand, 1860s-1900s," *History of Psychiatry* 25, no.4 (2014): 470.

## Chapter 2. Entering the World of the Asylum: Rationales for Committal and Admission

### *Defining 'Lunacy' and Legal Implications for Older People*

Across the time period covered by this project (1863-1898), the initiation of committal proceedings and admission into an asylum under 'medical management' were viewed as socially-sanctioned methods for dealing with the 'insane.'<sup>1</sup> Under the 1882 *Lunatics Act*, the formal process of certification and committal required involvement of Resident Magistrate and medical review by two medical practitioners to confirm the diagnosis of a mental disorder or impairment. Under this Act, the term "Lunatic" applied to "any insane person, idiot, lunatic, or person of unsound mind and incapable of managing himself or his affairs."<sup>2</sup> Lunatics were further separated into groups, including "Dangerous Lunatics" (denoting a "derangement of mind, and a purpose of committing suicide or some crime for which he would be liable to be indicted"), "Lunatics at large, or insufficiently cared for," and "Lunatic Prisoners."<sup>3</sup> Older people undergoing committal proceedings could be framed within these categories depending on their nature of - and the official responses to - their 'disorder.' For example, in 1878, J.A., a 67-year-old widowed nightman from Palmerston who had been in New Zealand for 13 years (including four years as a soldier in the North Island), was seen "wandering from his home with a hatchet."<sup>4</sup> He was arrested and admitted with "melancholia with delusions," and was identified as a "drinker" with a past history of "convulsions and Delirium Tremens." He was described as "a Lunatic wandering at large and not under proper care and control." A lack of external social support was also one of the deciding factors in favour of asylum care, and some of the individuals identified in this study appeared to have been living in a state of destitution. For example, D.A., a 60-year-old male labourer from Silverstream, was admitted in 1883 with "acute mania" and "delusions," was described as a "weak starved looking creature has evidently not been sufficiently fed for some time past."<sup>5</sup>

On the journey towards admission, individuals would typically find themselves subjected to a series of legal and medical procedures designed to ascertain their mental state, behaviour and capacity for self-care. This process would often involve obtaining relevant accounts from family members, the constabulary (if involved), and other witnesses.<sup>6</sup> As the number and capacity of New Zealand's asylums expanded from the 1850s, institutionalisation under

medical control - coupled with restriction of many basic freedoms for those patients recorded as being 'insane' - was becoming increasingly legitimised as a social solution. Records of direct contact with the constabulary and connections with the prison system (even if temporary) were a relatively common feature of this committal and admission process. For a number of individuals in this study, the reasons given for arrest often made specific reference to "Lunacy," and the related committal papers included police reports of the behaviour at the time, such as violence, threatening behaviour, or actions perceived as socially unacceptable or unusual (such as "wandering about the streets aimlessly"). An example is provided by J.C., who is recorded as being admitted to Otago's asylums three times over his lifetime: 1865, 1869-70 and 1871-1908. J.C., originally from Scotland, had been an unmarried farm servant in New Zealand. Various diagnosis and clinical descriptive terms were applied across his multiple admissions. The diagnosis in the second admission (when he was 40) was "mania." Witnesses reported that he had "threatened to kill people" and was observed "rushing forward and trying to stop horses in the streets."<sup>7</sup> In 1871, J.C. - then resident in Clyde - was arrested and noted in his committal documents to be "wild and destructive" and "delusional," with a "confusion of ideas."<sup>8</sup> During this third admission, he turned 60 in 1889. A clinical review in 1893 (at aged 64) noted that J.C. was a "[v]ery powerfully built man [and] exceedingly well-nourished" with a "massive head and face" and a "very bull dog and criminal aspect."<sup>9</sup> In September 1908, J.C. died at Seacliff at the age 79 from "chronic valvular [heart] disease."<sup>10</sup>

Descriptions relating to self-harm and suicidality featured prominently in the committal and admission process for some patients, as illustrated by the experiences of N.A. Originally from Norfolk in England and resident in New Zealand from the early 1860s, N.A. had been a hotel-keeper in Invercargill since 1869.<sup>11</sup> In September 1882, N.A. was committed and admitted to the Dunedin Lunatic Asylum; at the time, he was 64 years of age and married, with a daughter living in Hobart. The committal papers reported that N.A. had recently been experiencing "extreme melancholy"<sup>12</sup> and had also attempted to commit suicide.<sup>13</sup> More specifically, he had "made an attempt on his life...having endeavoured to stab himself with a dinner knife": this resulted in "a deep flesh wound" in "the region of heart."<sup>14</sup> N.A. was also "suffering from insomnia" and "very restless and suspicious." This was accompanied by a fixed belief that he had been "ruined" and was "now penniless," although, in her witness account, his wife S. seemed to indicate otherwise. In fact, his wife S. agreed to pay Dunedin Lunatic Asylum "two guineas per week for maintenance, care and medicine." N.A. remained in the asylum until his death early the following year as a result of seizures and debility from his refusal to eat.<sup>15</sup>

Self-injury manifested in complex ways and could be difficult to predict or prevent. In 1882, B.A., a 62-year old male customhouse officer resident for 14 years in New Zealand and originally from Sutherlandshire in Scotland, was affected by severe persecutory delusions and became convinced that “he has committed some great crime and has injured his wife in some way, there being no truth in such statements.”<sup>16</sup> This patient also feared that he would be “killed like a sheep” and “roasted” or “boiled in hot water.”<sup>17</sup> He had then “[t]ried to drown himself in Clutha River and has on several occasions recently endeavoured to force various articles down his throat such as corks - pieces of bone etc.” On his admission, the medical instructions specified that B.A. “must be watched carefully.”<sup>18</sup>

For individuals with a mental disorder and an actual or supposed propensity to violence, asylum-based management was therefore used as a means (apart from imprisonment) of addressing concerns about the safety of the individuals themselves, their family members, and the surrounding community.<sup>19</sup> Based on the records for the study population, it is difficult to assess the relative likelihood of violence being initiated by those patients who were aged 60 years and over. A number of individuals in this age group were described as being “kind”, “good-natured” and “harmless,” while others were profoundly affected by “melancholia” or loss of cognitive function. Such descriptions were at odds with some of prevailing perceptions that asylums primarily housed ‘dangerous lunatics.’

More generally, the formal definition of ‘insanity’ from a medico-legal perspective was contested throughout the nineteenth century. The criteria for being classified as a ‘lunatic’ were often ill-defined, and significant limitations were acknowledged even at the time. William A.F. Browne, famed Scottish asylum doctor and author of the influential 1837 treatise *What Asylums Were, Are and Ought to Be*, attempted a relatively broad definition and tied in references to brain pathology: he considered insanity to be “inordinate or irregular, or impaired action of the mind, of the instincts, sentiments, intellectual or perceptive powers” associated with “an organic change in the brain.”<sup>20</sup> In his 1854 book *Medical Testimony and Evidence in the Cases of Lunacy*, English physician Thomas Mayo suggested that a characteristic of insanity was that the affected individual’s “intellect has been perverted.”<sup>21</sup> However, many of these attempts at classification were not directly useful in a legal context when deciding on the need for committal, and could even result in “ridicule” of physicians in courts of law because of the “great variety, and sometime total dissimilarity, of opinions entertained by them with reference to the correct definition of insanity.”<sup>22</sup> In *Remarks on Insanity* (1850), Henry Monro - the last in a line of five generations of high-profile physicians, all of whom had treated mental illness

- pointed to more general failings of the classification process: “All who have charge of charge of asylums must well know how very different the clear and distinct classifications of books” are from “that medley of symptoms which is presented by real cases.”<sup>23</sup>

There was also limited consistency in the official certifications of a mental disorder for the purposes of committal. As historian David Wright observed in his analysis of the certification process in Victorian Britain: “there was no checklist of symptoms upon which the doctor should comment, merely the admonition that *something* had to be written.”<sup>24</sup> Wright also noted that committal documents tended to focus on brief descriptive statements of the patient’s unusual behaviour, but there was usually limited evidence of the committing doctors referring to or drawing on contemporary concepts of ‘neuro-psychiatric theory’ to justify either their diagnosis or proposed management of the patient.<sup>25</sup> This brief and matter-of-fact style of medical assessment is evident in many of the committal documents identified in this study, as shown in the description of 76-year old woman H.B. (arrested in Oamaru in 1883) as a “poor feeble old woman with only one tooth left” who was “incoherent in thought and speech.”<sup>26</sup> Asylum doctors, in comparison, were more likely to apply formal diagnostic terms to their patients, and – given the advantages of more prolonged contact – could explore and reflect on possible aetiologies, exacerbating factors and the overall clinical course.

More generally, various explanations have been presented to account for these patterns of committal and admission in the ‘asylum era.’ British historian Emily Andrews has argued that one of the functions of asylums and related institutions for people with mental disorders related to “absorbing and containing unmanageable and undesirable behaviour.”<sup>27</sup> A number of social theorists in the 1960s and 1970s - such as Foucault in *Madness and Civilization* (1961) and *The Birth of the Clinic* (1963), or David Rothman in *Discovery of the Asylum* (1971) - had speculated on the role of asylums as part of an organised system of ‘social control’ for non-conforming groups in the community. It has also been proposed that the ‘mad poor’ were formally sequestered - and in effect, punished - because they were effectively unable to work and therefore interrupted the operation of modern capitalist economy; alternatively, these individuals were seen as the unfortunate “casualties” of the brutal and destabilising process of industrialisation.<sup>28</sup> As Bronwyn Labrum argues, these authors had often emphasised the “social functions” of committal, in which authorities targeted those labelled ‘mad’ because they “represented threats to persons, property, law and order and “articulated moral norms.”<sup>29</sup>

However, explanations that largely centred on centrally-directed decisions simply to manage ‘inconvenient people’<sup>30</sup> (to use Andrew Scull’s term) have been criticised and are not supported

by more nuanced analyses of the historical evidence. As John Walton notes in his discussion of pauper lunatics, “it is difficult to show...that the asylum population was dominated by a subculture of the disorderly poor, chosen for the threat they posed to property, decorum and the social order.”<sup>31</sup> More recently, historians have emphasised the role of the families, neighbours and local authorities in directing ‘challenging’ people with mental disorders towards institutional care.<sup>32</sup> In the New Zealand context, Labrum has examined the often-neglected role of family members in the committal process, including the importance of “domestic and social crisis as catalysts for admission.”<sup>33</sup> In the context of Victorian Britain, John Walton’s examination of the context of case admissions to the Lancaster Asylum also indicated that various “domestic troubles” were the main drivers of committal, including families who had reached their emotional and financial limits in terms of providing care.<sup>34</sup> The “multiple uses” of the asylum by working class families in the nineteenth century were highlighted in Constance McGovern’s study of the State Asylum in Harrisburg, Pennsylvania. McGovern concluded that older people often entered asylums because their families had reached the end of their practical or psychological capacity to provide ongoing care, often after many years of home management.<sup>35</sup> The shift to institutional care could arise, for example, if the older person had become “violent, disruptive or difficult to handle.”<sup>36</sup>

In summary, the question of whether the older person could continue to be managed in a particular familial or social environment was likely to be more pertinent than any coordinated government agenda to have such individuals formally classified or certified as ‘insane.’<sup>37</sup> Historians have argued that kin support for older people during nineteenth century was often not as extensive or as benevolent as had been previously assumed, and that other options for care were often necessary.<sup>38</sup> In some situations, families may have already resorted to ‘informal’ options for their relatives affected by mental disorders, such as through the use of outhouses, locked rooms, or cellars.<sup>39</sup> In his analysis of people with dementia in various Australian asylums during the nineteenth century, Brian Draper noted that often the condition “had been present for years and it was severe behavioural change that led to admission”; other contributing factors were an evident lack of capacity for self-care in the individual or financial constraints affecting the family.<sup>40</sup> A similar range of issues were identified in Edgar-André Montigny’s analysis of Rockwood Asylum in Ontario (1866-1906), which revealed that the majority of older patients were described as being “uncontrollable” (including reports of older family members who went wandering for miles or were found standing on railway tracks), “violent to themselves or others,” (such as attempting to burn down their homes with family

members inside), and/or “suicidal.”<sup>41</sup> As British historian Emily Andrews has noted, in many situations “it was a family member who made the initial approach to the authorities to set the process of certification in motion...it was the family, not the medical authorities, who turned a person into a ‘patient’.”<sup>42</sup>

Andrew Scull has speculated on another social factor that may have influenced committal decisions: the role of perceptions of shame and public disgrace associated with having a person with mental illness in the household.<sup>43</sup> Asylums, especially those situated in more remote locations away from major centres, were seen as a way of ‘hiding’ the affected person from public view. In his 1993 analysis of ‘madness’ and society in Britain, Scull argued that individuals with mental illness could find themselves incarcerated in a “state-supported asylum system which isolated them both physically and symbolically from the larger society.”<sup>44</sup> This description reflects some elements of the experiences of older patients at the Dunedin Lunatic Asylum or, even more notably, at the relatively remote and self-contained Seacliff facility. However, as Foucault once observed, such approaches to madness can create a contradictory effect: “Confinement hid away unreason, and betrayed the shame it aroused; but it explicitly drew attention to it, pointed to it.”<sup>45</sup> However, there was often ambivalence within families - and Victorian society more generally - on the reliance on asylums.<sup>46</sup> Evidence from Canada from the 1860s to 1890s indicates that many families preferred community care options for their older relatives, and viewed admission to the asylum as a “last resort.”<sup>47</sup>

### *Crossing the Institutional Threshold*

Clinical descriptions at the time of committal and admission highlight characteristics of the older person that were seen as particularly warranting entry into the asylum setting. For this study population, **Appendix B** provides a summary table of the primary diagnoses at the time of committal and admission (where known) and their relative frequencies across the total population and subgroups.<sup>48</sup> Common diagnostic groups included various disorders relating to older age, such as “Senile decay”, “Senile dementia” or mental effects relating to “debility” and “old age.” Based on age of admission, all ten cases who received the diagnosis “senile decay” or “senile dementia” occurred in patients admitted at or over 60 years of age. A marked or progressive decline in overall level of cognitive functioning - which often included significant impairments in memory and diminished capacity for self-care - appears to have been a contributing factor. Of the other conditions described at the time of admission, the presence

of delusions was amongst the most common. These delusions were frequently of a persecutory or threatening nature, and in many records aligned with the formal diagnosis of “delusional insanity.” For example, A.A., a 60-year-old male cabinet maker and carpenter from Brighton who had been in New Zealand for 16 years, was admitted in 1880 with “delusional insanity” and a history of “heavy” alcohol consumption. He was “talking in a wild and incoherent manner.” It was also noted that he “[b]elieves he is sentenced to be hanged,” a perception that appeared to be related to A.A.’s past involvement in a manslaughter case.<sup>49</sup> Another affected individual was M.F., a 67-year-old ploughman living in Waiholo and originally from County Tyrone in Ireland. M.F. was admitted in 1882 with “dementia” and delusions that “six thousand soldiers” were pursuing him and wished to take his life.<sup>50</sup>

Other historical studies of asylum populations prior to 1900 have also indicated that comparable reasons given for committal and admission.<sup>51</sup> For example, Trevor Turner’s detailed analysis of the private Ticehurst House Asylum in Sussex found references to “delusions” (or phrases including that term) in 48.6% case notes for patients admitted between 1850-1889.<sup>52</sup> For individuals first admitted at or over the age 60 years, the broad range of reported conditions in the Otago asylums is also comparable to other international studies of asylum populations, with common classificatory terms in admission notes including “senility,” “senile dementia,” or simply “old age.”<sup>53</sup> The term “senile decay” was also frequently used to describe this group of patients.<sup>54</sup> In the New Norfolk Lunatic Asylum in Tasmania, the term “dementia” was applied to 74% of patients aged 60 years or over in the 1890s, and many also had the presumed “cause of insanity” listed as “old age” or “senile decay.”<sup>55</sup> In the 1859 report *On the State of Lunacy and the Legal Provision of the Insane*, it was noted that Worcester Asylum admitted numerous patients over the age of 60, many of which were considered to be affected by the “superannuation of old age.”<sup>56</sup> Graeme Yorston’s analysis of 250 older people (aged 60+) patients admitted into two asylums in Oxfordshire between 1826 and 1899 indicated a range of disorders, with the most common being “dementia” (45.2%), “mania” (32.8%) and “melancholia” (16.4%).<sup>57</sup>

For a number of patients in this project, the available admission notes made references to, or speculated on, the aetiology of the condition or possible precipitating factors. Personal and social factors were referred to as triggering or exacerbating the individual’s mental condition, including the effects of trauma and grief. According to the 1863 records, S.B., a 68-year-old woman living in Dunedin (originally from Scotland), was admitted with “dementia.” It was observed that she “sits with her head perpetually down on her chest” and “takes no notice” of

her surroundings.<sup>58</sup> Her physicians believed that she had become “insane on hearing of the death of her son on her arrival in the colony from home.” It was noted that in fact her son “had sent for her [from Scotland] and was drowned on the coast before her arrival.”<sup>59</sup> This reference to the overwhelming personal events reflects the conclusions of Catherine Coleborne, who noted that “extreme emotional imbalance,” such as grief, were widely accepted as causes of insanity in the nineteenth century.<sup>60</sup> As Coleborne notes, other patient records also refer to potential triggering factors for the mental disorder, such as “bereavement” or “family disputes.”<sup>61</sup>

A range of other health-related conditions raised the likelihood that an older person would be considered for entry into the asylum system. References to excessive alcohol consumption and its health consequences appeared in a number of the reviewed committal papers and admission notes. An example is provided by Q.A., a 65-year-old married fruit-merchant resident from Dunedin (originally London). Q.A. was admitted in April 1877 for one month, and again in May 1878 for two months, with the diagnosis of “delirium tremens.” The 1877 clinical notes reported that Q.A. “howls and barks like a dog at short intervals” and “has threatened violence several times,” including driving his daughter out of the house after trying “to strike her with the poker.”<sup>62</sup> He claimed that he was “being starved by his family [wife and sons] who wish to kill him.” In the 1878 admission papers, witnesses reported that he “wanders about town all night unless supplied with alcoholic drink.”<sup>63</sup> It was noted that he had experienced multiple previous attacks, including with convulsions, and “[h]ad been a heavy drinker at somewhat long intervals for 25 years.”<sup>64</sup>

Excessive alcohol use was seen by many nineteenth century physicians as playing a significant role in the development or exacerbation of mental illness, especially amongst men.<sup>65</sup> The attribution of mental disorders to alcohol intake was noted in many asylums internationally. For example, based on Allan Beveridge’s 1995 study of ‘madness’ at the Royal Edinburgh Asylum, alcohol excess was increasingly referred to as a cause of insanity for both men and women as the nineteenth century progressed.<sup>66</sup> There was broad agreement that the adverse health effects from alcohol could be manifested in various forms, such as ‘alcoholic mania’ (also called ‘*mania a potu*,’ or pathological alcohol intoxication leading to extreme disinhibition and violent behaviour), delirium tremens (a period of mental confusion arising from alcohol withdrawal after chronic consumption, formally described and labelled by English physician Thomas Sutton in 1813), and alcoholic dementia.<sup>67</sup> A propensity to excessive

alcohol consumption was viewed by some authorities as a disease in itself.<sup>68</sup> In 1851, the Swedish physician Magnus Huss formally introduced and defined the term ‘alcoholism.’<sup>69</sup>

According to Provincial Surgeon Edward Hulme, up to half of patients admitted into Otago’s asylums between 1863-68 had conditions that were related to or affected by their alcohol intake.<sup>70</sup> In 1876, during his tenure as Inspector of the Dunedin Asylum, Duncan MacGregor had written an article for the *New Zealand Magazine* in which he suggested that people with habitual and extreme drinking problems were suffering from a “neurotic disease” with a hereditary basis.<sup>71</sup> In the case of delirium tremens, in 1877 it was noted by Inspector of Lunatic Asylums Frederick W. A. Skae that in New Zealand the condition was viewed (and in fact explicitly included in the *Lunatics Act* of 1868) as a form of “insanity” and seen as a legitimate reason for admissions into asylums - “especially at Dunedin.”<sup>72</sup> Under the *Lunatics Act* of 1882, a separate Chapter covered the legislation relating to “Habitual Drunkards,” including those “suffering from delirium tremens or other dangerous physical effects of habitual drunkenness.”<sup>73</sup> The physical and mental complications of alcohol use are consistent with the elevated patterns of consumption recorded as a feature of life in Otago since the start of European settlement, despite pressure from Protestant settlers who - at least publicly - favoured self-control and even prohibition in relation to alcohol consumption. “Copious supplies of alcohol” (notably beer and whiskey) were imported which - when further supplemented by potent home brews - “lubricated every public function.”<sup>74</sup> The Otago Gold Rush from the 1860s also encouraged an influx of diggers - often unmarried younger men - with a reputation for drinking. As Olssen notes: “[t]o the horror of the Presbyterians the miners drank and gambled with abandon...hastily improvised pubs and shanties became the centres for social life.”<sup>75</sup> High rates of delirium tremens were noted in New Zealand’s other frontier settlements, such as Hokitika during the West Coast Gold Rush, where the Surgeon-Superintendent reported markedly high rates of ‘lunacy’ directly linked to alcohol consumption.<sup>76</sup>

Another basis for asylum admission included the disorders with a reasonably well-recognised (or assumed) aetiology or physiological cause, including various ‘neurological’ disorders. This spectrum included reports of persistent seizures, strokes, “disseminated sclerosis” (now referred to as multiple sclerosis), and movement disorders, such as paralysis agitans (Parkinson’s disease). For example, G.E., a farmer from Southland, was admitted twice in 1873 and then again from 1875 to 1901. He was diagnosed initially with “general paralysis of the insane” but then subsequently with “disseminated sclerosis” (multiple sclerosis). In 1890, he turned 60, at which time he was described as “a harmless old man.”<sup>77</sup> He was affected by a

combination of complex delusions (including that he “imagines his neighbours have been injuring his cattle with the object of ruining him”), but also tremor - especially in lower limbs – as well as difficulty in speech. His physicians concluded that “quite apart from his mental state[,] his nervous complaint renders him totally unfit to do anything whatever for himself in the way of earning a living.” G.E. died in November 1901.

A number of male patients were admitted into the Dunedin Lunatic Asylum and Seacliff with signs of neurosyphilis. In some cases, admission records indicated the progression of the disorder, which could be relatively rapid in the late stages. For example, 62-year-old cabdriver E.A., originally from Northamptonshire in England and resident in New Zealand for twelve years,<sup>78</sup> was admitted in September 1882 with “general paralysis” (neurosyphilis). E.A. displayed a “loss of memory in a high degree,” and he was also found “to be suicidal.”<sup>79</sup> Within three months of admission he had experienced a “fit of some kind” as a result of which he “lost the use of [his] right side”; this patient then died two months later. For V.A., a 65-year-old farmer from Lawrence (originally from Cornwall and 20 years on the colony), it was noted on his admission in 1880 that he had general paralysis that was “far advanced,” with memory loss and “extravagant delusions.”<sup>80</sup> This patient died the following year.

