“With tact, intelligence and a special acquaintance with the insane”

A history of the development of mental health care (nursing) in New South Wales, Australia, Colonisation to Federation, 1788 – 1901

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2005
Candidate’s Declaration

I certify that this thesis has not already been submitted for any degree and is not being submitted as part of candidature for any other degree.

I also certify that this thesis has been written by me and any help received in preparing this thesis, and all sources used, have been acknowledged.

..........................................................
Pro matre mea

Una E. Smith R.N.

When, in November 1976, I told my mother I had been accepted into the mental health nurse training course at the then Parramatta Psychiatric Centre (Cumberland Hospital), I did not anticipate her reaction. “Why the hell for? – you should have spoken to me first!” I then discovered something about my mother I had not known before; she had commenced nurse training at the same institution (then the Parramatta Mental Hospital) in the early 1950s, about five years before I was born. She told me she had left before completing her training to join the army, because it was such a bad job having to look after “mad people.” She related stories of the strict discipline of the senior sisters and matron and how she and her fellow nurses would find ways to circumvent the rules – especially those concerning curfews imposed on junior nurses. Whilst Mum had memories of some good times on the wards, she also told some horror stories concerning the behaviour of patients. She predicted that I would not last a month in the job.

To her surprise I stayed and, over the next three years of training, I was able to tell her that the work was not nearly as bad as she had told me. So much seemed to have changed and although there were similarities, it was quite different to the stories she had told me. During my second year of working as a registered nurse, to my surprise, Mum announced that she wanted a change in her life and intended to undertake the nurse training course. However, she did not possess the minimum educational requirements for admission to the course. Not to be thwarted, Mum undertook a College of Technical and Further Education certificate course in first line management, to prove that she was capable of further study, and passed with flying colours. Mum was accepted into nursing and undertook the very last full three year hospital course being offered at Cumberland Hospital (before basic nurse education moved to higher education institutions) and she became a registered nurse in 1986.

On becoming a nurse, Mum really did experience the change in her life that she had wanted. After nearly 25 years of being a working mother and raising three children (all of whom began careers of their own), she suddenly had a professional and social life which she relished and enjoyed to the full. There are still many mutual colleagues, who remember Mum with much affection. Whilst I moved onward and upward, obtaining a series of clinical qualifications and promotions which evoked from Mum, genuine pride, she was content to remain and enjoy being, a registered nurse clinician (for which I could not have been prouder and something I have returned to since).

Sadly, less than two years from her anticipated retirement, Mum was diagnosed with a terminal illness, which she bore with a dignity that I still think back on with amazement. During the final three months of her life, I spent as much time as possible with her. During this period Mum related much about her life that I would not have ever known otherwise. I recall that one conversation concerned her initial horror at the thought that I intended to become a mental health nurse, and the irony of Mum following me back into the profession. Just hours before she died, Mum told me that she had hoped to see me commence doctoral studies and, should the opportunity arise, I should undertake it.

Mum, this is for you.
Acknowledgements.

This work would never have been possible without the patience, support and tolerance of family, friends and colleagues. Special thanks go to my (very tolerant) friends, Marion Johnson, Catherine Quince, Bob Walsh, Ron McClelland, Raylene West and Enid Chalker. Also friend and at times helper, Olga Tatrai of the Parramatta Historical Society.

In particular I wish to mention Jacqui Ristau and Sandra Dayao of Cumberland Hospital’s Library – both of whom helped me to track down articles and books regarding the history of mental health care and treatment and articles from 19th and early 20th century journals. The staff of the Mitchell Library Sydney and Archives Authority of New South Wales also deserves a special mention for their efforts in locating primary sources.

Professor Colin Holmes is especially thanked, for encouraging me to commence the work and for supervising its early stages and, Associate Professor Carol Liston who also provided early supervision and later advice and encouragement. Special thanks to Dr Sarah Mott who graciously agreed to act as my Associate Supervisor at an extremely late stage of the work.

Extra special thanks is offered to my Principal Supervisor, Dr Rene Geanellos, whose patience, support and practical help went well beyond what one might have reasonably expected. When serious health problems left me wondering if I should continue, Rene also became “therapist” and it is no exaggeration to say that without her kindness and encouragement, this work would never have been produced.

Last but never least, to my partner Michael Cleary, whose endless love, care and concern – often in the face of extreme self-absorption and at times irritability on my part, can never be repaid; I offer my deepest love and gratitude.
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Abstract.

This thesis, utilising a descriptive-interpretive methodology and chronological narrative approach, traces a history of mental health carers (nursing) from the foundation of the penal colony of New South Wales in 1788 until the Federation of the Australian colonies to form a nation in 1901. During the earliest days of the colony, the plight of the mentally ill was given little consideration by the governing authorities, particularly the convict insane, who lived (and died) by their wits and suffered cruel punishment if their behaviour was seen as recalcitrant. The first real consideration given to the insane occurred with the establishment of Australia’s first lunatic asylum at Castle Hill in 1811. However, the earliest carers of the insane were drawn (often unwillingly) from the convict population and as such were largely unsympathetic towards their charges. As the colony developed, other lunatic asylums were established and in time carers were drawn from the working classes but were not always regarded as suitable persons for the purpose. The first experienced (qualified) carers of the insane, Joseph and Susannah Digby; arrived in the colony in 1839 to administer New South Wales’ first purpose built asylum at Tarban Creek. The Digbys’ arrival saw conflict over the provision of adequate resources for the care of the insane with government indifference towards their needs becoming a cyclic feature of “boom and bust” resourcing of mental health services, which continues to the present day. Later, conflict with colonial doctors resulted in the dismissal of the Digbys and the ascendancy of medicine over mental health care. It was the medical profession that began the process of professionalising mental health carers; training and educating them as specialised nurses, ostensively as assistants to doctors following the medical profession’s adoption of scientific treatment of the insane. However, the price the medical profession exacted from mental health nursing was high, for example, professional dominance originally based on social class, a dominance of which aspects continue as a feature of the relationship between the two professional groups until the present day. This thesis exposes the reluctance of Australia’s first professional nursing body, The Australasian Trained Nurse’s Association, to initially recognise the new profession and explores the eventual (if incomplete) acceptance of mental nurses and nursing by general nurse colleagues. This thesis makes a contribution to the profession of mental health nursing by providing an understanding of the origins and development of that profession in New South Wales. Further, the thesis examines ways in which the historical development of mental health nursing has influenced the work of mental health nurses and nursing in the present, and exposes recurrent dominant issues of the past which will, if they remain unaddressed, continue to influence that profession in the future.
Chapter 1.

Introduction.

This chapter reveals the purpose behind this work - which came about due to changes in the delivery of mental health care/services in New South Wales. In this regard, the closure or downsizing of many of the state’s older mental health facilities resulted in a process of re-evaluating their historical origins and led to the establishment of a number of historical committees. Soon, these committees became aware that the historical origins of mental health nursing had been neglected and thus little was known about them. This deficit, in turn, became the impetus behind this project. A literature review offers a broad overview of the international history of mental health care and nursing prior to, and including, the 19th century. This chapter also explores the nature of history and provides discussion of the ideas informing the work.

1.1: The origins of the need and purpose for this work.

Since the adoption of recommendations from the 1983 Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled (hereafter the Richmond Report), changes to the delivery of mental health services, in New South Wales, have seen the dismantling of a structure which gradually developed over the previous 150 years. Central to the Richmond Report’s recommendations was the implementation of the process of deinstitutionalisation of the mentally ill, from institutional to community care. During the two decades since this report, a number of the old asylums have been closed and the remainder drastically reduced in size. Given that the history of European settlement extends

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1 Richmond, D., Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled, Government Printer, Sydney, 1983.
back little more than 200 years, the fabric of some of these asylums represents a tangible link to the colonial past. Leading up to and following the Bicentennial anniversary of the European settlement of Australia, in 1988, public recognition of the historical and heritage value of the old asylums significantly increased. From the time deinstitutionalisation began in earnest, some staff working in old asylums began to note the gradual disappearance of artefacts and important fabric (for example, fireplaces, doors and window bars - often through theft), from hospital buildings vacated during the downsizing process. From the mid 1980s, small groups of staff (mostly nurses) simultaneously arose and formed historical committees within individual institutions. These committees, often without official sanction, were determined to preserve as much of the past as possible, before it was lost. This, mostly voluntary work, resulted in several significant collections now extant, associated with the history of mental health care. These individual historical committees eventually “found” one another and also discovered a network of people, from other specialist nursing and health care groups, already engaged in much the same work, and who had formed a networking and support organisation (the Health and Medicine Museums Special Interest Group, under the auspices of Museums Australia Inc). It was soon discovered that the acquisition and preservation of artefacts had less meaning without interpretation, which necessarily involved historical research. In New South Wales, whilst some information regarding the history of psychiatry was

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available, very little research had occurred concerning the history of mental health nursing.

In this way, just as the old structure of mental health administration and service delivery was being dismantled, the impetus to examine the history of mental health nursing in New South Wales gained momentum. Staff, particularly nurses, unsettled by the changes and unsure of the future, began to reminisce and in some ways, to mourn the passing of a bygone era. However, no-one knew very much about the past, other than through the recollections of those with the oldest or longest memories, and information thus gained was limited to a relatively short time span (fortuitously since, at least two mental health hospital histories include the memories of nursing staff).\(^3\) Also, it was apparent that most nurses’ knowledge of the subject (including my own) was based on very brief potted histories, given to novice nursing students during induction into hospital nurse training school programmes. Almost invariably, nurses were given the impression that the historical past of mental health nursing belonged to some dark age of patient incarceration and abuse, in which a variety of instruments of torture (restraints) were the only tools of trade, and the nurses and attendants were little more than gaolers. In this version, change only came about through the introduction of psychotropic drugs in the mid 1950s. This history was then compared to the present, where enlightened mental health nurses, humanity, education and modern nursing and treatment methods, would ensure no return to this ignominious past.

Being an inaugural member of a hospital historical committee, that had established and opened a museum to display artefacts of the past, and as honorary curator of the collection, I was frequently asked about the history of mental health care. Over time, and with some research, most questions could be answered relatively easily, except on one point – the history of nursing the mentally ill. This situation was compounded when the hospital museum became frequently utilised by a variety of tertiary institutions with undergraduate nurse education courses, as visiting students were particularly eager to know something of the history of mental health nursing. In talking with students, I became aware that their knowledge of the subject was based on the same scant information (the aforementioned potted history), received when I commenced psychiatric nurse training in 1976. In this way, I became aware of substantial gaps in the knowledge of the history of mental health nursing.

1.2: Limiting the scope of the project

When considering the history of mental health nursing in New South Wales, in my naivety, my first impulse was to document as much as possible of the two centuries since colonisation in 1788. It was quickly apparent that, for the purposes of this project, such a work would at best be extremely superficial. Discussions with colleagues involved with the various hospital historical committees, and questions from visitors to the Cumberland Hospital Museum, revealed an intense interest in knowing what occurred in the colonial period (pre 1901). It was also thought that, during this period, knowledge regarding the care and carers of the mentally ill was more deficient, particularly during the convict period (1788 – 1840). Curiosity regarding who past mental health nurses were,

4 Glengarry – Cumberland Hospital Museum Parramatta.
the origins of mental health nursing work, when training began and what was
taught, were all issues considered important. Such work, therefore, had the
potential to ensure the greatest interest and practical usefulness, and moreover,
might become a foundation from which further research was inspired. My
decision to examine the history of mental health nursing during the colonial
period of New South Wales was thus arrived at.

Excluded from this work, however, are the two private asylums established in
New South Wales during the mid to late 19th century. Bayview House, Tempe,
established by an American, George Tucker, in 1865,5 and Mount St Margaret
Hospital, Ryde, established in 1891,6 are excluded for two reasons. First, at
Bayview House, carers of the mentally ill fell outside the purview of official
records, thus leaving little evidence. And second, at Mount St Margaret Hospital,
the early carers were members of a religious order (Catholic nuns), thus they
came from a different philosophical and spiritual position than nurses and
attendants at government asylums.

1.3: The geographical limits of the project.

At the time of European settlement, in 1788, the entire east coast of the continent
of Australia (then known as New Holland), and inland as far as the centre of the
continent, was known as New South Wales. The island of Van Diemen’s Land
(later Tasmania) was also under the authority and control of the Governor of
New South Wales. However, the historical boundaries of New South Wales have
changed considerably in the last two hundred years. For example, Van Diemen’s
Land became a separate colony in 1825 and in the same year, the western portion

6 A Century of Care - Mount St Margaret Hospital Ryde, 1891-1991, op. cit.
of the continent became known as Western Australia. In 1836, the colony of South Australia was established, followed by Victoria in 1851 and Queensland in 1859. Then, in 1911, Queensland boundaries were changed and a portion of New South Wales, in the centre north of the continent, was separated, and this became the Northern Territory. This work only includes the history of the nursing care of the mentally ill, and their carers, within the modern geographical boundaries of New South Wales, which have remained unchanged since 1859 (with the exception of the establishment of the Australian Capital Territory within its borders in 1910). As the geographical extent of New South Wales was so large, in the early 19th century, asylums were established in areas later contained within the borders of other colonies: notably, New Norfolk Asylum established in 1826 (Tasmania), Moorcroft-House Asylum established in 1841 (South Australia) and Yarra Bend Asylum established in 1848 (Victoria). These asylums, being outside the modern borders of New South Wales, are excluded from the work.

1.4: Aim of the work.

The aim of this work was to provide a first step in bringing to light an informed and cogent historical account of mental health nursing in colonial New South Wales during the period 1788 - 1901. In doing this, a gap in the knowledge of mental health nursing would be addressed which, in turn, would:

- provide a lineage for the profession of mental health nursing in New South Wales,
- illuminate the origins and development of mental health nursing practice(s),

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• expose some problems of the past and how these were dealt with – possibly providing lessons for today, and
• at a practical level, simply and no less importantly, satisfy a need to know – in effect, to inform the present of the past.

1.5: Review of the Literature.

1.5.1: Brief prelude to modern mental health nursing.

The origins of what is today the profession of mental health nursing lie in the religious houses and monasteries of the medieval church and perhaps, more particularly, later in the formation and development of specialised asylums for the care and treatment of the insane. The first dedicated institution (asylum) for the insane in Europe was established near Hamburg (Germany) in 1375, followed by one at Valencia (Spain) in 1410. In Britain, the Priory of St Mary of Bethlehem had been established in 1247 near London, however it would be another 150 years before it was recorded as caring for lunatics. Subsequently, it has been reckoned as perhaps the oldest psychiatric facility extant in Europe today, and in the 750 years since its foundation, contraction of its name to “Bethlem” and corruption to spelling has seen its name enter the English language as “Bedlam,” a by word for a “wild and crazy place.” Originally those who cared for Bethlem’s inmates were religious Brothers, later known as

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* This review is intended only as a broad overview of the history of mental health care – when relevant, the literature is utilised within this work where appropriate.


12 Ibid, p.41.
“basketmen,” as they were required to beg food from the tables of the rich to feed themselves and their patients - the food being collected in wicker baskets. The expression “basket case,” a derogatory term for a mentally ill person, probably derives from this aspect of the Brothers’ work. Apparently the term “Basketman,” to describe some of the carers of the patients, continued to be used until 1815, following the secularisation of the asylum in 1546. The first “nurse” recorded at Bethlem was in 1693 and she was appointed to care for the physically sick patients; the position was eventually combined with that of Matron, usually occupied by the steward or porter’s wife.  

The earliest asylums for the insane were established at a time of great turmoil in Europe, where the Roman Catholic Church had become increasingly concerned about divine versus evil forces and where logical and independent thought were being repressed, particularly following the inauguration of the Inquisition by Pope Gregory IX in 1233. The mentally ill, viewed and feared by the Church (and public) as being possessed or influenced by the Devil, were thought to be cured only through exorcism by a priest or by individual repentance (and penance). During the later years of the 15th century and early 16th century, the Inquisition reached the zenith of its destructiveness, persecuting and suppressing anyone (including the mentally ill and particularly women), whose behaviour or thinking were unconventional. These people were defined as “heretics” and suffered horrendous tortures and agonising deaths, often through public execution, most notoriously - witch-burnings.

Seemingly a contradiction, in view of the sordid history of abuses wrought by the Inquisition, the earliest asylums and subsequent formal care of the insane was instituted under the auspices of the Catholic Church. One modern study refutes the traditional history of the suffering of the mentally ill under the Inquisition. This study examined 57 descriptions of mental illness in the Middle Ages, finding that only 9 (16%) attributed sin or wrongdoing as the cause of the insanity. This study suggests it was well understood at the time, that there were other causes for mental afflictions, opposing “modern stereotypes of child-like and superstitious modes of thinking which were putatively exhibited by medieval persons.”15 Nevertheless, superstitious thinking (or perhaps faith) within medieval society did not always impact negatively on the mentally ill such as in the case of the legend of the Patron Saint of the insane, Dympna (or Dymphna or Nymphna). She was said to have existed in the 7th century, the daughter of a Celtic (Irish or British) king who fled with her confessor (St Gerebernus) to Belgium following the incestuous advances of her father. Dympna joined a religious order and cured two people of madness allegedly caused by demonic possession. Dympna and her companion were eventually tracked down by the king and murdered near Gheel – then a small village just north of Brussels. During the 12th century, Dympna’s and Gerebernus’s remains were placed in a church, an event said to be marked by numerous cures of madness and epilepsy with the church itself becoming a refuge for the insane. An asylum for the insane was subsequently established at Gheel during the 13th century and also from that time, a practice developed where the townspeople of Gheel opened their homes

to shelter the mentally ill, a custom that persists to this day – serving as a model for community based care of the mentally ill for the past seven centuries.  

Within the Catholic Church, Religious Orders developed with some specifically providing pastoral and practical assistance such as poor relief and health care to the community. Novices in all Catholic Orders were taught to serve the sick as though they were serving Christ and caring for the insane required special understanding and nursing management. One Order that catered for the needs of the mentally ill were (and are)\textsuperscript{17} the Brothers of Charity also known as the Brothers of Saint John of God or Hospitallers. The Order’s founder, Jaco Cuidad (1495 – 1550), was born in Portugal had worked as a mercenary, labourer, shepherd and lastly a bookseller. During 1538-39, he experienced a period of madness, “running aimlessly through the streets, tearing his hair, and giving away his stock of books.” A visiting preacher was able to calm him after which he devoted his energies to the care of the sick and poor and he was canonised as St John of God in 1690. Following his death, a group of followers drew up rules and became a religious Order.  

The Order established asylums across Europe and were considered outstanding in their \textit{nursing care} of the mentally ill. Ironically, the Order demanded high fees to provide humane, but what was essentially custodial, care for the wealthy mentally ill. The Brothers’ expertise might have inspired humane care and treatment of the poor in French post-revolutionary public asylums. The Order flourished in pre-revolutionary France where “they elaborated the rules of nursing care for the mentally ill, thus


\textsuperscript{17} Today the Order administers approximately 200 hospitals plus many clinics and homes devoted to the care of the sick, mentally ill and developmentally disabled worldwide. See Nolan, P., \textit{A History of Mental Health Nursing}, Chapman & Hall, London, 1993, pp. 24 – 25.

preparing the field for the medical profession’s efforts to develop therapeutic strategies.” Consequently, and although there is no direct evidence, it has been argued that the work of the Brothers of Charity predated and influenced the reforms of Philippe Pinel at the Bicêtre and Salpêtrière Hospices in the late 18th century.¹⁹

Although religious houses and Orders cared for the insane, those taken in were only a small fraction of the mentally ill population. The overwhelming majority were cared for at home or within their own community. Care of the insane with limited “Christian charity and almsgiving” has been criticised in recent times as “haphazard and ineffectual,” particularly as the main goal of giving “was governed largely by the desire to ensure one’s own salvation.”²⁰ Nevertheless, The Catholic Church was a large international organisation and in the case of its nursing Orders (such as the Brothers of Charity), over time and through exchange of ideas, a wealth of accumulated knowledge of nursing and health care must have been gathered.

During the 16th century, in reaction to the excesses of the clergy of the Catholic Church (including the Inquisition), a division occurred in the Western Christian Church. Known as the Reformation, this split produced a permanent division between Roman Catholicism and what became known as Protestantism. The zeal of the Protestant reformists to suppress the old religion through religious conversion to the new faith realised a new wave of abuse directed at dissenters. The methods of the Catholic Inquisition involving witch hunts, torture and execution was readily adopted. Perhaps the one of the best documented and most

renowned examples occurred in New England, North America in the period 1688–93. In Salem (a Puritan community) a wave of public hysteria occurred following the claims of a group of young girls to have been bewitched. Ultimately more than 250 people were incarcerated and twenty three people died (nineteen executed, two in prison and one under torture), as a result of the girls’ accusations. Many of those implicated as witches were already known to behave oddly, and later analysis of the records demonstrates that at least some of those accused (as well as the accusers), were probably mentally ill.\textsuperscript{21}

The Reformation spread rapidly through western Europe and in those countries where Protestantism took hold, Catholic religious houses and institutions were brutally suppressed or dissolved, including those providing health care. For example, as noted earlier, the first “asylum” in Britain was the Priory of St Mary of Bethlehem, a Catholic institution with religious Brothers (monks), providing the care of the insane. The Brothers were removed by the Protestant King Henry VIII’s Dissolution of religious houses but the asylum survived as a secular institution and was one of several hospitals spared closure following a petition to the King from the elite citizens of London.\textsuperscript{22} In some countries where Protestantism was embraced, the loss of organised Catholic (nursing) Orders left health care in the hands of untrained locally hired people, often described as “slovenly and careless, if not drunken and cruel” and further, in places such as Britain, nursing as a profession had to be recreated in the mid 19\textsuperscript{th} century and mental health nursing even later.\textsuperscript{23} Thus a valuable body of nursing knowledge

\textsuperscript{21} Deutsch, op. cit., pp.32-38.
\textsuperscript{22} Porter, R., Bethlem/Bedlam: Methods of madness. op. cit., p.41.
\textsuperscript{23} Weiner, op. cit., p.336.
and expertise (which incidentally pre-dated medical psychiatric knowledge and expertise), was forgotten for over two hundred years.

In Catholic countries such as Belgium, Religious Orders continued to provide mental health nursing care – even in public asylums. When the city council of Ghent decided to construct a new asylum for males (the Guislain Institute), upon its opening in 1858, it was staffed by the Brothers of Charity. From the Institute’s opening, the Brothers were given special instruction on the care of the insane by the Medical Superintendent, however, (perhaps tellingly) when the first staff manual was produced in 1906 (composed by a Brother Alfred), only a few pages are devoted to psychiatric (medical) treatment and “there is the explicit remark that theory is not so important as practical ‘know how’.”

In Catholic France at the time of the French Revolution, Religious Orders (including nursing) were nationalised and then dissolved in 1792. However, the Revolutionary Assembly ordered that those who cared for the poor and sick were to continue in their occupation under the municipal administrators. Consequently, “no sooner had the Sister of Charity ceased to exist than she than she was reconstituted as the citizen nurse.”

Such was the reputation of Catholic nursing Orders, when, after two centuries of repression, the nominally Protestant Holland began to establish large asylums for the insane in the mid nineteenth century, in some (albeit in predominantly Catholic regions), Catholic Orders were contracted to provide the nursing care.

In the town of Den Bosch, a small madhouse (the Rainier Van Arkel Asylum)

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had been established in 1442 by as an act of local civic benevolence (neither the church nor doctors were involved). During the 18\textsuperscript{th} and early 19\textsuperscript{th} centuries, this asylum grew in dramatically in size and was managed by the local civil authorities. As the result of demands of the State for reform of asylums in the mid 19\textsuperscript{th} century, the local authorities sought the help of the Catholic Church. From the Order of the Congregation of Mercy, eight Brothers of Our Lady of Lourdes and ten Sisters of Mercy took over the nursing care at the asylum – the lay staff were dismissed. Later more asylums were staffed by this Congregation, namely Coudewater and Voorburg.\textsuperscript{26} The absence of recognition of the influence of Catholic Orders in the development of mental health nursing care (even in those places where the Orders were not suppressed) has been questioned, with further critical research suggested to uncover potential links between their methods and the history of medical reform of mental health treatment and care.\textsuperscript{27}

A major effect of the Reformation was the undermining of subordination to the authority of the Catholic clergy. This in turn, during the 17\textsuperscript{th} and 18\textsuperscript{th} centuries, led to a search for meaning outside the traditional ways of thinking about the events of the world and conduct of human affairs. Thinking moved away from the mystical or supernatural (for example, ideas based on God’s or the Devil’s influence), to explanations based on empirical inquiry, observation and reason. Up until this time, the medical profession’s knowledge base relied heavily upon ancient (principally Greek) philosophies and theories and was (perhaps necessarily) incorporated with the prevailing religious dogma. The Catholic Church had banned the dissection of human bodies for centuries, however during


\textsuperscript{27} Ibid, p. 335.
the period of the Reformation, this ban was lifted and combined with empirical inquiry and reason, doctors were able to commence on the path leading to modern medicine. Also, over time, madness became viewed as “a disease of the physical body, not of the metaphysical soul.”