The manifestations of neurosyphilis were increasingly recognised in the nineteenth century, including the condition termed ‘general paralysis of the insane’ (also called *dementia paralytica*). The complex clinical pattern of advanced syphilis was a topic of intense debate amongst physicians of the Victorian era, including the nature of the underlying pathological processes that could cause both paralysis and dementia in the later stages of the illness.<sup>81</sup> Mania and delusions (often delusions of grandeur) were also commonly reported in GPI, creating a striking contrast of patients with an expansive and grandiose mental state coupled with a debilitated and failing physical state.<sup>82</sup> The appearance of GPI - described by Scottish alienist Thomas Clouston as the “most terrible of all brain diseases” - was widely understood to be an ominous sign.<sup>83</sup> Studies on the relatively high prevalence of neurosyphilis/GPI, especially amongst males, have been reported in other institutions of the era (including asylums in Auckland and Yarra Bend in Melbourne).<sup>84</sup>

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## Chapter 2: Notes

<sup>1</sup> Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), 109

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- <sup>2</sup> *Lunatics Act* 1882 (New Zealand), No 34, s 2.
- <sup>3</sup> *Lunatics Act* 1882 (New Zealand), No.34, s 42.
- <sup>4</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”
- <sup>5</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 582.
- <sup>6</sup> *Lunatics Act* 1882 (New Zealand), No 34, s 19-23.
- <sup>7</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”
- <sup>8</sup> *Ibid.*
- <sup>9</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 64.
- <sup>10</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 64.
- <sup>11</sup> Invercargill Archives, <http://archives.ilibrary.co.nz> [Accessed 3/1/2022]
- <sup>12</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”
- <sup>13</sup> *Ibid.*
- <sup>14</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 525.
- <sup>15</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 526.
- <sup>16</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”
- <sup>17</sup> *Ibid.*
- <sup>18</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 518.
- <sup>19</sup> Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven: Yale University Press, 1993), 323.
- <sup>20</sup> Quoted in Scull, *The Most Solitary of Afflictions*, 346.
- <sup>21</sup> *Ibid.*, 345.
- <sup>22</sup> William B. Neville, *On Insanity: Its Nature, Causes and Cure*, 1836. Quoted in Scull, *The Most Solitary of Afflictions*, 347.
- <sup>23</sup> *Ibid.*, 346.
- <sup>24</sup> David Wright, “The Certification of Insanity in Nineteenth-Century England and Wales,” *History of Psychiatry* 35, no.9 (1998): 280.
- <sup>25</sup> *Ibid.*, 280.
- <sup>26</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”
- <sup>27</sup> Emily Andrews, “Institutionalising Senile Dementia in nineteenth century Britain,” *Sociology of Health Illness* 39, no. 2 (2017): 248.
- <sup>28</sup> Porter, “Madness and its Institutions,” 287.
- <sup>29</sup> Labrum, “Looking Beyond the Asylum,” 126.
- <sup>30</sup> Scull suggested that for much of the nineteenth century “the asylum remained a convenient way to get rid of inconvenient people.” See: Andrew Scull, *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia: University of Pennsylvania Press, 1981) 16.
- <sup>31</sup> John Walton, “Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840 – 70” in *The Anatomy of Madness: Essays in the History of Psychiatry - Institutions and Society*, eds. William F. Bynum, Roy Porter, and Michael Shepherd (London: Tavistock, 1985), 138.
- <sup>32</sup> Andrews, “Institutionalising Senile Dementia,” 248.
- <sup>33</sup> Labrum, “Looking Beyond the Asylum,” 126.
- <sup>34</sup> Walton, “Casting Out and Bringing Back in Victorian England,” 139.
- <sup>35</sup> Constance McGovern, “The Community, the Hospital, and the Working-Class Patient: The Multiple Uses of Asylum in Nineteenth-Century America,” *Pennsylvania History* 54, no. 1 (1987):17-33.

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- <sup>36</sup> Edgar-André Montigny, *Foisted Upon the Government?: State Responsibilities, Family Obligations, and the Care of the Dependent Aged in Late Nineteenth-Century Ontario* (Montreal, Que: McGill-Queen's University Press, 1997), 819.
- <sup>37</sup> Andrews, "Institutionalising Senile Dementia," 249.
- <sup>38</sup> Theodore Hoppen, *The Mid-Victorian Generation, 1846-1886* (Oxford: Clarendon, 1998), 317.
- <sup>39</sup> Walton, "Casting Out and Bringing Back in Victorian England," 136.
- <sup>40</sup> Brian Draper, "Dementia in Nineteenth-Century Australia," *Health and History* 23, no. 1 (2021): 45.
- <sup>41</sup> Montigny, *Foisted Upon the Government?*, 828.
- <sup>42</sup> Andrews, "Institutionalising Senile Dementia in nineteenth century Britain," 248.
- <sup>43</sup> Scull, *The Most Solitary of Afflictions*, 309.
- <sup>44</sup> *Ibid*, 1.
- <sup>45</sup> Foucault, *Madness and Civilization*, 70.
- <sup>46</sup> Scull, *The Most Solitary of Afflictions*, 309.
- <sup>47</sup> David Wright, James Moran and Sean Gouglas, "Hamilton and Toronto Asylums, Canada, 1861-1891," in *The Confinement of the Insane: International Perspectives, 1800-1965*, ed. Roy Porter and David Wright (Cambridge; New York: Cambridge University Press, 2003), 105.
- <sup>48</sup> As noted in the preceding chapter, this sample of 55 patients was not obtained through a fully randomised process and is intended to be illustrative but not comprehensive or representative of the entire population of older people in the asylum over this period. Terms such as 'schizophrenia' and 'bipolar disorders' were not current in this period, and use of the term 'depression' for a discrete diagnostic condition was not yet established.
- <sup>49</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>50</sup> *Ibid*.
- <sup>51</sup> Bloomfield, "Dunedin Lunatic Asylum," 27.
- <sup>52</sup> Trevor Turner, "A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890," *Psychological Medicine* S21 (1992): 19.
- <sup>53</sup> Coleborne, "White Men and Weak Masculinity," 471.
- <sup>54</sup> Scull, *The Most Solitary of Afflictions*, 371.
- <sup>55</sup> It is probable that the diagnostic grouping of 'dementia' would have included individuals who today would be classified as having chronic schizophrenia or other long-term neuropsychiatric disorders. See: Anthea Vreugdenhil, "'Incoherent and Violent If Crossed': The Admission of Older People to the New Norfolk Lunatic Asylum in the Nineteenth Century," *Health and History* 14, no.2 (2012): 99.
- <sup>56</sup> John Aldridge, *On the State of Lunacy and the Legal Provision of the Insane* (London: Churchill, 1859), 25.
- <sup>57</sup> Yorston, "Old and Mad in Victorian Oxford," 408.
- <sup>58</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 43.
- <sup>59</sup> This account could relate to a tragedy in 1861 in which a smaller boat moving between two larger ships became swamped at the mouth of the Taieri River mouth, resulting in the drowning of a ship's captain (aged 31). The captain, also from Scotland, had the same surname as S.B.. His body was never recovered. *Otago Witness*, 1861. Papers Past. <https://paperspast.natlib.govt.nz/newspapers> [Accessed 10/1/2022.] Full newspaper reference omitted to prevent identification of the individual.
- <sup>60</sup> Coleborne, "Families, Patients and Emotions," 432.
- <sup>61</sup> *Ibid*, 433.
- <sup>62</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>63</sup> *Ibid*.
- <sup>64</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 10.
- <sup>65</sup> Coleborne, "White Men and Weak Masculinity," 470.

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- <sup>66</sup> Allan Beveridge, "Madness in Victorian Edinburgh: A Study of Patients Admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908. Part I," *History of Psychiatry* 6, no.22 (1995): 37.
- <sup>67</sup> German Berrios and Roy Porter, *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), 659.
- <sup>68</sup> Bloomfield, "Dunedin Lunatic Asylum," 27.
- <sup>69</sup> Berrios, *A History of Clinical Psychiatry*, 661.
- <sup>70</sup> Jeremy Bloomfield, "Dunedin Lunatic Asylum," 26.
- <sup>71</sup> See: Brunton, "A Choice of Difficulties," 199.
- <sup>72</sup> In comparison, in Britain, patients with delirium tremens usually only ended up in asylums 'by mistake.' See: McCarthy, "Connections and Divergences," 26.
- <sup>73</sup> *Lunatics Act* 1882 (New Zealand), No.34, s 42.
- <sup>74</sup> Olssen, *A History of Otago*, 45.
- <sup>75</sup> *Ibid*, 61.
- <sup>76</sup> Discussed in: Brunton, "A Choice of Difficulties," 54.
- <sup>77</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 98.
- <sup>78</sup> *Otago Daily Times*, 1883, Papers Past. <https://paperspast.natlib.govt.nz/newspapers> [Accessed 4/1/2022.] Full newspaper reference omitted to prevent identification of the individual.
- <sup>79</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>80</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 327.
- <sup>81</sup> Gayle Davis, "The Most Deadly Disease of Asylumphom: General Paralysis of the Insane and Scottish Psychiatry, c.1840-194," *Journal of the Royal College of Physicians of Edinburgh* 42 (2012): 267.
- <sup>82</sup> As noted in one of the standard psychiatric textbooks of the Victorian era: Lecture X in Thomas Clouston, *Clinical Lectures on Mental Diseases* (London: J&A Churchill, 1883), 369-70.
- <sup>83</sup> Davis, "The Most Deadly Disease of Asylumphom," 266.
- <sup>84</sup> Coleborne, "White Men and Weak Masculinity," 472.

## Chapter 3. The Medicalisation of Ageing in Otago's Asylums

### *'Clinical Communities' in Otago's Asylums*

The case records used in this project reveal how relatively structured 'clinical communities' developed within Otago's asylums. An important historical source is the Dunedin Lunatic Asylum Keeper's Journal from 1863 to 1867, kept by the Keeper (or Superintendent) and providing an ongoing record patient admissions, discharges, updates, and related events of the wards (such as acts of violence, property destruction and escapes). These notes could be relatively general, such as the first entry for 23 September 1863 that "The Patients all Well toDay and visited by Dr Burns and found them all Well."<sup>1</sup> Further information was provided by the Provincial Surgeon's Daily Reports, which are summaries written by the Provincial Surgeon regarding his visits to the Dunedin Lunatic Asylum from 1862.

Examples of specific staff roles and responsibilities in the management of older patients is provided by the asylum records for a 68-year-old woman, S.B., from Dunedin. She was admitted in October 1863 with "dementia" which was considered to have been triggered by grief over the loss of her son at sea. The initial medical examinations required for committal were conducted by Edward Hulme and Robert Burns.<sup>2</sup> It was noted in the Provincial Surgeon's Daily Reports for that month (October) that "All patients improving" - except for S.B. and two others.<sup>3</sup> In February 1864, the Keeper noted that S.B.'s "husband visited her today by permission of Dr Hulme."<sup>4</sup> In April 1864 the asylum notes indicated that "All female patients [were] at work with the needle," except for S.B. In May 1864 she was reported to be one of only two female patients then in the asylum who had not "improved."<sup>5</sup> A different pattern of contact with asylum staff was recorded for U.C., who had multiple admissions with "mania" between 1887 and his death in 1907. He encountered a wide range of asylum staff in 1877, 1877-1880 (under the care of James Hume and "Dr. D. MacGregor"), 1883-1884 (when "A.H. Neill" diagnosed him with "acute mania"<sup>6</sup>) and finally from 1884-1907. In U.C.'s last and most extended admission, in 1890 Truby King engaged in legal proceedings and also conducted correspondence with this patient's brother J. (who resided in Dunedin) regarding ongoing but unsuccessful attempts to secure maintenance payments.<sup>7</sup>

As demonstrated by these and other case studies of older patients, the provision of care within the asylum involved multiple staff members over the period 1863-1898. From the 1860s, the names of Edward Hulme and James Hume appear on many of the committal and admission

documents for the Dunedin Lunatic Asylum; Robert Burns frequently also appears as a co-signatory. As briefly noted in the Introduction, Edward Hulme (1812-1876), originally from Kent in England, had studied at the Royal College of Surgeons in London as well as the famous Salpêtrière asylum in France. This experience is believed to have contributed to Hulme's interest in more humane approaches to asylum care and principles of 'moral therapy' originally promoted by Phillipe Pinel (1745-1826) and his successor Jean-Étienne Esquirol (1772-1840). Hulme arrived in Otago in 1856, and was appointed as the first Provincial Surgeon the following year, with responsibilities that included the superintendency of Dunedin hospital and later the asylum.<sup>8</sup> His manner has been described as "short-tempered, distant, and abrupt," and he was pivotal in forcing through institutional reform in Otago's rudimentary health system, despite resistance from the Provincial authorities.<sup>9</sup> Robert Burns, whose name often appears on the on the committal papers, was born in Edinburgh and completed his surgical training there in 1856, before migrating to Dunedin in 1858. Soon after his arrival he was appointed Assistant Surgeon to Hulme at the city's hospital; he remained in the position until 1876 when he was appointed surgeon to the Dunedin Gaol.<sup>10</sup> Both Hulme and Burns were also foundation members of the Otago University Council.<sup>11</sup>

James Hume was appointed as Keeper and Superintendent of the asylum in 1864 and remained in the post until 1882.<sup>12</sup> His name also appears at the end of many of the ongoing case notes, which provide updates on major mental, behavioural and physical changes in the patients. As will be discussed further in Chapter 4, biographer Jane Thomson notes that Hume introduced a number of innovations to the asylum, including "a more healthy and varied diet," work and leisure pursuits to avert "Lazy Morbid indifference," as well as a weekly church service, regular concerts and "outings in the company of attendants."<sup>13</sup> Hume also emphasised "kindness and patience" in the treatment of patients.<sup>14</sup> His workload was substantial: in 1870, it was recorded that Hume typically worked each day from 6 a.m. to 10 p.m., with issues on the wards often also requiring his attention during the night.<sup>15</sup> He reported that for periods of up to three months he was not able to venture outside the asylum grounds at all.<sup>16</sup> An official 1877 report by the Inspector of Lunatic Asylums Skae noted that "the Medical Officer lives close at hand, and devotes much time and attention to his work"; in addition, "two or three of the attendants have houses within the grounds."<sup>17</sup>

The case records also allow identification of other doctors who worked at the asylum, often for far shorter periods. The name "Dr E.W. Alexander" appears on the original admission papers, such as for patients C.C. ("affected with delusions") in 1869<sup>18</sup> and R.C. (with "mania") in

1871.<sup>19</sup> Edward William Alexander was born on the Atlantic island of Saint Helena and received his training at King's College Hospital in London. He then spent time at the Hôpital-du-Midi in Paris, where he may have been exposed to French theories on the management of insanity.<sup>20</sup> He was described as "a smart little man who has travelled a great deal on the Continent and speaks several modern languages well."<sup>21</sup> He arrived in Lyttleton in 1862 and practiced in Christchurch before being appointed as the medical officer at the Dunedin Lunatic Asylum in 1868 on £240 per year.<sup>22</sup> However, the Provincial government withdrew its funding for this post in 1871, and medical supervision reverted back to reliance on a visiting doctor on £200 per year.<sup>23</sup> In 1878, "D. MacGregor" signed the admission papers for J.A., a 67-year-old widowed nightman from Palmerston, diagnosed with "melancholia with delusions."<sup>24</sup> This is a reference to Duncan MacGregor (1843–1906), whose official roles were reviewed in the Introduction. MacGregor had been the Inspector of the Dunedin Asylum from 1873-6<sup>25</sup> and - when the role of Inspector became effectively nationalised in 1876 - worked as a Visiting Medical Officer to the asylum from 1876.<sup>26</sup> Biographer Margaret Tennant notes that MacGregor held firm opinions on psychiatric management. He was in favour of "hard manual work" for patients, and he also sought to organise asylum care so that those patients were considered 'curable' were separated from those with chronic 'incurable' mental illness, including those with "senility."<sup>27</sup>

In 1882 James Hume retired as Keeper of the Dunedin Asylum and - along with Edward William Alexander, referred to above - went on to found New Zealand's first private clinic, Ashburn Hall. Alexander Hyndman Neill was then appointed the Medical Superintendent. Neill, originally from Londonderry in Ireland, trained in Edinburgh and was appointed assistant surgeon in the British Army in 1857. In 1860-1, he served in New Zealand with the 65th Regiment. After a period back in Britain, he returned to New Zealand, taking up the position of medical superintendent at the Wellington Asylum in June 1881, before moving to Dunedin later that year.<sup>28</sup> Neill's name appears at the end of many of the ongoing case notes. For example, his January 1883 entry for K.B., a 75-year-old woman originally from Glasgow, noted that the patient had "senile dementia" and "was dirty [here indicating faecal incontinence] and troublesome"; she was also "constantly trying to remove her clothing." However, he also acknowledged that K.B. "takes her food well and rests fairly well."<sup>29</sup> Neill also briefly summarized any results from postmortems and inquests. By 1884, all patients from the original Dunedin Asylum had been relocated to Seacliff,<sup>30</sup> and A.H. Neill was to continue as the Medical Superintendent until 1889.

Frederic Truby King was born in Mangorei, Taranaki, in 1858 and received his medical training in Edinburgh, graduating in 1886.<sup>31</sup> His formal preparation for a career in mental health was in fact limited, comprising a short training course in insanity run by the eminent physician Sir Thomas Clouston, Lecturer in Mental Diseases and based at the University of Edinburgh and Royal Edinburgh Asylum.<sup>32</sup> King also studied public health as part of his degree and was the first New Zealand doctor with a diploma in this field; this aspect of his education is likely to have influenced his interest in the influence of environmental and dietary factors on health.<sup>33</sup> On his return to New Zealand, King worked for a short period at the main hospital in Wellington before being appointed as the Medical Superintendent of Seacliff Lunatic Asylum from 1889. He remained in this position until 1921. For this study population, his name appears in various correspondence, discharges, transfers (such as to the main hospital in Dunedin), and certificates on administrative and legal matters.

For the Seacliff years, the ongoing case entries included in this research project were often infrequent, rarely signed and did not usually include the names of other physicians or other member of the asylum staff. The handwriting, style and level of clinical detail changes often changes dramatically between entries, suggesting frequent changes in staff. Assistant doctors who are known to have worked at Seacliff in the study period - including Drs. James Graham Jeffreys and Herbert MacAndrew - are not referred to in the case notes reviewed for this project, and their contributions to patient care cannot be determined for this study population.<sup>34</sup> References to other physicians appeared in the records less directly. In a case entry for 1893, the presence of “Dr Fooks” can be identified because it is noted that a male patient, Y.C., with “delusional insanity” always insisted on calling this particular physician “Dr Wiggenezer.”<sup>35</sup> This is a reference to the New Zealand-born Dr. Ernest E. Fooks, who had recently been appointed to the asylum. Fooks had registered as a doctor in 1890<sup>36</sup> and from that year until 1893 had worked at the Wellington Lunatic Asylum in Porirua. Fooks later became Medical Superintendent at Auckland Asylum (1896).<sup>37</sup>

The records indicate that the operation of Dunedin Lunatic Asylum and Seacliff were highly dependent on “imported” doctors, or doctors born in New Zealand who had received all or part of their training overseas. In the Victorian period, physicians from Britain and the Empire could be highly mobile, with their identities, ideas and practices being globally transferred from one “Imperial site” to another.<sup>38</sup> From the 1850s, New Zealand also formed part of a complex international network and was strongly influenced by external social and medical theories and practices, including those pertaining to ageing and mental disorders. Historians such as Angela

McCarthy and Catharine Coleborne have examined these processes of globalised (or trans-Imperial) information diffusion. They noted that in the New Zealand context (as in Australia), medical publications – such as the *British Medical Journal* and, specifically relating to mental illness, the *Journal of Mental Science* – played a crucial role in the “transnational transfer of theories” and “diagnostic definitions” to colonial centres.<sup>39</sup>

As a result of these international influences, some consistency emerged in the diagnostic systems and treatment methods used in New Zealand’s asylums (with corresponding changes also occurring in parts of Australia). For example, the principles of ‘moral therapy’ and non-restraint were introduced from asylums in France and Britain.<sup>40</sup> More generally, alienists and other doctors working in the field of mental illness became more established and ‘respectable’ by the end of the nineteenth century, moving from their traditionally more dubious status on the fringes of reputable medicine. This expanded profession profile in Britain and the Empire was reinforced by more formalised medical training in mental illness, the establishment of professional associations, and the appearance of more reputable texts and journals in the field.<sup>41</sup> The vast expansion of the asylum system itself also facilitated new career opportunities for doctors who sought to specialise in disorders of the mind.<sup>42</sup>

In addition to superintendents and physicians, attendants and nurses also played a central role in creating the ‘clinical communities’ at Dunedin Lunatic Asylum and Seacliff. In the Dunedin Lunatic Asylum, the number of attendants in 1870 included eight men and six women.<sup>43</sup> The ratio of attendants to patients as usually around 1:10 in New Zealand public asylums during this period. Attendants typically worked 12-hour days, and their responsibilities and tasks could be diverse, including maintaining order, monitoring patients to ensure their safety and also to report on any physical or mental changes to the physicians, and occupying patients with ‘diverting’ activities where possible.<sup>44</sup> From the 1890s, many asylums shifted away from the use of attendants - which Duncan MacGregor and others considered to be more like prison warders - towards a system more reliant on trained nurses. The proportion of women appointed to positions as asylum staff also steadily increased.<sup>45</sup> From 1887, Seacliff also appointed a farm manager who – under the direction of the medical superintendent – coordinated patient labour and ensured that the estate was run efficiently: the intended purpose of this ‘farm asylum’ was not only to be ‘therapeutic,’ but also economically sustainable.<sup>46</sup>

An inquiry into the management of Seacliff Asylum in 1887 also partially revealed the internal social stratification amongst the staff, and how this could create tensions around the kinds of interactions that were considered suitable. Based on testimony given at the Inquiry, Matron C.

Grundy had informed one of the assistant medical officers that socialising with the attendants was not appropriate for a person in his position. For his part, the doctor in question, Dr. James Jeffreys,<sup>47</sup> reported that he preferred to take his meals in his room rather than eating with the Matron and the Clerk. Jeffreys also complained about the lack of collegial contact with A.H. Neill, at that time the Seacliff Medical Superintendent.<sup>48</sup> Attendants and nurses are also mentioned in some of the case notes for this study population, including references to periodic confrontations with patients. In 1889, a 60-year-old man, U.C., with “acute mania” was “found to have matches in his pocket” by two attendants “Cummings and Hoare.” The patient “strenuously denied” this accusation when questioned by the asylum physician.<sup>49</sup> Names of attendants and nurses also appeared in some records of patient deaths, with the time and day given. F.C., first admitted to the asylum in 1881 with “lunacy,” died in 1898 “in the presence of Att[e]n[dan]t W.A Parke.”<sup>50</sup> The death in 1908 of 84-year-old L.C. - originally admitted in 1864 with “mania” and delusions - was noted have occurred “in the presence of Att[endant] John C. Quill.”<sup>51</sup> K.F. from Port Chalmers, diagnosed with “dementia,” was by the age of 78 noted to be “failing fast”: she died in December 1903 “in the presence of Nurse Whiting.”<sup>52</sup>

This overview of the clinical ‘communities’ created in Otago’s asylums for the period 1863-1898 indicates how social interactions were generally dictated by different levels of authority and assumed expertise. Historians have explored various purposes and functions of the organisational hierarchy within asylums. In practical terms, a clear delineation of roles was required because asylums evolved into such large institutions with so many employees.<sup>53</sup> The greater emphasis on professionalisation across the period - often based on British models - defined and reinforced work roles, and also acted to consolidate the dominant position of the medical profession within the system.<sup>54</sup> The medical superintendent could decide on the fundamental questions of patient discharge or continued incarceration, and could mediate between patients and their families. Superintendents also monitored staff behaviour, and could choose initiate, set the terms of, or terminate employment for medical officers, nurses and attendants. Matthew Philp has suggested they acquired “essentially autocratic powers over buildings, patients and staff.”<sup>55</sup> As discussed by Foucault, the asylum had evolved into “medical space” in which “the doctor takes a preponderant place”: it has also been asserted that the superintendent’s authority was often reliant on the force of their “personality” and “character” even more than their assumed scientific knowledge.<sup>56</sup>

Despite their senior position within the asylum power structure, superintendents did not enjoy complete autonomy, and their actions were subject to legal requirements and official controls,

including over the budget. Although King and the controlling and opinionated Duncan MacGregor (appointed national Inspector of Lunatic Asylums from 1886-1906) were in accordance on some issues, their differences were at times apparent. For example, in 1898 King wrote to MacGregor complaining of the latter's failure to observe "official etiquette and courtesy" which - King noted - was a "cause of pain and worry to other superintendents and is liable at any time to give rise to serious misunderstandings."<sup>57</sup> As Warwick Brunton notes, "[b]alancing the interests of patients, staff, and taxpayers was never easy and the ideal was inevitably compromised."<sup>58</sup> More widely, it was acknowledged that the superintendent, who had once been seen as central to guiding 'moral treatment' through direct personal interaction, was increasingly reduced to a more "remote supervisory role" that left them "[s]ubmerged in paperwork."<sup>59</sup>

Superintendents were also subject to other influences, such as pressure from family members and attacks through the media. In the 1890s, King's management practices were subject to repeated criticisms by newspapers (such as the *Globe*, published in Dunedin between 1890 and 1893), including in relation to a staff 'rebellion' over conditions on top of accusations by attendants over poor quality of care and ill-treatment of patients.<sup>60</sup> King was exonerated and the three complainants (attendants Arundel, Impey, and Clark) were dismissed for insubordination. In 1891 Sidney Maxwell, an embittered attendant who had recently been dismissed, publicly referred to King as a tyrant to his staff.<sup>61</sup> These accounts suggest that the network of professional relationships in this system were not static and were subject to complex pressures. Given the close and interconnected world of the asylum, it is likely that some of these internal dynamics and conflicts amongst staff members also influenced the experiences and wellbeing of patients.