28 The theories of Claudius Galen (131-200), involving the notion that ill-health could be attributed to an imbalance of four humours or elements within the body had a particular attraction for doctors and would not be completely dispelled until the mid 19th century. Physicians believed that mental illness could be attributed to an excess of one of Galen’s humours – melaina kole (black bile) and where the term *melancholia* was derived. Imbalances of the various humours had to be corrected which led to medical practices such as bloodletting, purging, vomits (and blistering of the skin) to relieve the imbalance.

Not that religion was kept entirely out of mental health care in Protestant countries. For example in Germany, the Kaiserswerth Reformed Church movement realised the founding of Protestant religious nursing Orders such as the Damsels of Charity (1560) and, at the Kaiserswerth Hospital, buildings were set aside for the care of the insane thus allowing the Sisters to gain experience in mental health care. Kaiserswerth’s reputation was such that Florence Nightingale, credited with the reform of (British) general nursing, spent some months there during 1851. In Britain during the mid to late 18th century, an industry called the ‘mad doctoring trade’ developed and many of these ‘mad

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30 Weeks, op. cit., pp. 97-98.
doctors’ were also Protestant clerics (untrained as physicians) and for those who could pay, treatment was provided in private madhouses. Reverend Dr Francis Willis (1718-1807)\textsuperscript{33} was one such mad doctor who received renown for his cure of King George III’s bout of insanity in 1788. Willis apparently achieved this through largely behavioural methods, after the failure of the Gallenic methods utilised by the trained physicians. Protestant sects also cared for their own and opened asylums. Perhaps the most famous was the York Retreat established in 1796 by the Quaker, William Tuke (1732-1822). Initially the retreat catered specifically for Quakers, however it later opened its doors to others and the methods utilised there, greatly influenced mental health care in the 19\textsuperscript{th} century.\textsuperscript{34}

During the mid to late 18\textsuperscript{th} century a few secular private madhouses and asylums were established in Britain, however these were operated for profit and payment for care and treatment (such as it was) expected. These private madhouses could have as few as two or three patients to many hundreds. Whilst some provided humanitarian care, the majority provided only the merest necessities of life and conditions were so bad they promoted mental disorder rather than cured it.\textsuperscript{35} Nevertheless, the establishment of St Luke’s Hospital in London in 1751 represented the first major attempt by the medical profession to assert its dominance over mental health care. St Luke’s Hospital is also considered to be the model on which other institutions for the insane were established, which “helped to legitimise the notion of institutionalization as a response to the


\textsuperscript{35} Nolan, P., op. cit., pp. 25-29.
problems posed by the presence of mentally disturbed individuals in the community."\textsuperscript{36}

The two centuries following from the beginning of the Reformation realised enormous social and political change in Western Europe. Of particular note was the industrialisation of Britain and later Western Europe beginning in the mid 18\textsuperscript{th} century. Dramatic social changes occurred as economies, previously largely agrarian based, became industry based. Where in the past, most of the population earned a (meagre) living from the land and cottage industries, technological advancement saw the rise of town based industry (thus urbanising the population) where more could be produced at cheaper cost and with less labour.\textsuperscript{37}

The people who suffered the most were the poor, the class in which the vast majority of the mentally ill were situated. Whereas in the past they might gain some assistance within their own community or through begging, the changes in society saw a decreasing tolerance for any behaviour that was disruptive or deviant.\textsuperscript{38}

In Britain, provisions for the relief of paupers had been in place under the Poor Laws since the time of Queen Elizabeth I. For the mentally ill, the local parish was made responsible for the provision of assistance and when a lunatic was unmanageable in the community, they might be confined in a goal or in one of the few asylums that existed, with the parish expected to pay the costs.\textsuperscript{39} During

\textsuperscript{36} Scull, op. cit., p.25.

\textsuperscript{37} The changes wrought by the Industrial Revolution are complex and far beyond the scope of this work. For an uncomplicated review see for example, Roberts, S.H., History of Modern Europe (Chapter 3), Angus & Robertson, Sydney, 1948, pp. 256-274.

\textsuperscript{38} For a detailed analysis of the effects of the Industrial Revolution on attitudes towards the poor and especially the mentally ill see Scull, op. cit., pp. 18-48.

the 18th century, parishes increasingly provided for the poor through the establishment of poor or workhouses, where those admitted were expected to be productive. These establishments also became convenient receptacles for the insane who could often been found in the most appalling conditions, naked and chained to the walls in cells or cellars. In Europe, institutions were also established to cater for the indigent. For example in France, Hôpital Généraux were established in major towns modelled on one established in Paris during 1656 and in Germanic countries, Zuchthäusern (houses of correction) were founded in every county. In North America, similar institutions were developed with New York opening the first in 1736 which included dungeons at one end of the cellar to confine the mentally ill. This international movement to provide institutions, ostensibly to assist the sick, invalid and poor, has more latterly been called the “Great Confinement” and has been interpreted as an attempt to incarcerate and control the idle and deviant (including the mad) within 18th and 19th century societies.

1.5.2: Advent of modern mental health nursing in the nineteenth century.
In the closing years of the 18th and particularly during the early 19th century, concern regarding the conditions endured by the mentally ill realised a movement for (what was then viewed as) the humanitarian reform of mental health care. The end result of reform was the establishment (especially from the

42 Santos, & Stainbrook, op. cit., p.49.
43 Foucault, M., ibid.
mid 19th century) of a huge number of large public lunatic asylums across Britain, Europe and North America. In spite of what may be regarded as the humane intentions of reform, the end result has attracted severe criticism. Scull’s work suggests that the asylums, far from fulfilling their intention, became places where the working class could disown responsibility for the care of sick, aged or incapacitated relatives by dumping them into asylums and the middle and upper classes could take satisfaction that to “treat” the insane at public expense, was illustrative of their philanthropic concern with the unfortunate.45

The establishment of these asylums was largely driven and influenced by the medical profession’s increasing assertions that mental disorder was indeed a disease that required medical treatment and potentially was curable.46 In turn, this medicalisation of mental health care made funding the construction and operation of asylums more palatable to the civil authorities, as after all, the mad were now seen as suffering from disease or illness, their plight was not their fault.47 Nevertheless, the medical profession’s optimism soured when definitive cures for insanity proved elusive. According to Russell, this “therapeutic failure” however, did not prevent doctors from attempting to make the most out of “less than promising circumstances.” There were patients within the walls, who could be counted, tabulated, classified in a variety of ways and quantified “in

45 Scull, op. cit., pp.119-220.
accordance with the fashionable practice of “statistics.” Further, with high mortality rates within the asylums, what couldn’t be learnt from the living, researchers might find in the dead who were “easy meat for the dissector’s scalpel.”\textsuperscript{48} The management of the asylums ultimately came under the purview of the medical profession represented in the medical superintendents who, in the face of therapeutic failure, “insisted on burying themselves ever deeper in administrative concerns’ [sic] as a means of concealing their professional incompetence.”\textsuperscript{49} Under the medical superintendents, asylum staff were organised (and controlled) through a system of paternalistic and hierarchical subordination and where the medical superintendent’s authority over every aspect of the asylum was generally absolute.\textsuperscript{50} Because the asylums reflected the “paternalistic, class ridden and authoritarian society from which they grew,” civil authorities offered rewards and incentives to doctors, whilst believing that attendants and nurses only responded to “fear and punishment.”\textsuperscript{51} Thus rules were drawn up that governed every aspect of the attendants’ and nurses’ work and almost every minute of their day (including time off duty).\textsuperscript{52} It is within the (rather dark) context of these 19\textsuperscript{th} century institutions and the eventual medical dominance of lunacy services, that the origins of modern mental health nursing can be found.


The increasing number and ongoing expansion of public lunatic asylums required the employment of staff to provide services and care. However this care was not based on the notion of service to God in the way Religious Orders had previously contextualised their work, it was largely secular, and increasingly under medical and civil authority. Most authors suggest that the early attendants and nurses of the insane were largely drawn from the lower working classes, their previous employment depending upon the site of the asylum. For instance, in country asylums, workers might be previously employed as unskilled agricultural workers, whilst in the urban environment recruits may have been semi-skilled in a trade such as building, glazing, and shoemaking. Female staff tended to be drawn from the servant or domestic class. They were often employed in domestic service and they could, in some asylums (via a chain of promotion), gradually advance to the position of keeper/nurse. There were also many ex-army recruits to the asylums. Carpenter has been harsher in his assessment of the recruits noting that “asylum work was often regarded as an occupation of last resort,” citing as evidence, the complaints of 19th century medical superintendents regarding the poor quality of their staff. This generalised view has been challenged noting that case studies of individual asylums demonstrates that they successfully competed in the broader labour market for workers.

From the early 19th century, the changing nomenclature utilised to describe the (nursing) carers of the insane during the 19th century provides a clue to the general nature of their work. Nolan observes that from the 18th to early 19th

In the 19th century, the term “keeper” was used to describe both the proprietor of the madhouse and those employed by the proprietor. The term implies that those who cared for the insane controlled the inmates’ movements “in the same way that zoo-keepers and game-keepers controlled animals and game.” The later term “attendant” became preferred “as indicating a more humanitarian approach” but also implied that the carer “attended” to the institution, “keeping it clean and tidy, maintaining order by controlling inmates and ensuring that there was sufficient farm and garden produce to render it viable.” Nolan also notes that the (nursing) staff were also essentially the medical superintendent’s servants and were expected to carry out his orders, thus they may be said to have attended upon the superintendent as well! Smith also comments on the nomenclature noting that it reflected and reinforced the lowly status of asylum staff. He also observes that the caring terms attendant to describe male and nurse to describe female staff, evolved with the (medical) emphasis on curative intent.

A significant part of the attendants’ and nurses’ work involved domestic duties and there was an emphasis on maintaining order, neatness and cleanliness of both the patients and the asylum. Attendants and nurses were expected to assist patients who were unable or unmotivated to maintain their own personal care (such as hygiene). They were also expected to be vigilant, watching out for suicide attempts or violence and intervening when necessary. Philosophically, the role and work of attendants and nurses in the early 19th century revolved around the expectations of humanitarian reform, which was embodied within the

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56 Nolan, op. cit., p.6.
57 Ibid.
59 Ibid.
principles of “moral treatment.”∗ Moral treatment developed contemporaneously in England and France in the 1790s with the origins of its practice attributed to Samuel Tuke at the York Retreat (England) and Philippe Pinel at the Bicêtre and Salpêtrière Hospices (France). The early success of moral treatment established the reputations of Tuke and Pinel and provided an impetus for the reform of mental health care. The basis of moral treatment was the notion that a therapeutic milieu of kindness, reason, productive work, appropriate leisure and diversion, would correct mental illness caused by immorality or other (psychological) weaknesses. Inherent in the principles of moral treatment was the idea that restraint, seclusion and other methods of coercion should only be utilised when all else failed.60 The attendants and nurses were thus expected to treat the patients with kindness and consideration - however, they were also expected to control and manage (without undue force) often dirty, unreasonable, unpredictable and sometimes aggressive/violent patients. Mechanical restraint and physical coercion was generally frowned upon and some reformers wanted restraint abolished all together.61

On the question of the abolition of restraint in England, the 1844 Report of Metropolitan Commissioners in Lunacy expressed serious reservations regarding total abolition. They were particularly concerned about the safety of attendants citing the example of a matron who had been attacked and nearly killed by a violent patient.62 Further,

“It is a great object to secure the services of respectable and superior persons as attendants and nurses; but if such

∗ Moral treatment is further discussed in chapter 6.
persons are to be induced to take charge of the insane, it is necessary to assure them that they are not to lead a life of ceaseless anxiety and to be in continual apprehension of violence.”

Moral treatment required a large number of staff and, as medical superintendents were expected to control costs, staff numbers were often kept to a minimum. Whilst outwardly the many large public asylums proffered the view of humanitarian treatment, within the walls patient care was much less salubrious, resulting in complaints that much hidden or secret cruelty occurred inside. The attendants and nurses, viewed as only one level up from the status of the patients, were complained of for exhibiting poor quality behaviour and morality which ill fitted them to their duties. Where facilities were available that operated purely on moral treatment principles, they were accessible only to the middle and upper classes.

For attendants, the dichotomy between operating as kind and humane carers and as agents of order and control was further complicated by changes in treatment modalities. Many doctors, whilst acknowledging the usefulness of the psychological principles of moral treatment, also believed in the importance of somatic (physical) therapies. Some continued to use the old treatments based in the Gallenic Humoral Theory – they bled, cupped and blistered patients, whilst others came up with new methods. This move to somatic treatments was based in the ideas of the philosopher, Rene Descartes (1596-1650) who espoused the notion of the mind as being distinct from the body but that they could influence

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63 Ibid, p.150.
64 Nolan, op. cit., pp.43-45.
65 Boschma, op. cit., p.19.
each other. During the 19th century, impetus for somatic therapies was boosted by scientific discoveries (such as micro-organisms as agents of disease) in other branches of medicine. The idea that insanity had a physical cause and thus a physical treatment and potential cure (ultimately a hope unrealised), was grasped by doctors working in asylums, where the confinement of large numbers of mentally ill people in one place allowed the scientific study of insanity. The Cartesian influence, backed up with a shift of treatment foci to a scientific organic orientation towards causation and somatic interventions, saw the rise of treatments which included hot and cold baths and showers, drugs and the application of electric shocks from static electricity machines. Some of these treatments even involved the deliberate terrorising of patients through, what would be described today as, torment and torture but was thought to be therapeutic by some. The attendants and nurses, still expected to be kind and humane, were the doctors’ assistants in these (at times barbaric) treatments. Their role must have been confusing to both themselves and patients, whilst on one hand they were expected to be kind and humane, on the other they were agents of confinement and confederates in inflicting pain and suffering. The somatic therapies were to eventually dominate asylum treatment, whilst moral treatment “developed into a round of exercise, useful employment, diverting entertainment, and general institutional routine.”

67 Ibid.
69 Tourney, op. cit., pp. 97-100. Also see Smith, op. cit., pp.194-207.
72 Russell, op. cit., p. 311.
It is not of any wonder that medical superintendents often could not attract or keep staff of a superior class and that complaints of staff cruelty to patients were common.\textsuperscript{73} Even later in the 19\textsuperscript{th} century, a medical superintendent was to lament,

\begin{quote}
I had a great number of men and women who were entirely unable to think abstractly, many of whom, in fact, had never mastered thoroughly the ‘three rs,’… Educated men and women do not, as a rule, seek these positions or feel attracted to this work, and when they enter it are not inclined to remain in it very long.\textsuperscript{74}
\end{quote}

Ultimately in the last quarter of the 19\textsuperscript{th} century, to solve the problem of obtaining and retaining a better class of staff, the psychiatric medical fraternity (then commonly known as Alienists) decided that formal training of attendants and nurses would provide the answer. Also, in the face of the failure of psychiatric treatment, the training of the staff might also bolster the medical profession’s (scientific) prestige; trained nurses would enable doctors to “argue that caring for the insane was skilled work and so helped psychiatrists refute charges of inadequacy and amateurism.”\textsuperscript{75}

Some training had occurred sporadically during the century, but it was not systematic or sustained.\textsuperscript{76} In Britain, for example, the first training of attendants and nurses in Britain is reported to have occurred in Scotland in 1856,\textsuperscript{77} but it was not until the publication of (probably the first) textbook for attendants and nurses in 1885, that training was begun in earnest. This textbook, \textit{Handbook for Attendants on the Insane} (also known as the \textit{Red Handbook}), was published by a

\textsuperscript{73} See for example, Smith, op. cit. and Smith, L.D. (2), Behind closed doors; Lunatic asylum keepers, 1800-60. \textit{The Society for the Social History of Medicine}, 1988, pp.301-327.
\textsuperscript{74} Dewey, R., Our Association and our Associates. \textit{American Journal of Insanity}, October, 1896, p.200.
\textsuperscript{75} Nolan, op. cit., p. 72. Also see Cheung & Nolan, op. cit., p.231.
\textsuperscript{76} Ibid, pp.60-62.
\textsuperscript{77} Hart, op. cit., p. 38.
doctors’ organisation, the (British) Medico-Psychological Association, which thereafter took on the promotion (and control) of training of asylum staff. However, unlike the United States where formal training schools were instituted (see following), the training in Britain occurred on the job with lectures given intermittently in the form of in-service training. Individual asylums were not forced to participate however, by 1899, over 100 were doing so.\(^{78}\) Nevertheless, the *Red Handbook* represented the first attempt in Britain to achieve uniformity of practice, and moved the previous oral tradition by which practice had formally been described, to a written one. Further, whilst it contained mostly medical rather than nursing knowledge, it provided the grounding for a literature base for mental health nurses.\(^{79}\) The *Red Handbook* also served to preserve the power and authority of the doctors and medical superintendents over the attendants and nurses. The introduction of the 1st edition in part stated;

> This Handbook… is designed [to] aid attendants to carry out the orders of the physicians; but it is distinctly understood that in no case is anything contained in this book to override the special rules of any institution or special orders in regard to any individual case.\(^{80}\)

In the United States, Dr Thomas Kirkbride (1809-1883) of the Pennsylvania Hospital, began a course of instruction in 1843.\(^{81}\) However, the first ever formal training school for attendants and nurses of the insane (where trainees were known as pupils), was established at the McLean Hospital Massachusetts in 1882, an innovation that was quickly taken up by other institutions. This resulted in seventy such training schools in the United States by 1935.\(^{82}\)

\(^{79}\) Nolan, op. cit., p.63-64.
\(^{81}\) Nolan, op. cit., p.62.
Tracing the history of the training of attendants and nurses of the insane in Europe is much more difficult. Boschma\textsuperscript{83} relates that training began in some asylums in Holland during the late 19\textsuperscript{th} century and clashes between religious ideologies and medicine, resulted in some compromises. For example, at the Veldwijk Asylum in 1890 the governing authorities, acknowledging the need for experienced and educated staff, proposed a monthly lecture by a physician as well as one by a minister of religion. Naturally, as mental illness was still seen as the consequence of sin, the minister taught about the symptoms and treatment of mental illness, while the physician was restricted to anatomy and physiology and somatic treatments. However, within a few years the influence of the medical model grew and eventually overruled the “lay” model of training. By 1896, the minister’s lectures were confined to church history, bible knowledge and catechism training and physicians taught all of the medical content. In 1897, Dr Mercklin of the Lauenburg Institute at Pomerania (Germany) distributed a questionnaire regarding the training of attendants and nurses to asylums in Germany, Austria, Switzerland and Holland. At his own asylum he had begun giving a series of lectures of one hour per week for five months with topics ranging from basic nursing procedures to types of insanity and care of the insane. He also included discussions on cases of misconduct, errors and negligence as they occurred. Mercklin’s survey revealed that twenty-one asylums had no training whatsoever, eighteen were intending to begin training and, at twenty-six, training for a longer or shorter time was being provided (it was not reported from

\textsuperscript{83} Boschma, op. cit., pp.141-174.
exactly his responses came from).\textsuperscript{84} Evidently therefore, some training was underway in European countries before the end of the 19\textsuperscript{th} century.

At the end of the 19\textsuperscript{th} century, the failure of psychiatric treatment to cure mental illness in spite of the hopes and best efforts, firstly of reformers and later the psychiatric medical profession, saw mental health care retreat into custodialism.\textsuperscript{85} This later provided opportunities for comparisons of asylums with prisons, attendants and nurses with guards, giving much fodder for critics such as Erving Goffman to work with.\textsuperscript{86} According to Russell, the failure of the asylum system was masked by frequent attacks upon the quality of the attendants (and nurses). Further, when the failure became obvious,

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\text{it was easy to point the finger at the shortcomings of the very human and ordinary nursing staff, and so avoid facing up to the greater ineffectiveness that existed at the higher reaches of the lunacy profession.}\textsuperscript{87}
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It would be against the wider historical background broadly and somewhat briefly outlined in this literature review, that mental health care and nursing in New South Wales would develop.

1.5.3: History of mental health care and nursing in New South Wales.

Histories of mental health care in New South Wales have been written but are, on the whole, brief historical accounts of institutions,\textsuperscript{88} of particular personages,\textsuperscript{89} of

\begin{itemize}
  \item \textsuperscript{84}American Journal of Insanity, January, 1897, pp. 438-439.
  \item \textsuperscript{85}Tourney, op. cit., pp.94-95.
  \item \textsuperscript{87}Russell, op. cit., p.311.
\end{itemize}
discrete periods when reform or advances were made, or of legal changes regarding mental illness and discussion of past psychiatric practices.\textsuperscript{90}

Bostock's\textsuperscript{91} seminal and important work, covering the first half of the 19\textsuperscript{th} century (but in particular detail only quite a short period 1838 – 50), examined the rise of the medical profession over mental health care in New South Wales. It is a major source for the few other works (including in part this work), written on the subject. Bostock reviewed the very poor care of the mentally ill in early colonial New South Wales; however, his work inherently alluded to, and justified, the advantages of medical care and medical administration of the insane. Moreover, whilst Bostock (a doctor) appears sympathetic to the non-medical administrators of the time, he did not fully expose the malevolence of the medical profession. Subsequently, other writers reviewing this period have also generally avoided the true nature of the medical \textit{coup de grâce}, over the non-medical protagonists.\textsuperscript{92}

There are exceptions; Curry examined events leading to the rise of the medical profession over mental health care in New South Wales, from the perspective of a nurse. Curry observed that, by avoiding the use of some evidence, Bostock

\textsuperscript{92} Bostock, op. cit.
“miss[ed] much of the spirit of the conflict.” By re-examining many of the same sources as Bostock, but interpreting them from a nursing perspective, Curry shed new light on the events under question. Implicit in Bostock’s interpretation is the notion of a medical advance made in the care and treatment of the insane; Curry views it as a coup d’état by doctors, the beginnings of the medical dominance of mental health nursing. Another nurse, Murray, also examined the same period and (some of the same) evidence, resulting in a similar conclusion to Curry. Murray’s conclusions however, went a step further; he stated the rise of the medical profession over mental health care was “illegitimate… the accidental by-product of one man’s ambitions… the tyranny of the expert” (these three histories are returned to later when epistemological issues are reviewed). Nevertheless, whilst Bostock, Curry and Murray, each in turn examined the same events in some detail, and as significant as those events were to the future of mental health care in New South Wales, they represent only one part of a long process leading to the present. Other histories of mental health care rarely mention nurses or nursing. Moreover, when mental health nursing is acknowledged, it is usually in the context of patient abuse or scandal, or otherwise, is brief and superficial. There is even one (albeit brief) published history of a New South Wales psychiatric hospital in which mental health nurses and nursing are not noted at all. Therefore, it is not surprising that the identity,

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96 For example, see Garton, op. cit., pp.173-177.

97 For example, see Lewis, M., Managing Madness, Australian Government Publishing Service, Canberra, 1988, pp.114-117.

occupational expectations and working conditions of attendants and nurses of the insane, particularly in colonial times (1788 - 1901), was something of a mystery, ignorant to even the professional descendants of early asylum workers.

This ignorance of mental health nursing’s past is perpetuated in histories broadly purporting to be of nursing, and this has elicited criticism. In this regard, the lack of recognition of mental health nursing by historians is said to have occurred because it “lacks glamour.” Further, the history of nursing is the history of general nursing, which has claimed “propriety rights” over the title (of nurse), and historians have tended to “confirm, rather than question, the dominance of (general) hospital nursing in the constellation of nursing and nursing-linked occupations.” There are no works purporting to be histories of nursing in New South Wales, however, there are three histories of the education and training of nurses. In these works, mental health nursing is scantily mentioned and in some cases completely ignored, giving the (erroneous) impression that mental nurse training and education has little past at all.

Perhaps of more concern, in one history (of the New South Wales Nurses’ Association – a trade union), the important contribution of mental nurses to the development of the organisation was devalued. In particular, at times trivialising and even ridiculing the work of a male mental nurse (Leslie Hart), it is stated for example;

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Perhaps he felt he had to prove himself in an environment where he was pitted against senior members of the
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100 Ibid, p.124.

nursing profession, whose qualifications were superior to his and who were women.\textsuperscript{102}

Hart, who, not just as a male, but also as a mental nurse, represented the two minority groups of the organisation’s membership, seems to have been poorly treated in this work. It claims that, following his election as General Secretary, Hart “ruled” the organisation – seeing “himself as a father figure, looking after a large group of women.”\textsuperscript{103} However, Hart was re-elected several times, by the overwhelmingly female general nurse majority, as General Secretary, until his retirement in 1968; a total of 22 years in the position. Hart’s popular re-election does not lend support to the author’s contentions as, for example, this was a situation where women could have removed Hart from the position if they so chose. Whilst well aware of the legitimate criticisms concerning history’s treatment of women, the propriety of attacking a person because of their gender, in this case male, with nothing but the author’s opinion to substantiate that position, seems questionable. More positively, Shultz’s work,\textsuperscript{104} purporting to be a history of nursing in Australia, includes a reasonable amount regarding mental health nurses and nursing. Even so, Shultz’s work has been criticised for lacking critical analysis.\textsuperscript{105} However, in her preface, Shultz clearly states she intended to document a nursing history; it was never intended to be a critical work.\textsuperscript{106} In this regard, how history is written, and what it purports to be, are important issues.

\textsuperscript{102} Dickenson, M., \textit{An Unsentimental Union}. Hale & Iremonger, Sydney, 1993, p.110.
\textsuperscript{103} Ibid, p.99.
\textsuperscript{106} Shultz, op. cit., p.ix.
1.6: History – what it is and what it is not.

When considering how to approach this work, and as a practising nurse clinician possessing no formal education in researching or writing “history” (but with a sideline interest in history), I began reading as much as I could about historical research methodology. I quickly discovered there are many different ways to approach the subject, however, one thing became clear; there was no definitive right way to produce a history – but, according to historians who took a particular epistemological position (and thus, methodological approach), there was an abundance of wrong ways.

Jenkins\textsuperscript{107} views history as one of a series of discourses which give meaning to the world. History’s object is to enquire about the past, however, as a discourse it is in a different domain to the discourse (the past) it discourses about - history and the past are two separate things. There is a distinction between history and the past; history is what is written about the past (strictly historiography), the past is what has occurred before and it cannot be brought back – it has been and gone, it no longer exists.

Moreover, history (the product of the labour of historians), can only recount a fraction of what occurred in the past, not as actual events, and in a very different media, for example, books, articles or documentaries. Because history can only recount a fraction of the past, as a series of events or situations, for instance, it leaves only fragmentary evidence. History, therefore, cannot recover the past’s entirety, it cannot know everything - its knowledge is limited and thus epistemologically fragile. Further, as the past is gone, no historical account (or

interpretation) can be compared with it, historical accounts can only be compared with other accounts. All historical accounts, regardless of how verifiable, are essentially the personal construct of the historian’s perspective as the narrator. For example, availability and the individual historian’s predilections affect their choice of historical evidence, while their knowledge and assumptions shape their constructs and interpretations. Also, the past, free of history, may be interpreted differently by alternative discoursive practices – for example, anthropology or sociology. Thus one past results in many accounts or interpretations.\textsuperscript{108}

Collingwood,\textsuperscript{109} in discussing how or in what conditions the historian can know the past, observes that the past is not a given fact which the historian can perceive empirically: s/he is not an eyewitness of the events. The historian’s knowledge of the past is mediated, indirect or inferential, and s/he can only construct an account from the relics (evidence) left behind. Historical evidence is not a natural event; it was shaped by the actions of human beings (agents) and the historian cannot know the past by simply believing the evidence left by those agents. Evidence of the past is not the past itself, but rather the thoughts translated into action, of the agent at the time. To gain some understanding of the agent’s actions, the historian must re-think or re-enact the agent’s thought in her/his own mind. Thus Collingwood believed that history was not the past, it was always the history of human thought.

Nevertheless, each thought (as an experience) is unique: no two thoughts are the same. Collingwood recognised this and observed that the historian’s re-enactment of thoughts of the agent was not the same act – but rather an act of the

\textsuperscript{108} Ibid.
same kind occurring in different contexts. Re-enacting another’s thought(s) does not contribute to historical knowledge, to do this, requires historians to be self-consciously thinking historically; “a form of thought possible to a mind which knows itself to be thinking that way.”¹¹⁰ Collingwood’s thinking historically is, according to Vincent, analogous to virtual reality of a past thought but in a present context; “the historian both knows the past thought and knows that it is past.”¹¹¹ However, there is a problem with this notion; given that human nature may not have been constant from age to age, how can the historian begin to really understand or re-enact the thoughts of an agent – especially of the distant past? Walsh says that we (in the present), can only think we understand past ages in the same way we think we know our contemporaries.¹¹² To believe otherwise opens the door to scepticism (the idea that we cannot know anything and a debate well beyond the needs of this work). Nevertheless, for the purposes of this work, Collingwood’s notions have some appeal, particularly as the past, under examination in this instance, is not so distant in time and culture, and there has been since, continuity in social and political ideologies (that is, changes to society have evolved rather than been forced by revolution).

Accordingly, by re-enacting the thoughts of a past agent’s evidence, one may experience, to some degree, how the agent felt about the circumstance(s): providing an opportunity to gain an inside perspective. For example, in this work, the past of mental health carers is examined by an occupational descendent. This descendent is informed by a body of knowledge (however more complex or “advanced”), which essentially concerns the same occupational

¹¹⁰ Ibid, p.289.
activity. Whilst the descendent cannot actually know what the past agent experienced, a feel for that experience is possible.

This feeling, informed by a related, albeit distant body of knowledge, combined with the self-conscious knowledge of thinking historically, provides an insight which may inform an interpretation of the felt experience of the past agent. However, this does not mean the historian knows what the past agent was thinking (and feeling), only what the historian thinks and feels (empathises) in relation to the circumstances of the re-enactment. This forms a personal and thus intersubjective interpretation which, in acknowledging multiple (constructed) truths, opposes positivist ideologies that demand objective interpretation to discover correctness or (singular) ‘truth.’ These epistemological issues are further discussed in the following section.

1.7: Discussion of the position informing this work.

The writing of history, like all knowledge production (or construction), is concerned with epistemological issues, such as, the nature and development of knowledge. Integral to this concern, is the part the researcher (historian) plays in that knowledge production. Epistemological debates about this issue reside on a continuum, with positivism (objectivity, reductionism, correspondent singular truth, observable facts) at one end, and relativism (subjectivity, wholism, coherent multiple truths, discernable understanding) at the other. Generally, authors refer to these epistemological positions as positivism and interpretivism (encompassing critical approaches) or, post modernism. As noted before, central to these epistemological and thus methodological debates, is the researcher’s or historian’s role in, and influence on, knowledge production. One example of the
influence of the historian on the production of knowledge is the work of
Foucault. In this regard, Foucault’s critical re-interpretation of concepts like
madness, sexuality and knowledge, lead to different understandings of those
phenomena. Thus, as further noted in the discussion that follows, different
epistemological orientations (and methodological approaches) to the evidence,
result in different interpretations, understandings and knowledge.

When Cushing says that the “writing of respectable history” depends on the
historian’s objectivity in allowing the facts (evidence) to speak for themselves,
she expounds a positivist view. In this view, the historian’s personal opinions
and ideology should not influence interpretation of the facts. However, as
pointed out by Holmes, echoing Carr, the facts cannot speak for themselves; they
are mute and need some-one to speak for them, they must be interpreted to have
meaning. Even so, Carr observes that history without the facts is rootless and
futile; the facts without history are dead and meaningless. Thus says Carr; history
is a continuous process of interaction between the history and the facts - "an
unending dialogue between the present and the past." This dialogue, according
to Holmes, subsumes "some interpretative elements" because the human mind
generally “cannot refrain from interpreting data of which it becomes aware.”
Holmes was also clear however; that for interpretation to have rigour it must be
faithful to accurate factual data (evidence), otherwise it is not history, but

114 Cushing, A., Methods and theory in the practice of nursing history. International History of
115 Holmes, C., History, interpretation and social theory: A personal rejoinder. International History
Books, Middlesex, 1961, p.11.
117 Ibid, p.34.
fantasy. That is, interpretation must be grounded in reputable evidence, in careful and considered evaluation, and in reasoned judgment about that evidence.

Both Cushing and Holmes (though representing opposing sides), make valuable contributions to the epistemological debate. Some facts may speak for themselves, for example, the penal colony of New South Wales was established in 1788 - this is description. Some facts however, cannot speak for themselves; opinion, conjecture, reasoned judgement or personal reminiscences are, as Collingwood said, mediated, indirect or inferential evidence - these are interpretations requiring further interpretation. For these reasons, a descriptive-interpretive approach was taken to this work. This is not to suggest a descriptive-interpretive approach creates a bridge between the positivist and interpretivist paradigms. This work is situated in the interpretive paradigm, however, interpretation is seen as residing along a continuum. Description is at one end of this continuum and interpretation (critical or otherwise) is at the other. In this way, descriptive evidence is seen as requiring little or no interpretation, although the context of its occurrence may. For example, that all the colonial governors were men describes events that do not require interpretation, however the personal, social and political forces (contexts) which act as determinants of such events, do require interpretation.

Choosing a descriptive-interpretive approach allowed me to engage with the evidence without the imposition of being orientated toward it in a particular methodological/ideological way. Nevertheless, I am aware of specific epistemological theories and positions, for example, Marxism, Feminism, Critical Theory, and these informed my work. For instance, understanding the
above noted theories allowed me to become aware of issues relating to power, class and gender when I encountered them in the evidence. In turn, I could weigh and consider their significance and determine how to take account of them in the processes of documentation and analysis/interpretation. A descriptive-interpretive approach is concerned with the interplay between evidence from the past (primary and secondary sources) and its understanding in the present (my documentation, description and interpretation). In turn, this historical account of mental health care (nursing) from colonisation (1788) to federation (1901), represents one of many possible accounts. This diversity in historical representation, within this and other work, arises from issues like the following:

- the availability, or not, of evidence. For example, the lack of evidence concerning the work of attendants and nurses in colonial New South Wales.
- the influence of fragmentary evidence which, by its very nature, orients the historian in a particular direction.
- inherent deficits in the ability of any historian to access, weigh the significance of, and interpret evidence.
- the inability to use all available evidence, resulting in the selection of particular evidence upon which to focus, which, in turn, results in a specific view or perspective.
- the way the historian documents and interprets evidence and through which s/he exemplifies their points or constructs their position.

To make these points more clearly, two examples are used: (1) conclusions regarding nurses and the implementation of moral treatment/management, and (2) Bostock, Curry and Murray’s constructions of history. In the first example,
the lack of evidence regarding the use of moral management by nurses in colonial New South Wales, led me to extrapolate from the evidence (interpret), and my own clinical knowledge, to conclude that, as nurses and attendants worked with the patients 24 hours per day, it was they who were best positioned to implement the tenets of moral treatment. In the second example, diverse interpretation of the evidence is the issue.

Bostock, Curry and Murray examined much of the same evidence regarding the medical ascendancy over mental health care, yet they reached quite different conclusions. Bostock’s sympathy for the non-medical personnel, involved in the conflict, is outweighed by his apologist assessment of the medical men. Bostock implies that, more than anything, government reluctance and inaction to properly resource mental health care was the root cause of change (from non-medical to medical ascendancy over mental health care), whilst the whole work implies that medical dominance of mental health care was a natural evolutionary process, and probably inevitable. Curry saw the situation in terms of political cynicism, medical arrogance and social denial. He suggested the medical/nonmedical conflict was a distracter from the real issues, such as poor resourcing of services and care for the mentally ill. He concluded the events under examination resulted in the beginning of a long process of doctors (and allied health workers), eroding and taking over the traditional role of the nurse. Murray was much more emphatic, he says the medical dominance of mental health care occurred outside any true social force for change, but rather, as a consequence of one doctor’s personal ambitions.
Bostock’s orientation toward and interest in the evidence was mental health care and medicine/psychiatry, and their influence, while Curry and Murray’s was in mental health nursing and critical review. These different interpretations and views of history exist because of the approaches (purpose, methodological position) taken toward the evidence and because of the diverse knowledge, orientation and positions of the researchers, and which, in part, determine the nature of the history that results. Even so, this is not necessarily a weakness as it provides diverse perspectives from which to comprehend events occurring in the past.

1.8: Accessing the sources.

Locating primary sources, for example, sources reported either by a participant of the event or an observer of the event,\(^{118}\) was initially challenging. Whilst some primary sources were relatively easily accessed through computer catalogues (for example Picman), of manuscript holdings at the Mitchell and State Libraries and the State Records Collection, some are not yet fully catalogued or more particularly, their contents are not indexed. This is especially true of sources that have not yet been reproduced or copied (for example, the Colonial Secretary’s Papers after 1826).

Whilst there are indices of contents for some of the early colonial newspapers (which could be either primary or secondary sources), most newspaper sources had to be gleaned by examining them for comment when, for example, issues were noted in Government Reports at around the date they were made public knowledge, or during the (oral) evidence collection at public Inquires (which

were sometimes attended by newspaper reporters). This results in very time consuming searches and readings, where the information may be interesting, but not really relevant to the focus of the work at hand.

Some primary sources can be discerned from secondary sources, defined as “sources from someone else, who may have not been an eyewitness,”119 or “interpretations of the past produced after the period being researched and provide context.”120 Difficulties accessing secondary sources, such as contemporary newspaper reports at around the time of the event(s) under examination, have been noted above, however, later secondary sources are more readily accessible by utilising indices such as the Cumulative Index of Nursing and Allied Health Literature (CINAHL) or internet search engines.

Secondary sources such as historiographies can be useful for locating primary sources, if they are properly and fully referenced (surprisingly many errors occur resulting in false leads). In this work, to ensure scholarly rigour and facilitate access to information by other researchers, particular attention was paid to ensuring that sources were properly and fully referenced (including where primary sources are held).

1.9: A brief overview of the work and thesis.

This work takes a narrative form – telling the story of attendants and nurses within the context of mental health care and the broader social and political world of a newly established and developing colonial society. It documents a foundational, descriptive-interpretative history. It is foundational because it

119 Ibid, p.197.
charts new ground and uses previously unused primary sources. It is descriptive because some evidence, as noted earlier, speaks for itself. It is interpretative because it seeks to create meaning from evidence that cannot speak for itself, for example, the beginning identification and analysis of recurring dominant issues (chapter 8). Originally, I sought to discern and document the history of mental health nursing, however, so few primary sources concerning this aspect of colonial mental health care were found, that such a history was impossible to write. Jenkins\textsuperscript{121} would call this a non-history, a past with little surviving evidence from which to create meaning and document (a history) in the present. In this way, the history of mental health nursing became, instead, a history of mental health care, although clearly mental health care was the context in which mental health nursing took place, encompassing as it did, personal, social and political issues and events.

This is a preliminary work, as no earlier attempt has been made to chart the history of mental health nursing in colonial New South Wales (1788 – 1901). One of the principal objectives was to bring to light as much information as possible regarding this history, and because it covers an extended period (113 years), it was felt appropriate to create a largely foundational descriptive-interpretive history, which would provide a basis for the work of others. Development of the care of the mentally ill is contextualised against significant historical events that occurred from time to time in colonial society, emphasising those which had a direct effect on mental health care (nursing). The structure of the work is best described as a broadly chronological narrative which seeks to chart the development of mental health care and relate the story of the carers of

\textsuperscript{121} Jenkins, op. cit.
the mentally ill in colonial New South Wales (although the chronology is interrupted when major issues develop and extend beyond the period they first emerged). In charting this history, it became clear that some of the issues exposed require further examination. However, a beginning was required and as the first attempt to chart a history of the care of the mentally ill, and of their carers, in colonial New South, the work is significant. In the following section, an overview of each thesis chapter is provided.

1.10: Overview of chapters.

Chapter 1. The *Introduction* reveals the purpose of the work which, initially, was in response to dramatic changes in the delivery of mental health care/services in New South Wales. The closure and downsizing of many of the state’s older mental health institutions began a process of re-evaluating their historical origins and importance, and through this process it became evident that the history of mental health nursing had been neglected. In turn, this deficit provided the impetus behind this work. This chapter also explores the nature of history and provides discussion of ideas informing the approach to the work.

Chapter 2. *The convict era*, examines the plight of the mentally ill convict population in early colonial New South Wales. In the literature, this topic is barely addressed. It also explores the subject of who actually cared for lunatic convicts. Early in this chapter, a concerted attempt was made to identify and bring together sources which shed light on how mentally ill convicts were treated or managed. The colony of New South Wales’ first Governor, Arthur Philip, was provided with instructions regarding the assets of mentally ill people. How they were to be cared for, however, was not articulated in Phillip’s instructions.
Mentally ill convicts (and pauper colonists) were not given any serious consideration for their welfare until the arrival of Governor Lachlan Macquarie. Macquarie was sympathetic to their plight and ordered the establishment of Australia’s first lunatic asylum at Castle Hill in 1811. The closure of Castle Hill Asylum and the subsequent opening of another lunatic asylum at Liverpool are charted. By the close of chapter 2, it becomes clear that the (nursing) carers of the mentally ill were convicts, people not experienced and often unwillingly assigned to the asylum. Thus, the origins of the work of mental health nurses in New South Wales, took shape within the social structure of the convict population.

Chapter 3. *The advent of Joseph and Susannah Digby*, examines, in some detail, the appointment of Joseph and Susannah Digby; the first “qualified” or experienced people to take charge of the first purpose built asylum, Tarban Creek (later Gladesville Hospital). Their appointment occurred after a request from Governor Bourke to the home government, for duly qualified carers of the insane. Possible reasons why the Governor did not appoint people already resident in the colony, nor appoint a doctor from the colonial medical service, are explored. The Digby’s tradition of care, very much founded on the philosophy of the Moral Management of the insane, is examined. Possibly unbeknown to them, the eminent mad doctor of Great Britain, Sir William Ellis, opposed their appointment – claiming that, as they were not doctors, they were unqualified to oversee the care of the insane. His opposition provided the moral authority for the medical profession in New South Wales to undermine the Digby’s work resulting in their eventual downfall.
Chapter 4. *The genesis of medical ascendency over mental health care in New South Wales*. This chapter examines the early work of the Digbys and their attempts to establish appropriate care for the colony’s insane. For example, the employment of non-convict keepers and nurses, in the face of government indifference and penny pinching. Public criticisms of their work, based on half-truths and innuendo, and orchestrated by members of the medical profession through the popular press, are revealed. Particular attention is given to evidence exposing the underhanded methods employed to unseat the Digbys from their positions as administrators of the Tarban Creek Asylum. The issue of how an elite professional group (doctors) claiming specialist knowledge, combined acceptance into upper class society and the support of some of colonial society’s elite, to achieve medical control and dominance over mental health care, is disclosed.

Chapter 5. *The more things change – the more they stay the same: 1850 – 1868*, reviews mental health care in colonial New South Wales during the two decades following its dominance by the medical profession. The positive developments of treatment and care, promised by the medical profession, were never realised, largely in part, due to continuing government indifference regarding the needs of the mentally ill. Also reviewed, is the significance of this period regarding the ways through which the medical profession began to extend its dominance, beyond the carers of the mentally ill, to include all staff associated with asylums. This dominance was achieved through official rules and regulations, as well as an Act of Parliament. Through such mechanisms of control, dissent, in relation to the medical superintendence of asylums, was not tolerated from any working class subordinate.
Chapter 6. *Though this be madness, yet there be method in it*, wherein the early development of the future profession of mental health nursing is explored.

Following a parliamentary inquiry into one asylum, which exposed corruption and mismanagement on a very large scale, the government finally decided to create an official department wholly concerned with mental health care. This “Lunacy” Department was given a reformist “Head,” Dr Frederic Norton Manning, who had already proven himself as the Superintendent of the Tarban Creek Asylum. Manning laid the foundations for the direction of future developments in mental health care in New South Wales, a legacy which was to last until the mid 1980s. On his agenda, which he articulated in 1868, was reform of the carers of the mentally ill – he stated they had to *have tact, intelligence and a special acquaintance with the insane*. He worked methodically to ensure that applicants for positions as attendants and nurses had a basic education, a prerequisite for the introduction of the formal training and education which commenced in 1885 at Gladesville Hospital for the Insane, spreading to all other asylums by 1894. Manning appears to have genuinely believed and hoped that “mental nurses” would be given the same professional respect their general nurse colleagues were gaining during this period – a hope that was never fully realised.

Chapter 7. *Origins and early development of mental health nurse training in New South Wales*, explores the development of formal education and training of asylum nurses in mental health care. It is speculated that the employment of general trained nurses for senior positions within the asylums (particularly Mrs Bessie Simpson), though unacknowledged, significantly contributed to the development of training courses for mental health nurses. The first Australian textbook for mental health nurses is revealed, and the early development of the
education and training curriculum is charted. Also examined, Australia’s first professional nursing organisation’s (the Australasian Trained Nurse’s Association) initial resistance to accepting mental health nurses as an equal professional group. Owing to the importance of the origins and development of the education and training of mental nurses, through an epilogue, this chapter extends beyond 1901 to briefly address the establishment of the New South Wales Nurse’s Registration Board in 1926.

Chapter 8. *Time present and time past... are both perhaps present in time future... and time future contained in time past*, discusses the general findings of the work and identifies three dominant issues (from the past) that directly influence mental health nurses and nursing in the present. These three issues are discussed thereby revealing their influences and potential implications for the future of mental health nursing. Limitations and strengths of the work are also outlined and the potential for future research is addressed.

1.11: A note on nomenclature.

Nomenclature in this work reflects that in existence at the particular time under examination. Some terms, such as, “lunatic,” “idiot,” “keeper,” “attendant,” were terms in common usage in the 19th century and no offence is intended by their usage.
Chapter 2.
The convict era.

This chapter examines the foundation of the colony of New South Wales in 1788, exploring the subject of who the mentally ill were, what measures were taken for their care and who actually cared for them in the early days of the colony. The colony’s first Governor, Arthur Phillip, was given powers to manage the assets of the mentally ill, but no instructions on how they were to be treated and cared for. It was not until after the arrival of Governor Lachlan Macquarie that official consideration was given to the proper and humane care of the insane with the opening of an asylum at Castle Hill in 1811. After a chequered history, the asylum was replaced by another at Liverpool in 1825. The care and treatment of the insane at both asylums is explored with the power struggles of officials, particularly at Castle Hill Asylum, overshadowing much of the care provided. Also explored is the plight of the insane who were not admitted to the asylums, with examples of their management provided. By the end of the chapter, it becomes clear that most of the early carers of the mentally ill were convicts who were inexperienced and often unwillingly assigned to the asylums.

2.1. The establishment of the penal colony of New South Wales.

On January 22\textsuperscript{nd} 1787, King George III officially announced the settlement of New South Wales in the British Parliament. The King noted this was necessary in order “to remove the inconvenience which arose from the crowded state of the gaols in the different parts of the kingdom.”\textsuperscript{122} Transportation of criminals

existed as part of the English penal system since the mid eighteenth century with British colonies in North America being the principal places of convict disposal. The American Revolution made continuation of this practice impossible; when the gaols became too overcrowded, the temporary response was to convert old ships into prison hulks. When the British lost the revolutionary war, the solution was to establish a new penal colony in New South Wales which had been discovered by James Cook in 1770.

The majority of British criminals were convicted for offences against property, such as petty theft, highway robbery, stealing livestock, grand larceny, receiving stolen goods, swindling and forgery. These people were mostly constituents of the extremely poor underclass of the British population which developed during the industrial revolution. This underclass became vast during the early to late eighteenth century as the British population almost doubled from five and a half million in 1714, to nine million in 1801.\(^{123}\) Transportation was Britain’s attempt to remove some of the undesirable underclass, whilst at the same time providing a source of inexpensive labour in the new colony. This labour would significantly assist the establishment and progression of British dominions on the other side of the world. Whilst some of those selected for transportation to New South Wales were convicted of crimes involving threats or violence, and later a few political prisoners were also sent, the overwhelming majority were convicted of theft forced by necessity in order to survive. In the face of an increasing crime rate, Georgian Britain enacted a variety of laws which included very severe penalties for crimes against property, including theft and the death penalty hung over anyone convicted of stealing property valued at 40 shillings or more.\(^{124}\)

The man chosen to lead the expedition and to establish and govern the new penal colony of New South Wales was a semi-retired naval officer, Captain Arthur Phillip. Phillip received his commission as Governor of the new colony from King George III in April 1787. On May 12th 1787, he left for Botany Bay with a fleet of eleven ships. These ships, later known as the First Fleet, carried 1482 people; officials, British marines, Royal Navy personnel, some family members and 759 convicts, on their twelve thousand mile journey. After a voyage of eight months, the fleet arrived at Botany Bay between January 18th and 20th 1788. Finding the place unsuitable, the fleet moved to a harbour a few miles north, settling near a fresh water source at the place which later became known as Sydney Cove.

2.2: Governor Phillip’s responsibilities towards the mentally ill.

Unlike New South Wales, where little more than the most basic infrastructure would take years to develop, Britain had, from the mid 18th century, established a large number of private madhouses. A few of these were for the very wealthy where every luxury could be expected by those able to pay. Most were simply boarding houses, where those with some financial means or support could be accommodated. The few public institutions admitting pauper lunatics, including the gaols, also expected payment from one source or another. Often the cost of maintaining these people was levied against their home parish, under the Poor Law, which existed from the reign of Elizabeth I and was consolidated in 1601.