Perceptions of the risk from escaped asylum patients at liberty on the community were also amplified by media reports. In the early 1890s, the *Globe* published a series of letters that were highly critical of the degree of freedom patients were permitted at Seacliff under the administration of Truby King. These letters expressed concerns that patients were allowed to "roam about unattended or with insufficient attendance" and even that any "escaped lunatics would do violence to our community."<sup>62</sup>

### *The Ageing 'Case': Patterns of Observation and Reporting*

As Andrew Scull observed, asylum case notes provide “a view refracted for the most part through the eyes and hands of those who ran the institutions in which [the patients] were confined, and who recorded the views and behaviours of the inmates for their own peculiar purposes.”<sup>63</sup> For many patients in the study population, especially those admitted for years or decades, the records of clinical evaluations were relatively infrequent (by modern standards). Apart from descriptions of notable changes in condition or events such as being discharged or transferred, many patients have entries each year or only once every few years. These entries may only be a few words or a sentence or two in length - such as “no mental change” or “continues the same” - and provide only a minimal summary of the individual’s status.

For other patients, the clinical descriptions of their mental and physical state can show often gradual variations over time, especially for some of the ‘longer-stay’ residents. For example, the previously discussed man in his sixties, C.C., was in the 1890s described in the notes as “good natured” with “a simple and childish in manner,” with a habit of attempting to build “boats in the middle of the bush.”<sup>64</sup> However, in the earlier stages of his admission twenty years earlier, the descriptions were very different: C.C. was recorded as being affected by “acute mania” with pronounced religious delusions, and “his conduct was violent and wild.”<sup>65</sup> B.A., a 62-year-old customhouse officer (mentioned above), was admitted in 1873 with “mania” and described as “highly nervous and suspicious” with “delusions with regard to his fellow-clerks [at the customhouse] undermining him.”<sup>66</sup> He returned to the asylum in 1882, by which time he was described as “feeble from old age” and affected by “almost complete loss of memory” and “illusions and delusions.”<sup>67</sup> These shifts in patient descriptions may relate to the progression or cyclical nature of the underlying illness, broader transitions in clinical classifications, different diagnostic labels preferred by particular treating doctors, or a combination of these factors.

Many recorded observations appear to capture what might be considered ‘behavioural issues’ – that is, the identification of behaviours that were considered challenging or disruptive, especially when considered in the context of the highly ‘managed’ asylum environment. Some of these behaviours were tied to an assumed personality type, and emphasis was also placed on emotional states or inferred tendencies, including references to individuals being “hot tempered” and “excitable,” or displaying “irritability of temper.” Amongst the range of descriptors used in the study population, references to aggression and even physical violence often featured. For example, a painter from Dunedin, U.C., admitted to the asylum four times

for mania between 1877 and 1907, was at the age of 75 reported have “a biting dirty tongue.” It was noted that he was “always in dispute with his fellows” and that he “works himself into rages.”<sup>68</sup> In his first two admissions, U.C. had been particularly “violent” and threatening - including reports that he had “attacked other inmates.”<sup>69</sup> U.C. was also described as a “run-away,” although no specific examples were provided. Other kinds of ‘disruptive’ behaviours were linked to a particular response or intervention. D.A., a 60-year-old male, was admitted in July 1883 with “acute mania,” “delusions” and “pious ejaculations” was reported to be “constantly repeating portions of the Apostle's Creed [and] beating his palms together.” The recommendation was that this patient “requires [a] single room.”<sup>70</sup>

Often these detailed descriptions of patient behaviours were not used for purposes that could be considered strictly diagnostic, and nor were they used to guide treatment (beyond the immediate resolution of the troublesome activity). However, such behavioural patterns were obviously considered undesirable in their disturbance of regular asylum routines and their demands on staff. These include commonly reported disturbances related to sleep, including episodes of sleeplessness, nocturnal restlessness, and disorientation. For the 65-year-old Dunedin cabdriver E.A., admitted with “general paralysis” (neurosyphilis) in 1882, it was observed that he is “restless at night” and that he “gets out of bed and wanders about.”<sup>71</sup> H.B., a 76-year-old woman admitted with “senile dementia” in 1883, could “not be induced to remain in bed but would stand naked in her room so she has to be dressed and kept in a chair.”<sup>72</sup>

Problems with personal hygiene were also frequently emphasised. K.F. from Port Chalmers, originally admitted at the age of 38, by 60 (in 1893) was later diagnosed with “dementia.” It was noted that she had “an intense antipathy to bathing.”<sup>73</sup> Loss of bladder or bowel control (urinary and/or faecal incontinence) was a condition particularly noted by physicians and attendants. This was usually in terms of the patient being “wet” (for urinary incontinence), “dirty” or “filthy” in their habits. Various kinds of sexualised behaviours or displays of partial or complete nudity were also discussed in the clinical notes. G.A., a 66-year-old watchmaker living in Dunedin and originally from England, was admitted in 1883 in physical and mental decline from advanced liver and heart disease. At the start of his three-month admission, the clinical notes record that G.A.’s behaviour caused concern because he “would not remain in bed and constantly stripped off his clothes.”<sup>74</sup> Interventions were initiated to manage T.C., a 79-year-old labourer from Queenstown, admitted with “religious melancholia” and “paralysis agitans” (Parkinson’s disease). The patient had been “found trying to pull up women's clothes

through the yard fence,” accompanied by acts of masturbation. It was instructed that T.C. was therefore “not allowed about unattended [latter part underlined].”<sup>75</sup>

For a small number of patients, personal attributes or behavioural patterns that were seen as more “favourable” - or at least relatively neutral - were recorded in the clinical notes. The descriptor “harmless” was also applied to a number of other patients, particularly those with advanced dementia. A 70-year-old woman, K.D., originally admitted at the age of 35 with “delusional insanity,” was later diagnosed with “dementia” and described in 1904 as being “a dear old lady passionately fond of animals and children.”<sup>76</sup> U.A., a 72-year-old “well educated” farmer who lost his farm in Forfarshire in Scotland and eventually joined his two sons in Otago, was admitted in a “state of senile decay.” He was noted to have a “kind disposition”; later in his seven-year period as an inpatient, he was also described as “very quiet and docile” and “well behaved.”<sup>77</sup>

### *Constructing ‘Pathologies’ of the Ageing Mind*

In broad terms, entry of the patient into a clinical “space” - such as a lunatic asylum - initiates a process of classification, in which the doctor attempts to decipher and organise the physical and mental characteristics they are observing.<sup>78</sup> For example, distinctive speech patterns and communication issues amongst patients were often relatively obvious and usually subject to clinical description and interpretation. It was noted that some patients tended towards delayed and interrupted speech (“difficulty expressing his ideas and is very slow in answering any questions”) or even a degree of mutism. In other clinical descriptions, patients - including those with “acute mania”, “senile dementia” and “delusional insanity” - were described as having “rambling” or “incoherent” speech. Terms such as “paralysis of speech” could be applied to patients with neurological disorders, such as a stroke. Clinical records also made reference to displays of laughter, especially in patients who were inclined to laugh for no obvious reason. According to records from 1893, J.E., a 60-year-old labourer of uncertain diagnosis “laughs and chuckles without reason and says foolish inconsequent things.”<sup>79</sup>

There have been diverse opinions on the legitimacy and consistency of these kinds of diagnostic processes and their implications for patients, physicians and health care systems more generally. In relation to the diagnosis of insanity in the Victorian era, Andrew Scull acknowledges that there was a “hard core of easily recognisable behavioural and/or mental disturbance,” but that the “boundary between the normal and the pathological was left

extraordinarily vague and indeterminate.”<sup>80</sup> In his opinion, there was often little attempt to resolve ambiguities or uncertainties in diagnostic terms and definitions amongst alienists and asylum superintendents. Scull proposed that this “theoretical indeterminateness of the concept of insanity” may in fact have benefitted the psychiatric profession, because they could claim expertise in an ever-expanding range of issues (or types of ‘deviance’) and ultimately even influence social policy.<sup>81</sup> In contrast with this presumption of a somewhat ‘loose’ conceptualisation of insanity, German Berrios, a leading historian of classifications and descriptions of mental illness, has argued that a more consistent “descriptive psychopathology” in fact developed during the course of the nineteenth century and was used in the diagnosis of psychiatric disorders.<sup>82</sup> From the 1850s, it became more common for medical writings to contain detailed descriptions of symptoms and references (although no doubt still highly incomplete by modern clinical standards) to some of the content and processes of their patients’ minds. New diagnostic terms and understandings were also introduced and refined across this period. Berrios concluded that this shared language became increasingly evident in the case notes and clinical discourse.<sup>83</sup>

Amongst the diagnostic descriptors specifically used for older patients used in the Dunedin Lunatic Asylum and Seacliff records, references to the individual’s overall level of cognitive functioning were amongst the most common. (This section will primarily focus on the period of time during which the individuals were at or over 60 years of age while in the asylum, either because they were admitted in this age group or because they attained the age of 60 years during their admission or readmission.) In individuals classified as having ‘senile decay’ or ‘senile dementia,’ clinical observations emphasise aspects such as poor memory (such as “memory bad”), limited capacity for speech and communication (as noted above), aspects of the facial expression (such as having a “vacant expression” or “vacant countenance”), or a general state of “mental enfeeblement.” For H.B., a 76-year-old woman admitted in April 1883 with “senile dementia” and “senile decay,”<sup>84</sup> the asylum notes reported that her “mind is a complete blank - does not know where she is or where she came from.”<sup>85</sup>

The association of between these descriptors and the clinical entity known as ‘dementia’ in the Dunedin Lunatic Asylum and Seacliff asylum case notes appeared to be broadly consistent with contemporary understandings of the condition. The use of related terms for such processes, including ‘senile decay’ or ‘decay of the mind,’ was also well-established in clinical practice in this period.<sup>86, 87</sup> With the shift to a more anatomical-clinical basis for mental illness in the nineteenth century,<sup>88</sup> the use of term ‘dementia’ (or *démence* in French) was increasingly

used to refer to chronic disorders of the brain associated with some underlying neuropathological process (such as ‘physiological decay’).<sup>89</sup> By the 1830s, a more precise sub-categorisation of ‘senile dementia’ was also appearing in the medical literature, promulgated by alienists such as James Cowles Prichard<sup>90</sup> (in Britain) and Jean-Étienne Esquirol (in France).<sup>91</sup> Prichard concluded that the progression of dementia followed four stages - loss of memory, followed by loss of reason, then loss of comprehension and finally loss of the basic instincts of bodily control and function.<sup>92</sup> In 1835, French alienist Louis-Florentin Calmeil characterised ‘senile dementia’ as a state affecting older people in which “external stimuli” are “less clear to them, they have little memory of recent events, live in the past...their affect gradually wanes away.”<sup>93</sup> John Charles Bucknill and Daniel Tuke’s highly influential *A Manual of Psychological Medicine* (1858, which ran to four editions) also emphasised that “memory loss” was a central symptom of all types of dementia, including the “senile” form.<sup>94,95</sup> In an influential 1874 *British Medical Journal* paper on senile dementia, asylum administrator and physician James Crichton-Browne also emphasised the signs of emotional “blunting” and accompanying changes in both personality and physical appearance.<sup>96</sup>

These new conceptualisations of ‘dementia’ were accompanied by more advanced clinical understandings of older age, supported by the writings of physicians and pathologists such as Léon Rostan (1790 –1866), Jean Cruveilhier (1791 – 1874) and René-Clovis Prus (1793-1850).<sup>97,98</sup> In 1839, German physician Karl Canstatt published a clinically-oriented text *Die Krankheiten des höheren Alters und ihre Heilung* [The Illnesses of Old Age and their Treatment] in which he sought to identify general aspects of the ageing process as well as system- and organ-specific manifestations of disease in older age.<sup>99</sup> Although the word ‘senile’ had originally and more neutrally been defined as ‘relating to old age,’ in clinical settings it subsequently came to be associated with decline and deterioration in the last stages of life. By the 1880s, the term ‘senility’ was being used as a diagnostic classification that broadly indicated a “degenerative process of mental faculties.”<sup>100</sup> However, a major consequence of the widespread uptake of the term ‘senility’ (or its variations) was that it was at times applied indiscriminately for all mental changes beyond a certain age, even in people who had been admitted to the asylum earlier in their lives with similar symptoms yet different diagnostic labels.<sup>101,102</sup>

As briefly discussed in the preceding chapter, the clinical records from the Dunedin Lunatic Asylum and Seacliff indicate that a number of patients were admitted with ‘delusional insanity.’ These delusions were often persistent and typically continued - although at times to

an attenuated or altered form - into older age. S.C., a farmer from Akatore, was first admitted in 1876 (at the age of 45) with a diagnosis of “delusional insanity,” stating that “invisible beings continually follow and trouble him.” In 1893, at the age of 62, he was still described as having a “mind full of delusions,” including that “he is the King of Fife [in Scotland].”<sup>103</sup> Another example is provided by H.F., a woman resident in Dunedin but originally from Switzerland. H.F. was admitted in 1880 (at the age of 51) with “melancholia” and “delusions...that the husband from whom she has just parted is dead.”<sup>104</sup> When assessed in Seacliff in 1894, at the age of 65, she was affected by “various delusions about being worked on by electricity.”<sup>105</sup> For other patients, the delusions did not appear (at least based on the clinical accounts) as overtly distressing, or they appeared to vary in intensity. E.E., an unmarried farm labourer originally from Nova Scotia, had been admitted at the age of 48 after six months in New Zealand. He was initially diagnosed with “melancholia” and auditory hallucinations. The notes reported that, by the time he reached the age of 62, E.E.’s “demeanour was quiet” and “amiable.”<sup>106</sup> Although he experienced “delusions of suspicion... that people would harm him if they could,” it was noted that “his delusions are latent and he seems quite contented.” Three years later, the clinical records indicated that his “delusions are not prominent.”<sup>107</sup>

Similar accounts of the frequency of delusional disorders in asylum populations have also been reported in other international studies. Patients with delusional disorders were often not considered to be ‘curable’ and could therefore remain incarcerated for extended periods. In Gillian Doody’s analysis of admissions to the Fife and Kinross District Asylum between 1874 and 1899, two-thirds of patients were reported to have delusions.<sup>108</sup> Edward Renvoize’s study of Yorkshire asylum between 1880 and 1884 reported that 73% of adult patients had delusions, and the term “delusional insanity” was amongst the most common diagnoses (across all patients over 20 years).<sup>109</sup> As with dementia, there was a reasonably well-defined conception of ‘delusional insanity’ within prevailing clinical paradigms. In their *Manual of Psychological Medicine* (1858), Bucknill and Tuke defined a delusion as “an intellectual error, caused by the pathological condition of the mind” that displayed itself “in false sensation, perception, or conception.”<sup>110</sup> Thomas Clouston, who ran the Royal Edinburgh Asylum and wrote extensively on classifications of mental disorders, described a delusion as “a belief in something that would be incredible to people of the same class, education, or race as the person who expresses it, the belief persisting in spite of proof to the contrary.”<sup>111</sup> Case-reviews of patients from the period suggest these delusions typically related to guilt, persecution (especially being followed or being poisoned by family members or neighbours), and either grandeur (usually related to

possessing a great fortune) or extreme penury.<sup>112</sup> Clouston also reported on a number of patients who believed they were being worked on by an “unseen agency”, such as malign people or spirits, including some who referred to the control by “electricity” or electrical devices.<sup>113</sup>

For other distinctive neurological or psychiatric symptoms, there was clinical uncertainty about their significance (or implications for treatment or recovery). These included perceptual disorders, such as hallucinations (typically auditory, such as hearing voices, as well as visual), which were often frightening and distressing. For example, B.E., a 66-year-old rabbitier from Oamaru with “delusions” and “dementia,” stated that he could not wear his shirt because it “had voices that spoke to him.”<sup>114</sup> Tactile hallucinations may have been present in a 60-year old patient from Invercargill, originally admitted at the age of 48 with “delusions,” who tied from of shirt with a bootlace “to keep the devil from rummaging and feeling all over him at night.”<sup>115</sup> The experience of hallucinations was extensively described in case studies and clinical textbooks of the period. In his 1845 book *Mental Maladies: A Treatise on Insanity*, Esquirol defined a ‘hallucination’ as “the thorough conviction of the perception of a sensation, when no external object, suited to excite this sensation, has impressed the senses”;<sup>116</sup> it was also well-recognised that they often had a tormenting and disturbing quality.<sup>117</sup> However, these mental phenomena did not always appear to fit into an obvious clinical pattern, and their prognostic significance was uncertain.

With reference to the style and form of the later Dunedin Lunatic Asylum and Seacliff clinical notes, it is probable that the prevailing constructs for mental illness contributed to the relatively limited clinical focus on or interest in ongoing ‘psychological’ symptoms experienced by older patients. Many of the clinical descriptions were brief and often related to physical complaints, as opposed to ‘psychic’ content. More generally, medical understandings of mental illness from the 1870s (until the advent of psychoanalysis) were shifting more towards a ‘somaticist’ basis, centred on the influence of bodily processes.<sup>118</sup> In terms of clinical assessment, such ‘biologically-oriented’ theories - with a stronger emphasis on neurological functioning and its hypothesised ‘defects’ - tended to downplay the importance of unique psychological dimensions of mental illness. Indeed, many alienists of the period “repeatedly called for a reclassification of mental disorders”<sup>119</sup> which would be based on stronger somatic-pathological foundations, as opposed to relying on ‘psychological’ approaches (an assumption that would soon be challenged by the Freudian revolution). This shift towards explanations assumed by many physicians to be more legitimately ‘scientific’ was also accompanied by new

understandings of brain pathology in the laboratory setting. In effect, suggestions that ‘insanity’ could be linked to factors *apart from* discrete physical changes within the brain could be seen as a reversal of scientific progress.<sup>120</sup>

This ‘somaticist’ approach was further extended by the English neurologist John Hughlings Jackson (1835 – 1911), who suggested that psychological states associated with loss of functioning - such as impairments in volition and speech, as with dementia - corresponded to a process of “dissolution” (or, in a sense, progressive “dismantling”<sup>121</sup>) of higher brain function.<sup>122</sup> At the end of this process, the ‘mind’ would essentially be lost and only a basic ‘physical’ level of functioning would remain.<sup>123</sup> Jackson compared this general process of “dissolution” with another group of disorders, which (he conjectured) occurred when the ‘higher’ centres of the brain could no longer effectively ‘inhibit’ (or properly regulate) the ‘lower’ centres of the brain. It was suggested that the latter kind of defect in control of ‘lower’ brain centres was responsible for producing phenomena such as delusions, hallucinations, and unusual or repetitive behaviours.<sup>124</sup> As noted, a major implication of such models of mental ill-health was that the specific details of the patient’s psychic processes (such as the possible origins, content and intensity of their delusions) did not warrant a high level of clinical attention, at least once the ‘internal’ neurological abnormalities had been determined. Such ‘subjective’ accounts from patients were not seen as being particularly informative – and they were often not formally recorded – especially once the treating physician believed that the underlying ‘defect’ in the nervous system had been identified.

The emphasis on assumed biological attributes of ill-health also extended to evaluating facial characteristics or other distinctive bodily features of patients. For example, D.F., a 48-year-old woman from Dunedin, was admitted in 1880 with “delusional insanity.” D.F. reported hearing “voices at all hours of the night” and “being disturbed by telegraphic communications;”<sup>125</sup> she was readmitted two years later again with “delusions” and “being troubled by something that comes to her ear at night and says it will take her away.” Her features were described as follows: “Head badly shaped. Forehead small rounded with hair descending low down.” Ten years later, it was further noted that she had “Hair on upper lip” and “features of a coarse low type.”<sup>126</sup> The appearance of the head was also emphasised in M.F., a 78-year-old man with “dementia”: “Head badly shaped with retreating forehead.” The relative size of the head to the body was at times also noted: the records for L.C., a 69-year-old single labourer with “mania” and delusions note: “Head large for size of body. Forehead prominent. Circumference of h[ea]d 23 inches.”<sup>127</sup> In contrast, U.C., a male patient, when admitted at 64 with “acute mania,” was described as a

“well made man with a good head.”<sup>128</sup> These observations are consistent with the heightened clinical focus on distinctive facial characteristics and various body ‘malformations’ that were, according to some prevailing opinions, predictive of various mental disorders. Such physical characteristics might also be linked to the process of ‘degeneration’<sup>129</sup> and seen as indicators of ‘hereditary weakness.’<sup>130</sup> From the 1870s, the role of heredity was increasingly discussed, influenced by the contemporary debates on degenerationism and links to family histories of mental illness, “feeble-mindedness”, or “socially unacceptable behaviour,” such as “drunkenness [and] sexual deviance.”<sup>131</sup> Based on her analysis of Auckland asylum case notes, Maree Dawson also noted the increasing references to ‘heredity’ as a cause of mental illness in the 1880s and 1890s.<sup>132</sup>

As discussed above, general physical indicators of health were often recorded in greater detail than psychological experiences. For example, patterns of food intake were commonly noted in the Dunedin Lunatic Asylum and Seacliff notes assessed in this study. It was noted that 73-year-old male patient M.A. “takes his food voraciously,” even though he was limited by “dementia of old age” and a “paralytic seizure” that left him unable to speak.<sup>133</sup> Patients were often described in terms of their nutritional state, with the phrase “well nourished” commonly used. Some even progressed to the stage of being “very [underlined] stout.” Conversely, other patients might show disinclination to eat. Issues with nutritional intake could create challenging situations for patients and staff, as shown in the case of N.A. (discussed earlier), a 64-year-old hotel owner who had been admitted in 1882 with “acute mania” coupled with “extreme melancholia.” In December 1882, he experienced “an epileptiform fit” that left him “very stupid and feeble.” Two days later, it was noted that he “refuses food and has to be fed by spoon.” In the following weeks, he continued to refuse “all food” and “owing to increasing debility” the medical staff “commenced to feed him by stomach pump three times daily.” In early January, it was noted that because N.A. “struggles violently when being fed,” it was necessary to “discontinue pump and endeavour to feed by means of spoon.” N.A. died in January 1883 from a further “epileptiform fit.”

Clinical records also referred to the presence of other specific illnesses (comorbidities), injury and death in institutional care. Many of these associated conditions occur more commonly in older age, reflecting the coexisting health risks in this asylum population apart from their mental illness. For example, 64-year-old W.D. from Dunedin diagnosed with “delusional insanity” was 12 years into her second asylum admission when she was “seized with a fit,” leaving her with partial paralysis on her left side. In subsequent months her physical state was

monitored intermittently, including assessments of the loss of power in the affected arm and leg.<sup>134</sup> Sensory impairments – including hearing loss and impaired vision – were commonly recorded. P.C. diagnosed with “dementia” was “quite deaf” by the age of 70; it was also noted he never spoke but “makes signs.”<sup>135</sup> Y.C., originally admitted in 1868 (aged 36) with “delusional insanity” was by the age of 80 also affected by “very defective” hearing as well as visual impairment that ultimately left him “blind and helpless.”<sup>136</sup>

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### Chapter 3: Notes

<sup>1</sup> ANZ DRO, “Dunedin Lunatic Asylum Keeper's Journal,” 23 September 1863.

<sup>2</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>3</sup> ANZ DRO, “Provincial Surgeon's Daily Reports,” 31<sup>st</sup> October 1863.

<sup>4</sup> ANZ DRO, “Dunedin Lunatic Asylum Keeper's Journal,” 22 February 1864.

<sup>5</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 43.

<sup>6</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>7</sup> Ibid.

<sup>8</sup> Michael Belgrave. Links and sources for “Hulme, Edward,” *Dictionary of New Zealand Biography*, first published in 1990. Te Ara - the Encyclopedia of New Zealand, <https://teara.govt.nz/en/biographies/1h37/hulme-edward/sources> (accessed 19 January 2022).

<sup>9</sup> Belgrave, “Hulme, Edward.”

<sup>10</sup> Robert Fulton, *Medical Practice in Otago and Southland in the Early Days* (Dunedin: Otago Daily Times and Witness Newspapers Limited, 1922), 59.

<sup>11</sup> Wright-St Claire, *Historia nunc vivat*, 195.

<sup>12</sup> Jane Thomson, “Hume, James,” *Dictionary of New Zealand Biography*, first published in 1993. Te Ara - the Encyclopedia of New Zealand, <https://teara.govt.nz/en/biographies/2h56/hume-james> (accessed 26 January 2022).

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Brunton, “A Choice of Difficulties,” 98.

<sup>16</sup> Angus, *History of the Otago Hospital Board*, 48.

<sup>17</sup> AJHR, *Report on Lunatic Asylums of The Colony*, 1877, Session I, H-08, 3.

<sup>18</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>19</sup> Ibid.