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125 Ibid, pp.67 & 77.
126 Shaw, op. cit, pp.7-8.
* The continent of Australia was already populated by indigenous peoples whose experience of European colonisation was almost universally disastrous upon contact. See Hughes, op. cit., pp. 7-18.
The Poor Law’s principle provisions outlined an expectation that each parish would set up a committee, overseen by Justices, to levy taxes for the relief of paupers. Administered at parochial level, each of the 15,000 parishes took responsibility for the relief of its own poor, in poorhouses or workhouses. Pauper lunatics were often forced into workhouses where they, due to their erratic behaviour, might be found chained in the cellar.

Many lunatics were, however, maintained by their families at home where they might be routinely beaten, kept chained or restrained, imprisoned in holes under the floors or forced to reside in barns and outbuildings designed for animals. Those who were turned out from home, or other accommodation, “swelled the stream of beggars that wandered the roads of early modern Europe.” Although there are no figures available, it is probable that this group constituted a significant proportion of those convicted of criminal acts, which attracted the punishment of transportation and servitude in New South Wales.

Governor Phillip’s Commission included responsibilities concerning the custody of idiots and lunatics and these responsibilities were based on the British Crown’s prerogative to manage the estates of the mentally ill. This Royal Prerogative was based on a Statute of Prerogativa Regis which existed since 1324. This statute originally provided protection for the goods and chattels of

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131 Ibid.
132 In general terms an “Ideot” was a person would today be classified as Developmentally Disabled and thus considered incurable. A “Lunatic” was a person who suffered a mental illness which was believed to be potentially curable (some lunatics were known to spontaneously recover and others recovered with “treatment” such as it was).
133 Knight, J., Lexicons of Lunacy. Bedlam Bicentennial and Beyond, Australian Congress of Mental Health Nurses, Sydney, 1988, p.54.
idiots. Their property was utilised for their care and sustenance throughout life, and what remained was passed to heirs. However, the profits made during the life of the idiot were kept by the Crown. Lunatics were treated differently; their estates were likewise used for their sustenance however, upon recovery, their property and any profits were restored to them or to their heirs after death.\(^{134}\) \(^{135}\)

Phillip’s orders were explicit:

> And whereas it belongeth to us in right of our Royal Prerogative to have the custody of ideots and their estates and to take the profits thereof to our own use finding them necessaries and also to provide for the custody of lunaticks and their estates without taking the profits thereof to our own use.

> And whereas while such ideots and lunaticks and their estates remain under our immediate care great trouble and charges may arise to such as shall have occasion to resort unto us for directions respecting such ideots and lunaticks and their estates Wee have thought fit to entrust you with the care and commitment of the custody of the said ideots and lunaticks and their estates and Wee do by these presents give and grant unto you full power and authority without expecting any further warrant from us from time to time to give order and warrant for the preparing of grants of the custodies of such ideots and lunaticks and their estates as are or shall be found by inquisitions thereof to be taken by the Judges of our Court of Civil Jurisdiction and thereupon to make and pass grants and commitments under our Great Seal of our said territory of the custodies of all and every such ideots and lunaticks and their estates to such person or persons suitors in that behalf as according to the rules of law and the use and practice in those and the like cases you shall judge meet for that trust the said grants and commitments to be made in such manner and form or as nearly as may be hath been heretofore used and accustomed in making the same under the Great Seal of Great Britain and to contain such apt and convenient covenants provisions and agreements on the parts of the committees and grantees to be performed and such security to be given them as shall be requisite and needful.\(^{136}\)

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\(^{134}\) Ibid.


\(^{136}\) Phillip's Commission. H.R.N.S.W., Vol. I., p.64.
Phillip’s orders can be seen as largely concerned with the protection and use of the property of the mentally ill. Phillip’s Commission was designed to ensure that those who could pay – would pay. As in the Prerogativa Regis, costs for the care and maintenance of a mentally ill person were to be paid from the person’s estate, or from any profits of the estate. Of particular note, the profits made on the property of “ideots” could be taken by the Governor and put to official uses not necessarily associated with the person concerned. However, once maintenance costs were deducted, the profits obtained from the property of lunatics were returned to their estates. This probably reflects the belief that idiocy was not curable, whereas, a recovery from lunacy might be possible. It is worth noting that unknown to the public, King George III suffered and recovered from an episode of mental derangement in 1765. He was to suffer further relapses in 1788 (enduring the indignity of mechanical restraint), 1801, 1804 and a final illness from which he did not recover in 1810.\textsuperscript{137} \textsuperscript{138}

Phillip’s Commission also provided for the custody of the mentally ill following inquisitions undertaken by judges. The conduct of these inquisitions and the expectations and standards inherent in the custody of the mentally ill, is not outlined in the Commission. However, it is clearly expected that the prevailing laws of Britain were to be considered: “…made in such manner and form or as nearly as may hath been heretofore used and accustomed in making same under the Great Seal of Great Britain.” At that time under British common law, the writ de idiota inquiringo, allowed for a jury of twelve men to decide if a person was mentally unfit. There were two grades of mental incapacity: a navitate (an idiot

or natural fool), and *non compos mentis* (a lunatic).\(^{139}\)\(^{140}\) A law was passed in 1744 (17 Geo. II, c. 5), authorising any two justices to apprehend dangerous (pauper) lunatics and securely chain and lock them up in gaol.\(^{141}\) This law was designed to protect society rather than to provide care for the mentally ill.

The authority vested in Phillip’s Commission was given to every governor of New South Wales until the appointment of Sir Ralph Darling in 1825. Darling’s Commission omitted the Royal Prerogative over lunatics and their estates because this could be accommodated under the New South Wales Judicature Act of 1823 (4 Geo. IV c. 96).\(^{142}\)\(^{143}\) Nevertheless, evidence of mental illness in colonial New South Wales was initially, difficult to ascertain.

### 2.3: Incidence of mental illness in the new colony.

The mental health of convicts does not appear to have attracted attention prior to the fleet’s departure from England, and seems not to have excused convicted persons from transportation. Although Phillip held the authority of the King’s Prerogative, no evidence has been found that either he, or his immediate successor, made official use of this power. Since the colony was founded as a penal settlement, it is very unlikely there were many people with estates necessary to require the governor’s intervention. There is also no evidence that Phillip officially used his power to incarcerate lunatic convicts, nor is there any official record of the incidence of mental illness during his governorship.

However, Captain David Collins, sent with the Fleet as the colony’s

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\(^{139}\) Knight, op cit., pp.48-50.
\(^{141}\) Tuke, op. cit., p.98.
\(^{143}\) Cummins, *The Administration of Lunacy and Idiocy 1788-1855*. op. cit., p.17.
first Judge-Advocate and Colonial Secretary, kept a personal journal recording his experiences of the voyage and the first years of settlement. Included in his writings were comments regarding the suicide and attempted suicide of convicts. He also made occasional remarks about the mental health of both convicts and others residing in the colony. Collins provides evidence that, at least in one instance, a convict was mentally ill prior to the departure of the Fleet. In 1789 he recorded the death of “an unhappy woman who had been sent on board in a state of insanity, and who remained in that condition until the day of her death.”

It is unlikely that this was an isolated case and in contrast, only days before departure, a lieutenant on the fleet’s flagship *H.M.S. Sirius*, exhibited behaviour that raised concern. Three naval surgeons were instructed to examine the officer and they confirmed he was insane - he was discharged from the ship and sent into confinement in a private madhouse.

During the voyage of the First Fleet, there were only forty eight deaths - forty convicts, five convicts’ children, one marine’s wife, one marine’s child and a marine. Under the circumstances, and with the primitive state of medical care, “it was a tiny death rate.” However, owing to the privations of the voyage, for example, under nourishment, the overcrowding below decks, cruel punishments, witness to and/or actual experience of sexual assault and rape, removal from familiar environments, family and friends, and the uncertainty of the future

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146 Hughes, op. cit., p.83.
147 Sexual assault/rape was a feature of many convict ships and contemporary sources often blamed the (female) victim. See Beddoe, D., *Welsh Convict Women*. Stewart Williams Publishers, Barry, 1979, pp. 119-121. Homosexual contact including coercion and rape was not unknown (but rarely spoken of) see Hughes, op. cit., pp. 264-272.
accompanied with hopeless despondency, “symptoms of psychotic illness would be an expected response.”\textsuperscript{148}

Collins recorded his feelings upon departure of the Fleet from Cape Town South Africa:

It was natural to indulge at this moment a melancholy reflection which obtruded itself upon the mind. The land behind us was the abode of a civilized people; that before us was the residence of savages. When, if ever, we might enjoy the commerce of the world, was doubtful and uncertain... All communication with families and friends now cut off... failed not to afford a most striking contrast with the object now principally in our view.\textsuperscript{149}

If Collins, a person of high rank and expecting to enjoy the best of existing comforts (such as they were) felt despondency, the incidence of stress induced and depressive illness within the convict population must have been high. The cause of death of one convict, Edward Thomson, on January 9\textsuperscript{th} 1788, was recorded as “worn out with melancholy and long confinement.”\textsuperscript{150} In 1789, at the age of eighty four, the oldest woman transported with the fleet, Dorothy Handland, hanged herself from a gum tree “in a fit of befuddled despair”; she is recorded as Australia's first suicide.\textsuperscript{151}

Collins recorded incidents of suicide, attempted suicide and alcohol abuse, which sometimes led to the death of convicts within the first few years of settlement. He even expressed some surprise at the suicide of a man who swallowed arsenic in 1795, as this particular convict seemed to be quite contented with his employment as a shop assistant.\textsuperscript{152} Collins may not have been the only person to

\textsuperscript{149} Collins, op. cit., p.xxxiv.
\textsuperscript{151} Hughes, op. cit., p.73.
\textsuperscript{152} Collins, op. cit., e.g. pp.25, 194, 405-6, 411, 423.
have noticed the mental (ill) health of some of the convicts, but he recorded his personal observations, and they survive largely because he organised for their publication in England. Thus, Collin’s (scant) observations provide at least some evidence, from which later commentators can draw conclusions, rather than relying purely on supposition or conjecture.

The penal settlement was established with very limited supplies as it was expected, through the use of convict labour, that the colony would become rapidly and largely self-sufficient. However, the first four years of settlement were a constant struggle for survival. Food supplies ran low as the hope of growing crops to feed the settlement produced very little food, resulting in the introduction of tight and still tighter food rationing. Theft of food became punishable by death, a rule not confined to convicts for in March 1789, six marines were hanged for this offence.\textsuperscript{153} For the convicts this was a particularly desperate time. Convicts were expected to provide the labour necessary to clear land and build the new colony and the rules were simple: “if they did not work, they would not eat.”\textsuperscript{154} Convicts with physical disabilities (including amputees), and the mentally retarded, were not considered sick and while ever they were capable of any task, they were put to work.\textsuperscript{155} It is no surprise that during the first year of settlement, more than fifty people died from illness, more than one hundred were being treated in the hospital, and fifty-seven were unfit due to old age and infirmity from hard labour (in total - approximately 15\% of the convict population).\textsuperscript{156}

\textsuperscript{153} Ibid, pp. 59-61.
\textsuperscript{154} Hughes, op. cit., p.89.
\textsuperscript{155} Earnshaw, op. cit., p.26.
\textsuperscript{156} Shaw, op. cit., p.10.
resources of the colony. Moreover, the Second Fleet, of 1790, which was particularly notorious for its very high death rate (25%) and the Third Fleet, of 1791 (10% death rate), both delivered large numbers of seriously ill people to the colony.\textsuperscript{157}

Under such harsh conditions, and given that food avoidance and refusal are common symptoms of a variety of mental illnesses, it is plausible that many mentally ill people simply perished; mental disorder not being noted as contributing to their deaths. The pressing need to find better soil in which to plant crops, saw the establishment of government farms at Parramatta (November 1788) and Toongabbie (April 1791), twenty-four to thirty kilometres west of Sydney. The use of convict labour to establish these farms was essential, the Toongabbie farm becoming notorious for its cruel conditions and high death rate. An ex-convict, Joseph Smith, interviewed by Caroline Chisholm in 1845 recalled:

\begin{quote}
I arrived in the colony fifty-six years since; it was Governor Phillip's time,...I was seven years in bondage...I have often taken grass, pounded it, and made soup from a native dog. I would eat anything then. For seventeen weeks I had only five ounces of flour a day. We never got a full ration except when the ship was in harbour. The motto was “Kill them, or work them, their provisions will be in store.” Many a time I have been yoked like a bullock with twenty or thirty others to drag along timber. About eight hundred died in six months at a place called Toongabbie, or Constitution-hill.

I knew a man so weak, he was thrown into the grave, when he said, “Don't cover me up; I'm not dead; for God’s sake don't cover me up!” The overseer answered, “Damn your eyes, you’ll die to-night, and we shall have the trouble to come back again....”
\end{quote}

\textsuperscript{157} Hughes, op. cit., p.105.
They used to have a large hole for the dead; once a day men were sent down to collect the corpses of prisoners, and throw them in without ceremony or service. The native dogs used to come down at night and fight and howl in packs, gnawing at the dead bodies...”

Whilst it is possible that Smith exaggerated the number of deaths, there is little doubt the death rate was high. This is supported by Collins who recorded that in 1791, a total of 155 male convicts died. The death rate dramatically increased to 418 in 1792, but fell back to 78 in 1793. Apparently it was not uncommon for seven or eight convicts to die in one day, often whilst at their slavish work. As Bostock notes, “Under such circumstances there could be no need for a mental hospital; a coffin solved the problem of maintenance.”

The Superintendent of the Toongabbie Government Farm, Thomas Daveney, was removed from his position in 1792, suspected of tyrannically abusing the confidence he had been given by the Governor. Collins records that Daveney began to abuse alcohol and in 1794 “came to Sydney in a state of insanity.” After drinking nearly half a gallon of brandy he died of injuries received whilst intoxicated. “He left a widow... who had for several years been deranged in her intellects.” Collins did not record her fate.

Whilst the extreme abuses of the Toongabbie Farm applied to male convicts, women were also poorly treated. Collins noted, in 1792, four or five convicts had been “seized with insanity.” He was unable to assign a cause for their conditions,

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162 Ibid.
163 Collins, op. cit., p.423.
stating that the majority were women who “were not harassed with hard labour,” and who shared such little comforts as were available.\textsuperscript{164} Collins identifies hard labour as a cause of mental illness yet he did not recognise that the stresses associated with transportation, and the hardships of the environment, may have resulted in mental aberrations.

Apart from David Collins’ personal observations, there was no official recognition of mental illness by the colonial administration. In turn, there were no specific provisions made for the care of the afflicted. It is possible to speculate that convicts, who displayed symptoms of mental illness, might have been viewed in two ways. Firstly, as recalcitrant – with those whose symptoms included disruptive behaviours attracting cruel punishments such as starvation, floggings and incarceration. Secondly, those whose afflictions were of a gentler nature (infirm or disabled), perhaps being placed in the hospital or supported in the community by spouses and friends (such as in the case of Thomas Daveney’s wife, who was managed at home, at least until his own alcoholism and derangement resulted in his death).

For most lunatics, being supported at home or even roaming at large, would have been preferable to hospital care. The service provided within the hospitals was primitive, lacking in supplies and undertaken by assigned convicts whose knowledge and experience left much to be desired. Soon after the arrival of the First Fleet, The Principal Surgeon, John White, and his four naval colleagues, established (initially in canvas tents) the colony’s first hospital (Sydney Hospital). White received his Commission from George III, who appointed him

\textsuperscript{164} Ibid, p.204.
as surgeon to the settlement, responsible to Arthur Phillip as Governor of the colony, rather than as Commander-in Chief of its military forces. White was thus able to emphasise his civil service status as distinct from the military surgeons, ensuring that convicts as well as the military were provided with medical care.\textsuperscript{165} In spite of this, convicts frequently had trouble obtaining treatment, and permission to enter the hospital was commonly refused as it was often believed they were feigning sickness.\textsuperscript{166} The potential to contract infectious disease within the hospital was well known - it was widely believed that “to go to the hospital was the sure road to the grave.”\textsuperscript{167} Other colonial hospitals were quickly established at Parramatta and Liverpool.

The hospital’s staff of nurses and attendants were conscripted from the convict population and whilst this excused them from the hard labour needed to establish the settlement, it was soon realised, by the convicts, that hospital positions were not without risk. For example, the poor state of hygiene saw several convict conscripts perish, as a result of contracting dysentery during their work.\textsuperscript{168} Convicts would not then readily volunteer to work in the hospital and, particularly females, were often forced into nursing as punishment for misdemeanours. Conversely, the male convicts selected to work in the hospital were considered either too old or infirm to carry out the more arduous tasks in the colony.\textsuperscript{169} It is unlikely, therefore, that much care or succour would be delivered by persons who were either sick themselves, or unwillingly placed into

\textsuperscript{166} Earnshaw, op. cit., p.33.
\textsuperscript{167} Appendix to the report of the Select Committee on Transportation 10/7/1812, cited in Bostock., op. cit., p.24.
risky and unpleasant service. In relation to the mentally ill, it is probable that only placid lunatic convicts were cared for in colonial hospitals, the turbulent more likely in the gaols (which were also established quite early, out of necessity, in the young colony). By the mid 1820s, at least 31 lunatic convicts were still being cared for in colonial hospitals.\textsuperscript{170}

As the colony developed greater infrastructure, lunatics as a distinct group (particularly those regarded as dangerous), were for some time before 1811, confined in the town gaol at Parramatta.\textsuperscript{171} In 1890, Chisholm Ross, writing on the early colonial period, said:

\begin{quote}
As is not uncommon many of the convicts were probably only partly responsible for their acts, but at that period no special provision was made, or even thought of, for people who were criminals first, whether or no their mental condition influenced their acts. ...in fact the mentally deranged and the criminal were placed together, the prison being their mutual house of detention.\textsuperscript{172}
\end{quote}

In the gaol, the lunatic was crowded in with the criminal, “preyed upon, subject to the vicissitudes of inmates and staff alike.”\textsuperscript{173} Most prison superintendents felt that forcing refractory convicts to care for the mentally ill was a fitting and degrading punishment and, as it would have been extremely dangerous for convicts to retaliate against the authorities, their frustrations were probably taken out on defenceless lunatics.\textsuperscript{174}

From the mid 1790s, conditions in the colony improved. This is because while the transportation of convicts to New South Wales was to continue until 1839,

\textsuperscript{170} Earnshaw, op. cit., p.30.  
\textsuperscript{171} Sydney Gazette, 1 June 1811.  
\textsuperscript{172} Ross, C., Letter from New South Wales. (23 December 1890), \textit{American Journal of Insanity}, January 1891.  
there was also an increasing influx of free settlers. These settlers, and later emancipated convicts, were to establish and develop new settlements and colonies on the Australian continent, and some associated islands. Very cheap labour, provided by the convicts, combined with entrepreneurial enterprise to realise the clearing of the bush around Sydney for agriculture and stock rearing, which in turn, increased food production. Also, the development of early industries, geared to the exploitation of natural resources (such as whaling and sealing), and mercantile interests, allowed the colony’s economy to expand. New South Wales was still a penal colony, but was now becoming a prosperous one (although much of the prosperity was in the hands of a few).¹⁷⁵ New cases of lunacy were no longer confined to the convict population, free (and sometimes prosperous) settlers would need to be cared for.

The early colonial government (invested in the Governor and the military), seems not to have made contingency plans in the event of free persons becoming lunatic. The management of convict lunatics was by now, well established (though the provision of appropriate care was dubious). However, on July 28th 1801, a court of criminal jurisdiction found that a man charged with theft was non-compos mentis at the time of the offence. The court directed that he be confined (presumably in a gaol) and properly cared for.¹⁷⁶ It is creditable, to those officials involved, that this man’s lunacy was recognised and responded to rather than the criminal behaviour caused by his illness. One suspects that in England, his criminality foremost would have dictated his fate, and he would have joined the thousands transported to the colony. As the power of the

¹⁷⁶ Neil, op. cit., p.4.
Governor to use his Prerogative was not invoked in this case, it must be presumed that the defendant did not have sufficient wealth to attract the Governor’s concern.

The first recorded use of the Governor’s Prerogative occurred on October 14th, 1805. Governor Phillip Gidley King ordered the Provost Marshall to “summon twelve good and lawful men (being Freeholders)” to form a jury to examine the former commander of the brig Venus, Charles Bishop. The inquiry, held on October 18th, found that Bishop was a “lunatick” no longer able to govern himself or his estate. His care and the management of his estate were given over to two volunteers from the landed gentry, John M’Arthur (Macarthur) Esq., and the Reverend Samuel Marsden. Bishop was reported to have been first committed ten months before the inquiry, and though where he was committed is unknown, back payment for his care and maintenance was offered:

we do hereby require such persons as have furnished the aforesaid Charles Bishop with necessaries for his immediate maintenance since first committal as a Lunatick on 10th of December, 1804, to present their respective bills to us for payment on Saturday next, the 30th instant, that they may be then liquidated as far as we hold unsold assets.

It appears Bishop’s assets were not sufficient to sustain him for in 1809 it was reported that, “this unfortunate Man is now insane. A pauper and Confined in the Gaol without, I learn, any funds to support him but the Prison Allowance.” Following consolidation and dispersal of Bishop’s assets by his appointed trustees, they probably felt they had fulfilled their obligations, especially as there were no funds left to manage. At that time, what people owned very much

178 Ibid.
defined their social status. It would appear that Bishop’s personal care was not the trustee’s concern. Besides, Macarthur and Marsden were busy managing and expanding their own substantial interests in the colony.

Twice more the Governor’s authority was enacted; in November 1810 a ship’s Master, Alex Bodie, was found to be insane by a Board of three military surgeons. His property was restored to him in 1812, following advice that he had recovered from his late malady. During 1812, a jury was convened to inquire into the mental state of Jonathan Burke McHugo. Of interest, the method used to inquire into the mental state of the first three subjects of the Governor’s Prerogative changed. A jury of twelve men was used for Bishop (the first case in 1805) and McHugo (the third case in 1812), whilst a board of surgeons determined the insanity of Bodie (the second case in 1810). It is suggested that the reason the instrumentality changed, from one to the other, then back again, was spontaneous decision making on the part of the Governor, suggestive of administrative whim. This may be the case, however, as the following discussion suggests, the political climate of the colony was perhaps more likely to have influenced these decisions.

Following Governor Phillip’s return to England in December 1792, and until the appointment of Captain John Hunter in 1795, the colony was ruled by the military – the New South Wales Corps. During this time, the officers of the Corps established themselves as the colony’s ruling class. These elite controlled the economy and established liquor, particularly rum (as it was cheap to import).

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180 Bostock, op. cit., p.21.
181 Neil, op. cit., p.4.
as the currency of the colony. Alcohol abuse was rife among convicts and the poor, creating health and social problems at the time and probably contributing to later mental illness.

Governor Hunter and his successor, Phillip Gidley King, had immense difficulty controlling the Corps. King’s successor, William Bligh, took up his commission in August 1806 and soon afterwards, asserting the legal authority of the Governor, tried to stop the trade in rum. Elements of the military actively resisted the curbing of their power, which resulted in several confrontations between themselves and Bligh. Ironically, the twentieth anniversary of the foundation of the penal colony, January 26th 1808, saw Bligh arrested in a military coup d’état later known as the Rum Rebellion.183

Following the coup d’état in 1808 and until the arrival of Governor Lachlan Macquarie in December 1809, who was sent out to restore order in the colony, the civil judiciary was subject to a military junta. The use of three military surgeons to determine the sanity of Alex Bodie in 1810 therefore, reflects the process utilised by Arthur Phillip, when the sanity of the officer of H.M.S. Sirius was determined, before the First Fleet departed from England in 1787. Governor Macquarie, busily manoeuvring to establish control of the colony, possibly had not, by the time of Bodie’s examination, completely rehabilitated the judicial system to its position prior to 1808.

When Macquarie arrived in Sydney, the country was unexplored beyond seventy kilometres from the township. The population of the colony, however, had

increased to more than 11,500 people which posed serious sociological problems. Apart from the continuing transportation of convicts and an influx of free settlers, there were also many emancipated (pardoned) convicts who had difficulty supporting themselves.\textsuperscript{184} During Macquarie’s eleven year administration, exploration of the country increased substantially seeing large areas opened up and new towns established, which increased useful work and profitable opportunities. Macquarie also began an infrastructure development programme in Sydney and the region. This realised the construction of many substantial public works and buildings. Macquarie was a social reformer; he ordered the construction of orphanages, new hospitals and better accommodation for convicts. Of note though, one of the first reforms undertaken by him, was the establishment of the colony’s first asylum for the care of lunatics at Castle Hill, about ten kilometres north of Parramatta.