<sup>20</sup> Elspeth Knewstubb, “Medical Migration and the Treatment of Insanity in New Zealand,” in *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*. eds. Angela McCarthy and Catharine Coleborne (Florence: Taylor & Francis Group, 2011), 109.

<sup>21</sup> Wright-St Claire, *Historia Nunc Vivat*, 33.

<sup>22</sup> Ibid.

<sup>23</sup> Angus, *History of the Otago Hospital Board*, 49.

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- <sup>24</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>25</sup> Margaret Tennant, "MacGregor, Duncan," *Dictionary of New Zealand Biography*, first published in 1993. Te Ara - the Encyclopedia of New Zealand, <https://teara.govt.nz/en/biographies/2m7/macgregor-duncan> (accessed 25 January 2022).
- <sup>26</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 320.
- <sup>27</sup> Tennant, "MacGregor, Duncan."
- <sup>28</sup> Wright-St Claire, *Historia Nunc Vivat*, 283.
- <sup>29</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 535.
- <sup>30</sup> Brunton, "A Choice of Difficulties," 241.
- <sup>31</sup> Wright-St Claire, *Historia Nunc Vivat*, 216.
- <sup>32</sup> Caldwell, "Truby King and Seacliff Asylum," 35.
- <sup>33</sup> *Ibid.*
- <sup>34</sup> All referred to in, for example, Seacliff chaplain John Ainslie Torrance's "Public Institutions," 77. Also see: Wright-St Claire, *Historia Nunc Vivat*.
- <sup>35</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 39.
- <sup>36</sup> *Otago Daily Times*, Issue 8762, 26 March 1890, 3
- <sup>37</sup> Fooks eventually moved to the Bay of Plenty, where in 1898 he opened a medical practice in Tauranga. He died soon after, at the age of 40, "from exposure and excessive use of cocaine and morphine." *Bay Of Plenty Times*, Volume 07, Issue 3657, 7 February 1898, 5. See: Wright-St Claire, *Historia Nunc Vivat*, 141.
- <sup>38</sup> Alannah Tomkins and Catharine Coleborne, "Professional Migration, Occupational Challenge, and Mental Health: Medical Practitioners in New Zealand, 1850-1890s," *Social History of Medicine* 34, no. 3 (2021): 877.
- <sup>39</sup> McCarthy, "Lives in the Asylum Record," 369.
- <sup>40</sup> Catharine Coleborne and Dolly MacKinnon, "Psychiatry and Its Institutions in Australia and New Zealand: An Overview," *International Review of Psychiatry* 18, no. 4 (2006): 371.
- <sup>41</sup> Jonathan Andrews, "The Rise of the Asylum in Britain," in *Medicine Transformed: Health, Disease and Society in Europe, 1800-1930*, ed. Deborah Brunton (Manchester: Manchester University Press, 2004), 322.
- <sup>42</sup> Scull, *Madhouses, Mad-doctors, and Madmen*, 17.
- <sup>43</sup> Angus, *History of the Otago Hospital Board*, 48.
- <sup>44</sup> Brunton, "A Choice of Difficulties," 459.
- <sup>45</sup> *Ibid.*, 333.
- <sup>46</sup> *Ibid.*, 461.
- <sup>47</sup> James Jeffreys was born in in the UK and trained in Durham. He registered to practice in New Zealand in 1887 and worked as an assistant medical officer at Seacliff in the same year. Wright-St Claire, *Historia Nunc Vivat*, 141.
- <sup>48</sup> Brunton, "A Choice of Difficulties," 316.
- <sup>49</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 261.
- <sup>50</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>51</sup> *Ibid.*
- <sup>52</sup> *Ibid.*
- <sup>53</sup> Brunton, "A Choice of Difficulties," 169.
- <sup>54</sup> Michael Belgrave, "Medicine and the Rise of the Health Professions in New Zealand, 1860-1939," in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, ed. Linda Bryder (Wellington: Bridget Williams Books, 1991), 9.

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- <sup>55</sup> Matthew Philp, "Scientific Pastors: The Professionalisation of Psychiatry in New Zealand 1877-1920," in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, ed. Barbara Brookes (Dunedin: University of Otago Press, 2001), 189.
- <sup>56</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1988 [1965]), 270.
- <sup>57</sup> Brunton, "A Choice of Difficulties," 181.
- <sup>58</sup> *Ibid*, 305.
- <sup>59</sup> John Walton, "Pauper Lunatics in Victorian England," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 16.
- <sup>60</sup> AJHR, *Seacliff Asylum: Inquiry by Dr. Macgregor into Complaints Made by Certain Attendants, With His Report Thereon*, 1893, Session I, H-29, 1-18.
- <sup>61</sup> These and other administrative pressures appear to have taken a considerable personal toll. King's health appears to have declined in the mid-1890s and he decided to take extended leave from the asylum, including a period of time back in Edinburgh to extend his studies on mental disorders. Brunton, "A Choice of Difficulties," 312.
- <sup>62</sup> Discussed in: Caldwell, "Truby King and Seacliff Asylum," 47.
- <sup>63</sup> Andrew Scull, "Rethinking the History of Asylums," in *Insanity, Institutions and Society, 1800-1914*, ed. Bill Forsythe and Joseph Melling, Joseph (London: Taylor and Francis, 2013), 304.
- <sup>64</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 54.
- <sup>65</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>66</sup> *Ibid*.
- <sup>67</sup> B.A. was then transferred to Ashburn Private Asylum in Dunedin in 1882 and his subsequent clinical outcome could not be determined. ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 518.
- <sup>68</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 261.
- <sup>69</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 261.
- <sup>70</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 582.
- <sup>71</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 517.
- <sup>72</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 553.
- <sup>73</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 17.
- <sup>74</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 601.
- <sup>75</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 70.
- <sup>76</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 46.
- <sup>77</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 398.
- <sup>78</sup> Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994 [1973]), 14-5.
- <sup>79</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 27.
- <sup>80</sup> Scull, *The Most Solitary of Afflictions*, 349.
- <sup>81</sup> *Ibid*, 392.
- <sup>82</sup> Berrios, *History of Mental Symptoms*, 17.
- <sup>83</sup> *Ibid*, 22.
- <sup>84</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>85</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 553.

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<sup>86</sup> Scull, *The Most Solitary of Afflictions*, 371. The diagnosis of ‘dementia’ was at times more broadly attached to the individual, with such patients being referred to as ‘dements’ in the clinical notes.

<sup>87</sup> The term ‘dementia’ has been used since the Roman era, with its derivation from the Latin root, *de mens*: “being out of, or away from, one’s mind.” See: German Berrios, “Dementia During the Seventeenth and Eighteenth Centuries: A Conceptual History,” *Psychological Medicine* 17, no.4 (1987): 830.

<sup>88</sup> Prior to the nineteenth century, ‘dementia’ in a clinical context could refer to a general state of cognitive impairment or deterioration in any age group, including as a result of head injury or even “excessive usage” of the brain. See: Alexander Kurz and Nicola T. Lautenschlager, “The Concept of Dementia: Retain, Reframe, Rename or Replace?” *International Psychogeriatrics* 22, no.1 (2010): 38; Berrios, *History of Mental Symptoms*, 172.

<sup>89</sup> In contrast, there has been a long-established separation between the two cognitive disorders ‘intellectual disability’ (originally referred to using terms such as ‘idiotism’ and ‘idiocy’) and ‘dementia.’ The state of intellectual disability was commonly understood as a largely irreversible state of mental impairment that was present from birth or a young age. Esquirol argued that “idiocy is not a disease but a state in which the intellectual faculties are never manifested or developed.” See: Berrios, *History of Mental Symptoms*, 160.

<sup>90</sup> James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert and Piper, 1835), 92-3. Also discussed in: Emily Andrews, “Institutionalising Senile Dementia,” 246.

<sup>91</sup> In *Mental Maladies: A Treatise on Insanity*, Esquirol described dementia as “a cerebral disease characterized by an impairment of sensibility, intelligence and will.” Translation of *Des Maladies Mentales* (1838). See: Boller, “History of Dementia and Dementia in History,” 127.

<sup>92</sup> Discussed in: Andrews, “Institutionalising Senile Dementia,” 247.

<sup>93</sup> From Calmeil’s *Dictionnaire de Médecine on Répertoire General des Sciences Médicales* (1835). Discussed in: Berrios, *History of Mental Symptoms*, 177.

<sup>94</sup> German Berrios and Hugh Freeman, *150 Years of British Psychiatry, 1841-1991* (London/Washington D.C.: Gaskell, 1991), 51.

<sup>95</sup> John Charles Bucknill and Daniel Tuke, *A Manual of Psychological Medicine* (Philadelphia: Blanchard and Lea, 1858), 124. According to sociologist Laurence Ray, this text appears to have been “widely used by asylum medical officers during the 1860s and '70s” because it provided “accounts of British and Continental alienists’ work; systematised classifications and etiology; and described the approved treatment option.” See: Ray, “Models of Madness in Victorian Asylum Practice,” 238.

<sup>96</sup> Discussed in: James Crichton-Browne, “Senile Dementia,” *British Medical Journal* 1, no. 698 (1874): 640-643.

<sup>97</sup> Berrios, *History of Clinical Psychiatry*, 57.

<sup>98</sup> For example, Prus’ work *Recherches sur les maladies de la vieillesse* [Research on Diseases of Old Age, 1840] provided a systematic description of illnesses associated with old age, and was based on his examination of the organs taken from around 400 people who had died over the age of sixty. See: David Troyansky, *Aging in World History* (New York: Routledge Taylor & Francis Group, 2016), 118.

<sup>99</sup> This was followed by works such as British physician George Day’s *Diseases of Advanced Life* (1849), which drew on aspects of Canstatt’s earlier work and also explored a range of health issues of old age, and *Practical Treatise on the Diseases and Infirmities of Advanced Life* (1863), by Dr Daniel Maclachlan, medical superintendent at the Royal Hospital in Chelsea. See: Henning Kirk, “Geriatric Medicine and the Categorisation of Old Age: The Historical Linkage,” *Ageing and Society* 12, no.4 (1992): 487-8; Mark Jackson, ed, *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2011), 344; Alan Barton and Graham Mulley “History of the Development of Geriatric Medicine in the UK,” *Postgraduate Medical Journal* 79: 930 (2003): 229; Graham Mulley, “A History of Geriatrics and Gerontology,” *European Geriatric Medicine* 3 (2012): 226.

<sup>100</sup> It could also be extended to conditions described as ‘senile mania’ and ‘senile melancholia.’ Kirk, *Geriatric Medicine and the Categorisation of Old Age*, 491.

<sup>101</sup> Haber, *Beyond Sixty-Five*, 90.

<sup>102</sup> Johnson, *Old Age from Antiquity to Post-modernity*, 14.

<sup>103</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 108.

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- <sup>104</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>105</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 177.
- <sup>106</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 144.
- <sup>107</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 144.
- <sup>108</sup> Gillian Doody and Allan Beveridge, "Poor and Mad: A Study of Patients Admitted to the Fife and Kinross District Asylum between 1874 and 1899," *Psychological Medicine* 26, no.5 (1996): 893.
- <sup>109</sup> Edward Renvoize and Allan Beveridge, "Mental Illness and the Late Victorians: A Study of Patients Admitted to Three Asylums in York, 1880-1884," *Psychological Medicine* 19, no.1 (1989): 25.
- <sup>110</sup> Bucknill, *Manual of Psychological Medicine*, 311.
- <sup>111</sup> Clouston, *Clinical Lectures on Mental Diseases*, 244.
- <sup>112</sup> Beveridge, "Madness in Victorian Edinburgh," 50.
- <sup>113</sup> *Ibid*, 52.
- <sup>114</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>115</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 191.
- <sup>116</sup> Jean Étienne Dominique Esquirol, *Mental Maladies: A Treatise on Insanity*, trans. E. K. Hunt (Lea and Blanchard: Philadelphia, 1845), 93.
- <sup>117</sup> Clouston, *Clinical Lectures on Mental Diseases*, 253.
- <sup>118</sup> Michael J Clark, "The Rejection of Psychological Approaches to Mental Disorders in Late Nineteenth-Century British Psychiatry," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 283.
- <sup>119</sup> *Ibid*, 171-2.
- <sup>120</sup> Scull, *The Most Solitary of Afflictions*, 240.
- <sup>121</sup> Berrios, *History of Mental Symptoms*, 182.
- <sup>122</sup> Clark, "The Rejection of Psychological Approaches to Mental Disorders," 283.
- <sup>123</sup> Bucknill, *A Manual of Psychological Medicine*, 124.
- <sup>124</sup> Clark, "The Rejection of Psychological Approaches to Mental Disorders," 284.
- <sup>125</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 226.
- <sup>126</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 226.
- <sup>127</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 16.
- <sup>128</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 261.
- <sup>129</sup> Deriving from theories formulated by the French alienist Bénédict Morel in his highly influential work *Traité des Dégénérescences Physiques, Intellectuelles et Morales de L'espèce Humaine*, published in 1857.
- <sup>130</sup> The popularity of these concepts in Australasia is discussed in: Graham Edwards, "Causation of Insanity in Nineteenth Century Australia," *Australian and New Zealand Journal of Psychiatry* 16 (1982): 57.
- <sup>131</sup> Dawson, "Halting the 'Sad Degenerationist Parade,'" 43.
- <sup>132</sup> *Ibid*, 45.
- <sup>133</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 622.
- <sup>134</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 523.
- <sup>135</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 111.
- <sup>136</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 664.

## Chapter 4. “Good Hygienic Conditions of Life:” Therapeutic Decisions and Older People in Otago’s Asylums

### *Therapeutic Options and Rationales*

There have been long-standing historical (and clinical) controversies over the role of the asylum in managing mental disorders, and whether these can be disentangled from the social functions of the asylum system more broadly. Some of ambiguities around the function of asylum care are illustrated by the experiences of R.C., a carpenter from Invercargill (originally Scotland) who had been in Otago’s asylums since the age of 42. At the time of his admission in 1871, R.C was diagnosed with “mania.” At his original court hearing and committal, it was noted R.C. has “at times been violent,” including that he “endeavoured to obtain powder and shot to shoot a man.”<sup>1</sup> Witnesses also reported that he had been stealing food from stations around Matakana. In terms of family connections, R.C. was unmarried but reference was made to R.C.’s brother.<sup>2</sup> He was eventually transferred to Seacliff. A review in 1893, when R.C. was 64 years of age, described him as a “powerfully built, well nourished man” with “dementia.” At the age of 75, he was reported to be a “reliable worker” who “has been at nearby Waitati [a fishing village close to Seacliff].” He also worked at the “Summer Byre,” which formed part of the asylum farm.<sup>3</sup> The clinical notes described him at this time as “a very contented, hale old dement.”<sup>4</sup> R.C. died in 1912, at the age of 83, from “cardiac disease.” The experiences of R.C. raise questions about whether, and to what degree, the asylum could formally be considered as a ‘therapeutic’ environment, given that this patient continued to be significantly affected by mental ill-health 41 years after his first admission. For this individual, and many others who entered the asylum network, there are uncertainties over the ultimate purpose of these institutions, and against which kinds of clinical or social benchmarks their ‘effectiveness’ can be determined.

One of the principal elements of treatment - at least in theory - was in fact the asylum itself, and the opportunities that the presence of the patient in such as institution might provide for care and recovery. Many alienists and administrators, especially in the early nineteenth century, adopted an optimistic view of the inherently beneficial role of the asylum itself. As Scully notes: “More and more the asylum was presented as a technical, scientific response to the patient’s condition, an environment which provided the best possible conditions for recovery”<sup>5</sup> –

especially when compared to other available institutional options, such as workhouses, privately-operated madhouses, hospitals, or prisons. The American physician and superintendent Luther Vose Bell (1806 –1862) argued that the purpose-built asylum “was emphatically an instrument of treatment.”<sup>6</sup> There were extensive debates about asylum location and the specifics of construction and design across the nineteenth century.<sup>7</sup> As Nancy Tomes notes, these detailed discussions around asylum development were also crucial in establishing the legitimacy of an emerging group of alienists and superintendents who favoured institutional care.<sup>8</sup> Tomes notes that “advocates had to convince the public that insanity was a curable disease, best treated in a mental hospital.”<sup>9</sup>

These objectives of the asylum are likely to have been in accordance with the views of individuals such as James Hume, who - as noted - was appointed as Keeper and Superintendent of the Dunedin Lunatic asylum in 1864. Hume was not medically trained but had asylum experience in Britain (at Glasgow Royal Asylum and then asylums in the Midlands). He also endorsed the progressive principles of asylum management outlined by the British alienist John Conolly,<sup>10</sup> whose highly influential works included *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (1847) and *The Treatment of the Insane without Mechanical Restraints* (1856).<sup>11,12</sup> As discussed by Lee-Ann Monk in her review of Australian asylums, Conolly’s writings were popular because they provided practical advice and “instruction in every detail of asylum management: site and planning, internal layout, including details of the arrangement of galleries and sleeping rooms, construction of windows and doors, diet appropriate for the insane and the sorts of clothing, amusements and employments thought suitable.”<sup>13</sup>

However, as noted in the Introduction, Otago’s asylums failed to fully achieve the institutional ideals outlined by Conolly and other reformers. The original Dunedin Lunatic Asylum soon proved to be insufficient for the task of accommodating an expanding patient population. The constraints on living space - which in some circumstances even impinged the basic requirements of sleeping, bathing and dining - undermined some of the therapeutic benefits claimed for admission into asylums. In 1877, a report by Inspector Frederick Skae’s report contained extensive criticisms of the conditions in many of New Zealand’s asylums, including the one in Dunedin. This was originally “built as a temporary Asylum for 36 patients, but has been gradually enlarged and now contains 236.”<sup>14</sup> As a result, male patients were forced to sleep in dayrooms and corridors. Skae also noted that “the extreme publicity of the situation, and the small amount of ground...available for the use of the patients, render it impossible to

conduct the management of this institution in accordance with modern ideas of the treatment of the insane.”<sup>15</sup> One of the obvious problems in design was that:

The great mass of the male patients are entirely restricted for exercise to the airing yards, where they present a very dismal spectacle. Many of them are violent and dangerous, and the fear of fights and serious accidents causes mechanical restraint and seclusion to be used to an extent which it is distressing to witness, and which no one would think of justifying in a properly constructed Asylum. These remarks do not apply to the female department, the condition of some parts of which is extremely satisfactory, and makes a very pleasing impression.<sup>16</sup>

In a global overview of asylums, *Lunacy in Many Lands*, a short summary noted that the Dunedin Lunatic Asylum was (in 1881) “clean and well-ordered, but the structures are in a state of dilapidation.”<sup>17</sup> Suburban encroachment was also impinging on the site, and the asylum buildings were gradually being demolished to make way for the new Otago Boys’ High School.<sup>18</sup> Seacliff Asylum was constructed on a grander scale and more in line with the international trends in asylum design. The goal was to construct an asylum that provided permanence, but also offered space to support recovery of patients (such as through opportunities for outdoor work and exercise). It has been suggested that Truby King’s later addition of items such as paintings and plants in the corridors, comfortable furniture, a billiard room and library in Seacliff were designed to achieve another purpose: to create a degree of comfort and ‘homeliness,’ in some respects mirroring an idealised view of Victorian family life.<sup>19</sup> However, even with this expanded institutional capacity, construction issues and overcrowding were also significant problems across the study period. The selected building site was on a clay foundation, which created a series of structural problems as the ground slowly moved underneath the north wing of the asylum. Serious cracks in both the buildings and sewerage pipework rendered parts of the new asylum unsafe and insanitary.<sup>20</sup> As Duncan MacGregor notes on his report on Seacliff in 1889:

Great embarrassment has been experienced in the management of this asylum during the year owing to the dangerous condition of the northern wing. The females were all removed from this part, and accommodation was, by dint of great care and effort on the part of Dr.[...] King and his staff, provided in the auxiliary building and the two large halls.<sup>21</sup>

New regulations were introduced in 1891 requiring 600 cubic feet of space per resident within asylums. Based on estimates by an official inspection of Seacliff in that year, the asylum had

an excess of 142 patients for the room available. By 1898, with 569 patients (of which around 80% were in dormitories), the number of excess patients - 141 - had barely changed.<sup>22</sup>

Overcrowding also limited the capacity to separate out different groups of patients within the asylum system. It was acknowledged that men and women required separate quarters and the opportunities for unsupervised interactions should be restricted. As Brownwyn Labrum notes in her study of Auckland asylum, a “rigid segregation of the sexes was maintained because of fears of sexual indiscretions and as a consequence of the Victorian ideology of separate spheres.”<sup>23</sup> There were also attempts to separate patients who were considered violent and uncooperative from those who were considered more compliant, anxious or vulnerable in some regard.<sup>24</sup> However, as James Hume at the Dunedin Lunatic Asylum noted as early as 1864, it was not possible to separate convalescent patients “emerging from the dark Cloud of Insanity” from the “reckless swearing refractory Lunatic.”: Hume observed that this kind of close contact “very Strongly retards recovery.”<sup>25</sup> With characteristic bluntness, Inspector-General Duncan MacGregor complained in 1887 that potentially ‘curable’ patients might not recover because they were placed together with “idiots”, “imbeciles” and “dirty, noisy, restless creatures.”<sup>26</sup> Apart from diverging management of ‘curable’ versus ‘incurable’ patients, further separation was based on designating certain areas that allowed periods of close supervision, including for patients with suicidal tendencies or epilepsy. This goal was partially achieved at Seacliff in the 1890s with the development of an “isolation system” in which dedicated rooms allowed “use of a specially-selected attendant” whose time was “devoted to the individual patient” for set periods of time.<sup>27</sup>

As Warwick Brunton notes, however, the shift towards vast asylums internationally and in New Zealand was seen in increasingly unfavourable terms by administrators and physicians such as Frederick W. A. Skae (New Zealand’s first Inspector of Lunatic Asylums) and Truby King.<sup>28</sup> Skae appears to have favoured a residential model based on smaller detached villas for longer-term patients, both in terms of building costs and the creation of a more ‘homely’ atmosphere; this was also consistent with King’s vision of smaller buildings set in a landscaped environment.<sup>29</sup> This approach incorporated elements of Scotland’s ‘boarding out’ system for managing people with mental disorders, which involved placement of non-violent ‘lunatics’ in the people’s homes in the community.<sup>30</sup>

Apart from the assumed ‘therapeutic’ value associated with the patient’s ongoing presence in the asylum, there were some references to more specific interventions. However, one challenge for the modern reader is in determining the clinical decisions around care. Canadian historian

David Wright notes that although Victorian asylum records may contain medico-legal documents relating to the committal process, admission registers and “medical case books for all individuals in which was indicated their mental and physical progress (or deterioration),” in fact detailed descriptions of actual “*psychiatric* treatment” appeared much less frequently.<sup>31</sup> Despite this limitation, it is apparent that the ‘treatment options’ at both the Dunedin Lunatic Asylum and Seacliff often involved some level of structured activity, principally focussed on repetitive labour that contributed to the operation of the asylum. This approach aligned with some of the original goals of the ‘modern’ asylum – namely, to ensure that the patient was “constantly stimulated” and “provided with dedicated and unremitting care.”<sup>32</sup>

This emphasis on physical activity formed part of the “therapeutic” approach from the earliest days on the Dunedin Lunatic Asylum. The superintendent James Hume, Provincial Surgeon Dr Edward Hulme, and Inspector of the Asylum Duncan MacGregor were in accordance on the benefits of “light employment or Exercise” in aiding recovery and improving the “temper” and “habits” of both male and female patients (including chopping wood and carrying water for men; cleaning the wards and kitchen work for women).<sup>33</sup> Patient engagement in these practical tasks also reduced labour costs, and therefore played some role in sustaining the financial viability of the asylum.<sup>34</sup> Overall, the clinical notes suggest that there were no marked differences in the assigned activities based on the specific category of mental disorder. Day-to-day management appeared more closely connected to behavioural patterns (such as displays of aggression or “obstinacy”) and work capacity (or the ability to complete set tasks). For example, according to the asylum records, some older patients with ‘delusions’ or ‘mania’ were actively engaged in working on the farm or in the kitchen, whereas others with these same diagnoses either refused to work or did not appear physically or mentally capable of sustained activity.

There was also an apparent relationship between the ‘assigned’ activities and gender. For men who were capable of such levels of physical activity, tasks at Seacliff included clearing bush, maintaining the vegetable garden and orchards, caring for livestock, and assisting with landscaping of the extensive asylum gardens. Women were often assigned to indoor activities in the kitchen or laundry. For example, the clinical notes report that K.D., a 78-year-old woman with dementia, “still works well in the kitchen,” although she could be “very hot tempered and if corrected in any way makes use of obscene and abusive language.”<sup>35</sup> A miner from Cromwell, V.C., with “delusional insanity” and later “partial dementia” was, while in his seventies, described as a “useful storeman” whose work was at times interrupted by episodes

of asthma.<sup>36</sup> A.E., a male boltmaker who was noted to be “excitable” and affected by “religious mania,” was also described as a “diligent worker” who, while in his sixties, regularly helped with painting in the asylum.<sup>37</sup> (King’s plan to overcome the “institutional” atmosphere of Seacliff asylum involved extensive re-painting of the corridors and rooms in different shades.<sup>38</sup>)

Annual parliamentary reports on the conditions at Seacliff in 1889 and 1890 noted 217 of the 265 of the male patients were engaged in outdoor work.<sup>39</sup> (As noted above, female patients were more usually assigned indoor activities, principally in the kitchen or laundry.<sup>40</sup>) However, partly in order to differentiate the labour demands in the asylum from those in prison, King emphasised that such work was voluntary and should not exceed around six hours a day.<sup>41</sup> There were nonetheless some potential dangers with this considerable emphasis on outdoor work, as demonstrated by the unfortunate fate of a 64-year-old man, C.C., with “acute mania,” who was recorded as dying from complications after accidentally sustaining an abdominal injury from a mattock.<sup>42</sup>

In some cases, asylum-based duties reflected the prevailing cognitive or behavioural patterns of the individual. For example, patients who demonstrated a devotion to animals might become involved in caring for livestock. A.C., a labourer resident in Dunedin and originally from Scotland, was admitted to the Dunedin Lunatic Asylum in 1863 at the age of 25. His diagnosis at the time was “melancholia.”<sup>43</sup> A.C. was still resident in the asylum in his 60s, with “very fixed” ongoing delusions of animals (such as pigs) speaking to him. Because of his fondness for animals - which he regarded as “almost human” - A.C. was for many years given some responsibility caring for the pigs and horses kept on the asylum grounds. A 62-year-old farmer, S.C., first admitted with a diagnosis of “delusional insanity,” was noted to be “devotedly fond of animals and gives his whole attention to the cows [at Seacliff].”<sup>44</sup>

Conversely, the clinical notes indicated that some residents might at times or more consistently refuse to work, even if they seemed physically capable of suggested activities. For example, B.E., originally admitted aged 35 with “delusions” and “dementia,” was by the age of 62 described as a “large well-built man” who had “not been working some time past owing to occasional excitement and inability to settle to his work.” However, “[h]is conduct on the wards as a rule is good.”<sup>45</sup> When B.E. reached the age of 73, the clinical records were slightly more favourable: he was recorded as generally being “a good worker,” but “at times is dull and refuses to work.”<sup>46</sup> The relatively spacious environment at Seacliff also provided an opportunity for more “unstructured” outdoor activities. D.C., a man in his 80s affected by

dementia and delusions was “allowed to walk about the grounds unattended” though it was noted that he “does no work.”<sup>47</sup>

An appropriate diet was also promoted as a central part of care in Otago’s asylums. As Duncan MacGregor claimed in 1874: “Good food, well cooked, is of more importance to the insane than all other curative means whatever.”<sup>48</sup> It is also generally recognised that the appointment of Truby King as Medical Superintendent of Seacliff in 1889 resulted in a substantial shift in asylum conditions. There was greater emphasis on balanced diets, together with outdoor activities and exposure to fresh air. As noted above, King was the first New Zealand doctor with a diploma in the field of public health and had an enduring interest in the role of environmental and dietary factors in preserving health and preventing illness.<sup>49</sup> King’s biographer Lloyd Chapman argues that the new asylum regimen reflected King’s commitment to a combination of “normal healthy nutrition” (including less meat but more vegetables, although this reduction in daily meat intake was initially resisted by patients) coupled with “gospel of open-air occupation and useful work for the insane.”<sup>50</sup> This had in turn been promoted by one of his former professors, leading Edinburgh alienist, Thomas Clouston. In 1885, Clouston had argued that:

[t]he treatment of mental disease is in many cases a fight against morbid, unsocial ways, degraded tendencies, and idle, selfish, listless, uninterested habits of mind, and we fight these by moral means, by employment, amusement, good food, fresh air, exercise, and good hygienic conditions of life.<sup>51</sup>

More specific dietary management was also used on occasion. King used iron-based supplements and extra allocations of milk on top of the usual diet to build up undernourished patients.<sup>52</sup> For the 76-year-old woman H.B. with advanced “senile decay” (who was to die six months after her first admission), a diet of “milk, bread, minced meat” was recommended; it was also added that “[o]wing to her debility she is allowed port wine during cold weather.”<sup>53</sup>

The structuring of patient’s time and activity with Otago’s asylums did not only extend to work, sleep and mealtimes. Entertainments and recreational pursuits were also incorporated into schedule. At the Dunedin Lunatic Asylum, despite the overcrowding and limited facilities, weekly dances were held from May 1864; a new hall built in 1869 allowed more room for such activities, as well as church services, concerts, plays and magic lantern shows.<sup>54</sup> Games such as cricket, bowls and croquet were popular, as were picnics and walking parties. James Hume and asylum attendants accompanied some patients into central Dunedin for concerts.<sup>55</sup> In 1891, King described in detail the activities made available to Seacliff patients in response to an

inquiry into conditions at the asylum. These included a band (“consisting of piano, ‘cello, double bass, four violins, two cornets, clarinet, and euphonium”<sup>56</sup>), billiard room, library (with books, newspapers, and periodicals), as well as the following:

- (a.) Sports, with the band playing on the front lawn, every Saturday afternoon, unless too wet or cold.
- (b.) Croquet for women on all fine mornings.
- (c.) Tennis for special patients. (Two asphalt tennis courts have been made at a total expenditure of about £30.)
- (d.) General picnic in summer.
- (e.) Fortnightly dance during six colder months. Music by band.
- (f.) Entertainments tendered by companies from Dunedin, or given by the staff, throughout the year.<sup>57</sup>
- (g.) Optical Lantern Entertainments.<sup>58</sup>

Pharmacological treatments specifically to manage mental disorders were infrequently mentioned. N.A., a 64-year-old man admitted in 1882 with “acute mania” (reported as displaying “insomnia” and restlessness), was prescribed “a chloral [hydrate, a sedative] draught at bedtime”; this was also accompanied by “digitalis as the heart's action is weak.”<sup>59</sup> The infrequent references to pharmaceuticals are not entirely consistent with other records on asylum care at the time. The administration of chloral hydrate - after its clinical applications were promoted in the late 1860s - was widespread in Victorian asylums,<sup>60</sup> but their use is rarely mentioned in the clinical notes retrieved from the Dunedin Lunatic Asylum and Seacliff as part of this research project. Detailed analyses of other asylum case records from the period revealed that - in addition to chloral hydrate - a range of other medications were used, including potassium bromide (also typically for sedation), some forms of alcohol (such as ale and wine), hyoscyne, opiates, cannabis indica, and various purgatives (such as castor oil and Epsom salts).<sup>61</sup> The limited discussion of pharmaceuticals within the Dunedin Lunatic Asylum and Seacliff could suggest that they were not often prescribed for older people, or that their administration was simply not routinely recorded in these particular case files. The former explanation is supported by an 1881 review of global asylums, *Lunacy in Many Lands*, which noted that in the Dunedin Lunatic Asylum “no sedatives are admitted” and that “[G]ood food, air, exercise, and tonics are the treatment for all cases.”<sup>62</sup> It has also acknowledged that King was never a proponent of routine pharmaceutical treatment for Seacliff patients.<sup>63</sup>

Use of seclusion was at times recommended to manage various behaviours considered to be disruptive. For example, in 1889, U.C., a 60-year-old man with “acute mania,” was “placed in seclusion” for behaving violently towards an attendant. On this occasion it was also noted that “he was found to have matches in his pocket and on being remonstrated with he became very insulting.”<sup>64</sup> For the older patient population included in this study, there were no specific descriptions of use of mechanical restraints or physical punishments contained in the clinical notes. Although extensive reliance on mechanical restraints in asylums (at least those based on British model) had become less clinically acceptable after the 1850s,<sup>65</sup> in Otago’s asylums the use of items such as locked gloves, ‘canvas dresses’ and other restrictive garments were still applied in some circumstances, especially for patients who were suicidal or violent; those requiring force-feeding were often also physically restrained.<sup>66</sup> In the Dunedin Lunatic Asylum, “shower-baths” (which created a contrasting ‘soothing/shocking’ effect by placing the patient’s body in a bath of warm water, while also showering cold water onto the bare head) were used to alleviate “mania” and potentially to address persistent misbehaviour,<sup>67</sup> but are not specifically described in the clinical notes for this sample of older patients.

The limited use of restraints reflects the preference for more progressive ‘moral management’ adopted in many progressive asylums following the British and French examples.<sup>68</sup> This was, in principle, based on routine vigilance and guidance by clinical staff and the creation of an institutional environment that emphasised behavioural self-control amongst patients.<sup>69</sup> It was based on the assumption that the individual’s rational faculties “needed to be reawakened and rekindled” to facilitate the return of self-discipline.<sup>70</sup> More generally, the asylum staff were seen as having a pivotal role in attempting to “civilize, domesticate and regulate human behaviour”<sup>71</sup>; physical coercion and prolonged restraint were not seen as playing a role in this process. To ensure a tranquil and therapeutic environment was maintained, it had been suggested by asylum reformer Samuel Tuke (grandson of the founder of the York Retreat) that attendants – who after all had “the most extensive and intimate contact with the patients” - should be “selected for their intelligence and upright moral character.”<sup>72</sup> James Hume had previously worked at Glasgow Royal Asylum (later Gartnavel), an institution that fully adopted the principles of ‘moral’ management, and he appears to have adopted this philosophy during his appointment as superintendent of Dunedin Lunatic Asylum from 1864 to 1882.<sup>73</sup>

These therapeutic options (or lack thereof) are comparable to those described in other analyses of asylum care of the period. In terms of patient management, there are obvious parallels between Seacliff and British institutions, such as West Riding Asylum at Wakefield. Between

1866-75, West Riding Asylum was under the administration of James Crichton-Browne, a highly regarded and widely published clinician and health reformer. Within the context of asylum management, he did not tolerate the use of physical restraints and rarely used seclusion.<sup>74</sup> Crichton-Browne ordered improvements to asylum sanitation and bathing facilities, and also ensured the provision of ample food and comfortable beds. He promoted the idea of self-sufficiency, with hundreds of patients engaged in work in the kitchen and laundry or involved activities such as painting, weaving, and shoemaking. Recreational activities such as walks, dances and games were also encouraged.<sup>75</sup>

### *Stasis, Recovery, Loss: Life-courses in Otago's Asylums*

Many asylum records encompassed relatively prolonged periods of time and allow some insights into the life-courses of particular individuals. This longitudinal dimension is demonstrated for patients such as H.C., a miner from Dunedin (born in Ireland), who spent 50 years within the asylum system. He was originally arrested and admitted in 1863, at the age of 28. At this time, his diagnosis was “mania,” and he was described as “very violent.”<sup>76</sup> He reached the age of 60 in 1895. In his 60s and 70s, he was still described as having fluctuating symptoms, including “exacerbations of mania” manifested by “destroying his clothes...[and] hurting himself in falling on the ground.”<sup>77</sup> At other times he was reported to be “quiet” and “well conducted.” H.C. was known to be still alive in 1913, aged 78. The full statistical summary of the duration and frequency of asylum admissions is provided in **Appendix C**. For the study population overall, the mean duration of hospital stay was 21 years, with a range of less than one year up to 51 years. Of those patients aged at or over 60 years at time of first admission, the mean duration of hospital stay was three years, compared with 32 years for patients who attained the age of 60 as an existing inpatient or upon re-admission. The number of patients admitted more than once was 12, or 21.8%.

Excluding patients with shorter admissions for delirium tremens, those who died and those transferred to another hospital or care home, only one patient, D.A., was definitely identified as being permanently discharged from the asylum, based on this sample of records.<sup>78</sup> D.A., a 60-year-old man from Silverstream, followed a reasonably clear path to ‘recovery’ (as defined by the clinical parameters of the time) and then eventual discharge. This patient was admitted in 1883 with “acute mania” and “numerous delusions” that “there were people coming to

murder him.”<sup>79</sup> Two months later, the clinical records reported that D.A. was “improved and is able and willing now to be employed out of doors,” and that he “is now rational.”<sup>80</sup> The following month he was discharged “[b]eing of sound mind,” and there are no further asylum records (at least covering the Otago and Southland region) for this individual. Compared to the more definitive outcome for D.A., evidence of marked clinical improvements were less obvious for other older patients. Even though there was little evidence that the asylum was facilitating recovery, there was little likelihood of discharge while obvious clinical issues remained, such as the presence of delusions or hallucinations. For example, D.C., a miner from Waikouaiti admitted in 1864 (at the age of 40) with delusions of persecution, was still described as being “full of delusions” while at Seacliff forty years later.<sup>81</sup> N.C., an unmarried labourer, had been admitted 20 years earlier (in 1873) experiencing “hallucinations” of people “haunting him,” and continued to report “hallucinations of sight and hearing” at the age of 70, including that “he is visited by fairies” during the night.<sup>82</sup>

In general, the asylum records reviewed in this study provided limited explicit discussion of prognosis or the specific goals of management. For H.B., a 76-year-old woman admitted in 1883 with “senile dementia” and “senile decay,”<sup>83</sup> it was concluded by the asylum staff that: “Nothing can be done for her beyond careful nursing and kind treatment.”<sup>84</sup> A number of patients appeared to display less severe or disruptive symptoms over time, although it is unclear whether these changes reflected the underlying biological changes as a result of ageing, or the inherently beneficial effects of residing in the asylum, or a combination of both factors. Other patients either experienced little change or tended to deteriorate, which is consistent with the irreversible and progressive nature of numerous medical conditions in older age, including various forms of dementia.

An ‘intermediate’ alternative to complete discharge was indicated by records of patients who were put ‘on trial’ to assess their capacity to live away from the asylum. Catherine Coleborne has observed that this management option of ‘trial leave’ in effect created a “porous boundary” between the world of the asylum and the community, in which the person with ‘madness’ entered the domain of the private household once again.<sup>85</sup> In the New Zealand context, these trial placements (known by various names, such as being ‘absent on trial’<sup>86</sup>) were often with friends or relatives and, at least initially, lasted for a few months. Bloomfield notes that a total of 16 patients (across all ages) were placed ‘on trial’ away from Dunedin Lunatic Asylum in 1870, of which 14 were discharged by the end of the period.<sup>87</sup> In this study population, R.B., a 73-year-old woman originally admitted with “senile decay” in 1881, was placed on a period

of trial discharge in the house of her daughter R. and son-in-law W. in Teaneraki (a farming locality now called Enfield) in 1884.<sup>88</sup> Sadly, R.B. died in the family home during this trial period.<sup>89</sup> Because R.B.'s death had occurred while she was still formally considered a 'patient,' her son-in-law wrote to the asylum asking for approximately five pounds reimbursement to cover the funeral expenses that he had incurred.

The personal trajectories for older people in Otago's asylum system therefore provide somewhat pessimistic picture, especially if the goals of admission were the significant recovery of wellbeing and independence. Other historical analyses have also noted these generally disappointing 'outcomes' for older asylum populations, which contrasted with the earlier period of relative optimism and advocacy in this form of care.<sup>90</sup> For many patients aged 60 years and over, the asylum was evolving as an option for long-term residential management of so-called 'incurables,' as opposed to a setting for more temporary episodes of care. The limited references to therapeutic planning in the asylum notes (apart from the basic decision that the individual would continue on as an inpatient as opposed to being discharged) also indicates a significant degree of stasis. As patients entered their later decades, any ongoing mental health issues were increasingly compounded by physical comorbidities, such as hearing loss, fainting attacks (syncope), and strokes with accompanying paralysis and speech impairments. Ultimately, towards the end stage of life, the asylum shifted to become a provider of what would now be considered palliative or end-of-life care.

As outlined in the previous chapter, one assumption that became widely accepted in Victorian medical practice was that many mental conditions would ultimately tend to converge towards, or culminate in, a state of mental decay or dementia.<sup>91</sup> Prominent and widely published alienists and neurologists, such as Henry Maudsley (1835–1918)<sup>92</sup> and Thomas Clouston (1840–1915),<sup>93</sup> provided case studies of patients who – possibly because of 'inherited' predispositions or environmental factors, including habitual alcohol intake, brain injury, or physical exhaustion<sup>94</sup> - appeared to follow steady path to irreversible mental decline.<sup>95</sup> These mental changes were thought to occur at various stages of life, but were often seen as accompanying the process of ageing. As noted in the previous chapter, the general term 'senility' was being increasingly applied to these kinds of irreversible cognitive decline affecting older people.<sup>96,97</sup> This seemed to reflect the more general pathological changes of 'old age' being observed in post-mortem studies: that is, bodies were seen as experiencing progressive "sclerosis, fibrosis, and degeneration."<sup>98</sup>

Affective or mood disorders, such as ‘melancholia,’ have long been linked to old age, but by the nineteenth century these states were explicitly seen as overlapping with - or as an early manifestation of - senile dementia.<sup>99,100</sup> For example, leading medical authorities (including Maudsley) argued that so-called “senile melancholia” was an indicator of irreversible organic deterioration of the brain.<sup>101</sup> In their *Manual of Psychological Medicine* (1879 edition), Bucknill and Tuke argued that: “Senile insanity may assume in the first instance the form of mania or melancholia, but essentially ends in dementia.”<sup>102</sup> This element of fatalism in scientific understandings of mental illness – especially in older patients - also tended to reduce the physician’s level of interest in therapeutic interventions, especially when the broad ‘neuro-pathological’ trajectory had already been clinically determined. It has been argued by US historian Carole Haber that, despite all the scientific advances, the physicians of the era “lacked a well-defined set of standards by which to evaluate the condition of the old,” and could not offer much in therapeutic terms to manage or mitigate the adverse effects of ageing.<sup>103</sup>

The trends towards long-term residency into Otago’s asylums were also observed in many other industrialised countries. With relatively small numbers of asylum patients in fact ‘deemed curable’ in a given year,<sup>104</sup> clinical realities were now challenging the earlier assumptions that episodes of institutional care might be brief and followed by a return to relatively independent life. Within three years of its opening in 1831, the Hanwell Asylum in West London was – according to its first superintendent William Charles Ellis – “being filled with old and incurable cases.”<sup>105</sup> Comparable complaints were recorded for other newly constructed asylums, which had originally been designed to accommodate patients considered to be more rapidly ‘curable’ - or at least partially amenable to medical intervention.<sup>106</sup> A report by the Metropolitan Commissioners in Lunacy in 1844 drew attention to the challenges of caring for the “incurable lunatic, requiring little medical skill in respect of his mental disease and frequently living many years.”<sup>107</sup> By 1875, the superintendent at Littlemore asylum in Oxfordshire complained that “this Asylum is becoming full of old and incurable cases who fill our Infirmaries with Patients wanting little else than the comfort and nursing required by all aged and infirm Persons.”<sup>108</sup> In Paris, alienists in the 1890s complained that patients with “true madness” were becoming rarer in the city’s asylums, which were instead filling up with older people or those with intellectual disability and “incurable” disorders.<sup>109</sup> Across Ontario in Canada, comparable changes in admission patterns also occurred in the asylums in Kingston,<sup>110</sup> Toronto and Hamilton.<sup>111</sup>

To accommodate the “enormous number of lunatics now known to exist in every civilized country” (as described by the President of the Asylum Officers’ Association, Joseph Lalor, in

1860),<sup>112</sup> the principles of asylum management also increasingly moved away from the more personalised case-by-case care that had been promoted by the original alienists. Lalor argued that large asylums should focus on “good order and quietude,” which would in part be achieved by “the influence of the example of the large mass of the quiet and orderly, on their more disorderly fellow inmates.”<sup>113</sup> This conclusion was echoed in 1890, when Dr. David Yellowlees, Superintendent of the Glasgow Royal Asylum (later Gartnavel Royal Hospital), suggested that a major benefit of the asylum system was that the older established patients provided “newcomers [with] the necessary example of industry, order and obedience.”<sup>114</sup> In Bucknill and Tuke’s *A Manual of Psychological Medicine* (1858), it was further argued that control and the “rein of discipline” can more effectively be applied to “the insane” because “the influence of rule and habit of the old inmates” serves as an “example on the newcomers”.<sup>115</sup> These arguments suggest that older patients, accustomed to routine, were increasingly seen as playing an important role in maintaining the internal stability of asylum life.

### *Approaching Death in the Asylum*

For many older residents, the asylum was to provide a setting for the final phases of their life. The journey towards death in this institutional context is shown by experiences of G.A., a 66-year-old watchmaker, who was transferred from Dunedin Hospital to the Lunatic Asylum in October 1883. At the time of his admission into the asylum, he was considered to be “evidently dying” from failing mental function (with “memory very defective” and “speech incoherent”) coupled with “debility of bodily disease and premature old age” from “advanced disease of liver and valvular disease of heart.”<sup>116</sup> Over the next three months, this patient suffered from a series of seizures and paralysis before eventually losing consciousness and dying at the asylum. Another account of the last stages of life is provided by W.A., a 60-year-old man from Greytown (now known as Allanton) in Otago. W.A. was admitted in May 1883 with “dementia of old age” but also was found to have “all the usual symptoms of General Paralysis.”<sup>117</sup> He had been “found wandering around in a helpless and aimless manner” with his gait was “shuffling and tripping” and his “memory gone.” By August of that year, it was observed that he had “failed greatly,” was unable to speak “with any degree of intelligence” and could no longer feed himself. The next month, an entry noted that he had experienced a “paralytic

seizure” and was reported to be “now quite helpless and unable to swallow.”<sup>118</sup> W.A. was to die the day after this entry.

An overall summary of the mortality and survival patterns for the study population is provided in **Appendix D**. The mean age at death overall for those who died in asylum care was 74 years (range 60 - 87 years). Of the overall study population, the number of patients who died while in care at the Dunedin Lunatic Asylum or Seacliff Asylum was 86%. Of those patients aged 60+ years at time of first admission, 76% died in asylum care (mean age at death: 71 years), compared with 91% for those patients who attained the age of 60 as an existing inpatient or upon re-admission (mean age at death: 75 years). For patients aged 60+ years at time of first admission, the most common recorded causes of death were “apoplexy” or “paralytic stroke,” followed by “exhaustion” and “debility of old age.” For those patients who attained the age of 60 in the asylum or were readmitted, the most common causes of death listed were “senile decay,” followed by bowel disorders (including cancer and obstruction), various cardiac disorders, and "phthisis" (advanced tuberculosis).

Death in the asylum could also be associated with more acute surgical and medical issues. B.C., an 81-year-old man from Dunedin originally admitted at the age of 44 with “dementia” and a history of alcohol use, was diagnosed with a hernia and underwent minor ‘in-house’ surgery to try and relieve the stricture.<sup>119</sup> However, he was to die from the following year (1902) from an associated bowel obstruction (volvulus) and peritonitis. The asylum physician made the diagnosis but emphasised that “surgical interference was not [underlined] to be thought of.”<sup>120</sup> Progression towards death for long-term patients could involve temporary or permanent relinquishment of control by the asylum. For example, transfers to the main hospital in Dunedin were required for some patients with late-stage conditions. In 1871, a 40 year old miner M.C. from Kyeburn Diggings was admitted with “melancholia” and was reported to be “always in a depressed state of spirits” and “subject to wandering about the country and not getting proper nutriment.”<sup>121</sup> When he reached the age of 71 (in 1902), now diagnosed with “dementia,” M.C. was transferred from Seacliff to Dunedin Hospital for progressive jaundice and a large mass in his abdomen.<sup>122</sup> He was transferred back to the asylum in July of that year and steadily declined, dying four months later from advanced liver cancer.