Macquarie’s quick attention to ameliorate the circumstances under which the colony’s lunatics suffered, was probably grounded in his own family’s experience of mental illness. Macquarie’s elder brother, Donald, “entered the nether world of madness” after he had been captured by the French in 1778. He returned to his mother’s farm a semi-imbecile and “shuffled through his remaining years until his death at the age of fifty on December 28\textsuperscript{th} 1800.”\textsuperscript{185} Macquarie, during his earlier military service, sent money home to support his family, asking “that they be solicitous about the needs of the forlorn and helpless Donald.”\textsuperscript{186} When informed of Donald’s death, Macquarie “was deeply saddened

\textsuperscript{184} Cummins, \textit{The Administration of Lunacy and Idiocy in New South Wales 1788 - 1855.} op. cit., p.21.  
\textsuperscript{186} Ibid, p.39.
as he had hoped… to have rendered comfortable the evening of Donald’s life.”

Macquarie held his brother in deep affection and was concerned for his well-being. Perhaps his own experience led Macquarie to be empathetic towards the mentally ill, and he was now in a position to better the lot of at least some who, like Donald before, were suffering.

2.4: Australia’s first lunatic asylum at Castle Hill.

In May 1811, Macquarie, accompanied by his wife, visited Parramatta. During their visit they were confronted with the miseries experienced by the mentally ill in the gaol. On July 1st, the Sydney Gazette reported that the Governor;

commiserating the unhappy condition of persons labouring under the affliction of mental derangement, has been pleased to order an Asylum to be prepared for their reception at Castle Hill, whither they have been accordingly removed from their former place of confinement, which was the town gaol at Parramatta, and every provision that humanity could suggest has been made for their accommodation and comfort.

The building modified for this purpose was a double-storey stone barracks built for convicts at the Government farm established in 1803. For the first three years the asylum’s inmates were cared for by a “keeper” and a cook, who were transferred initially with six lunatics from the Parramatta Gaol. This suggests that the separation of lunatics, from the general population at the gaol, had already occurred before the asylum was established. The keeper’s name is simply recorded as “Cullen”, the cook, a female, is nameless to history. They were probably both trusted convicts.

188 Sydney Gazette, 1 July 1811, p.1.
Administration of the institution came under the general supervision of the Military Commandant at Parramatta.\textsuperscript{190} The first superintendent is said, by one authority, to be unknown,\textsuperscript{191} another reports the institution was not of sufficient importance to warrant a resident superintendent.\textsuperscript{192} In January 1814, following a redistribution of administrative responsibilities, supervision of the asylum was given to the Resident Magistrate at Parramatta, Reverend Samuel Marsden (noted earlier as a trustee of the estate of Charles Bishop).\textsuperscript{193} It is unknown just how much of Marsden’s time was given to supervision of the asylum. However, apart from pastoral activities and the continuing expansion of his considerable land holdings, he also occupied several other civil appointments.

Marsden held this appointment until August 1814, following which a resident Superintendent and Surgeon were appointed to the asylum. The first resident Superintendent, George Suttor, a land holder who sided with Governor Bligh during the rebellion, was recommended for this appointment by Marsden. Suttor’s enterprises in the colony were not as successful as he hoped, so he had, for some time, sought a civil appointment to supplement his income.\textsuperscript{194} Granted a salary of fifty pounds per annum, Suttor was grateful for the appointment; he recorded in his memoirs:

\begin{quote}
My Friend, the Rev. Samuel Marsden, about this time commenced his trips to New Zealand, and had to give up his superintendence of the Lunatic Asylum at Castle Hill. This was offered to me by the Government and Mr. Marsden. I thankfully accepted it with the use of all the Government cleared land there, which, I thought would be beneficial to my family, particularly as they were all very young and had been much injured by the rebellion.\textsuperscript{195}
\end{quote}

\begin{itemize}
\item \textsuperscript{190} Ibid.
\item \textsuperscript{191} Bostock, op. cit, p.22.
\item \textsuperscript{192} Neil, op. cit., p.10.
\item \textsuperscript{193} Sydney Gazette, 15 January 1814, p.1.
\end{itemize}
At the same time, Macquarie personally drew up instructions to guide Suttor in his administration of the asylum:

Instructions for Mr G. Suttor, Superintendent of the Lunatic Asylum at Castle Hill

1. - You are hereby ordered and directed to pay the most particular attention to the cleanliness and comforts of the Lunatics placed under your charge, in as far as their unhappy condition and the means you possess will admit of. You will see that they wash their hands and faces every morning and that they shave and put on clean linen every week, namely on Sundays and Thursdays.

2. - You are not to allow the Keepers or other persons attending them to exercise any unnecessary severity towards the Lunatics but see that they are at all times treated with mildness, kindness and humanity. The Keepers and other attendants are to receive strict orders to this effect.

3. - You must be particularly careful that the Provisions issued from the Government stores for the use of the Lunatics are properly dressed and regularly served out to them at proper hours [sic]. You must also be very careful that no Person shall defraud the Lunatics of any part of the Rations allowed them by the Government; a crime which here-to-fore very common, and which if ever again committed must be severely punished when detected.

4. - With a view to promote the health as well as comfort of the Lunatics, you are to get a good garden into cultivation as soon as possible at Castle Hill, in order that they may be furnished with a constant supply of vegetables, particularly potatoes and cabbages. Such of them as are fit for manual labour are, with the permission of the surgeon, to be employed in cultivating the garden thus ordered, at stated hours every day; which will be the means of not only amusing them, but will likewise prove a wholesome exercise highly beneficial to their health.

5. - With respect to the medical treatment of the Lunatics placed under your charge, you are to follow and comply with such directions and advice as you may receive from time to time from the Surgeon appointed to attend the Lunatic Asylum at Castle Hill; and you are on no account to make any of the Lunatics work in the garden or elsewhere, without the approbation and sanction of the
Surgeon, as he alone is capable of judging whether such labour be good for their health or not.

6. - You will not fail to report to me in writing, once every month, the number and state of the Lunatics under your charge; specifying such casualties, increase or decrease as may have occurred during the preceding month. You are to commence making these monthly reports on the first of the next month of October.

Given under my Hand at Government House, Sydney, this 12th Day of September, 1814.

[Signed] L. Macquarie

These instructions, the first recorded in Australia governing the care of the mentally ill, demonstrate a remarkably enlightened and sympathetic approach. There is an insistence on cleanliness and comfort; recognition of the benefits of occupation and amusement; medical care; the keeping of medical records; and an expectation that the keepers would not abuse their charges. Very little is known about the keepers under Suttor’s control, it is believed that they were convicts, and/or the sanest of the inmates. In 1815, Mrs Martha Entwhistle, possibly a free woman, was employed as a nurse. The use of the term nurse for female carers of the mentally ill (as opposed to keeper for male carers), seems to have been employed from the earliest days of the colony. During the late 1840s (as will be seen in chapter 4), the term for both male and female carers became attendant. Female carers again becoming commonly known as nurses in the late 1870s – male carers continued to be called attendants until the late 1950s.

The first resident medical officer was Dr William Bland, a former naval surgeon who was now a convict. In 1813, at Bombay, he killed an opponent in a duel and

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was subsequently transported to New South Wales. Bland was from a wealthy and respected family and his crime was viewed as one of honour. Whilst he was indeed a convict, he seems to have expected to be, and evidently was, treated as a gentleman.

Macquarie appointed Bland to the asylum from July 1814 and issued instructions regarding his duties in September. These instructions included the provision of medical treatment; distribution of medical supplies and comforts; the writing of monthly medical reports on the condition of the patients and the use of part of the asylum’s land for cultivation. The administrative arrangements of the asylum were to produce considerable friction as Suttor was responsible for the management of the institution and Bland responsible for medical care. Neither however, answered to the other, both officers reported directly to the Governor. Although it was expected that Suttor and Bland would cooperate to ensure the comfort and care of the lunatics, conflict quickly ensued.198

Both Suttor and Bland believed they were in control of the asylum. When Bland interrupted a prayer meeting being conducted by Suttor, the difficulties between them came to a head. Suttor had organised the meeting, with patients and staff in attendance, without first advising Bland. Dr Bland burst in and drove the patients out, demanding that the keepers inform him if anything of the sort occurred again. Suttor was humiliated before his charges, his authority was challenged and the keepers (all convicts), would have been confused about who had the right to make decisions at the asylum and whom they should obey. Macquarie ultimately

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supported Suttor; Bland’s role was to provide medical treatment only. Bland was advised that Suttor could conduct religious services, while Bland in turn, could advise Suttor which patients were unsuitable to attend. The stresses associated with the conflict between the two men saw Bland resign as soon as his sentence expired in September 1815, and he went on to establish Sydney’s first private medical practice. 199

January 1815 saw an important change in the asylum’s reporting procedures. The monthly reports of the superintendent and surgeon, previously made to the governor, were in future to be sent to the Resident Magistrate at Parramatta. The Reverend Samuel Marsden was again holding this position, following his return from missionary work in New Zealand. 200 It is noteworthy to observe that reports from the asylum were not made to the Principal Surgeon of the colony. Conversely, the civil hospitals, as opposed to the military, including parts of various government institutions where medical treatment was provided, such as the gaols, reported to the Principal Surgeon. 201 This administrative separation of psychiatric services, from other health services, was to continue in New South Wales until the mid twentieth century.

A convict, Henry Ravenscroft, recorded as both keeper and surgeon, was resident at the asylum and became Bland’s successor. Little is known about him or his career, however, it seems there was little or no conflict between him and Suttor. Ravenscroft, apparently not a gentleman, was removed from the asylum in

201 Cummins, The Colonial Medical Service II, op. cit.
March 1817 and sent to Newcastle Gaol, after he was accused of embezzling the patients’ bedding.\textsuperscript{202}

Administration of the asylum was again to be disrupted by conflict.

Ravenscroft’s successor, Dr Thomas Parmeter, a convicted and transported bigamist, was appointed in April 1817. Parmeter’s ambitions ran to hopes that he might gain complete control of the asylum. He wrote several complaints about Suttor. In one, to the Principal Surgeon, he stated that one of the keepers, William Maddox, had reported Suttor ordered him not to obey any of the surgeon’s directions. Parmeter’s ambitions were clearly stated in his letter to the Principal Surgeon:

\begin{quote}
...the object I have in view, of being fully authorised by His Excellency the Governor, to have the entire management of the Patients, and to be obeyed by the Keepers, as Assistant Surgeon of the Asylum, confining the Superintendent to the very letter of his instructions, that is, of delivering out their rations and keeping the patients clean etc.\textsuperscript{203}
\end{quote}

Governor Macquarie apparently sided with Parmeter, sending for Suttor to reprimand him for his outrageous and insulting behaviour towards the surgeon. Suttor made various complaints against Parmeter, in particular, that the surgeon was withholding soap (a medical comfort), thus preventing the proper cleanliness of the patients. Parmeter then suggested the asylum be transferred to Windsor, claiming that bathing in the river would be beneficial to the patients and that the Government Stores would be in close proximity. What Parmeter didn’t disclose, was that he held property at Windsor. He was now living at this property and only visiting the asylum, where he had installed an “assistant” who was not

qualified in medicine, about once a week. Suttor laid a formal charge of neglect against Parmeter in December 1818. Parmeter naturally then counter-charged, accusing Sutter of using the lunatics to labour on his farm and complaining that Suttor was waging a vendetta against him. Suttor probably saw no problem with the use of the lunatics (as labourers) on his farm. The convict assignment system granted landholders a number of convicts as labourers to help establish and manage their properties. If a lunatic convict was capable of work, Suttor probably felt he had the right to use this labour.

During this long period of conflict, a patient was murdered by another whilst they collected firewood on June 8th 1818. Parmeter was quick to suggest this would not have occurred if he was in charge. Following inquiry into the charge made by Suttor, and the counter-claims of Parmeter, the Magistrate, unable to arrive at an opinion, forwarded the evidence to Macquarie. The Governor, to settle things once and for all, dismissed them both from their posts in February 1819. Parmeter’s sentence had now expired and he went on to establish a medical practice in Sydney. The previously good relationship between Suttor and Macquarie, however, had now soured. Suttor says in his memoirs, “...I did not find this appointment productive of that happiness and prosperity I had anticipated; on the contrary it produced more vexation, anxiety and trouble than pleasure and profit.” Suttor wanted to take up land in the Bathurst region, but he couldn't do this until after the departure of Macquarie in 1821, as the Governor only conferred this “privilege... to a few of his pets.”

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204 Best, op. cit p.7.
206 Campbell to Parmeter & Campbell to Suttor, 21 January 1819. Colonial Secretary’s Papers, S.R.N.S.W., (reel 6006), 4/3477, pp.276 & 277.
207 Mackaness, op. cit., pp.57-58.
Little is known about the daily activities of patients or the treatment given to them, however, violent patients were placed in restraints, either hand cuffs, or strait waistcoats. Dr Parmeter did mention the treatment of one patient in his monthly reports. This included; purging with emetics, blisters to the temples, opening of arteries and insertion of a Seton. At the inquiry into Suttor and Parmeter’s administration, the keepers reported that blistering, purging, head shaving and bleeding had been prescribed by the doctor. Parmeter also once ordered a patient to be flogged; given a dozen lashes as punishment for stealing clothing and bedding.209

The prescribed flogging of a patient was intended to reinforce discipline. As the staff and most of the patients were convicts, it probably also served to remind them of their place - at the very bottom of the social hierarchy. Parmeter was replaced by a visiting military surgeon, Major West, who was appointed in March 1816. West visited the asylum twice weekly and held this position until 1821 when he succeeded by Dr Henry Grattan Douglass (a private medical practitioner in Parramatta). Both these visiting doctors appear to have avoided involvement in the internal politics of the asylum.

Macquarie chose a clerk in the Commissary Office, William Bennett, as the new Superintendent. Bennett's appointment commenced in March 1819 and a new list of directions were drawn up to guide his administration of the asylum. These instructions included specific orders to ensure the cleanliness of the patients, their clothing, rooms and beds; the preparation and proper serving of meals at

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* A thread inserted beneath the skin causing inflammation which acted as a counter-irritant for a more deeply seated inflammation.
regular times; and observation of patients to ensure that sickness was reported to the surgeon. Also, the expectation of kind and humane treatment continued to be emphasised:

> You are at all times to treat these unfortunate persons with kindness and humanity, and on no account unless in case of unavoidable necessity, ever to inflict Corporal Chastisement.  

Macquarie also made it clear that the lunatics were not assigned convicts, and the use of their labour was specifically prohibited except, “such light work in a garden as may (under the opinion of the visiting Surgeon) be deemed conducive to their health.” Bennett did indeed establish a vegetable garden and was pleased to report in 1822, that the patients had nearly one acre under cultivation.

A significant change in Bennett’s instructions from those given to Suttor, was the granting of greater power to utilise his own judgement in matters that arose in emergency and which were not specifically covered in the instructions:

> Wherein these instructions may be found not to meet any extraordinary Exigency you are to be guided by their General Tenor and meaning in the exercise of a sound Discretion.

As noted earlier, possibly to prevent conflict, Macquarie decided not to appoint a new medical officer to the asylum, instead, directing visiting surgeons from the free community to attend the patients’ medical needs. At the time of Bennett’s appointment, there were forty-five patients and three convict staff; two male

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211 Ibid.
212 Bennett to Goulburn, 2 July 1822. Colonial Secretary's Papers, S.R.N.S.W. (Reel 6053), 4/1756, p.20.
213 Campbell to Bennett, 27 February 1819. ibid.
keepers and a female nurse. Bennett succeeded in his requests for more staff; by 1821 there were two keepers, two nurses and a herdsman - all convicts.

Within a month of his appointment, however, Bennett complained that some of his staff were “under [unnamed] improper influences.” The Governor ordered that they be replaced by two other convicts “who may be confided in.” One of these was to act both as cook and keeper, the other was “in addition to his Duty as Keeper to procure stores and water.” Two women were to be obtained from the Female Factory at Parramatta (the women’s prison), one to act as “nurse for the female patients,” the other a “washerwoman.” Both “will be expected to repair Clothes for the patients.”

Bennett was to have further trouble with his staff and he replaced a keeper named Paget due to (again unnamed) “Gross Misconduct.” Bennett also reported that the junior nurse (who was the daughter of the senior one), was pregnant to one of the keepers, Edward New. Bennett noted they had requested permission to marry; a request he opposed. He commented that the nurse already had an illegitimate child, and felt their presence was a “nuisance” to the establishment.

The asylum’s convict staff were not regarded very highly by the governing authorities, being placed on equal terms, or less than equal terms, as the patients. They often endured poor rations and in November 1823, Bennett was forced to appeal to the Colonial Secretary as rations for the staff were not received at all.

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214 Campbell to Bennett, 14 April 1819. Colonial Secretary’s Papers, S.R.N.S.W. (Reel 6006), 4/1742, p.259.
215 Bennett to Goulburn, 3 February 1822. Colonial Secretary’s Papers, S.R.N.S.W. (Reel 6053), 4/1756, p.17.
216 Bennett to Goulburn, 1 May 1822. Colonial Secretary’s Papers, S.R.N.S.W. (Reel 6053) 4/1756, p.20.
Bennett coped with a variety of shortages, having to appeal to the authorities for bedding and clothing, for both staff and patients. Overcrowding was a serious problem, the double storeyed building, 100 feet by 24 feet, accommodated both patients and convict staff - i.e., fifty people in total. When in May 1821 Bennett requested additional clothing for the staff, he was informed his request was unprecedented. By January 1822, Bennett reported the staff were now destitute of clothing, and in May 1823, he was forced to repeat his request as a matter of urgency. Even while preparations were being made in November 1826 to close the asylum, Bennett was again obliged to request clothing for the staff. He reported that they blamed him for their failure to receive them.\(^{217}\)

Following criticism by a group of prominent citizens, a Grand Inquest was convened to examine conditions at various government institutions of the colony, including the lunatic asylum. In April 1825, this Inquest found the asylum was “highly unfit, in every point, for its present occupation.”\(^{218}\) The Inquest recommended construction of a purpose built institution, nearer the town of Parramatta and close to a source of wholesome water. It was some years before this was to occur. In 1826 the asylum was so dilapidated that it was considered impossible to repair. On 10 November 1826, the patients were transferred to the Liverpool Courthouse, which was converted for their reception. William Bennett, who was of advanced age, was informed he would be allowed to retire. In recognition of his service he was granted an annual pension of forty pounds sterling.\(^{219}\)

\(^{218}\) Neil, op. cit., p.68.  
\(^{219}\) Ibid, pp.70-71.
The Castle Hill Asylum was, for fifteen years, the only specifically designated shelter for the mentally ill and although there were problems: the struggles for administrative supremacy, inadequate staff, poor provisioning, overcrowding and isolation, to name but a few, it also represented official recognition of the plight of the mentally ill and the Colonial Administration’s acceptance of responsibility for their care. However, the asylum was an improvisation, using a building designed for another purpose and was poorly constructed (the Grand Inquest described it as dilapidated in 1825). Coupled with it being some distance over a very poor road to the nearest town, its demise was probably inevitable. Moreover, the asylum’s closure and the subsequent transfer of patients to Liverpool was probably as much a cost saving measure as it was an attempt to improve the lot of the mentally ill. This type of improvisation, to provide for the needs of the mentally ill, was to become a feature of the history of development of mental health services throughout the 19th century in New South Wales.

2.5: The Liverpool Asylum.

In spite of recommendations for the construction of a purpose built asylum, the authorities decided that makeshift accommodation would suffice. Governor Ralph Darling wrote to the British authorities:

These unfortunate people were formerly kept at Castle Hill, six miles beyond Parramatta, but as the Land on which the Building stood was given up to the Church it became necessary to provide for them elsewhere. The Court House at Liverpool, which is a Government Building, afforded the best indeed only means of accommodating them at the moment and it was given up accordingly.\textsuperscript{220}

\textsuperscript{220} Darling to Huskisson, 29/5/1828., \textit{H.R.A.}, Vol. XIV, pp.210-211.
The Liverpool Asylum has been described thus, “The thirteen years of its existence are colourless in incident and show no change in procedure. Psychiatry is in the doldrums.”\footnote{221} The personnel were again mostly assigned convicts. The first Superintendent was a Mr Lloyd, who was removed from the position in January 1828. The Superintendent of the convict barracks at Parramatta, Mr Thomas Plunkett, was then appointed and remained as the Superintendent until the asylum's closure in 1838. The lessons learnt from the earlier power struggles between the medical and non medical officials of the Castle Hill Asylum, seem to have been heeded. A resident medical officer was never appointed at the Liverpool Asylum, instead, Dr Patrick Hill was appointed as Visiting Surgeon.

The cost of operating the Liverpool Asylum was a constant nuisance to the Government, and the cost of maintaining the patients was considered a burden on the colony’s finances, as most were convicts and/or paupers. Patients who were not convicts or paupers were charged up to seven shillings per day for their maintenance. Governor Darling reduced the charge to three shillings per day in 1830.\footnote{222} In order to reduce costs, and by the authority of the outgoing Governor, Sir Thomas Brisbane, the decision was made to repatriate recently arrived lunatics back home. In 1825, two men, a surgeon and a Royal Navy Purser, were examined and judged insane and after nearly two years incarceration, were returned back to England. Brisbane’s action caused consternation with the English authorities who were used to exporting, rather than importing undesirable people. Earl Bathurst, writing to Governor Darling in 1826, expressed his view that “a recurrence of the Inconvenience” should be avoided in the future. Bathurst complained that Brisbane should have, under the authority of

\footnote{221}{Bostock, op. cit., p.33.} \footnote{222}{Ibid, p.35.}
his Commission, ensured the care and custody of people suffering from derangement. Bathurst somewhat sarcastically noted, “I am not surprised that he should have resorted to the means reported in his Dispatch, to rid the Colony of the expense of maintaining these persons.” However, Bathurst was peeved at the prospect of having to organise the payment of costs associated with their passage home, and upon their arrival, “from not knowing in what manner to dispose of them.” He particularly wished to know if either lunatic had an estate from which costs could be recouped and requested that an account of costs already incurred, be transmitted to him.²²³

In 1838, close to the end of the Liverpool Asylum’s existence, Thomas Plunkett recorded the entire personnel of the establishment, their positions and salaries.²²⁴

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Position</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomas Plunkett</td>
<td>Free</td>
<td>Superintendent</td>
<td>£100 per annum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£32 /10 /- lodging allowance</td>
</tr>
<tr>
<td>Dennis Gillespie</td>
<td>Free</td>
<td>Overseer</td>
<td>Two Shillings and Three pence per day victualed on the establishment</td>
</tr>
<tr>
<td>William Greenaway</td>
<td>Bond</td>
<td>Cook</td>
<td>no pay, no allowance</td>
</tr>
<tr>
<td>A. Donovan</td>
<td>Bond</td>
<td>Gate Keeper</td>
<td>no pay, no allowance</td>
</tr>
<tr>
<td>John Griffith</td>
<td>Bond</td>
<td>Night Watchman</td>
<td>no pay, no allowance</td>
</tr>
<tr>
<td>George Crootz</td>
<td>Bond</td>
<td>Keeper</td>
<td>no pay, no allowance</td>
</tr>
<tr>
<td>William Shauman</td>
<td>Bond</td>
<td>Keeper</td>
<td>no pay, no allowance</td>
</tr>
</tbody>
</table>

The staff noted as “bond” were convicts assigned to the institution. There had been a female nurse who was also a convict, but she was transferred to the new asylum at Tarban Creek (with the female patients) and received a gratuity of eight pence per day.²²⁵

²²⁴ Table in Bostock, op. cit., p.37.
²²⁵ Ibid.
Little is known of the medical treatment given at the Liverpool Asylum. Upon its closure, an inventory revealed that the asylum had on hand; 12 handcuffs, 1 leg iron, and 6 strait waistcoats. Physical restraint would appear to have been practised, but perhaps not to the extent that might be imagined. The asylum in 1838, provided shelter and care for fifty male and thirty female patients - eighty in total.\textsuperscript{226} Therefore, there were insufficient mechanical devices to restrain every patient, suggesting they were only used on \textit{some} patients, probably only on those whose behaviour was considered dangerous in some way. It is possible that excessive restraint was used on a \textit{few} patients; however, existing asylum records throw no light on incidence of use.\textsuperscript{227} Several years after closure of the Liverpool Asylum, its former visiting surgeon, Dr Patrick Hill, was quick to condemn the conditions which had existed there:

\begin{quote}
That was a miserable place – a mere asylum for the safe keeping of lunatics; there were no means of classification at all, not even of separating them at night; it was a wretched establishment, and there was no possibility of doing all I might wish in the matter of treatment.\textsuperscript{228}
\end{quote}

The Liverpool Asylum appears to have been little more than a place of confinement for lunatics. There is no evidence that any form of organised recreational or occupational activity occurred. As it was established in a building unsuited for the purpose, and existed near the centre of the town of Liverpool, there was probably little room for anything other than confinement. Moreover, the staff, consisting of untrained convicts and administered by a former turnkey (with the assistance of a convict overseer), would probably have been incapable

\textsuperscript{226} Ibid, p.38.  
\textsuperscript{227} State Records of N.S.W. has but seven letters, (mainly concerned with patient transfers) listed under "Lunatic Asylum, Liverpool." Information regarding day to day activities at the asylum is extremely scarce.  
\textsuperscript{228} Report of the Select Committee on the Lunatic Asylum Tarban Creek, \textit{N.S.W. L.C.V. & P.}, Evidence (second Session), New South Wales, 1846, p.33.
of much more than confining the patients. Even a physical description of the asylum appears to have been lost, since its closure, and it seems the building was not reused later for other purposes. Therefore, it must be presumed that as a structure, the Liverpool Asylum was not very imposing or regarded as important, the asylum’s demolition perhaps regarded with relief by the citizens of Liverpool. On November 19th 1838, the first transfer of female patients occurred to the new asylum at Tarban Creek, and on January 10th 1839, the male patients from Liverpool were similarly transferred.