Changes in overall trends in mortality were recorded in the context of Otago’s asylums across the study period. For example, in the year 1895, increased death rates at Seacliff were observed relative the preceding year, with a rise from 4.3% in 1894 up to 5.6%.<sup>123</sup> King attributed these

higher rates to the larger proportion of patients of advanced age and declining physical health that were being admitted:

Contrasting forcibly with these legitimate asylum cases, we have had to admit a considerable number of persons certified as insane who ought to have been treated in their own homes, or removed to charitable institutions, or who, being inmates of such institutions, ought, if possible, to have been retained there. Year by year the tendency increases to certify to the asylum moribund persons, worn out by old age and other causes, and who, though technically insane, are so only as a symptom of approaching death.<sup>124</sup>

The relationship between declines in health and often crowded asylum conditions was also a possibility, especially for communicable diseases such as tuberculosis. In this study population, Q.C., a goldminer admitted in 1868 with “unsound mind” at the age of 33,<sup>125</sup> had at the age of 61 been working in the kitchen and was considered to be in reasonable physical health. By the age of 64, however, it was noted that Q.C. had “the appearance of chronic phthistical case,” and “phthisis” (pulmonary tuberculosis) was listed as the cause of death two years later.<sup>126</sup> However, it is difficult to establish when such chronic infections were first acquired or to assess whether life within asylum may have hastened the individual’s emergence of tuberculosis and physical deterioration. Tuberculosis was a highly prevalent disorder in the wider community across this period, contributing to substantial morbidity and premature mortality in all age groups.<sup>127</sup>

A topic of ongoing clinical investigation amongst alienists of the Victorian era was the degree to which ‘insanity’ in itself could be considered as a ‘fatal’ disorder.<sup>128</sup> The question was prompted by the higher observed death rates amongst some individuals with mental illness. As noted elsewhere, there is no doubt that the progressive decline associated with general paralysis of the insane (GPI) would have reinforced this view,<sup>129</sup> but many leading doctors also emphasised the broader relationship between physical and mental disorders. For example, British asylum administrator and physician James Crichton-Browne suggested in 1880 that it was “more and more apparent that a bodily derangement is responsible for every mental disorder, and that a mental element mingles with every bodily disease.”<sup>130</sup>

The connection to the asylum and the wider sphere of medical practice did not necessarily end with the death of the individual. Outcomes of inquests and post-mortems were recorded for a number of patients in this study population. As the British historian of psychiatry Jonathan Andrews has noted, through the process of public inquests and media reporting, the patient’s

subjection to the “clinical gaze” of the asylum staff was replaced with the wider and often dehumanising attention of the medico-legal system and the general public.<sup>131</sup> For N.A., admitted in 1882 at age 64 years with “extreme melancholy, was to die early the following year from a seizure and refusal to eat. The asylum notes report somewhat tersely that “Inquest held ... Usual verdict. Natural causes.”<sup>132</sup> The inquest in 1908 for L.C., an 84-year-old man originally admitted in 1864 with “mania” and delusions, concluded that his (possibly unexpected) death was as result of “cerebral haemorrhage.”<sup>133</sup> In 1885, Dr. A.H. Neill, Superintendent of the Dunedin Lunatic Asylum and then Seacliff, expressed a commonly held medical view on the importance of autopsies for asylum patients to allow a greater understanding of underlying pathological processes in the brain.<sup>134</sup> M.F., admitted at the age of 67 in 1882 with “dementia” and delusions, died in 1896 with the cause listed as “senile decay.” He was 81 years of age. M.F.’s autopsy revealed that his “brain was found to be much atrophied especially on the left side,” but the “organs were healthy.”<sup>135</sup>

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#### *Chapter 4: Notes*

<sup>1</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>2</sup> *Ibid.*

<sup>3</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 63.

<sup>4</sup> ANZ DRO, “Seacliff Mental Hospital Medical Casebooks,” 63.

<sup>5</sup> Scull, *The Most Solitary of Afflictions*, 132.

<sup>6</sup> Discussed in: Scull, *Madhouses, Mad-Doctors, and Madmen*, 10.

<sup>7</sup> *Ibid.*

<sup>8</sup> Nancy Tomes, “A Generous Confidence: Thomas Story Kirkbride’s Philosophy of Asylum Construction and Management,” in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 122.

<sup>9</sup> *Ibid.*, 123.

<sup>10</sup> Brunton, “At Variance with the Most Elementary Principles,” 154.

<sup>11</sup> Berrios, *150 Years of British Psychiatry*, 44.

<sup>12</sup> John Conolly’s life and work are summarised in: Andrew Scull and Charlotte MacKenzie, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, N.J.: Princeton University Press, 1996).

<sup>13</sup> Lee-Ann Monk, *Attending Madness: At Work in the Australian Colonial Asylum* (Leiden: Brill, 2008), 85.

<sup>14</sup> AJHR, *Report on the Lunatic Asylums in New Zealand, 1877*, Session I, H-08, 3

<sup>15</sup> *Ibid.*, 3.

<sup>16</sup> *Ibid.*, 3.

<sup>17</sup> George Tucker, *Lunacy in Many Lands*, (Sydney: Government Printer, 1887): 676-8.

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- <sup>18</sup> Brunton, "A Choice of Difficulties," 240.
- <sup>19</sup> Waltraud Ernst, "The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand: Main Themes," in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, ed. Linda Bryder (Wellington: Bridget Williams Books, 1991), 81.
- <sup>20</sup> AJHR, *Seacliff Lunatic Asylum*, 1888, Session I, H-07, 2-3.
- <sup>21</sup> AJHR, *Report on the Lunatic Asylums in New Zealand*, 1889, Session I, H-22, 3.
- <sup>22</sup> Caldwell, "Truby King and Seacliff Asylum," 38.
- <sup>23</sup> Bronwyn Labrum, "A Women's World in a Male Universe: Treatment and Rehabilitation at the Auckland Lunatic Asylum, 1870-1910," in *New Countries and Old Medicine: Proceedings of an International Conference on the History of Medicine and Health, Auckland, New Zealand, 1994*, ed. Linda Bryder and Derek Dow (Auckland: Pyramid Press, 1995), 197.
- <sup>24</sup> Porter, "Madness and its Institutions," 297.
- <sup>25</sup> Quoted in: Bloomfield, "Dunedin Lunatic Asylum," 23.
- <sup>26</sup> Discussed in Matthew Philp, "Scientific Pastors," 191.
- <sup>27</sup> AJHR, *Papers Relating to the Seacliff Asylum Inquiry*, 1891, Session II, H-29, 7.
- <sup>28</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 327.
- <sup>29</sup> *Ibid*, 327.
- <sup>30</sup> The option of 'boarding out' - together with the expansion of district asylums - had superseded the use on royal or chartered asylums in Scotland's main cities that had predominated prior to the 1860s. This transition contrasted with the network of county asylums established across England by the mid-nineteenth century, for which the legal and administrative framework had been established in the 1808 *County Asylums Act* and formalised after 1845. See: Brunton, "The Scottish Influence on New Zealand Psychiatry," 309; Ethel Shanas and Marvin Sussman, *Family, Bureaucracy, and the Elderly* (Durham, N.C.: Duke University Press, 1977), 44.
- <sup>31</sup> David Wright, Laurie Jacklin, and Tom Themeles, "Dying to Get Out of the Asylum: Mortality and Madness in Four Mental Hospitals in Victorian Canada, c. 1841-1891," *Bulletin of the History of Medicine* 87, no. 4 (2013): 595.
- <sup>32</sup> Scull, *The Most Solitary of Afflictions*, 147.
- <sup>33</sup> Bloomfield, "Dunedin Lunatic Asylum," 29.
- <sup>34</sup> Caldwell, "Truby King and Seacliff Asylum," 35.
- <sup>35</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 46.
- <sup>36</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 47.
- <sup>37</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 254.
- <sup>38</sup> Caldwell, "Truby King and Seacliff Asylum, 1889-1907," 40.
- <sup>39</sup> Lloyd Chapman, *In a Strange Garden: The Life and Times of Truby King* (Auckland N.Z.: Penguin Books, 2003), 54.
- <sup>40</sup> *Ibid*, 79.
- <sup>41</sup> Jane Adams, "Criminal Lunacy: A case Study of Seacliff Lunatic Asylum, 1882-1912," in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, ed. Barbara Brookes (Dunedin: University of Otago Press, 2001), 73.
- <sup>42</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 54.
- <sup>43</sup> ANZ DRO, "Dunedin Lunatic Asylum Register of Patients," 1863.
- <sup>44</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 5.
- <sup>45</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 21.
- <sup>46</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 21.
- <sup>47</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 15.

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- <sup>48</sup> Philp, "Scientific Pastors," 189.
- <sup>49</sup> Caldwell, "Truby King and Seacliff Asylum," 35.
- <sup>50</sup> Chapman, *In a Strange Garden*, 54.
- <sup>51</sup> See: Brunton, "The Scottish Influence on New Zealand Psychiatry," 309.
- <sup>52</sup> Paul Stock and Chris Brickell. "Nature's Good for You: Sir Truby King, Seacliff Asylum, and the Greening of Health Care in New Zealand, 1889–1922," *Health & Place* 22 (2013): 110.
- <sup>53</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 553.
- <sup>54</sup> Bloomfield, "Dunedin Lunatic Asylum", 29.
- <sup>55</sup> Bloomfield, "Dunedin Lunatic Asylum", 31.
- <sup>56</sup> AJHR, Papers Relating to the Seacliff Asylum Inquiry, 1891, Session II, H-29, 7.
- <sup>57</sup> Visiting performers included the Dunedin Orchestral Society and the All Star Variety Company; locals from the Seacliff community also attended these events at the asylum. Caroline Hubbard, "Seacliff and Ashburn Hall Compared, 1882-1911," in *Unfortunate Folk: Essays on Mental Health Treatment, 1863-1992*, ed. Barbara Brookes (Dunedin: University of Otago Press, 2001), 110.
- <sup>58</sup> This was described as follows: "The first lantern-entertainment devised at Seacliff was given last Christmas Eve by means of an apparatus which we have for the most part constructed in the establishment. The lantern is provided with oxy-hydrogen lime-light, and the image is projected from the gallery of the large hall to the stage, a distance of 80ft., on to a screen 24ft. in diameter - probably the largest in the colony." AJHR, *Papers Relating to the Seacliff Asylum Inquiry*, 1891, Session II, H-29, 7.
- <sup>59</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 525.
- <sup>60</sup> Scull, *The Most Solitary of Afflictions*, 290.
- <sup>61</sup> Renvoize, "Mental Illness and the Late Victorians," 25-26.
- <sup>62</sup> Tucker, *Lunacy in Many Lands*, 677
- <sup>63</sup> Ernst, "The Social History of Pakeha Psychiatry in Nineteenth-Century New Zealand," 82.
- <sup>64</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 261.
- <sup>65</sup> Scull, *Masters of Bedlam*, 193.
- <sup>66</sup> Brunton, "A Choice of Difficulties," 364.
- <sup>67</sup> Bloomfield, "Dunedin Lunatic Asylum 1863-1876," 31.
- <sup>68</sup> Porter, "Madness and its Institutions," 295.
- <sup>69</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 311.
- <sup>70</sup> Porter, "Madness and its Institutions," 291.
- <sup>71</sup> Catharine Coleborne, "Making 'Mad' Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum," in *Law, History, Colonialism: The Reach of Empire*, eds. Diane Elizabeth Kirkby and Catharine Coleborne, (Manchester University Press, 2001), 111.
- <sup>72</sup> Suggested by Tuke in 1813. See: Scull, *The Most Solitary of Afflictions*, 147.
- <sup>73</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 316.
- <sup>74</sup> Berrios, *150 Years of British Psychiatry*, 408.
- <sup>75</sup> *Ibid*, 411.
- <sup>76</sup> ANZ DRO, "Dunedin Lunatic Asylum Keeper's Journal," 1863.
- <sup>77</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 7.
- <sup>78</sup> It is possible that some older patients with shorter periods of admission were less likely to be identified in the sampling process because of gaps in the detailed case records. Because of these potential biases and the incomplete sample, it is difficult to estimate a formal 'recovery rate' for older patients in the asylum system more generally.
- <sup>79</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."

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- <sup>80</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 582.
- <sup>81</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 15.
- <sup>82</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 89.
- <sup>83</sup> Ibid.
- <sup>84</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 553.
- <sup>85</sup> Coleborne, *Madness in the Family*, 122.
- <sup>86</sup> Ibid, 124.
- <sup>87</sup> Bloomfield, "Dunedin Lunatic Asylum", 31.
- <sup>88</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>89</sup> Ibid.
- <sup>90</sup> Porter, *Madness: A Brief History*, 119.
- <sup>91</sup> Clark, "The Rejection of Psychological Approaches to Mental Disorders," 286.
- <sup>92</sup> Henry Maudsley, *The Pathology of Mind* (London: Macmillan, 1879), 473-6.
- <sup>93</sup> Clouston's role is discussed in detail in: Beveridge, "Madness in Victorian Edinburgh," 24-6.
- <sup>94</sup> Berrios, *150 Years of British Psychiatry*, 377.
- <sup>95</sup> Clark, "The Rejection of Psychological Approaches to Mental Disorders," 286.
- <sup>96</sup> Boller, "History of Dementia and Dementia in History," 126.
- <sup>97</sup> Apart from the clinical classification of 'dementia,' a vast range of other terms were also applied to abnormal states or levels of consciousness. Historically, expressions such as 'confusion', 'stupor', 'catalepsy' and 'catatonia' could also be applied to impaired responsiveness that was associated with severe psychiatric or mental disorders (including what is now called schizophrenia). 'Delirium' was often applied to a short-lived or reversible state of mental confusion or disorientation, which could have multiple physical or mental causes, including alcohol intoxication or high fever. However, most of these terms were applied more generally and not necessarily linked with the ageing process. See: Berrios, *History of Mental Symptoms*, 233. In their explorations of processes affecting the brain, nineteenth-century physicians also debated the interconnections between epilepsy and 'insanity.' It was argued that the two conditions were closely related, with clinical investigations into the nature and cerebral origins of various 'epileptic manias' and other 'overlap' conditions. See: Berrios, *History of Clinical Psychiatry*, 156-7.
- <sup>98</sup> Carole Haber, "From Senescence to Senility: The Transformation of Senile Old Age in the Nineteenth Century," *International Journal of Aging and Human Development* 19, no.1 (1984): 42.
- <sup>99</sup> Lewis Willmuth, "Medical Views of Depression in the Elderly: Historical Notes," *Journal of the American Geriatrics Society* 27, no.11 (1979): 497.
- <sup>100</sup> Simon Hill and Richard Laugharne, "Mania, Dementia and Melancholia in the 1870s: Admissions to a Cornwall Asylum," *Journal of the Royal Society of Medicine* 96, no.7 (2003): 362.
- <sup>101</sup> Maudsley, *The Pathology of Mind*, 476.
- <sup>102</sup> Discussed in: Willmuth, "Medical Views of Depression in the Elderly," 497.
- <sup>103</sup> Haber, *Beyond Sixty-Five*, 61.
- <sup>104</sup> Scull, *The Most Solitary of Afflictions*, 274.
- <sup>105</sup> Ibid, 173.
- <sup>106</sup> Ibid, 174.
- <sup>107</sup> Ibid, 269.
- <sup>108</sup> Ibid, 275.
- <sup>109</sup> Patricia E. Prestwich, "Family Strategies and Medical Power: Voluntary Committal in a Parisian Asylum, 1876-1914," in *The Confinement of the Insane: International Perspectives, 1800-1965*, ed. Roy Porter and David Wright (Cambridge; New York: Cambridge University Press, 2003), 97.

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- <sup>110</sup> Montigny, *Foisted Upon the Government?*, 823.
- <sup>111</sup> David Wright, "Hamilton and Toronto Asylums, Canada, 1861-1891," 115.
- <sup>112</sup> Joseph Lalor, "Observations of the Size and Construction of Lunatic Asylums," *Journal of Mental Science* 7 (1860): 105.
- <sup>113</sup> *Ibid*, 106.
- <sup>114</sup> David Yellowlees, "Presidential Address," *Journal of Mental Science* 36 (1890):488.
- <sup>115</sup> Bucknill, *A Manual of Psychological Medicine*, 491.
- <sup>116</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 601.
- <sup>117</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 564.
- <sup>118</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 564.
- <sup>119</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 25.
- <sup>120</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 25.
- <sup>121</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>122</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 71.
- <sup>123</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1896 Session I, H-07, 5.
- <sup>124</sup> In terms of overall trends, the official report for 1895 noted that the proportion of Seacliff patients over 60 years of age had doubled between 1885 and 1895. AJHR, *Report on Lunatic Asylums of the Colony*, 1896 Session I, H-07, 5.
- <sup>125</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>126</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 40.
- <sup>127</sup> Wright, "Dying to Get Out of the Asylum," 606.
- <sup>128</sup> Cathy Smith, " 'Visitation by God': Rationalizing Death in the Victorian Asylum," *History of Psychiatry* 23, no. 89 (2012): 106.
- <sup>129</sup> Wright, "Dying to Get Out of the Asylum," 604.
- <sup>130</sup> James Crichton-Browne, "Circles of Mental Disorder – Modern Nervous Diseases," *The Journal of Psychological Medicine and Mental Pathology* 2, no.6 (1880): 170.
- <sup>131</sup> Jonathan Andrews, "Introduction: Lunacy's Last Rites." *History of Psychiatry* 23, no. 1 (2012): 4.
- <sup>132</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 526.
- <sup>133</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 16.
- <sup>134</sup> Matthew Philp, "Scientific Pastors," 191.
- <sup>135</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 80.

## Chapter 5. Limited Choices and Difficult Decisions: Caring for Older People with Mental Disorders in Colonial Societies

### *Colonial Asylums as Social 'Solutions'*

As discussed in preceding chapters, the case records from Dunedin Lunatic Asylum and Seacliff indicate often prolonged periods of admission for older people with little evidence of significant 'recovery' and likelihood of discharge. Older patients who entered the asylum system included those who developed mental disorders (including dementia) in the community after reaching 60, as well as those who had aged in the asylum 'with' chronic neuropsychiatric disorders that had never fully resolved (such as earlier-onset 'mania' or 'delusional insanity'). The social implications of these trends in the New Zealand will now be more fully explored and placed in an international context.

The available options for management of older patients affected by mental illness or cognitive decline were influenced by a range of geographical, socio-demographic and clinical factors.<sup>1</sup> The wider community impacts of older people living with mental ill-health are illustrated by the experiences of C.A., a 78-year-old carpenter originally from Argyllshire in Scotland and resident in New Zealand for 20 years. C.A. was a widower with a son and daughter. He was admitted in April 1879 with a diagnosis of "senile decay." Over the previous two years, he had displayed "a failure of memory" and "was under the impression that he is in his native town and among the friends of his youth."<sup>2</sup> It was noted that C.A. had "lived latterly at Tapanui with his son" but had "became unmanageable and requires constant attention which his son could ill afford."<sup>3</sup> Witnesses reported that he "wanders about in the bush in a purposeless manner." The admission documents also described a particular concern that C.A. "frequently manifests a desire to take off all his clothes" and that he wandered about "all but naked."<sup>4</sup> As suggested by this example, people diagnosed with severe psychiatric and/or neurological illness presented challenges for families and the wider community in colonial New Zealand. Although kin-based care in the domestic setting was one of most common options for managing those with mental ill-health,<sup>5,6</sup> in many cases those on lower incomes "had little excess income to take care of themselves, let alone their incapacitated relatives."<sup>7</sup> The preceding chapters have also highlighted the number of relatively isolated older people in New Zealand, especially

unmarried men who arrived during the early phases of settlement, who lacked any form of established social support.

From the 1870s, New Zealand communities were forced to address another emerging issue: how to accommodate increasing numbers of older people that were becoming infirm or 'dependent.' Demographically, the settler communities had until the last decades of the nineteenth century been relatively young. In 1870, there was only one person over the age of 65 for every 100 settlers in New Zealand, whereas in rural Britain there were approximately eight per hundred people in this age bracket.<sup>8</sup> As noted in the Introduction, this demographic shift had arisen both because the earlier 'pioneers' were progressively ageing, but also because larger numbers of older people were now migrating to the colony, often with their extended families. Perspectives on care for older people related to the prevailing attitudes and priorities of the community, but - as noted in relation to the challenges in meeting the needs of those with mental ill-health - also reflected the financial or personal capacity of individuals or their families to secure adequate support.

As David Thomson notes, these concerns formed part of the wider debate "over where to locate the balance of responsibility in welfare matters: with the individual, the family, a wider net of kin and acquaintances, the local community, the nation state, or with some mix of each of these?"<sup>9</sup> In the face of these intersecting social challenges, the solutions developed by various Provincial and national governments in New Zealand were often belated and insufficient for the actual level of community need. As discussed in the Introductory sections, provincial administrations - including those of Otago and Southland - initially lacked the necessary infrastructure to provide suitable care on a large scale. New Zealand's early settlements could not rely on established networks of charitable foundations and poorhouses that provided basic social support (usually at subsistence-level) elsewhere.<sup>10</sup> In practical terms, one of the community-centred options by which to 'manage' people with mental illness - including in old age - was through an asylum system, an approach that had already become established across Britain, continental Europe, North America, and other colonial centres<sup>11</sup> (such as Australia). For example, in England and Wales, the development of large-scale asylums had been galvanised by the *County Asylums Act* of 1845, which required every county to provide accommodation for its "pauper lunatics."<sup>12</sup> At the national level, an official Lunacy Commission was also appointed specifically to oversee the welfare of patients and provide direction on asylum management and standards.<sup>13</sup> The construction and funding of asylums in

New Zealand, based on these pre-existing international exemplars, therefore provided a partial response to the cumulative socio-demographic pressures affecting the new colony.

However, this apparent solution ran into various problems in practice. As discussed in the Introduction, a perverse financial arrangement was established that was to encourage the transfer of older people from other institutions into asylums. The 1885 *Hospitals and Charitable Institutions Act* required that local bodies provide half the cost of maintenance (such as through local taxation) of “the aged poor” in their region, with the central government providing the other half of the funding. For local authorities, it proved less expensive to simply transfer older people into lunatic asylums, which were principally funded by the government.<sup>14</sup> In his official 1887 report, New Zealand’s Inspector of Asylums Duncan MacGregor complained that the asylum population included an “unusually large number of aged people who are suffering merely from senile decay” and argued that in other countries - especially Britain - such people would instead “find refuge in workhouses and other similar institutions.”<sup>15</sup> He argued that these “merely friendless” older people had “grown old without contracting family ties,” and recommended that charitable refuges should be used to accommodate these individuals instead.<sup>16</sup> In May 1890, MacGregor even arranged a forced discharge of “six harmless senile patients” from the Auckland Asylum (‘The Whau’) because they did not meet the legal definition of ‘insanity’; these displaced older people ended up in police cells and were eventually taken in by the Salvation Army with the direct assistance of Sir George Grey.<sup>17</sup> However, the local authorities, press and public opinion generally reacted against this kind of coercive targeting of vulnerable older patients, who were referred to as “The Whau Exiles” by the *Auckland Star*, which provided regular updates on their fate.<sup>18</sup>

From the 1880s, various attempts at ‘efficiency’ across the hospital and charitable aid system were introduced, including more stringent rules for payment of patients housed in asylums. Under the earlier arrangement, those considered as ‘destitute’ had usually been provided with hospital treatment free of charge. However, Dr George Grabham, Inspector of Asylums and Hospitals (1882-6), reported that many patients who were being “treated in the hospitals are not proper objects of charity”: he complained that “[t]he hospitals are encumbered with aged persons, incurable cases, and worthless persons, who would find a home in a workhouse in England.”<sup>19</sup> This demonstrated to Grabham that “the collection of maintenance-money is defective,” which he suggested should be resolved by more efficient payment systems once the patient had recovered and was again receiving income from their employment.<sup>20</sup>

The Seacliff records demonstrate how these efficiency measures played out in practice. Correspondence shows how asylum administrators tried to procure financial contributions from patients' families. In 1890, the institution sought payment from the family of a 61-year-old man, U.C., who had been admitted with "acute mania" on four occasions over the preceding 13 years.<sup>21</sup> It was recorded that the patient's two sons were financially supporting the U.C.'s wife, who was also being nursed by the couple's daughter. However, it was further determined that the patient's brother was "fairly well off," with a property and two shops in Dunedin. On the 6<sup>th</sup> of March 1890, a resident magistrate issued an order for the brother to contribute 2/- per week for U.C.'s maintenance. Further correspondence from 1900 indicated that U.C.'s brother declined further payment from that year.<sup>22</sup> Catharine Coleborne has described similar trends in pursuit of maintenance for asylums in Auckland, Sydney, Melbourne and Brisbane from the 1860s to 1914.<sup>23</sup> As in the case of Seacliff, such attempts at securing financial contributions from family members typically ended in failure. Coleborne concluded that: "Gains made in the collection of maintenance fees were slim, leaving the vast majority of asylum patients to be supported by the state."<sup>24</sup> This is perhaps not surprising given that the original motivations for placing a family member to an asylum in the first place were often economic, a response to the unsustainable expense of needing someone at home to provide care for an older person with mental ill-health.

### *Ambivalence and Accommodation: Responses to Ageing and Mental Ill-Health*

The asylum records raise broader questions over whether and to what degree the needs of an older population - who were experiencing various mental, physical and social 'consequences' of ageing - were ultimately understood and accommodated within the context of New Zealand's colonial society. An example of the experience of 'old age' affected by infirmity is shown by F.C., a married labourer and a resident of Invercargill, who was admitted to the asylum in 1881 at the age of 49. F.C. was originally from County Cork in Ireland and had been in New Zealand for seven years. His diagnosis at the time of admission was "lunacy," and he was noted to be "confused in his thoughts" and "very violent."<sup>25</sup> F.C. reached the age of 60 in 1892. In a clinical review at Seacliff in the following year, he was described as "feeble-minded" with "no ambition."<sup>26</sup> He was apparently "quite contented to spend his life in the asylum." Overall, he spent a total of 17 years in the asylum until his death at the age of 66.

In terms of clinical outcomes while in the asylum, there was a prevailing assumption that patients not discharged within six months tended to remain there permanently. These individuals were often deemed ‘incurable’ and could comprise well over 75% of the population in New Zealand’s large asylums by the late nineteenth century.<sup>27</sup> As noted, the situation is comparable to that which had developed across centres, such as Britain. In their Annual Reports from the 1860s onwards, the national Lunacy Commissioners drew official attention to the increasing numbers of older people being sent to asylums.<sup>28</sup> In view of the acknowledged limitations of asylums and doubts over their therapeutic effectiveness, an important consideration is therefore whether there were any other available options for large-scale care of older people with mental ill-health in nineteenth century New Zealand. This is an issue that was actively debated at the time, as shown by the experiences of G.E., a previously mentioned patient in his sixties with advanced “disseminated sclerosis” (multiple sclerosis). G.E. was described as “a harmless old man” who, it was noted, “might well be in a poorhouse or other such charitable institution.”<sup>29</sup> Other care options were also discussed for L.A., a 68-year-old shepherd who had been arrested and imprisoned on “charge of vagrancy” in April 1884.<sup>30</sup> He was then transferred to the asylum, with a medical assessment concluding he was “partially paralysed,” incontinent, and “physically and mentally...quite unfit to take proper care of himself.”<sup>31</sup> He was considered by the asylum physicians to be “more an imbecile than a lunatic.” The clinical notes stated that L.A. was “stupid and silly in a case more suitable for [the Otago] Benevolent Institution [in Caversham, at the time principally used as a care home for the elderly] than a Lunatic Asylum.”<sup>32</sup>

Apart from family-based management and asylums, there were other settings that were used for care of older people with mental ill-health in Otago, especially from the 1860s. For example, small, often church-run, charities – such as the Patients’ and Prisoners’ Aid Society and those operated by the Salvation Army and Knox Church - were established in Dunedin, but the available records indicate most of these operated on miniscule budgets.<sup>33</sup> The largest organisation offering charitable relief was the Otago Benevolent Association, which was supported by public funds. This Association had been established in 1862 as an initiative of private citizens (including Julius Vogel) but it secured public funds to manage many of the demands of charitable aid in the province.<sup>34</sup> By 1864, it was spending around £1 700 per annum and assisting 1500 people a year (around 2.5% of the entire Provincial population).<sup>35</sup> This Association - later generally known as the Otago Benevolent Institution, although this also referred to the physical building it founded - provided an outdoor relief system and

accommodation. In many cases, financial support was designed to be temporary and often did not constitute a living allowance.

The Otago Benevolent Institution home, located in Caversham and informally known as the ‘Benny,’ at first principally offered support to children, unmarried mothers and older people.<sup>36</sup> In the 1890s the proportion of residents over the age of 65 steadily increased and the Institution more fully transitioned into an ‘old person’s home.’<sup>37</sup> Ongoing expansions were necessary to accommodate the influx: a new wing was added in 1880, followed the next year by a new block for women and then a 52-bed block in 1894; by the end of that decade, the Institution contained an estimated 285 residents.<sup>38</sup> Many residents had worked on the original goldfields, and as David Thomson notes, a number of residents had Chinese surnames, indicating that they were recipients of charitable aid “although anti-Asian prejudice was virulent” at the time.<sup>39</sup> Many of these individuals had medical or age-related reasons listed for their admission, including “debility” or “old age.”<sup>40</sup> A few individuals with chronic illness “shuttled back and forth between the Benevolent Institution and Dunedin Hospital.”<sup>41</sup> The historical evidence therefore suggests some potential overlap in the care provided by ‘rest homes’ (as the Otago Benevolent Institution effectively became) and asylums for older people, although it is probable that the nature and extent of mental and physical incapacity affecting the individual may have influenced the final choice of institution.

Another welfare option (briefly referred to in the Introduction) that may have been relevant to some older people was outdoor relief, which referred to various forms of support for people in their own residences. Different provinces made their own arrangements for how this operated in practice, with many using paid government officers or agents to coordinate relief. In Otago, this was also administered by the Otago Benevolent Institution Trustees, who had around 400 cases (men, women and children) listed at the start of each year in the 1890s.<sup>42</sup> Most of those supported were orphaned children, young or middle-aged women who were either widowed or affected by desertion, and older men no longer able to work; older women represented a relatively small proportion of those assisted.<sup>43</sup> Of the successful applications for outdoor relief from the Otago Benevolent Institution in 1895, 103 of the 690 approvals (15%) fell within the category “old and past work.” The specification of being “past work” was required because “old age” in and of itself was not a sufficient reason to receive charitable support.<sup>44</sup> In comparison, charitable approvals for “widows” comprised around 30%.<sup>45</sup> Most adult applicants who requested aid received money, around 8/- to 10/- a week for an average of two months.<sup>46</sup> The system of outdoor relief, and its control by Otago Benevolent Institution more specifically,

was periodically attacked by members of the charitable aid board (established as part of the 1885 *Hospitals and Charitable Institutions Act*) for its supposed extravagance and for favouring residents in poor parts of Dunedin instead of those in rural areas.<sup>47</sup> The often temporary nature of the support, and its limited capacity to support for individuals who were not able to safely remain in their home environment, suggests that outdoor relief would not have been sufficient, in its original form, to address the growing demands for care of older people with mental ill-health.

Another institutional ‘context’ for older individuals with mental disorders was the prison system. In 1895, Captain Arthur Hume, who had been appointed Inspector-General of Prisons in 1880, turned his attention to two groups that, in his view, were inappropriately ending up in prison. The first group were people affected by alcohol dependence, especially those with delirium tremens. The second group comprised “aged paupers,” who incarcerated “simply because they are too old for labour, or to earn an honest living.”<sup>48</sup> Hume – who was in effect responsible for imposing order in the nation’s “chaotic collection of prisons left after the abolition of provincial government”<sup>49</sup> – had also more generally highlighted the “cruelty and inhumanity” of keeping people with mental disorders “shut up in prisons.”<sup>50</sup> Prison and asylums were also interconnected over the issue of ‘criminal lunacy,’ although in this case – as with older people with mental ill-health more generally – the weight of responsibility often shifted towards the asylum as the primary care provider.<sup>51</sup> The *Lunatics Act* of 1882 specified that a person who had committed and been charged for a crime but appeared to be a ‘lunatic’ could be removed from any prison or house of correction and transferred to an asylum. This decision required the approval of the Colonial Secretary certification from two medical practitioners.<sup>52</sup> Duncan MacGregor had argued for a separate facilities for “criminal lunatics,” whom he described in 1890 as “extremely violent and dangerous” individuals that created “great difficulties and turmoil amongst the patients and the staff.”<sup>53</sup> Although a minority of the ‘criminal’ individuals transferred from the Gaol or prison and housed at Seacliff had been charged with violent crimes (such as murder, rape and assault), in fact many more had been arrested for more minor offences such as vagrancy (up to a third), drunkenness, theft and indecent exposure.<sup>54</sup> Many ‘criminal lunatics’ – especially single or widowed men - ultimately died in the asylum, with some living well into their sixties, seventies and even eighties.<sup>55</sup>

These social challenges and responses relating to the care for older people with mental disorders have many international parallels. In Britain and the Empire, parts of Europe, and North America, various forms of institutionalisation for this population were becoming

increasingly common from the 1850s. However, there were also major contrasts. As noted above, in Britain older people on lower incomes might find themselves placed in poorhouses or workhouses (Poor Law institutions in England operating between 1834 and 1929). In 1851, it is estimated that 3.2% of the population of England and Wales over the age of 65 were living in workhouses, asylums and/or Poor Law hospitals; this percentage had risen to 5.1% by 1891.<sup>56</sup> For example, a review of the Bedford workhouse population (total 200-300 inmates) for 1840s and 1850s in the UK revealed that around 15% were aged 60 or over.<sup>57</sup> Lunacy Commissioners at times attempted to separate out ‘ordinary paupers’ in the workhouse from those classified as ‘lunatics,’ which might be transferred to asylums.<sup>58</sup>

As noted in the Introduction, this collective system of parish assistance and Poor Law relief that had evolved over many centuries in England was not directly translated to New Zealand’s emerging colonial society. Under the *Destitute Persons Act* (1846), responsibility for care of the ‘destitute’ in New Zealand was instead placed to a far greater degree on the extended family, including obligations placed upon siblings, children and grandchildren for support of older people.<sup>59</sup> As discussed, only after some decades was a basic “public relief” system implemented, following the passage of the *Hospital and Charitable Institutions Act* of 1885.<sup>60</sup> Kay Saville-Smith has suggested that across these decades the state was gradually moving towards greater acknowledgement of issues affecting older New Zealanders. Saville-Smith argued that “being elderly” was in effect being seen as both a ‘medical’ problem - requiring support services and care - but also an ‘economic’ problem because of increased dependency later in life.<sup>61</sup>

Based on detailed international studies of asylum populations, the rise in the proportion of older patients observed in New Zealand was also comparable with many other institutions, especially from 1850. For example, in Gillian Doody’s analysis of 526 patients admitted into the Fife and Kinross asylum in Scotland between 1874-99, 8.5% of men and 10.1% of women were over the age of 60.<sup>62</sup> In Edward Renvoize’s study of the North Riding Asylum in York (which housed 595 ‘pauper lunatics’ in 1884), it was estimated that 14% of male patients and 12% of female patients were diagnosed with ill-health from old age for the years 1880-1884, with 25% of overall asylum deaths linked to “senile decay.”<sup>63</sup> In the New Norfolk Lunatic Asylum in Tasmania, the proportion of people at or over 60 years rose from 6% to around 16% between 1830 and 1899.<sup>64</sup> Many centres also observed higher rates of admission for women.<sup>65</sup> For example, between 1850 and 1871, the Lancaster Asylum experienced a rise in the percentage of patients over sixty from 6% to 13% for men and from 10% to 18% for women.<sup>66</sup> Women

also had longer admissions and lower death rates compared with men. With the subsequent establishment of a larger network of asylums with ever increasing capacity, Edgar-André Montigny argued that these developments may in effect have offered families an “option” for managing older people viewed as “burdensome.”<sup>67</sup> Even so, as John Walton has noted, in most cases “the county asylum provided relief for desperate families rather than an easy option for the uncaring or irresponsible.”<sup>68</sup>

As in New Zealand, clinical and political debates in other jurisdictions also focussed whether the older people ending up in asylums could be transferred or managed elsewhere. As British historian Emily Andrews has noted specifically with reference to older people with dementia, they were caught in the “institutional nexus” of asylums and workhouses and “were never welcome there.”<sup>69</sup> Asylum administrators openly questioned whether their budgets should be used to manage older patients. In 1867, the Scottish asylum doctor Charles Lockhart Robertson (1825 – 1897) estimated that a quarter of asylum patients would benefit from being transferred to the workhouse, and another 15% would be best managed in the family home.<sup>70</sup> In 1858, John Charles Bucknill - medical superintendent at Devon County Asylum, co-author of *A Manual of Psychological Medicine* (referred to above), and editor of the *Journal of Mental Science* - concluded that too many patients with ‘incurable’ disorders (such as “idiocy,” epilepsy and senile dementia) were ending up in the asylum, whereas too many of those with at least partially reversible disorders (such as melancholia) ended up in the workhouse.<sup>71</sup> In his 1880 book *The Care of the Insane and their Legal Control*, Bucknill continued with his earlier line of criticism: he compared the so-called “old madhouses” which contained “only obvious and dangerous cases of lunacy” with the “modern asylum,”<sup>72</sup> which (by 1880) instead provided care to “a motley crowd of persons of weak minds and low spirits,” “paralytics and epileptics” and “persons in various stages of mental decay.”<sup>73</sup> An 1877 report of the condition of asylums by J. Mortimer Granville was unsparing in his opinions that asylums were at risk of becoming merely “depositories for the troublesome old people” that often filled poor-houses.<sup>74</sup> In 1881, the Lunacy Commissioners even attempted to argue that, in effect, ‘senile dementia’ and decay were ‘natural’ processes that often accompanied old age, and therefore could not be seen as comparable to other forms of ‘insanity.’<sup>75</sup> The long-term management of older people in asylums also raised serious economic questions about responsibility for care. An 1897 Annual Report on asylums in Ontario claimed that such care constituted in effect “an enormous tax upon the state;”<sup>76</sup> a report from the Hamilton Asylum in Ontario the following year described how “liberality of the [Provincial] Government in providing such ample accommodation at

cheap rates, or even free” acted as “a powerful stimulus” in transferring “the burden from the home to the state.”<sup>77</sup>

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## Chapter 5: Notes

<sup>1</sup> According to medical historian Roy Porter, the French alienists of the early nineteenth century in effect became the first ‘geriatric psychiatrists’ in order to manage this expanding population of older patients. France was one of the main centres in which the question of care of ‘institutionalised’ older people became more formally recognised. This situation arose because massive hospitals and asylums - such as the Bicêtre and Salpêtrière in Paris - came to house large numbers of older people. German Berrios, *History of Clinical Psychiatry*, 57.

<sup>2</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Coleborne, “His brain was wrong, his mind astray,” 50.

<sup>6</sup> Brunton, “The Scottish Influence on New Zealand Psychiatry,” 311.

<sup>7</sup> Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-nineteenth-century England* (London/Washington: Leicester University Press, 1999), 140.

<sup>8</sup> Thomson, *Old Age in the New World*, 152.

<sup>9</sup> David Thomson, “The Welfare of the Elderly in the Past,” in *Life, Death, and the Elderly: Historical Perspectives*, ed. Margaret Pelling and Richard Smith (London: Routledge, 1991), 213.

<sup>10</sup> Shanas, *Family, Bureaucracy, and the Elderly*, 44.

<sup>11</sup> Sally Swartz, “The Regulation of British Colonial Lunatic Asylums and the Origins of Colonial Psychiatry, 1860-1864,” *History of Psychology* 1, no.2 (2010): 162.

<sup>12</sup> Porter, *The Anatomy of Madness*, 103. In Scotland, royal or chartered asylums in the main cities formed the basis of care until around 1860, after which there was an expansion of district asylums and reliance on ‘boarding out’ (initially funded by charitable donations, this involved placement of non-violent ‘lunatics’ in the people’s homes in the community). Brunton, “The Scottish Influence on New Zealand Psychiatry,” 309.

<sup>13</sup> Porter, *The Anatomy of Madness*, 103.

<sup>14</sup> McCarthy, “Connections and Divergences,” 27.

<sup>15</sup> AJHR, *Report on Lunatic Asylums of the Colony*, 1887, Session I, H-09, 1.

<sup>16</sup> In Auckland, a large bequest would eventually be used towards construction of the Costley Home for the Aged Poor. This replaced the Auckland Old Men's and Old Women's Refuges in 1890. Tennant, “Elderly Indigents and Old Men's Homes,” 4.

<sup>17</sup> “Those Harmless Lunatics.” *Auckland Star*, Volume XXI, Issue 106, 6 May 1890, 5; “The Care of The Aged and Infirm.” *Otago Daily Times*, Issue 8797, 6 May 1890, 2.

<sup>18</sup> “The Whau Exiles.” *Auckland Star*, Volume XXI, Issue 237, 7 October 1890, 5; “The Asylum Scandal.” *New Zealand Herald*, Volume XXVII, Issue 8256, 15 May 1890, 5.

<sup>19</sup> AJHR, *Report on Hospitals in New Zealand*, 1885, Session I, H-18, 2.

<sup>20</sup> AJHR, *Report on Hospitals in New Zealand*, 1885, Session I, H-18, 2. The legislation to which Grabham refers is the *Destitute Persons Act* of 1877.

<sup>21</sup> ANZ DRO, “Seacliff Mental Hospital Statutory Admission Papers.”

<sup>22</sup> Ibid.

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- <sup>23</sup> Catharine Coleborne. "Pursuing Families for Maintenance Payments to Hospitals for the Insane in Australia and New Zealand, 1860s-1914," *Australian Historical Studies* 40, no. 3 (2009): 310.
- <sup>24</sup> *Ibid*, 321.
- <sup>25</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>26</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 210.
- <sup>27</sup> Brunton, "The Scottish Influence on New Zealand Psychiatry," 324.
- <sup>28</sup> Scull, *The Most Solitary of Afflictions*, 275.
- <sup>29</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 98.
- <sup>30</sup> ANZ DRO, "Seacliff Mental Hospital Statutory Admission Papers."
- <sup>31</sup> *Ibid*.
- <sup>32</sup> ANZ DRO, "Seacliff Mental Hospital Medical Casebooks," 641.
- <sup>33</sup> Thomson, "Old Age in the New World," 166.
- <sup>34</sup> Thomson, *A World Without Welfare*, 86.
- <sup>35</sup> *Ibid*.
- <sup>36</sup> Tennant, "Elderly Indigents and Old Men's Homes," 4.
- <sup>37</sup> *Ibid*, 6.
- <sup>38</sup> Thomson, *A World Without Welfare*, 95.
- <sup>39</sup> *Ibid*, 96.
- <sup>40</sup> *Ibid*, 96.
- <sup>41</sup> Angus, *History of the Otago Hospital Board*, 118.
- <sup>42</sup> *Ibid*, 117.
- <sup>43</sup> Thomson, *A World Without Welfare*, 95.
- <sup>44</sup> Tennant, *Paupers and Providers*, 146.
- <sup>45</sup> *Ibid*, 89.
- <sup>46</sup> Angus, *History of the Otago Hospital Board*, 117.
- <sup>47</sup> *Ibid*, 116.
- <sup>48</sup> Quoted in: Adams, "Criminal Lunacy," 67.
- <sup>49</sup> John A. B. Crawford, "Hume, Arthur," *Dictionary of New Zealand Biography*, first published in 1993. Te Ara - the Encyclopedia of New Zealand, <https://teara.govt.nz/en/biographies/2h55/hume-arthur> (accessed 20 February 2022)
- <sup>50</sup> Adams, "Criminal Lunacy," 67.
- <sup>51</sup> *Ibid*, 66.
- <sup>52</sup> *Ibid*.
- <sup>53</sup> *Ibid*, 67.
- <sup>54</sup> *Ibid*, 67.
- <sup>55</sup> *Ibid*, 78.
- <sup>56</sup> Shanas, *Family, Bureaucracy, and the Elderly*, 44.
- <sup>57</sup> David Thomson, "Workhouse to Nursing Home: Residential Care of Elderly People in England since 1840," *Ageing and Society* 3, no. 1 (1983): 44. Medical care in many workhouses was provided by an in-house infirmary, where local doctors would provide a basic service paid for by the Overseers of the Poor or Guardians of the Workhouse.

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<sup>58</sup> In 1847, the term ‘lunatic’ in England was formally defined as “applying to all persons kept in workhouses, who, by reason of deficiency, infirmity, derangement, or other unsoundness of mind...were not deemed competent to take care of themselves, or proper to be left entirely under their own guidance and control, without supervision of any kind.” However, a series of inquiries - including one by the Poor Law Board in 1866 - revealed serious problems with the standards of ‘health care’ provided in the workhouse environment, in which those with mental illness, neurological disorders, communicable diseases, or other forms of ill-health and disability were often all crowded together with other residents. See: Bartlett, *The Poor Law of Lunacy*, 186, 221; William Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), 185; Margaret Stacey, *The Sociology of Health and Healing* (London: Unwin Hyman, 1988), 63; John Walton, “The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870,” in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 189.

<sup>59</sup> Thomson, “Old Age in the New World,” 148.

<sup>60</sup> Tennant, “Mixed Economy or Moving Frontier,” Kindle.

<sup>61</sup> Saville-Smith, “The State and the Social Construction of Aging,” 79.

<sup>62</sup> Doody, “Poor and Mad,” 888.

<sup>63</sup> Renvoize, “Mental Illness and the Late Victorians,” 22.

<sup>64</sup> Vreugdenhil, “ ‘Incoherent and Violent If Crossed’ ”, 95-6.

<sup>65</sup> The reasons for this increase were complex and associated with both social and clinical trends. Growing reliance on asylums for care in Britain was partially related to declining levels of Poor Law relief (usually in the form of weekly subsistence payments) for women affected by the pressures of precarious economic status, isolation, disability and age-related declines in health. The inadequacies of the Poor Law system became even more apparent in the economically depressed period from the 1870s to the 1890s, when the proportions of older people in Britain supported by the original pensions was cut by half and those still who still received the (now much reduced) payments often fell below subsistence levels. Elaine Showalter, “Victorian Women and Insanity” in in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 316-7.

<sup>66</sup> Walton, “The Treatment of Pauper Lunatics in Victorian England,” 189.

<sup>67</sup> Montigny, *Foisted Upon the Government?*, 819

<sup>68</sup> Walton, “Casting Out and Bringing Back in Victorian England,” 141.

<sup>69</sup> Andrews, “Institutionalising Senile Dementia in nineteenth century Britain,” 244.

<sup>70</sup> Berrios, *150 Years of British Psychiatry*, 60.

<sup>71</sup> John Charles Bucknill, “The Custody of the Insane Poor,” *Journal of Mental Science* 4: no.25 (1858): 461-2. Also discussed in: Emily Andrews, “*Senility Before Alzheimer: Old Age in British Psychiatry, C. 1835-1912.*,” (PhD diss., University of Warwick, 2014).

<sup>72</sup> John Charles Bucknill, *The Care of the Insane and their Legal Control* (London: Macmillan, 1880), xxxvii.

<sup>73</sup> Bucknill, *The Care of the Insane*, 3.

<sup>74</sup> J. Mortimer Granville, “The Care and Cure of the Insane: Being the Reports of the Lancet Commission on Lunatic Asylums, 1875-6-7, for Middlesex, the City of London, and Surrey.” Discussed in: Karen Chase, *The Victorians and Old Age* (Oxford: Oxford University Press, 2009), 44.

<sup>75</sup> Andrews, “Institutionalising Senile Dementia in nineteenth century Britain,” 251.

<sup>76</sup> Montigny, *Foisted Upon the Government?*, 820.

<sup>77</sup> *Ibid.*

## Conclusion

This history of medicine project has explored aspects of the management and understandings of older people with mental disorders in the context of colonial Otago and Southland. Between 1863 and 1898, Dunedin Lunatic Asylum and Seacliff ultimately came to accommodate a spectrum of both ‘long-stay’ individuals who were ageing (or readmitted) ‘within’ the system as well as a cohort of older patients first admitted for care at age 60 years and over. Many individuals were or would later become highly dependent, often requiring support to meet their basic needs, particularly in the later stages of life. Various clinical identifiers were used by physicians to indicate a ‘disordered’ mind, including various forms of “mania” and “delusional insanity” more common in the population admitted earlier in life, whereas “senile dementia,” “senile decay” and related conditions were more often recorded for those first admitted in older age. Agitation, overt acts of verbal or physical aggression, and episodes of self-harm and suicidality were also acknowledged as signs of mental disturbance and often reported in some detail. This study population also suffered from other age-related disorders such as strokes, hearing loss, and issues with mobility, which would have compounded their loss of wellbeing and autonomy.

This ongoing expansion of the asylum system provided one response to the social pressures of caring for older individuals affected by declining mental health in New Zealand’s colonial communities. Many individuals and their families viewed the prospect of incarceration in an asylum with a profound sense of dread, and there was general awareness that the majority of older patients admitted to such institutions would not be ‘cured’ or released back into the community. Nonetheless, because of the day-to-day pressures and demands of providing support for older people affected by mental disorders, many families did end up overcoming their reservations over the use of asylums. Long-term admission of older relatives could reduce the burden of care for families at an emotional and financial level, especially if the household budget was already limited.<sup>1</sup> New Zealand’s settlement patterns in the early and mid-nineteenth century had also created a subpopulation of relatively isolated older people - especially a preponderance of men employed in often solitary occupations - who had few social supports to draw on during times of advancing age or declining health. In terms of the options available caring for older people with mental illness in the nineteenth century, the New Zealand experience in many regards corresponds with observations from British, European, North American and colonial centres, in which asylums were seen as socially “regrettable but

indispensable necessities.”<sup>2</sup> Beyond the family setting, asylums were often “the only places a confused or ill aged person could receive anywhere near the amount of supervision or medical care they needed.”<sup>3</sup> It is difficult to determine whether the assumed ‘benefits’ of asylum care fully justified the prolonged periods of admission, or if higher quality care of older people with significant mental disorders could have been offered in other settings in the context of colonial New Zealand (such as rest homes run by charitable organisations).