The fact that Liverpool Asylum was very overcrowded is attested by Dr Hill’s statement when he said, *there were no means of classification at all not even of separating them at night.* Hill’s term *classification* refers to the separation of the better or free class of patients, from the convict population. The number of free patients totalled almost 50% of the asylum’s population in 1838.²²⁹ Most of these free patients were probably paupers and/or ex-convicts without other means of support or care. There were also a few free settlers, who were charged a daily fee if they or their family could afford it. The number of patients accommodated at Liverpool Asylum increased according to the colony’s general population. For example, in 1825, the colony’s population was approximately 38,300 with 35 patients confined in the asylum. At Liverpool Asylum’s closure in 1838, the colony’s population had reached 98,200 with the asylum accommodating 87 patients.²³⁰ The colony’s lunatic population under specialised (if dubious) care, can be seen to represent around .09% of the colony’s population. Clearly, there were people with mental illness who were not confined at the Liverpool Asylum

²²⁹ Bostock, op. cit., p.37.
and who, according to their social class, resources and standing, suffered a variable fate.

### 2.6: The life of lunatics not admitted to the asylum.

By the late 1820s the colony’s economy was booming, partly driven by pastoral activities and cheap convict labour. Also, very profitable industries had developed around the whaling and seal fur trade. A thriving middle and upper class of very wealthy people arose. These *nouveau riche* were comprised of both entrepreneurial free settlers and emancipated convicts, many of whom sort to distance themselves from the working and convict classes through social pretensions - the *respectable class*. Even amongst the wealthy, a snobbish sense of privilege existed. For instance, free settlers saw themselves as an exclusive class quite distinct from wealthy emancipists, and their exclusionary elitism even extended to the free born children of convicts - who were regarded as somehow tainted.\(^{231}\) It was unthinkable that these respectable people or their loved ones, if unfortunate enough to become ill (let alone insane), would be forced into association with the convicts or paupers in a hospital or asylum. With no private facilities yet in existence, care at home, by family or friends and servants, was the only alternative. Concern about the care of insane *respectable* people existed for many years and in 1855, it was noted that no facility existed in New South Wales that could “supply better means of classification, - and to provide for a superior class of patients.”\(^{232}\)

The private home care of lunatic members of respectable families was kept from public gaze. However, persons with high social profiles suffered the same public

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\(^{231}\) See Hughes, op. cit. pp.323-367, & Cannon, op. cit., pp.41-76.

intrusions into their private lives as celebrities endure in modern times. The best example concerns the Macarthur family. In 1832, John Macarthur, a member of the Legislative Council and one of the colony's wealthiest citizens, was judged insane under a formal writ of de lunatico inquirendo; Macarthur was so disturbed he was placed in restraints. He was not directly cared for by his family, but rather by his servants. His family were forced to remove themselves from his presence as they, and in particular his wife Elizabeth, were the foci of his persecutory delusional beliefs. Fortunately for him, his assets were more than sufficient to ensure he was confined at his home, Camden Park, until his death in 1834.\textsuperscript{233} Evidently Macarthur displayed symptoms of mental illness for some time, but his wealth and social standing had allayed any previous moves to confine him. A Sydney newspaper somewhat spitefully reported,

\begin{quote}
We never held the Honourable John’s antics to be in the most tenantable sort of order. He is now mad in law - tho not more crackbrained now than he was thought to be years ago.\textsuperscript{234}
\end{quote}

In stark contrast to the care of society’s elite, was the disposal of lunatic convicts and pauper free settlers, who were not confined in the asylum. In 1828 the Principal Superintendent of Convicts, F.A. Hely, reported that colonial hospitals were caring for 31 lunatic convicts and there were another 214 cripples, invalids and idiots within the convict population. Members of the latter group were ineligible for hospital or asylum care as long as they could work. Hely also made a distinction between \textit{idiot} and \textit{lunatic}; \textit{idiot} referred to the harmless, \textit{lunatic} to the criminally or dangerously insane.\textsuperscript{235} Special invalid gangs were created for

\begin{footnotes}
\item[234] Ibid, (reference notes) p.585.
\item[235] Earnshaw, op. cit., p.30.
\end{footnotes}
disabled convicts and committal to one of these gangs was not taken lightly by the authorities, as convict labour “represented a substantial Government asset.”236 This even extended to convicts who were assigned as servants in non-government positions:

If a servant be declared unfit for private service from any mental or bodily incapacity the Principal Superintendent of Convicts will by warrant direct his removal under charge of a constable to an invalid gang.237

The importance of convict labour, to establish the infrastructure of the new colony in the first fifty years of its existence, has already been made clear and cannot be overstated. The use of invalid and lunatic convicts to perform work was probably not regarded at the time, as something strange or unusual. In contemporary Britain, invalids and the harmless mentally ill existed in mainstream society and could be found integrated into the agricultural (and also probably in the manufacturing) workforce.238 The invalid convict gangs were assigned tasks ranging from collecting seashells for burning into lime, to adjunct labour on the road gangs. Whilst by modern standards assignment to the invalid convict gangs, of disabled and mentally ill convicts, might appear heartless and even cruel, a worse fate could befall them. The minor aberrant behaviour of convicts was still punished by the whip, solitary confinement and reduction in diet. Those who were mentally ill and could maintain some control over their behaviour, therefore, would have quickly learned to exercise that control.

With the establishment of lunatic asylums in the colony, it might be anticipated that greater awareness of the idiosyncrasies of lunatic behaviour would have

236 Ibid, p.31.
become known. After all, the asylum admitted lunatics who displayed socially unacceptable and incorrigible behaviours, even those seen in convicts. However, this was not necessarily so, and apparently some authorities would not refer convicts to an asylum, even when their mental incapacity was glaringly obvious.

Perhaps the most tragic and disturbing case is that of Charles Anderson. Anderson was an orphan and passed out of the workhouse into the Royal Navy at age nine. At the Battle of Navarino in 1827, he was wounded in action receiving a brain injury which left him irritable and when combined with alcohol consumption, resulted in hostile and violent behaviour. At age eighteen during one of his shore leaves, he became drunk and smashed several windows resulting in him being charged and convicted of burglary, and sentenced to seven years transportation. He was so difficult to manage upon his arrival in Sydney, the authorities decided to confine him to a rock in the harbour, known as Goat Island. Over the next few years he escaped by swimming to shore three times. He received a total of more than 1,600 lashes for petty offences including looking around whilst at work and watching the steamers in the harbour. He spent two years chained to a rock, his only shelter being a coffin sized cavity hewn out of the sandstone. At night he was confined to this cavity, with a timber lid pierced with airholes, covering him until morning. His food was pushed to him with a pole like a wild animal. The other convicts were forbidden to talk to him and his wounds stank of putrefaction and were infested with maggots. Sadistic Sydneysiders, to amuse themselves, would row out to his rock and throw crusts and offal at him.
Governor Bourke, ashamed by the behaviour of the colonists, sent Anderson to the lime kilns of Port Macquarie on the New South Wales north coast. He escaped again and in the process killed an overseer. Normally, committing murder would have attracted execution, however, in deference to Anderson’s obvious mental disorder, the Governor commuted the death sentence and sent him to the notorious penal settlement of Norfolk Island for life; Anderson was now only twenty four years old – but looked forty.\footnote{Clay, J., \textit{Machonochie’s Experiment}. John Murray, London, 2001, pp.172-174.} \footnote{Hughes, op. cit., pp.511-512.}

At the time, Norfolk Island was under the Superintendence of the prison reformer, Alexander Machonochie. Machonochie, recognising Anderson’s condition, gave him the simple responsibility of herding the island’s semi wild cattle. To avoid the taunting of other convicts, Anderson was permitted to stay away from the barracks usually sleeping outside with the cattle. He was congratulated on his taming of the herd and was spoken to with kindness. Eventually, he was given the responsibility of managing the signal station atop the highest point on the island. In 1843, Governor Gipps, whilst visiting the island, wished to see the former beast of Goat Island (whom he must have heard about), and was amazed at Anderson’s transformation. Anderson was dressed in a sailor’s uniform and exhibited an open and frank demeanour – he had been returned to his human condition. Unfortunately, over time, Anderson’s mental state deteriorated and he was placed in the asylum where he ended his days, having completely lost his reason. But even during his madness, he remained attached to Machonochie and his family.\footnote{Clay, ibid., Hughes, ibid.}
Machonochie’s management of Anderson occurred at a time when, in Britain, the idea of treating lunatics with kindness and compassion and providing them with meaningful occupation, was already well established in some asylums and was gathering pace in others. However, in New South Wales, the treatment of lunatic convicts, especially away from the asylum, continued to be harsh and cruel. As noted previously, severe punishment followed undesirable behaviour but it could also result in permanent disability including and/or worsening mental illness.

During the early part of the 19th century, child labour was commonplace and abuses were rife. It was also common for children who committed petty crimes (when caught) to suffer the same fate as adults, including transportation to New South Wales. Usually those who arrived in Sydney were imprisoned in the Carters Barracks (close to where Central Railway Station now exists). At these barracks, children “by frequent application of the birch,” were taught a trade. 242 One (unnamed) boy of thirteen, who had been transported for poaching a hare, had been flogged so severely he had been changed into a “grizzled, gaunt and half naked old man.” He was described by a visitor as a “gibbering animal… [who had a habit of] sticking his finger through the peep-hole [of his cell] to try and poke someone’s eye out”. 243 This boy’s eventual fate is unknown.

In the absence of government support, most ordinary people had to work to support themselves (and their families), often into old age. As might be expected, pauper free settlers and ex-convicts found work not eagerly sought by others. Some of this was very unpleasant work, which even most convicts would not undertake, however, it might be taken up by those whose mental state was

242 Cannon, op. cit., p.59.
243 Clarke, M., Stories of Australia in the Early Days. London, 1897, Cited in Cannon, ibid. (N.B. The veracity of this story may be suspect as it was originally published in a popular journal).
tenuous. The most conspicuous example involved Alexander Green, convicted for theft in 1824, and sentenced to transportation for the term of his natural life. In 1825, Green was given a conditional pardon (a form of parole contingent upon the person not attempting to return to Great Britain), and soon became Sydney’s official scourger (flogger) of convicts. In spite of returning to petty criminal activities from time to time, and his apparent alcoholism, Green was in 1828, appointed as Public Executioner of Sydney Town and the Colony of New South Wales. Over time, Green’s mental state deteriorated and even though this was obvious to the authorities, they did not move to replace him. During his career, Green hanged 490 people however, by 1855 his behaviour became so disturbing the authorities had to remove him from his position.

At his last six executions (five of which were public), Green’s bizarre behaviour began to elicit public comment, with Green particularly appearing to enjoy dropping the trap in the gallows - before the condemned had completed their final prayers. Following his last (botched) execution, Green was found to be so completely insane he was immediately confined to the Tarban Creek Asylum, where he remained until the end of his life.244

For the upper working or lower middle classes who could not manage an insane relative at home, and might reasonably have been expected to contribute to the costs of supporting them in an asylum, there existed a loophole in the law. If they sought to admit a relative to the asylum (before the bench of the Supreme Court) they would be expected to pay costs. However, if the insane relative was arrested (for example, for disturbing the peace), it became a police matter. If judged

insane by the police, the person could be transferred to the asylum and admitted by the Governor’s authority, the relatives thus avoided incurring “the trouble and cost of proceeding under the sanction of a Judge.” Consequently, relatives turned many mentally ill people onto the streets and the police were forced to deal with them. In 1855, a parliamentary committee recommended inquiries should be made of those admitted to asylums via the police, and if relatives could contribute to the patient’s upkeep, then under the law, they should be compelled to do so.  

2.7: Lunacy and the benevolent asylums.

Some chronically infirm or invalid paupers were lucky enough to be admitted to the Sydney Benevolent Asylum, which had been constructed at Government expense and completed in 1821. Management of the asylum was undertaken by the Benevolent Society which was financed by charitable subscribers. For a person to be admitted the endorsement of a subscriber was required, and with so many in need the asylum quickly became overcrowded. In time, and with an ageing population of paupers, many of whom were ex-convicts, more charitable institutions were needed.

In the third quarter of the 19th century, the Government took control of the Sydney Benevolent Asylum and reused several institutions, constructed during the era of convict transportation, as benevolent asylums also kept under Government control. The Hyde Park Barracks in Sydney, the former Convict Hospital at Liverpool, the George St. and Macquarie St. Barracks at Parramatta,

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245 Report from the Commissioners of Inquiry on Lunatic Asylums, op. cit., 1855, pp.10-11.
246 Ibid.
and the Convict Barracks at Port Macquarie, were some of the old institutions reused to accommodate the aged and infirm, and sometimes the insane. Naturally, these benevolent asylums also became quickly overcrowded, and as there were dedicated lunatic asylums (Tarban Creek and Parramatta Asylums), the insane (including those who demented after admission), were removed from benevolent asylums. As the lunatic asylums were also overcrowded, there was resistance to receiving these people, especially the aged insane who were considered incurable.

On December 26th 1863, Dr George Walker, Medical Officer of the Hyde Park Barracks, wrote to the Colonial Secretary (via the asylum’s Board), complaining of the difficulty in transferring patients to the lunatic asylum. In particular, Walker noted that the medical certificate necessary to transfer a patient stated, in the opinion of the (two) examining medical practitioners, “(the patient) would be benefited by such Asylum”. Walker then pointed out,

> the very fact that old age is the cause in most cases of the mental malady – and as the cause is persistent – a difficulty arises in obtaining the transfer… since the medical men who are called to furnish the necessary document are unwilling to certify to the opinion that any benefit can accrue to a patient whose advanced years have bought with them the downfall of reason and intelligence.

The Colonial Secretary responded on January 11th 1864, saying he could not “see the force of Dr Walker’s objection to the form of (the) Certificate.” He further stated, “surely there ought to be no difficulty in certifying that any lunatic – whether his lunacy arise from old age or otherwise – ‘would be benefited by treatment in such asylum’ or by removal from one institution to the other. Dr

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248 Walker to Chairman Hyde Park Asylum Board, 26 December 1863 (with Colonial Secretary’s Annotation). *Colonial Secretary Inward Letters*, S.R.N.S.W., 64/702, box 4/519.
Walker seems to me to confound the question of benefit with that of curative treatment.” Dr Walker wrote again, pressing the same complaint and saying that the doctors who examined insane patients for transfer to the lunatic asylum used “an arrogant piece of presumption” and would not transfer lunatics as there was no benefit to the patient in the transfer. Their argument (said Walker) was thus;

Your inmates are afflicted with insanity, the result of old age – old age is incurable – ergo the insanity is incurable – and ergo no benefit can accrue to any [old insane] patient from treatment in a lunatic asylum."

The Colonial Secretary replied that he could not see Dr Walker’s problem with the form of the certificate, he felt Walker’s argument seemed “a question of philology rather than medical science.” The Colonial Secretary believed that if a person was insane, regardless if the insanity was considered curable or not, the person would benefit from a transfer “to another institution designed for the Treatment of mental disease.” Further, he observed, regarding the arrogant presumption of doctors (as claimed in Walker’s letter), “I fear presumption of that kind is not likely to be either cured or benefited by altering the form of the certificate.” In any case, the Colonial Secretary did not seem to have been very interested in Walker’s concerns, and as the argument was going round in circles, he referred the complaints to the Legislative Council.

249 Colonial Secretary to the President of the Board - Hyde Park Asylum, 11 January 1864 (Colonial Secretary’s annotation Walker to Chairman Hyde Park Asylum Board). Colonial Secretary’s Inward Letters, S.R.N.S.W., 64/702, box 4/519.
250 Walker to Chairman of the Hyde Park Asylum Board, 25 January 1864 (with Colonial Secretary’s Annotation). Colonial Secretary Inward Letters, S.R.N.S.W., 64/702, box 4/519.
251 Colonial Secretary to the President of the Board – Hyde Park Asylum, 5 February 1864. (Colonial Secretary’s Annotation Walker to Chairman Hyde Park Asylum Board), Colonial Secretary Inward Letters, S.R.N.S.W., 64/702, box 4/519.
252 Ibid.
These early developments represent the foundation of mental health care in colonial New South Wales: conflict between medical and non-medical men regarding control of asylums; overcrowding; staffing difficulties; variable care depending on class, resources and social position; and in the final analysis, the fate of mentally ill people being determined by the humanity or otherwise of governments and carers. All this aside, the carers of the mentally ill were convicts, often assigned unwillingly to the asylums, and thus the origins of the work of mental health nurses are firmly rooted in the social structure of the convict population.

Introduced into this difficult situation were Joseph and Susannah Digby, the first trained and experienced carers of the insane to work in New South Wales. The Governor, Richard Bourke, may have felt optimism at the prospect of professional assistance, which could only improve the situation for some of the colony’s most disadvantaged, the mentally ill. Unfortunately, this did not entirely prove to be the case.
Chapter 3.

The advent of Joseph and Susannah Digby.

This chapter examines the appointment of New South Wales’ first experienced mental health carers, Joseph and Susannah Digby, as administrators of the first purpose built asylum at Tarban Creek. Their tradition of care, based on the concept of Moral Treatment, and the problems they faced at the new asylum are explored. Governor Richard Bourke’s request for the “home” authorities to appoint suitably qualified carers of the insane, rather than appoint people already residing in the colony, is also investigated. The Digbys’ appointment by British authorities, aroused the criticism of a prominent doctor in England and this criticism was later to provide the moral authority for the New South Wales medical profession to undermine their work.

3.1: The establishment of Tarban Creek Asylum.

Favourable economic conditions experienced by the New South Wales colony in the mid 1830s, allowed the government to consider expenditure on capital works and projects of benefit to colonial society. In 1835 Governor Richard Bourke reported to the Colonial Office, that the colony’s treasury had amassed a surplus, having at its disposal £92,535 for colonial uses. Bourke proposed spending the money on public works such as the construction of schools, new gaols and courts, a customs building and road repairs. Bourke also sought permission to erect a new and permanent lunatic asylum stating, “A lunatic asylum is an Establishment that can no longer be dispensed with.”¹ He described the present

asylum, at Liverpool, as a “wretched hired building,” and proposed that construction of the new asylum would be wholly at the expense of the colony.

The British Government approved construction of the new asylum in August 1835 and work began almost immediately. The site selected was eight miles from Sydney on a promontory of the Parramatta River, which ironically was already known as Bedlam Point. It is generally believed that construction of the new asylum gave rise to the area being locally referred to as Bedlam however; evidence suggests the name existed from at least 1822.² Although there is no conclusive proof, it has been hypothesised that a much earlier building was used as an asylum near the site, perhaps prior to the establishment of the Castle Hill Asylum in 1812.³ The newly built institution was named Tarban Creek Asylum after a nearby watercourse.

3.2: Expertise from abroad – the appointment of the Digbys.

In April 1837, Governor Bourke reported that the new asylum was “now rapidly approaching completion.”⁴ The asylum would accommodate up to 60 patients in separate cells (Bourke’s description of the rooms) and if necessary, more could be accommodated in the Keeper’s house. Bourke requested that Lord Glenelg, the British Colonial Secretary, make inquiries and engage a suitable married couple to be employed as “Keeper and Matron”, as he felt it would “not be possible to obtain in the Colony Persons well qualified for its superintendence.”⁵ Bourke noted that the salaries of the appointees would be

³ Ibid.
⁵ Ibid.
paid from the medical expenditure of the colony (thus a charge on the British Treasury), but also cautioned:

As wages are very high at present... it will be necessary that the sum allowed should be liberal to prevent the Parties from becoming discontented and induced to leave their employment for more profitable occupation.  

Lord Glenelg responded to Bourke’s request for a Keeper and Matron with Bourke’s successor, George Gipps, receiving the reply in August 1838:

I have received your Predecessor’s Despatch… suggesting that a Steward and Matron should be sent out from this Country to take charge of the Lunatic Asylum which has lately been completed in New South Wales.

I have appointed Mr. Joseph Digby and his Wife [Susannah]  

Ibid.

6 Name added – she was unnamed in the correspondence.


3.3: Possible reasons for Bourke’s request for well qualified mental health carers of the insane from England.

The appointment of Joseph and Susannah Digby represents a profound change in the colonial government's attitude towards the care of people with a mental illness. Rather than confining lunatics to an institution under the supervision of convict overseers, Bourke’s request suggests he hoped more appropriate care and treatment would occur under the guidance of an experienced superintendent.

Bourke’s opinion, that there was no one in the colony sufficiently qualified to superintend the new asylum, suggests he saw the management of the mentally ill as more than mere confinement. This disqualified gaolers such as Thomas Plunkett, the incumbent at the Liverpool Asylum. Bourke also did not appear to believe the asylum superintendency should be gifted to a political ally, as in the case of George Suttor, nor given to a bureaucrat from the civil service such as William Bennett (both of the Castle Hill Asylum).

Whether or not Bourke considered members of the colony’s medical profession is unknown. There was no lack of medical personnel in the colony and by the mid 1840s there were 1.8 doctors per 1000 population within New South Wales. In Sydney, one doctor per 375 persons compared favourably with London's one to 374.10 The colony’s medical fraternity became a powerful and influential body of men, often with substantial pastoral holdings and political interests. They began to draw together and in 1838, formed the New South Wales Medical Board. By 1839, this body began examining the credentials of the colony’s medical practitioners and those deemed qualified were enrolled on a professional

register. Given the excellent economic conditions, it is possible that many doctors were deriving a lucrative living from private practice and were simply not interested in the position of asylum Superintendent.

Whatever the reasons, Bourke did not appoint a doctor from the Colonial Medical Service nor consider placing the asylum under the administration of the Medical Service, thus keeping lunacy separate from other health care services. It is possible that Bourke was aware of the problems associated with the permanent appointment of doctors at the earlier Castle Hill Asylum, where conflict regarding authority and power caused so much disruption. Consequently, asylum doctors were appointed only in the capacity of visiting medical officers. It is worth noting that most colonial doctors had interests apart from medicine which diverted their attention from their profession, their qualifications being, “commonly acquired as convenient stock-in-trade to help pave the way to some better position in life.” For example, Dr Patrick Hill, the visiting medical officer for the Liverpool Asylum, whilst having a reputation as a competent medical man, “enjoyed a far greater reputation… as a successful squatter” in the pastoral country around Goulburn (approx. 170 kilometres south of Liverpool) – his main “hobby” being the manufacture of cheese. Given the likelihood a doctor would not give the asylum his full attention, and perhaps mindful of the earlier problems at the Castle Hill Asylum with resident doctors, one might speculate that Bourke consciously titled the most senior position of the asylum as Keeper in order to discourage doctors from wanting the job.

13 Ibid.
It is also possible Bourke did not believe medical qualifications made one necessarily the best suited or qualified person to superintend, i.e., administer a lunatic asylum. For example, Bourke did not ask the British authorities for a Medical Superintendent; he requested a suitable married couple to act as Keeper and Matron and expected them to administer the new asylum. It was not unknown, in some British asylums, for medical men to operate or superintend mad-houses with their wives appointed as Matrons. This enhanced profitability and in some instances attracted the admiration of society, for example, Sir William and Lady Ellis at the Hanwell Asylum. But on the whole, the medical men’s wives were not engaged in the work of the asylum. Even so, had Bourke requested the British authorities to send an experienced mad-doctor, it is doubtful any doctor or his wife would be interested in the positions of Superintendent and Matron of a lunatic asylum in the antipodes. New South Wales did not enjoy a good reputation in England, mainly due to its status as a penal colony and the taint of its convict population. A contemporary commentator, Peter Cunningham (co-incidentally a naval surgeon) observed, It must be admitted that it is the only country in the world which you are ashamed to confess the having visited. I have made several slips of this kind before strangers, and I certainly never yet gained a friend by the disclosure. Every one, through some excuse or another, endeavours to elude the pleasure of my society.¹⁴

Thus it is extremely unlikely that a successful mad-doctor or his wife would be tempted to leave England for the uncertainties and possible social stigma of living in a penal colony, and working mainly with convicts, on the other side of the world. In any case, it would appear Bourke wanted people who could

administer the asylum and who could provide (and perhaps demonstrate to the other staff), care for the patients; treatment could continue to be provided by visiting medical officers.