The institutional ‘solution’ represented by the asylum also reflected a less optimistic view of the health outcomes that would realistically be achievable for many older patients with long-standing mental health conditions. Provision of a basic degree of safety and comfort (or at least freedom from destitution) became indicators of ‘successful’ asylum care, as opposed to ‘recovery’ rates.<sup>4</sup> At Seacliff, a number of clinical reports for these patients seem to indicate reasonable overall states of nutrition and relatively low rates of injury or suicide. Although alcohol (mainly wine and ale) was used for therapeutic purposes as a stimulant in some asylums, excessive intake or use of spirits appears to have been restricted or prohibited, thereby mitigating one of the major identified risk factors in this population. However, the clinical notes made little reference to preparing older residents for future discharge or the return to life outside the asylum; management was largely directed towards ensuring continued existence within the highly regulated hierarchical structure of the institution.

The sense of disconnection for older people was amplified by the diminished contact with the outside world: reports and records from Seacliff from the 1890s indicate that less than 6% of patients (across all ages) had family and friends routinely enquiring about them, and 70% of patients never received any regular visitors, even though the staff often encouraged such external contacts.<sup>5</sup> John Walton’s observations on the asylums of Victoria Britain had considerable relevance to the emerging situation in New Zealand in the last decades of the nineteenth century: he argued that the original promise of asylum care had been subject to “the combined pressures of increased scale, cheeseparing economies, overworked medical superintendence” as well as a rise in proportion of “aging patient populations.”<sup>6</sup> As British alienist Henry Maudsley had warned in his Presidential Address on “Insanity and its Treatment” delivered to the British Medico-Psychological Association in 1871: “the confinement, the monotony” and “the absence of family relations...which are inevitable in an asylum” may for some patients eventually outweigh “the benefit of the seclusion.”<sup>7</sup>

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## *Conclusion: Notes*

<sup>1</sup> Vreugdenhil, “‘Incoherent and Violent If Crossed,’ ” 92.

<sup>2</sup> Montigny, *Foisted Upon the Government?*, 827.

<sup>3</sup> Ibid.

<sup>4</sup> Scull, *The Most Solitary of Afflictions*, 271.

<sup>5</sup> Hubbard, “Seacliff and Ashburn Hall Compared,” 110.

<sup>6</sup> Walton, “Pauper Lunatics in Victorian England,” 191.

<sup>7</sup> Henry Maudsley, “Insanity and its Treatment,” *Journal of Mental Science* 17 (1871): 330.

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## Appendix A. Socio-demographic Characteristics of the Study Population

Statistical approaches were used to generate summaries of the patient frequencies by age, gender, occupational history, marital status and other relevant demographic factors. All statistical analyses were conducted and graphs generated using the Stata software package (version 15.1).

The study population comprised a total of 55 patients who were either 60+ years at time of asylum admission (n=21; 38.2%) or attained the age of 60 as an existing asylum inpatient or upon re-admission (n=34; 61.8%) in the period 1863-93. A summary table is provided for the main socio-demographic characteristics (**Table A.1**). Of the total study population, 11 (20.0%) were female and 44 (80.0%) male. Of those patients aged 60+ years at time of first admission, 5 (23.8%) were female and 16 (76.2%) male, compared with 6 (17.6%) females and 28 (82.4%) males of those patients who attained the age of 60 as an existing inpatient or upon re-admission. Across the general population, males (for all age groups) comprised 60% of the roughly 70 000 people in Otago in 1871.<sup>1</sup>

For the overall study population, the mean age at first admission was 51.9 years (standard deviation: 14.1; range 25-80 years). Of those patients aged 60+ years at time of first admission, the mean age at admission was 67.3 years (standard deviation: 6.2), compared with 42.4 years (standard deviation: 7.5) for patients who attained the age of 60 as an existing inpatient or upon re-admission. Ages at first admission for the two groups are shown in **Figure A.1**.

**Table A.1.** Socio-demographic characteristics and patterns of asylum care

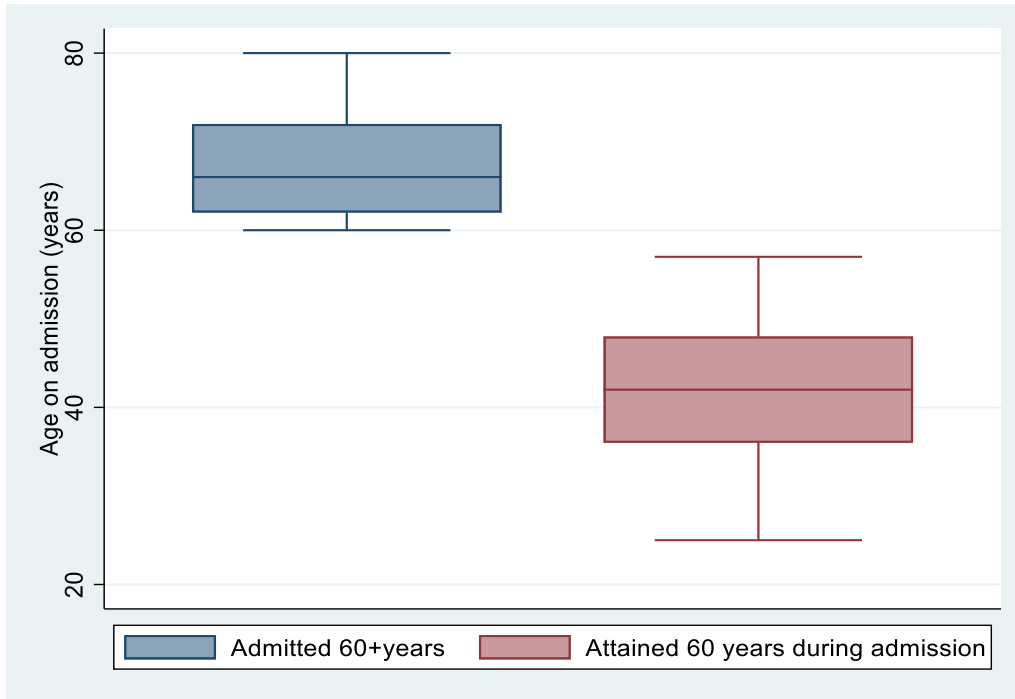
	<b>Overall population</b>	<b>Patients first admitted 60+ years of age</b>	<b>Patients who attained the age of 60 during admission/readmission</b>
<b>Socio-demographic characteristics</b>			
<b>Male: female (%M:%F)</b>	44:11 (80.0%:20.0%)	16:5 (76.2%: 23.8%)	28:6 (82.4%:17.6%)
<b>Age on first admission (mean and SD*)</b>	51.9 (14.1)	67.3 (6.2)	42.4 (7.5)
<b>Main occupations at time of first admission (n; %)</b>	<p><b>M:</b>  “Labourer”: 13 (29.5%)  “Miner”: 6 (13.6%)  “Carpenter”: 3 (6.8%)  “Farmer”: 3 (6.8%)  Other: 13 (29.5%)  Not recorded: 6 (13.6%)</p> <p><b>F:</b>  “Domestic duties”: 1 (9.1%)  “Washerwoman”: 1 (9.1%)  Not recorded: 9 (81.8%)</p>	<p><b>M:</b>  “Labourer”: 2 (12.5%)  “Miner”: 2 (12.5%)  “Carpenter”: 2 (12.5%)  “Farmer”: 2 (12.5%)  Other: 7 (43.8%)  Not recorded: 1 (6.2%)</p> <p><b>F:</b>  “Domestic duties”: 1 (20.0%)  “Washerwoman”: 1 (20.0%)  Not recorded: 3 (60.0%)</p>	<p><b>M:</b>  “Labourer”: 11 (39.3%)  “Miner”: 4 (14.3%)  “Carpenter”: 1 (3.6%)  “Farmer”: 1 (3.6%)  Other: 6 (21.4%)  Not recorded: 5 (17.8%)</p> <p><b>F:</b>  Not recorded: 6 (100.0%)</p>
<b>Marital status at time of first admission (n; %)</b>	<p><b>M:</b>  Married: 13 (29.5%)  Widower: 8 (18.2%)  Unmarried: 11 (25.0%)  Not recorded: 12 (27.3%)</p> <p><b>F:</b>  Married: 6 (54.5%)  Widow: 1 (9.1%)  Not recorded: 4 (36.4%)</p>	<p><b>M:</b>  Married: 6 (37.5%)  Widower: 6 (37.5%)  Unmarried: 0 (0.0%)  Not recorded: 4 (25.0%)</p> <p><b>F:</b>  Married: 4 (80.0%)  Widow: 1 (20.0%)  Not recorded: 0 (0.0%)</p>	<p><b>M:</b>  Married: 7 (25.0%)  Widower: 2 (7.1%)  Unmarried: 11 (39.3%)  Not recorded: 8 (28.6%)</p> <p><b>F:</b>  Married: 2 (33.3%)  Widow: 0 (0.0%)  Not recorded: 4 (66.7%)</p>

\*SD = standard deviation

\*\*where location and age of death recorded

For the overall study population at the time of admission, 19 (34.5%) resided in the city of Dunedin and environs, 7 (12.7%) resided in Invercargill, 4 (7.3%) resided in Oamaru, and 15 (27.3%) resided in other locations in regional Otago and Southland. For 10 patients (18.2%), the place of residence at the time of admission could not be determined. The most frequently recorded regions and countries of birth in the overall study population were Scotland (14; 25.5%), England (11; 20.0%) and Ireland (8; 14.5%). There was no recorded country of birth for 17 (30.9%) individuals. The most commonly recorded religious affiliations in the overall study population were “Presbyterian” (16; 29.1%), “Anglican” (9; 16.4%), “Protestant” (not otherwise specified) (6; 10.9%), and “Roman Catholic” (5; 9.1%). There were no recorded religious affiliations for 12 (21.8%) individuals.

**Figure A.1.** Boxplots for ages at first admission for patients aged 60+ years at time of first admission versus patients who attained the age of 60 as an existing inpatient or upon re-admission



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<sup>1</sup> Olssen, *A History of Otago*, 71.

## Appendix B. Primary Diagnoses and their Relative Frequencies across the Study Population

Clinical diagnosis at the time of first admission was assessed for the population overall, by gender, and according to whether the first known admission occurred before or after the age of 60 years. **Table B.1** provides a summary table is provided for the primary diagnoses and their relative frequencies across the total population and subgroups. For the overall population, the most common diagnoses were: (i) Various mental disorders relating older age, such as “Senile decay”, “Senile dementia” or mental effects relating to “debility” and “old age” (n=10; 18.2%); (ii) “Delusional insanity” or disorders in which delusions are prominent (n=10; 18.2%); (iii) “Mania” not further specified (n=9; 16.5%); (iv) “Melancholia” (n=6; 10.9%); and (v) “General paralysis” (often referring to neurosyphilis) (n=6; 10.9%). Other forms of “dementia” not further specified were reported for five patients (9.1%), and these are listed separately from ‘senile’ forms of dementia because the term could be used to include a wider range of mental disorders in the nineteenth century. (Terms such as ‘schizophrenia’ and ‘bipolar disorders’ were not current in this period, and use of the term ‘depression’ for a discrete diagnostic condition was not yet common.)

Based on age of admission, all ten cases who received the diagnosis “senile decay” or “senile dementia” occurred in patients admitted at or over 60 years of age. In contrast, nine of the 10 patients affected by “delusional insanity” or disorders in which delusions are prominent, and seven of the nine affected by unspecified “mania,” occurred in patients who attained the age of 60 during admission or readmission. “Melancholia” as the principal reason for admission was also relatively more common in this population. Men were more likely than women to be admitted into the asylum with these mental disorders, with large gender disparities noted especially for “Mania” not further specified (no females), “Melancholia” (16.7% of females) and “General paralysis” (no females). For two patients who attained the age of 60 during admission, the diagnosis at the time of admission was not available in the records.

**Table B.1.** Primary diagnoses on admission and their relative frequencies across the total population and subgroups

Primary diagnosis / diagnostic terms on admission	Frequency in overall study population (%) (n=55)	Frequency in patients admitted 60+ years of age (%) (n=21)	Frequency in patients who attained the age of 60 during admission /readmission (%) (n=34)	Frequency of males: females (n)
“Senile decay” / “Senile dementia” / Mental effects of “debility” and “old age”	10 (18.2%)	10 (47.6%)	-	M 6 : F 4
“Delusional insanity” or disorders in which delusions are prominent	10 (18.2%)	1 (4.8%)	9 (26.5%)	M 7 : F 3
“Mania” not further specified	9 (16.5%)	2 (9.5%)	7 (20.6%)	M 9 : F 0
“Melancholia”	6 (10.9%)	1 (4.8%)	5 (14.8%)	M 5 : F 1
“General paralysis”	6 (10.9%)	3 (14.2%)	3 (8.8%)	M 6 : F 0
“Dementia” not further specified	5 (9.1%)	2 (9.5%)	3 (8.8%)	M 3 : F 2
“Lunacy”	2 (3.6%)	-	2 (5.9%)	M 2 : F 0
“Acute mania” in conjunction with “extreme melancholy”	1 (1.8%)	1 (4.8%)	-	M 1 : F 0
“Religious mania”	1 (1.8%)	-	1 (2.9%)	M 1 : F 0
“Delirium tremens”	1 (1.8%)	1 (4.8%)	-	M 1 : F 0
“Hallucinations”	1 (1.8%)	-	1 (2.9%)	M 1 : F 0
“Unsound mind”	1 (1.8%)	-	1 (2.9%)	M 1 : F 0
Diagnosis on admission not available	2 (3.6%)	-	2 (5.9%)	M 1 : F 1

## Appendix C. Duration and Frequency of Asylum Admissions in the Study Population

The means and ranges for the length of admission times and proportions of admissions spent in the asylum while over the age of 60 were calculated. The periods of care for the study population relate to the Dunedin Lunatic Asylum and the first decades of operation of the Seacliff Asylum. A summary table is provided for patterns of asylum care (**Table C.1**).

**Table C.1.** Socio-demographic characteristics and patterns of asylum care

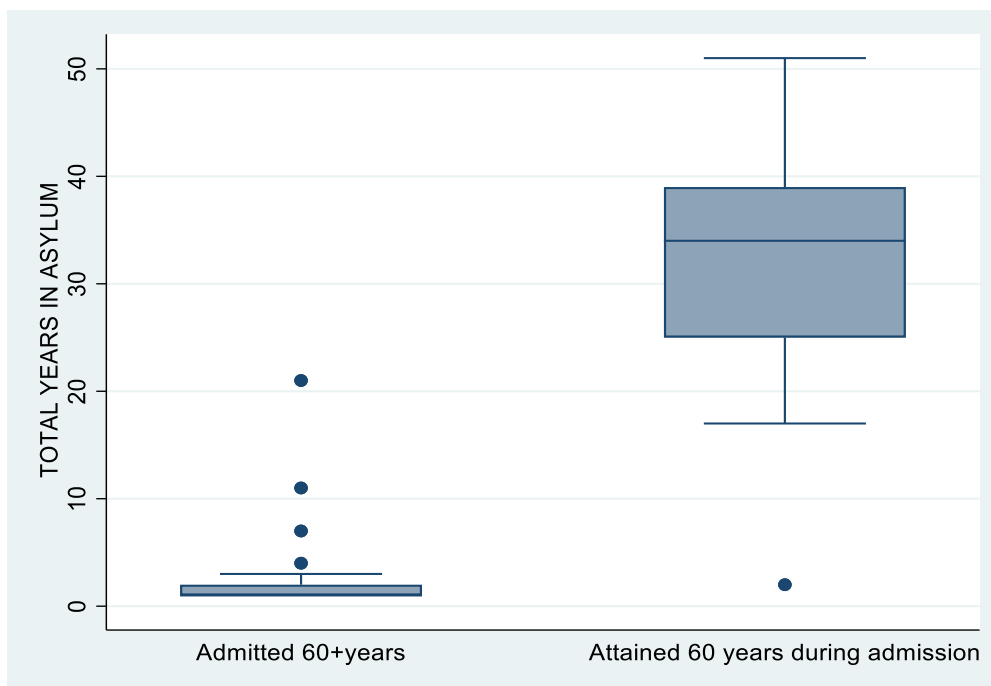
	<b>Overall population</b>	<b>Patients first admitted 60+ years of age</b>	<b>Patients who attained the age of 60 during admission/readmission</b>
<b>Patterns of asylum contact and care</b>			
<b>Years in asylum** (mean and SD*)</b>	21.0 (16.8)	3.0 (4.8)	32.0 (10.9)
<b>Number asylum admissions (n; %)</b>	1 admission: 43 (78.2%) 2 admissions: 10 (18.2%) >2 admissions: 2 (3.6%)	1 admission: 19 (90.5%) 2 admissions: 2 (9.5%) >2 admissions: 0 (0.0%)	1 admission: 24 (70.6%) 2 admissions: 8 (23.5%) >2 admissions: 2 (5.9%)
<b>Deaths in asylum care** (n; %)</b>	47 (85.5%)	16 (76.2%)	31 (91.2%)
<b>Proportion total lifespan in asylum** (mean and SD)</b>	0.29 (0.21)	0.04 (0.06)	0.42 (0.13)

\*SD = standard deviation

\*\*where location and age of death recorded

Of the total study population, the mean duration of hospital stay was 21.0 years (standard deviation: 16.8; range <1 to 51 years). Of those patients aged 60+ years at time of first admission, the mean duration of hospital stay was 3.0 years (standard deviation: 4.8; range <1 to 21 years), compared with a mean duration of hospital stay of 32.0 years (standard deviation: 10.9; range 2 to 51 years) for patients who attained the age of 60 as an existing inpatient or upon re-admission. Boxplots showing years in the asylum for the two groups are shown in **Figure C.1**.

**Figure C.1.** Boxplots of years in asylum for patients aged 60+ years at time of first admission versus patients who attained the age of 60 as an existing inpatient or upon re-admission



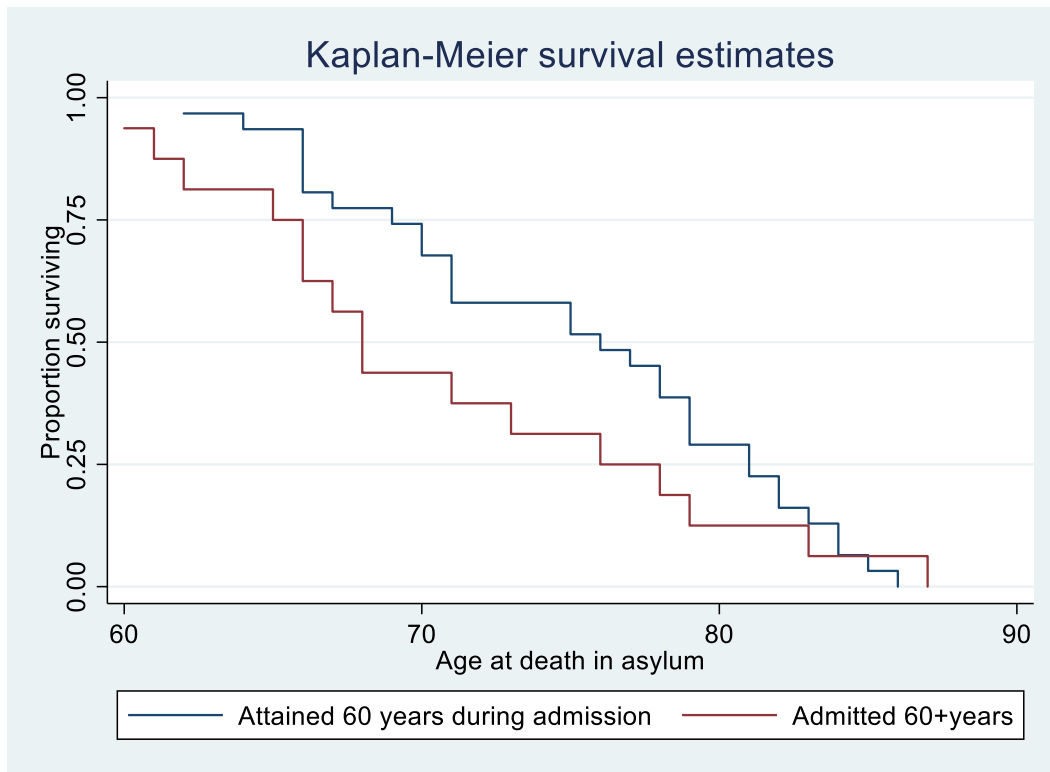
Of the total study population, the number of patients admitted more than once was 12 (21.8%). The maximum number of recorded admissions was four for U.C., a man who was 55 years of age on his first admission. Of those patients aged 60+ years at time of first admission, the number of patients admitted more than once was two (16.7%), compared with 10 (83.3%) for patients who attained the age of 60 as an existing inpatient or upon re-admission.

## Appendix D. Survival and Mortality Patterns in the Study Population

The mean age at death overall for those who died in asylum care was 73.5 years (standard deviation: 7.6; range 60 - 87 years). Of those patients aged 60+ years at time of first admission, the number of patients who died in asylum care was 16 (76.2%; mean age at death: 70.6 years), compared with 31 (91.2%; mean age at death: 74.9 years) for those patients who attained the age of 60 as an existing inpatient or upon re-admission. This disparity between age at death between the groups (4.3 years) was further investigated using formal statistical testing. Using two-tailed t-tests assuming unequal variances, group comparisons were conducted for mean ages at time of death. The associated p-value was 0.08, which is not statistically significant at the  $\alpha=0.05$  level.

For the subset of patients who died in the asylum, Kaplan-Meier survival curves were generated and compared for patients admitted before or after the age of 60 years. In general terms, Kaplan-Meier survival curves are used to evaluate survival periods for longitudinal data sets where the follow-up time is defined. Survival curves are shown using step functions in which a vertical drop indicates the change in the survival curve when the outcome (here, patient death) occurs.<sup>1</sup> The Kaplan-Meier survival curves for the two populations known to have died in asylum care after reaching the age of 60 is shown in **Figure D.1**. Based on visual inspection, the survival curves suggested that, overall, patients who attained the age of 60 as an existing inpatient or upon re-admission tended to experience longer survival times compared to those aged 60+ years at time of first admission. However, more formal estimations using an unadjusted Cox proportional hazards regression model yielded a hazard ratio<sup>2</sup> of 1.30 (with patients having a first admission over 60 compared with a first admission under 60 as baseline) but this estimate was non-significant ( $p=0.354$ ; 95% confidence interval 0.69-2.80). These findings suggest that the differences in survival times between the two groups are not statistically significant<sup>3</sup> based on this preliminary modelling. However, the sample size for this study was relatively small, resulting in moderately wide confidence intervals for the hazard ratio.

**Figure D.1.** Kaplan-Meier survival curves for patients aged 60+ years at time of first admission versus patients who attained the age of 60 as an existing inpatient or upon re-admission



For those patients who died while in asylum care, the proportion of their lifespan spent in the asylum was estimated. For those admitted under the age of 60, the average proportion of the patient’s entire lifespan spent within an asylum was 0.42 (standard deviation: 0.13), compared to a proportion of 0.04 (standard deviation: 0.06) for those first admitted at or over the age of 60 years. A separate analysis was conducted for the subgroup admitted under the age of 60 who then subsequently died in the asylum. Relative to their total admission period, the average proportion of time in the asylum spent while over the age of 60 years for these patients was 0.43 (that is, these patients were aged 60 years or older for - on average - 43% of their total admission period; standard deviation: 0.17 or 17%).

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## *Appendix D: Notes*

<sup>1</sup> Betty Kirkwood and Jonathan Sterne, *Essential Medical Statistics (2<sup>nd</sup> edition)* (Malden, Mass: Blackwell Science, 2003): 276.

<sup>2</sup> In these regression models, the hazard rate measures the likelihood of experiencing an event of interest (here being death), accounting for the fact that the individual has survived to a specific time. The hazard ratio compares hazard rates across to groups – in this case survival in patients admitted over 60 compared with patients admitted under 60 as baseline. Here a hazard ratio is greater than 1 indicates that having first admission over 60 is increased with decreased survival.

<sup>3</sup> Hazard ratios are not significant if the 95% confidence intervals include the value 1, which in effect corresponds to no effect of the predictive variable.