Bourke’s successor, Governor George Gipps, inheritor of the half built asylum, may have been likeminded. The Deputy Inspector General of Hospitals and Head of the Colonial Medical Service, Dr John Vaughan Thompson, believed the asylum should be classified as a hospital and was pressing for the appointment of a resident medical officer. The idea the asylum was a hospital was not supported by Gipps, who stated in 1839;

The lunatic asylum is not a hospital, it therefore is not under the charge of the Deputy Inspector of Hospitals, though in the management of it, it will be necessary to have the benefit of his advice.

The reason for Gipps’ decision is unclear however, from September 1839, quarterly medical reports from the asylum were directed to the Deputy Inspector of Hospitals and these were to be written by a doctor. Moreover, Gipps eventually accepted the need for a resident medical officer particularly as the Tarban Creek Asylum site excluded easy and ready access to a visiting doctor from the Colonial Medical Service; the closest being ten miles away at Parramatta. To this position Gipps appointed Dr McLean, late Staff Surgeon in the Army who had recently settled in the colony. His pay was set at 7s. 6d. per Diem with apartments in the asylum including rations and fuel. However, Gipps was adamant that the resident medical officer's duties were confined to the

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15 Cummins, C.J., *The Administration of Lunacy and Idiocy in New South Wales, 1788-1855*. School of Hospital Administration, University of New South Wales, 1968, p.28.


treatment of physical illness and disease, “All orders respecting the admission of
patients, etc. will of course, in future, be addressed to Mr Digby.”

Nevertheless, for the first time in two decades the medical profession had a
foot in the door, and in the future, this presence would spark debate concerning
professional qualifications and authority to provide treatment for the mentally ill.

There is no surviving evidence to shed light on Gipps’ personal views concerning
the care of the mentally ill. In determining that the asylum was not a hospital,
Gipps may have had in mind a purpose, at least in part, similar to that defined
fifty years earlier by James Currie:

the objects of a Lunatic Asylum are two-fold - to provide
accommodations for the poor suitable to their
circumstances, and to make provision for those of
superior stations, who are able to remunerate the expense.
The objects of such an institution are two-fold in another
sense: It holds out a shelter both for the curable and
incurable. To the first it proposes the restoration of
reason, and while it relieves society from the
burthen of the last, it covers the hapless victims
themselves from the dangers of life, and from the selfish
contempt of an unfeeling world.

On the other hand, it is possible Gipps was not motivated by high ideals when
contemplating the asylum and its work. Perhaps Gipps was pragmatic in his
assessment of the situation. His predecessor began the construction of the asylum
and organised its administration and perhaps Gipps had no reason to be
dissatisfied with, or feel a need to change, the arrangements.

18 Cummins, ibid., p.28.
19 Hunter, R. & Macalpine, I., Three Hundred Years of Psychiatry 1535 – 1860. Carlisle Publishing
In any case, the Digbys’ qualifications were considered appropriate by Lord Glenelg, probably because of their training and experience at St Luke’s Hospital for Lunatics; they had been appointed by the Home Government and were now on their way to New South Wales.

Curiously, the actual designation of Joseph Digby’s position is confusing. Governor Bourke requested a Keeper to administer the new asylum. Lord Glenelg’s correspondence refers to Digby as Steward, who would nonetheless, administer the asylum under the auspices of a Committee of Superintendence. Governor Gipps never established the Committee of Superintendence (nor did his successor). However, later correspondence and official documents record Digby as Superintendent. Whether or not Digby himself appropriated the designation of Superintendent is unknown, but colonial establishments, especially those catering for the convict population, tended to be governed by a Superintendent. There is no evidence that Governor Gipps formally appointed Digby as Superintendent and therefore, presumably by convention, Digby was referred to as Superintendent by colonial officials and accepted the designation.

3.4: Background of the Digbys’ tradition of care.

The Digbys’ actual qualifications are unknown. Lord Glenelg’s decision to appoint them was, apart from the high testimony (i.e., excellent references) of Dr Sutherland, probably based on the good reputation of St Luke’s, the institution in which they were trained and employed. St Luke’s Hospital for Lunatics opened in 1751 with William Battie, already an eminent physician, appointed its

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21 For example, Rules and Regulations issued by Mr Digby 1842, Cited in Bostock, op. cit., pp.67-68.
manager. Battie devoted himself exclusively to madness and due to his success had become the leading *Mad-Doctor* of the day. He was previously employed at the Bethlem Hospital (Bedlam) and due to its then dreadful state and management, he saw an urgent need to improve the conditions and treatment of the insane. Battie, with a group of likeminded philanthropists, organised a public subscription to build St Luke’s Hospital as a (fee charging) public institution, with the aim of providing care to anyone who required it. Being a person of distinguished social standing, and the first physician of repute with a scientific background to work with the insane, he raised the treatment of madness to a respectable medical specialty. For example, Battie allowed access to the hospital’s workings to medical students and was the first physician to give lectures on mental diseases. He also stated (without specifics or details), that the servants of institutions for lunatics should be *peculiarly qualified* for their work – probably the first printed statement that mental nursing required special training and/or personal qualities.

Battie’s 1758 publication, *A Treatise on Madness*, was the first by a specialist physician to examine the care and treatment of the mentally ill, and was designed to “be of service to other Students, who have not the same opportunity of seeing practice.” Battie’s example led to the establishment of four more hospitals for lunatics in England, based on his principles, by the end of the eighteenth century. A large number of publications concerning mental illness and the care and treatment of lunatics, which appeared in the late eighteenth century, are also claimed to “bear the stamp of his influence.”

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23 Hunter & Macalpine, op.cit., p.404.
In *A Treatise on Madness*, Battie observes that the causes of insanity are largely unknown. Covertly criticising the management of the Bedlam Asylum, he attacked the lack of shared information regarding the treatment of madness blaming “a few select Physicians, most of whom thought it advisable to keep the cases as well as the patients to themselves.” The mad-doctoring trade was a profitable business and this lack of information sharing resulted in the specialty being held back, “and every Practitioner at his first engaging in the cure of Lunacy has had nothing but his own natural sense and sagacity to trust to.”

Battie also attacked the traditional medical treatments of the time, such as the use of opium, purgatives and emetics. He was especially critical of bloodletting as a general treatment for all illness and in particular madness; “The lancet, when applied to a feeble and convulsed Lunatic, is no less destructive than a sword.”

He stressed that in the care of the lunatic, “management did more than medicine.” Battie reached this conclusion because he observed that many lunatics recovered spontaneously, for greater or lesser periods and without medical intervention.

Battie’s assertion that in the care of the lunatic management more than medicine was the best practice indicates a belief that science alone would not cure patients - there was an art to mental health care. Battie’s method of management involved befriending the patient, encouraging and supporting them, he also observed that “confinement alone is oftentimes sufficient, but always so necessary, that without it every method for the cure of madness would be ineffectual.” Confinement in this sense meant removal from home to the hospital environment, indicating

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28 Ibid.
Battie viewed asylums as having therapeutic potential. Battie did not rail against restraint, presumably regarding it as an acceptable intervention. Battie’s achievements and influence won him fame not only with like minded mad-doctors, but apparently also with ordinary people. His name has entered common language and his memory is perpetuated by the word batty, meaning silly or crazy.

The methods used by Battie and other likeminded mad-doctors of the time, were eventually to become known as moral management (later moral treatment). In this context, the term moral is difficult to define. Whilst not excluding modern concepts of morality such as right conduct and chasteness, it was used by mad-doctors in the late 18th to mid 19th century to describe those causes and treatments of insanity which were of an emotional or psychological nature. The moral causes of insanity therefore, included grief, fright, disappointment in business, conjugal infidelity, pride, jealousy and fanatical excitement.29

The success of St Luke’s Hospital began to influence the care and treatment of the insane in other institutions. Most significantly, after a visit to St Luke’s, the Quaker philanthropist Samuel Tuke was directly inspired to found the York Retreat.30 Tuke was moved to establish the Retreat after the death of a Quaker girl following the harsh medical treatments forced on her at the York Asylum in 1791. As a result, Tuke proposed the building of a new asylum in 1792, and in

29 Bostock, op. cit., p.119.
the same year, began raising funds for its construction; the Retreat being
eventually opened in 1796.\textsuperscript{31}

Initially only Quakers were admitted, but later the Retreat admitted others. At the
Retreat, the usual medical treatments of the time such as bleeding, blistering,
setons and evacuants (purgatives and vomits), had been used, however following
evaluation, these proved to be ineffectual in the treatment of insanity.\textsuperscript{32} The role
of the doctor nevertheless was seen as important, even though mainly providing
treatment for physical illness or disease. The therapeutic potential of the asylum
is noted at the York Retreat. For example, the milieu was intended to be as
cheerful and homelike as possible and the Retreat employed a milder form of
moral treatment, refining and enhancing Battie's management of the insane.
Patients were treated with kindness and humanity. It was believed that even the
maddest person would have some part of their reason intact, and could therefore,
respond to positive attention. Also, the comfort of the patient was a priority and,
innovative at the time, very disturbed or violent patients were kept separate from
the more genteel and tranquil.

The York Retreat also pioneered meaningful occupation for its patients.
Described as an experiment in 1798, patients were encouraged to undertake tasks
proportionate to their strength. Work activities included cultivation of the
Retreat’s land, the employment of female patients in knitting, sewing or domestic
duties, and the use of convalescent patients to assist attendants. These activities
were identified as promoting a sense of self-worth and usefulness in the patient,
“It was found that they [the patients] were fond of this exercise, and that they

\textsuperscript{31} Tuke, D.H., \textit{Chapters in the History of the Insane in the British Isles}. 1882, E.J. Bonset,
Amsterdam, (facsimile reprint 1968), pp.113-114.
\textsuperscript{32} Ibid, p.136.
were much better after a day spent in this work than when they remained in the house."\textsuperscript{33} This aspect of the York Retreat's management of the insane, became a feature of the majority of lunatic asylums during the late 19\textsuperscript{th} and a good part of the 20\textsuperscript{th} centuries.

Unlike elsewhere in Britain, the York Retreat avoided the use of physical/mechanical restraint. Emphasis was placed on assisting patients to find and strengthen their control of symptomatic behaviours, that is, patients were encouraged to develop self-awareness and self-restraint, which has its modern equivalent in psychotherapeutic interventions. If this failed, assessment was undertaken to ascertain the minimal external coercion necessary to manage those patients unable to control themselves. \textit{Coercion}, the York Retreat's term for physical/mechanical restraint, was regarded as a “necessary evil” as it was believed to compromise the moral remedies employed there.\textsuperscript{34} Physical restraint was seen as harsh, unkind and inhumane, the antithesis of the Retreat’s philosophy of care. No absolute rule of non-restraint was laid down however, the use of chains was prohibited. The Retreat utilised physical/mechanical restraint, in the form of straps, strait waistcoats and seclusion, only as a last resort. Mechanical restraint was not used as a punishment and was applied as a temporary measure to decrease the risk of harm to self or others, the restraints removed as soon as the patient's irritability subsided.

The philosophy of care instituted at the York Retreat was almost contemporaneous with Philippe Pinel’s in France. Pinel instituted similar reforms at the Bicêtre and Salpêtrière asylums in 1793 and 1795 respectively.\textsuperscript{35}

\textsuperscript{33} Tuke, op. cit., pp.125 & 137-138.
\textsuperscript{34} Ibid, p.140.
methods used at the Retreat, a refinement of Battie's principles, were so successful and publicly acclaimed that they were adopted in many British institutions, including St Luke’s, during the early nineteenth century. By 1833, Dr Alexander Robert Sutherland had introduced occupational activities into St Luke’s, however, the use of mechanical restraint continued because the staff : patient ratio of 1 to 7 was considered relatively small.  

Battie's founding principles at St Luke’s Hospital continued to be used well after his retirement in 1764. Daniel Hake Tuke, writing in 1882, noted that his great grandfather and the founder of the York Retreat, William Tuke, revisited St Luke’s in 1812. Referring to a manuscript written following that visit, he noted William Tuke's comment that whilst radical reforms were needed (he felt there was too much use of mechanical restraint), the principle of management more than medicine was the continuing practice at St Luke’s. D.H. Tuke further observed that the House of Commons Committee, investigating abuses in British lunatic asylums during 1815, found little at St Luke’s to trouble them.  

Moral treatment, largely based on Battie’s principles, was the historic tradition of care that Joseph and Susannah Digby understood and through which they gained their experience, ergo qualifications. Accordingly, the management and methods of the new Tarban Creek Asylum would be drawn from that tradition and therefore, from their knowledge of the St Luke’s version of moral treatment. Having gained senior and well paid government appointments in a thriving and

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prosperous British colony, Joseph and Susannah Digby might well have considered their future with some optimism. However, and probably unbeknown to them, their appointment was already attracting criticism which would culminate in the undermining of their work and their later unhappy departure from the colony.

3.5: The Digbys’ appointment publicly attacked.

During 1838, Sir William Charles Ellis, prominent physician, former Superintendent of the Wakefield and Hanwell Asylums and then owner of the Southall Park Asylum, published his work: *A Treatise on the nature, symptoms, causes and treatment of Insanity*. In this book, Ellis espoused the benefits of moral treatment and particularly the belief that proper occupation of the patient was the key to good asylum management. However, although Ellis very much supported moral treatment, including physical restraint when all else failed, he also provided numerous case studies where he advocated the usual medical methods. For example, drugs, emetics, purges, bleeding (through the use of both lancet and leech), blistering, head shaving and the application of cold compresses to the scalp, feature strongly throughout the text. Thus, he was also very medically orientated. Moreover, these treatments were described in spite of the book’s disclaimer that;

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It will be seen that the medical remedies, on which much reliance is to be placed, are but few, and that they are principally of use in the early stages of the disease.38
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Ellis was also a staunch advocate of a new branch of medical (pseudo)science known as phrenology - examination of the external features of the cranium which

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was supposed, by its disciples, to provide indication of the mental faculties of the patient. By feeling the temperature, bumps, indentations and ridges of the cranium, Ellis believed he could prescribe appropriate treatment. Phrenology’s proponents also believed the environment could be adapted to suit the faculties found in their patients. In this way, phrenology provided a scientific basis on which moral management within the lunatic asylum could be considered as medical treatment.\(^{39}\)

Because Sir William and his wife (who acted as Matron of the various asylums he superintended), were devout Methodists and thought their work was divinely inspired, they attempted to bring Christian principles into their asylums. Ellis led daily prayers for the staff and patients and at one time (until the law expected chaplains to be appointed to asylums), conducted religious services on Sundays.\(^{40}\) Apparently Ellis saw his work as Superintendent of the asylum as God’s work. Ellis, described as a “self-taught, progressive and humane medical superintendent,” was, in 1835, the first doctor knighted exclusively for services to the insane.\(^{41}\) He was a powerful and influential doctor. Ellis believed only a “medical man, and a benevolent one,” should be entrusted with the care of the insane.\(^{42}\) As a result, Ellis used his book to publicly attack the appointment of the Digbys:

> I deeply regret, that during the progress of the work, I have learnt that Government have sent out, as the superintendent of the only public asylum in New South Wales, an individual, without medical education whatever. The only knowledge of the disease possessed by himself and his wife, the matron, has been derived


\(^{41}\) Hunter, & Macalpine, op. cit., pp.870-877.

\(^{42}\) Ellis, op. cit., pp.314-316.
from their being keepers in a private asylum. Now, I have nothing whatever to say in disparagement of the characters of these individuals: so far from it, as far as I could judge of the superintendent, whom I saw at Hanwell, I believe him to have a sincere desire to do good; and I know that he regrets his want of knowledge.

Nevertheless, Ellis predicted dire consequences from the Digbys’ appointment, citing abuse and mistreatment within the British Asylums:

in England, in the midst of medical knowledge, and of a population advanced in morals, intellect and benevolence, there existed in Asylums evils, appalling and revolting to humanity. And by this appointment, Government have set the example of placing these institutions, in a country uninfluenced by moral checks, under the control of a class of persons, entirely unqualified for their management.... The nature of the appointment shows, that, in the opinion of Government, insanity is not a curable disease: and with the sanction of such authority, must we not expect, that asylums, to be built there, will be considered rather as prisons for the safe custody of the insane, than as hospitals for their cure?

Ellis crafted this slander carefully, praising Joseph Digby’s good personal qualities whilst denigrating his fitness for the position, an opinion Ellis would probably have applied to any appointee not a doctor. Ellis also suggests Digby himself had doubts about his own abilities. Digby's desire to know more was interpreted by Ellis as self doubt. Whether Digby, upon meeting Sir William Ellis, actually or even perhaps humbly stated that his knowledge was wanting, or whether Ellis solicited this opinion from others, is unknown. There appears to be no surviving evidence that Digby ever knew of this attack, or if he did, that he ever tried to defend himself.

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43 It is not known for certain if Ellis met Digby either before or after his appointment as Superintendent – however, Ellis says Digby expressed self doubt as to his abilities (see over) suggesting they met after Digby was advised of his appointment. Ellis refers to “Superintendent” (not Keeper) in his book as Digby had by then left for Australia just before the book’s publication.
44 Ellis, op. cit.
45 Ibid.
According to Ellis, the appointment of non-medical and therefore unqualified personnel to the new asylum “in a country uninfluenced by moral checks” (New South Wales was still a penal settlement), was a recipe for disaster. Here Ellis seems to be suggesting that, apart from providing proper treatment for insanity, medical practitioners had a role in counteracting the ills of a morally bankrupt society. He was (perhaps in keeping with his religious views and his own divinely inspired medical work?), claiming for the medical profession, not only the treatment of physical and mental disease but also a part in the remediation of the moral ills of society. He also clearly believed, as did many other doctors, that the medicalisation of mental health care was essential. Without a medical man in control, the asylum was merely a place of confinement where lunatics would be put away. Only a doctor and no one else therefore, would make the asylum an establishment where care and cure could be anticipated and expected. Moreover, by criticising the appointment of the Digbys, Ellis provided the moral authority for the medical profession, in the colony, to attack their appointment. Against this background of medical opinion, the Digbys took up their appointment in New South Wales.

3.6: The Digbys take up their appointment.

If Joseph and Susannah Digby were optimistic about their prospects in the colony, then the financial austereness of Governor George Gipps probably brought the reality of their situation into sharp focus. Gipps’ well known stinginess\(^{46}\) was compounded by a severe economic depression, caused in part by excessive speculation and the loss of free labour, arising from the abolition of

transportation of convicts to the colony. 1840 to 1846 were the worst years of the depression, and many colonists were brought to the brink of ruin, even one of the colony’s largest banks collapsed with liabilities in excess of £250,000.\textsuperscript{47}

Soon after arriving in the colony, Joseph Digby expected and requested that he and his wife receive back pay, of half their salary, from the time of their embarkation on February 11\textsuperscript{th} until their arrival on July 1\textsuperscript{st} 1838. The Governor rejected the request, noting he had no authority to issue such a payment. The Governor did, however, authorise payment of their salaries from the day of their arrival.\textsuperscript{48} The Digbys first visit to the new asylum occurred shortly after their arrival in the colony. They found their accommodation was not yet completed, in fact, they believed their rooms were uninhabitable and later irritated Governor Gipps by requesting that expenses incurred renting elsewhere, be reimbursed. The Governor flatly refused, noting he had ordered the Digbys to take up residence at the asylum immediately, in the hope their presence might accelerate its completion.\textsuperscript{49} Gipps also refused Digby’s request for the provision of furniture for their rooms, as the accommodation for officers of the institution were private apartments, and he felt they should not be furnished at Government expense.

Over the next few years, Digby was to make a variety of requests and demands for equipment, supplies, alterations and additions to the asylum. Governor Gipps, who exercised restraint in expenditure and valued economy over almost everything else, was rarely sympathetic to Digby’s and the asylum’s needs. But

\textsuperscript{48} Bostock, op. cit., pp.40-41.
Digby’s persistence and his dogged determination to provide the best possible care for the mentally ill under his charge, saw him realise, with some effort, much of what he believed to be necessary.\textsuperscript{50} The Digbys eventually took up residence at the asylum, in September 1838, and began preparations for the reception of patients. Governor Gipps visited the asylum on October 19\textsuperscript{th} and expressed his wish that patients be admitted as soon as possible.

On November 19, Tarban Creek Asylum received its first female patients – 28 from the Liverpool Asylum and 11 from the Female Factory (a convict prison) at Parramatta. Digby wrote to the Colonial Secretary on November 22\textsuperscript{nd} noting he had 39 patients but only 30 beds (yet opened) which required, in some instances, placing two to a cell. Digby was also unhappy about the condition of the patients from the Liverpool Asylum, complaining they arrived in a filthy personal state, with dirty clothing, and no change of linen or garments.\textsuperscript{51} With Tarban Creek Asylum nearly completed, the remaining patients (35 males), were transferred from the Liverpool Asylum in January 1839 – the Liverpool Asylum was then closed. From the very beginning, however, staffing difficulties were experienced at the new Asylum.

3.7: Staffing difficulties at the Tarban Creek Asylum.

During the Governor’s first visit to Tarban Creek in October 1838, Joseph Digby asked Gipps if he might employ a married couple to supervise the work of the three convict keepers, two nurses and domestic staff.\textsuperscript{52} The Governor was initially unsympathetic to this request. Digby then wrote to the Governor in

\textsuperscript{50} See Bostock, op. cit. and McDonald, ibid, for many examples of the niggardliness of Gipps.
\textsuperscript{51} Bostock, op. cit., p.44.
\textsuperscript{52} Ibid, p.43.
November, stating that the very lowest number of non convict staff required was 11: a man as head keeper, his wife as head nurse, 2 men as under keepers, 2 women as under nurses, 1 male cook, 1 male porter/general indoor servant, 1 male outdoor servant, 1 female laundry servant, and 1 female housemaid/cleaner. Further, Digby noted that if the majority of staff were to be drawn from the convict ranks, it was necessary that he be allowed to employ a free man and his wife to overseer the convict workers. Governor Gipps replied that he could see no reason why more staff should be employed at the new asylum than existed at the old. He did, however, allow three more male convicts to be assigned to Digby, and as many convict women as were deemed necessary for domestic cleaning duties. Digby then asked for and justified the roles of eleven non convict staff - eventually gaining permission to employ four; a significant achievement in only a few months. Digby may have succeeded in his wish for at least some non convict staff, due to colonial society’s sensitivities regarding convict labour. For instance, the asylum’s patients included an increasing number of free persons and whilst they may have been lunatics, the idea they would be under the supervision of convicts would not have sat well in the wider community (Digby later sought the Governor’s permission to employ a free man to attend to the “private” patients). Perhaps too, a curious phenomenon was exposed; when making requests of Government, always ask for more than you really want which leaves room to negotiate down to what you need. In January 1839, Digby advised Governor Gipps he had employed Patrick Moran and Michael Byrne and their wives as keepers and attendants, each man receiving £40 per annum and their wives £20, with rations and lodging.

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53 Ibid, p.44.  
54 Ibid, p.48.  
Joseph Digby, after four months of determined lobbying, succeeded for the first
time in Australia, in employing carers of the mentally ill who were not drawn
from the convict population. Nevertheless, he had no control over the assignment
of individual convicts to the asylum, regardless of their suitability for the work,
and though Digby did dispose of unsuitable convict keepers from time to time, he
could only do this by enduring the bureaucracy associated with dealing with the
Colonial Secretary. Not that all assigned convict keepers were unsuitable. For
example, in April 1839 an assigned convict, Ninian Turner, was reassigned to the
Border Police.\(^{56}\) Digby protested, as Turner was an excellent and kindly keeper.
The Governor observed that Turner had demonstrated himself a deserving and
well conducted man and that he should choose for himself. Whilst Turner may
have been a good and conscientious keeper, the nature of the work must have
been somewhat unpleasant. When given the option of being assigned elsewhere,
Turner chose to join the police. Digby was forced to accept that (until the end of
1846 when an inquiry recommended that all staff should be salaried), a
percentage of the asylum’s staff would be assigned or bonded convicts.

Digby, in being permitted to hire salaried non convict staff, could assess their
suitability and dismiss them later if they were found wanting. Nevertheless,
during his early administration of the asylum, staffing difficulties were a source
of great anxiety for Digby and there was always the problem of recruiting
suitable people to act as keepers and nurses. For instance, within weeks of
employing the first non convict staff, one of the female keepers resigned as she
was too nervous and timid around the patients, and in consequence, her husband

\(^{56}\) The Border Police were a quasi military force raised by Gipps to deal with Aboriginal resistance.
also resigned. Further, in March 1839, Patrick and Honora Casey were dismissed as altogether unsuitable for their duties and were replaced by James and Anne Wright. However, the Wrights were later found to be unsuitable and dismissed at the end of 1842; Wright, for insolence and intemperance and his wife for getting drunk and violently assaulting Mrs Digby and some of the female patients; …and also for harbouring, tampering with, and giving rum to two prisoners of the Crown assigned to the Establishment.

In reply, the disgruntled Wrights charged that Digby was using the patients and staff for his own purposes and that Mrs Digby was cruel to the patients. The Governor dismissed their complaints but warned Digby not to make excessive use of his charges for his own purposes. Another serious incident occurred during 1843 when Digby discovered two of the male convict keepers were sexually abusing female patients, which resulted in the keepers’ imprisonment on Cockatoo Island. The visiting Magistrate for Tarban Creek, Captain Joseph Long Innes, visited the asylum to make out a report, which fortunately, proved largely favourable to Digby’s management of the incident.

By early 1847, the asylum employed only salaried staff; the days of the assigned convict were now over. The new staff establishment included:

- 4 male keepers at £30 per annum
- 3 female keepers at £18 per annum
- 1 male cook at £20 per annum
- 2 laundry women at £15 per annum.

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57 Ibid, p.54.
58 Digby to Colonial Secretary (with Governor’s annotation), 10 January 1842. Colonial Secretary Letters Received. Cited in McDonald, op. cit. p.280.
59 Ibid.
During October 1847, due to her deteriorating health, Mrs Digby was unable to continue her work as Matron. She had been thrown from a horse in 1844 and suffered a head injury with lasting symptoms that later led to allegations she was perpetually intoxicated – a charge which was successfully refuted. Nevertheless, Mrs Price was appointed as Head Nurse, in Mrs Digby’s stead, with a salary of £50 per annum.\textsuperscript{61} Earlier however, when both convict and non convict staff were still employed at the asylum, rules governing their conduct towards patients were issued by Joseph Digby.

3.8: The duties of the keepers.

During 1842, Digby issued a set of rules for the staff, outlining expectations regarding their conduct towards patients and providing a glimpse of their day to day duties and activities:

[The Keepers were] under no circumstances to strike the patients, to use exciting expressions to them, or in any way to ill-use them, but to treat them as afflicted beings, and in a quiet but firm manner, and not to suffer themselves to be irritated by any offensive remarks the patients make towards them, but always to bear in mind that, being insane, they have not the same control over their actions as they themselves have.

In every case of illness, a report to be made immediately to the Surgeon and likewise to the Superintendent.

All Medicines to be duly and regularly administered, and particular attention to be paid to all orders from the Surgeon respecting the Medical Treatment of the Patients, to report the state of the bowels, or any sudden change that may take place in their health, and that the slightest appearance of any sore to be reported to the Surgeon and the Superintendent.

\textsuperscript{61} Bostock, op. cit., pp.108 & 112.
No confinements to be put upon any of the Patients without acquainting the Superintendent, before or immediately afterwards, and no confinements to be taken off without first obtaining his authority.

All patients confined in the chairs to be exercised at least 3 times during the day, and all fatuous and helpless patients to be exercised daily and the calls of nature strictly attended to.

The whole of the Mess Rooms, Sleeping Rooms and Galleries, to be cleaned and in order by 8 o’clock every morning; the Patients to be supplied with plenty of water, soap and clean towels; and all of them to be washed before Breakfast, their hair combed and their heads cleaned.

Breakfast to be served out, at 8 o’clock in the summer time and ½ past 8 in the winter. The Keepers to be present at every meal, to remain there till each meal is finished; and on no account to hurry them over it. The Keepers, male and female, to dine at 1 o’clock and the patients at 2 o’clock. Tea at 6 in the summer and 5 in the winter precisely. All the Patients are to sit at the tables in proper order at their meals.

The Patients are to be put to bed, not before 7 o’clock in the summer, nor before 6 o’clock in the winter. All Clothes, Handkerchiefs and Ligatures of every kind to be put outside the door of each Patient’s sleeping room; and all the doors to be fastened securely. The Chamber Utensils to be scoured every Friday.

Any noise, during the night or day, to be attended to instantly, and the slightest accident to be reported to the Superintendent.

Every Patient to be shaved, on Mondays, Thursdays and Saturdays; and no Patient whatever, under any circumstances, to be allowed to shave himself or any other Patient.

The Airing grounds, Verandahs and Privies to be cleaned every day and the walls to be lime-washed weekly. Each Mess Room to be scrubbed every morning, the Sleeping Rooms on Tuesdays and Fridays and the Galleries and passages, etc. once a week.
In cold weather, good fires must be constantly kept in the Patient’s Mess Rooms. The windows to be cleaned the first Tuesday in every month.

Each Patient to be washed in a bath every Saturday afternoon, in Summer, and once a fortnight, in Winter, and in dirty and debilitated cases as often as required; and their finger and toe nails to be kept in order.

The dirty and wet straw in the cribs to be changed every morning in the Palliasses* when necessary in case of illness, and the inside of the cribs to be washed every morning.

All torn clothes to be taken to the Matron in order to have them repaired, and the Patients must be kept clean and tidy at all times – to have clean linen every Sunday morning and clean sheets once a fortnight.

All tin plates, cups and spoons are to scoured and kept clean and all articles of clothing, furniture, etc. Given into charge of the Keepers shall be mustered the first day of every month and, if destroyed through neglect or want of proper precaution, the value of each Article shall be deducted from their pay.

All Patients on admission to be immediately washed in the Bath from head to foot and have their hair cut short; their bodies to be examined and if there is any appearance of wounds or sores, to report it immediately to the Surgeon and the Superintendent.

No Keepers to shew [sic] the Patients to any person whatsoever without being so ordered by the Superintendent or Surgeon of this Establishment.

All Patients employed inside and outside the walls of the Asylum shall be strictly watched by the Keepers in charge of them and on no pretence to leave them a moment without first putting them under the charge of a responsible person and before returning to their wards their persons to be strictly examined in order that nothing of an injurious nature may be conveyed therein.63

In a letter to the Colonial Secretary in 1846, these Rules and Regulations were acknowledged by Digby as being based on the knowledge and experience he

* Straw mattresses.
gained at St Luke’s Hospital. Digby emphasised and expected asylum keepers to demonstrate kindness and tolerance in their dealings with patients. Also, particular attention is drawn to the personal cleanliness of the patients, their environment and the institution’s equipment. The degree of personal hygiene expected would be unacceptable in modern mental health care settings but was probably equal, if not superior, to that generally accepted by society at the time. Careful attention to the patient’s physical health is demanded and for the first (known) time in Australia, keepers were expected to conduct a physical examination of the patient upon admission and to report their findings; an important nursing activity that continues in modern health care settings.

Also of note is the complete control by Digby, as Superintendent, over the use of mechanical/physical restraint (confinements). They are separate to medical treatment which fell under the purview of the doctor (“surgeon”), although Digby clearly expected to be kept informed of any patient illness, and by implication, any necessary medical intervention/s. Accordingly, there was no expectation that the doctor need be informed of the application (or removal) of restraint. Digby’s use of restraint was minimal – consistent with his previous experience at St Luke’s, however later, it was to contribute to Digby’s downfall.

As Superintendent, Digby was required to deal with a variety of problems and issues. For example, the procedure for admission of patients to the asylum had always been lax, and, as most of the lunatics were convicts, their admission (usually from other convict establishments such as gaols), was simply a transfer with the sanction of the Governor. The number of presentations to the asylum of

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64 Digby to Colonial Secretary, 18 August 1846. Cited in Bostock, ibid, p.66.
65 Bostock, ibid, p.129.
free settlers however, began to increase, and without strict formal procedures, it was inevitable that problems would occur. In this regard, both Governor Gipps and Joseph Digby contributed to revised procedures for admission to the asylum.

3.9: Procedures for admission to the lunatic asylum.

Prior to establishment of the Tarban Creek Asylum, procedures for admission to lunatic asylums were somewhat haphazard and informal. From the earliest days of the colony and until the establishment of the N.S.W. Supreme Court in 1823, the Governors, with their delegated authority under the Prerogativa Regis, were responsible for the proper management of the estates of lunatics and idiots. Instructions for the confinement of pauper lunatics and idiots were never provided and thus, left to the discretion of the Governor. Following establishment of the Supreme Court, the King’s Prerogative was translated to the jurisdiction of the Court (4 George IV c 96), which authorised the Court to appoint guardians for the estates of lunatics and idiots following the process of *writ de lunatico inquirendo* (the determination of a person’s sanity by a jury). For paupers and convicts, the generally accepted method for committal to an asylum occurred through a process of Summary Jurisdiction. Magistrates and Justices of the Peace, especially in country areas, could issue tickets for the confinement of lunatics wandering at large, often brought before the Justices for disturbing the peace. Frequently the person was confined in a gaol, where the prison authorities made arrangements for the lunatic’s transfer to the asylum, thus making the gaols a form of reception house.\(^6\) The authority to transfer lunatics from other Government institutions, to the asylum, was retained by the

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Governor. He could order the admission of a lunatic to the asylum, following an application made through the Colonial Secretary’s office. All discharges from the asylum were entirely at the discretion of the Governor, and would only be granted after the patient had been assessed as recovered by at least two officials, one of whom was usually a doctor. Patients who escaped from the asylum were treated as prisoners and were returned when captured.

With the establishment of Tarban Creek Asylum and the arrival of Joseph and Susannah Digby, Governor Gipps decided to revise the procedure for admission to the asylum. This decision was prompted after an attempt by the Deputy Inspector General of Hospitals, Dr J.W. Thompson, in January 1839, to usurp the Governor’s authority and direct the admission of two patients from Sydney Hospital to the Tarban Creek Asylum. Gipps was adamant, no person was to be admitted to the asylum from a hospital (and presumably a gaol) without an order from the Colonial Secretary.

Concerned about the laxity in medical certification of those sent for admission to the asylum, Digby approached the Governor in June 1839. His representation included evidence of procedures used at St Luke’s Hospital, based on the English Act of 1828 (9 George IV c 41). Gipps promptly ordered:

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67 Before self-government the Colonial Secretary was the most important administrative position in the Legislative Council. As the colony grew, the Colonial Secretary became the Governor’s right-hand man supervising the work of the government with many powers delegated to him. After self-government in 1856, it became the pre-eminent Cabinet position with most N.S.W. Premiers holding the portfolio until the 1930s. See Hawker, G.N., The Parliament of New South Wales 1856-1965. Government Printer, Ultimo, 1971, pp.46-47.
68 Bostock, op. cit., p.57.
69 Ibid, p.59.
70 Ibid, p.49.
Let a letter therefore be addressed to the Principal Medical Officer of the Colony… requesting him to direct the different Medical Officers under his orders not to forward any Patient to the Asylum or make any application to the Government for the admission of a Patient, without sending at the same time a Certificate of their having examined the Patient, and their belief that he is insane.

Let a Notice be published in the Gazette, that no application for the admission of any person to the Lunatic Asylum can be attended to, unless it be accompanied by a Medical Certificate from some Practitioner duly qualified to give evidence in Inquests\(^1\) that the said Practitioner of Medicine has examined the person, and believes him to be insane.\(^2\)

As can be seen, these orders made a medical examination mandatory before a person could be admitted to the asylum. This was a single examination requiring only one doctor and this arrangement appears to have been satisfactory until November 1843.

At about this time, the loss of a civil damages suit for wrongful incarceration by officials of the Tarban Creek Asylum, and the consequent substantial compensation granted by the court to the ex-patient, Charles Hyndman, resulted in a review of legalities involved for admission to the asylum.

### 3.10: The ‘Cabbage Tree Mob’ fiasco.

Captain Charles Robertson Hyndman was a retired Lieutenant of the English Regiment of the 11\(^{th}\) Dragoons, living at the north coast town of Port Macquarie where he had become a prominent citizen. He was involved in the local community and had developed a political profile as a staunch critic of Governor

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\(^1\) An Act to define the qualifications of Medical Witnesses at Coroners Inquests and Inquiries held before Justices of the Peace in the Colony of New South Wales. 2 Vic. No. 22, 1838.

Gipps. He was also known to be somewhat eccentric, often voicing grand plans for the betterment of society. He was apprehended at a Sydney race course for creating a disturbance but refused to pay sureties at the police bench for future good behaviour. He was then removed to the Gaol at Woolloomooloo where he expressed a variety of ideas that suggested he was insane. Hyndman’s claims included: he was the Captain of the Cabbage Tree Mob, a secret force of 7000 men whom he had to restrain from burning Sydney; he frequently stayed in the streets all night to inure himself to hardship which would inevitably follow the approaching rebellion; he had saved Queen Victoria’s life and consequently, he enjoyed an intimate friendship with Prince Albert and Lord Combermere.\textsuperscript{73} Hyndman had also uttered threats of violence towards Governor Gipps. Hyndman was subsequently examined by two medical practitioners who both believed him not only insane but in need of restraint.\textsuperscript{74}

Captain Innes, in his capacity of Visiting Magistrate, went to see Hyndman at the gaol on 9 September 1843 (they were known to each other) and informed him that he carried a warrant for his admission to Tarban Creek Asylum. Hyndman was surprised and sought permission to write to two legal friends, a request that was granted. Later in the day, Hyndman was transported to the asylum without trouble in Captain Innes’ carriage and without a constable as escort. Hyndman’s friends (both magistrates), immediately sought his release but without success. They then set about obtaining his release through a writ of \textit{habeas corpus}, which happened to coincide with his discharge. On admission, Hyndman was seen by Digby and he again expressed a number of ideas involving seditious

\textsuperscript{73} Hyndman v. Innes and Another. \textit{Sydney Morning Herald}, 18 November 1843, pp.2-3.  
\textsuperscript{74} Bostock, op. cit., p.75.
conspiracies, contempt of the Colonial Authorities and a belief that he held some power over the minds of the lower order of the people.\textsuperscript{75}

From all this evidence, it is apparent Hyndman was mentally ill at the time of his Admission, however, he recovered within several weeks and was duly discharged into the care of his friends. Hyndman then sued Captain Innes and Joseph Digby for wrongful imprisonment, employing to represent him Mr Richard Windeyer, prominent barrister and Member of the Legislative Council. Under Windeyer’s careful prosecution, various witnesses bore testimony to Hyndman’s sanity explaining away his foibles as jokes, with one witness actually suggesting the Cabbage Tree plot really existed.\textsuperscript{76} Windeyer used Innes’ kindness, in conveying Hyndman to the asylum in his own carriage, against him, suggesting Innes could not really have thought Hyndman mad especially given that a constable was not required to escort him. Windeyer’s twisting of the facts and clever oratory ultimately convinced the jury (2 assessors), “that due caution and care had not been exercised in order to ascertain the state of the plaintiff’s mind” and awarded Hyndman damages of \textsterling100.\textsuperscript{77}

Ironically, more than twenty years later on March 3 1864, Hyndman was again admitted to Tarban Creek. This time his recovery was slower and he was not discharged until October 15 1866. The Superintendent kept careful notes of this admission, and whilst Hyndman had not been treated for more than twenty years, he had a reputation for causing problems in the community. During his second admission, he again showed evidence of grandiose delusions and persecutory ideation and acted violently towards other patients at times. He believed he was

\textsuperscript{75} Ibid, pp.75-76.
\textsuperscript{76} Hyndman v. Innes and Another. ibid.
\textsuperscript{77} Ibid, p.3.
the Grand Arch of a secret society of which Christ himself was the Head; returning to his earlier beliefs he stated he had the city of Sydney at his mercy in 1842. Hyndman also believed there was a plot, by both the patients and attendants of the asylum, to assassinate him. Later he developed a serious depression, declaring he had sinned against the Holy Ghost. On the description of his symptoms, Hyndman more latterly (in 1979), was given a diagnosis of Affective Psychosis. Importantly, it was Hyndman’s 1843 admission and resultant successful court case, that lead to significant changes to the admission of free persons to the Tarban Creek Asylum.

3.11: Aftermath - the colony’s first Lunacy Act.

Alarmed at the verdict concerning Captain Hyndman, Digby contacted the Governor and expressed his opinion that under the circumstances, he felt he could not admit free patients without two distinct medical certificates, from two doctors who had examined the person separately and apart. Further, he wanted a medical statement of the case and the recommendation of two magistrates. Governor Gipps went further, ordering that no free persons were to be admitted to the asylum until the Legislative Council passed a (hastily drafted) Bill. At the second reading of the Bill, in the Legislative Council on December 8th 1843, a number of objections were raised and amendments made to some of the Bill’s clauses. Mr William Charles Wentworth, supported by Richard Windeyer (Hyndman’s Barrister), were concerned about the possible abuse by the Governor, of his power to remove insane persons to the asylum. Wentworth and Windeyer were also vehemently opposed to provisions within the Bill that

79 Bostock, op.cit., p.78.
indemnified staff against acts already performed in the incarceration of patients in the asylum. Additionally, they expressed concern about the restriction of visitors to the asylum, noting that in Hyndman’s case, his two magistrate friends were turned away by Digby when they called to see him. Wentworth said it was necessary to ensure that such visits were allowed or “the Asylum might be converted into a Bastile (sic) of the very worst kind, and persons who, when confined there were of perfectly sane mind, might be rendered insane by the severity of their treatment.” After some debate, it was decided that a Board of five Official Visitors would be appointed annually by the Governor, with the Legislative Council authorised to appoint two more to that number. On 12 December 1843, the Legislative Council passed the Bill into law; the Dangerous Lunatics Act 1843 (7 Victoria, No. 14):

An Act to make provision for the safe custody of, and prevention of offences by, persons dangerously insane; and for the care and maintenance of persons of unsound mind.

Apart from these issues, the Act laid down procedures for committal of the criminally insane; the Governor could direct their admission to the asylum, upon acquittal, on the grounds of insanity or idiocy. Also, the criminally or dangerously insane were to be kept in strict custody until the Governor’s pleasure be known, or in such place and in such manner as he sees fit. Nevertheless, they were to be given the same liberty (at reasonable times), that they had in prison to consult with legal advisors and see friends.

80 Sydney Morning Herald, 8 December 1843, p.2.
81 Ibid.
The two mechanisms by which non dangerous lunatics (and potential suicides) could be confined, included the certification of two medical practitioners (dual certification continued until the Mental Health Act of 1958), or following an application to a Judge of the Supreme Court by relatives or guardians, accompanied by two medical certificates. In these circumstances, discharge from the asylum was at the Governor’s discretion and would occur following certification, by two medical practitioners, that the person was now of sound mind - the certifications being then transmitted to the Governor’s office. Within the Act, the costs of patients’ maintenance in the asylum were also covered. Convicts (and presumably paupers) were to be supported at the expense of the colony while those who were possessed of the means, were expected to pay for their own maintenance.\(^8^2\)

Passing of the Act by the N.S.W. Legislative Council, resulted in an interesting consequence for Governor Gipps. He was required to send all legislation to Britain for final approval, and in his correspondence to Lord Stanley, Gipps queried the power of the Legislative Council to appoint Official Visitors.\(^8^3\) In reply, Gipps was told in no uncertain terms what he must do:

\[\text{I must take this earliest opportunity of recording the conviction of Her Majesty’s Government that usurpations of this kind by the Legislature of Administrative functions must be firmly opposed. Large experience elsewhere has shown the tendency of such encroachments to multiply themselves, and to mature into a system at once invincible and in the highest degree injurious to the Public Interests.} \]

\[\text{…no greater abuse can exist than that the nomination to Public Employments and other similar Acts should be done by persons, who cannot be called to account either in their individual or their collective capacity for the}\]

\(^8^2\) Dangerous Lunatics Act 1843. 7 Victoria, No. 14.
The New South Wales Legislative Council was created, in 1824, by an Act of the British Parliament. Initially, its membership consisted of no more than seven (wealthy) persons nominated by the Governor. The Council’s role was to act as an advisory body to the Governor but it also served to avert attention from the political reality; New South Wales was governed by a military autocracy. In subsequent years, the council’s number had grown to no less than ten and no more than fifteen members, still nominated by the Governor who continued to hold executive authority. Under an Imperial enactment of 1842, the council again expanded with twelve members nominated by the Crown and, for the first time, twenty-four elected by the people.\textsuperscript{85} The Legislative Council’s insistence on being allowed to appoint two Official Visitors under the Lunatics Act, appears to be the first successful local attempt to be more than a mere advisory body to the Executive Authority of the Governor. If Governor Gipps was not particularly concerned about the implications, then the Home Government certainly was – if the Council was given beginning parliamentary self-determination, more would surely follow. On September 8\textsuperscript{th} 1845, the Legislative Council amended the Act and removed the Council’s prerogative to appoint Official Visitors; the Visitors would be appointed only by the Governor (9 Victoria No. 4). The appointment of

\textsuperscript{86} This was not truly representative government. The elected and electors (no women) were bound by strict rules; to stand for election the man must be possessed of at least £2000 in assets or have an annual income of no less than £100. To be eligible to vote; the elector must have property to the value of at least £200 or occupation of a house to the value no less than £20. See \textit{A Century of Journalism – the Sydney Morning Herald 1831-1931}. John Fairfax & Sons Ltd, Sydney, 1931, p.92. Thus, this was a government, biased on gender and wealth, toward rule by the ruling class.
Official Visitors continued to be made under the auspices of the Governor (albeit with parliamentary recommendation), until the 1990 Mental Health Act, whence they were appointed by the Minister for Health. At the same time as these significant legal events were occurring, however, overcrowding within the asylum was becoming acute.

3.12: Overcrowding - the Governor’s improvised solution.

Joseph and Susannah Digby continued to administer Tarban Creek Asylum enduring the same problems as before: lack of funding, inadequate facilities, poor provisions and what had become gross overcrowding. Overcrowding was an issue from the first day of admissions to the asylum when (as noted previously), Digby was forced to place two patients to a cell because the facility was not fully completed. In the years since, a steady rise in admissions with few discharges, and a government unwilling to build new wards to keep pace with the increase in patient numbers, resulted in severe accommodation difficulties. The asylum was originally built to accommodate 60 patients. In February 1839 there were 89 patients in residence, within a year the number rose to 97; by February 1841 the number had risen to 135.

During 1842, Digby convinced the Governor to roof over two of the airing yards to provide extra accommodation, but Gipps refused to roof over a yard on the female side as he didn’t have the necessary funds and could not see the need. Overcrowding was primarily the result of two factors;

- Following the abolition of transportation in 1839, the next few years saw most of the convict population either emancipated or given a Ticket of

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87 Bostock, op. cit., pp.61-62.
Leave (a form of parole). However, there were many who were aged and infirm, invalid or lunatic and with no means of support, they continued to be maintained in government institutions such as hospitals, benevolent and lunatic asylums.

- Large numbers of free immigrants began to flood into the colony. The colony’s population in 1839 was about 113,400; by 1845 it had risen to almost 188,000, an increase of nearly 75,000 people.† If one accepts that a certain proportion of any population will have or will develop a mental illness, then clearly Tarban Creek’s accommodations were entirely inadequate.

By 1844 the patient population reached 148 and the situation became acute.89

Digby’s incessant representations, however, eventually forced the Governor to address the problem. To deal with the gross overcrowding of Tarban Creek Asylum, Gipps found a simple and cost effective solution. Writing in June 1846 to Gladstone in Britain, Gipps reported:

The Lunatic Asylum of New South Wales is a Colonial Establishment, and the Convicts, who are maintained in it as patients, have hitherto been paid for out of Convict funds. The Asylum, however, became of late so crowded, that it was necessary either to remove the Convicts or add to the Building. The former was considered most advantageous to the Home Government, as the Convict patients so removed can now be maintained at less cost [the males in the Hospital at Liverpool, the females in the Factory at Parramatta] than in the asylum; whereas, when the arrangement for placing the Convicts in the asylum was adopted eight years ago, the Convict buildings were all so crowded that there was no room in them for Lunatics.90

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† N.B. The population statistics did not include Indigenous people whose numbers were unknown.
Gipps went on to report that the Attorney General made minor changes to the Lunacy Act, as some of the lunatic convicts’ sentences had expired and some doubt was raised concerning the legality of removing them. Through this decision, Gipps made Tarban Creek an asylum for free people. The Liverpool Hospital was then still a convict institution, however, by moving female patients to the factory at Parramatta, Gipps found a new role for the former female convict prison. The latter would soon become a lunatic asylum in its own right. The Digbys probably could not derive any great satisfaction from this decision, as by now they were embroiled in a very public controversy orchestrated by members of the colony’s medical profession.
Chapter 4.

The genesis of medical ascendancy over mental health care in New South Wales.

This chapter examines the undermining of Joseph and Susannah Digby’s care of the insane and their administration of the Tarban Creek Asylum. This undermining commenced with public criticisms that were orchestrated by members of the colony’s medical profession, based on innuendo and half-truths, and expressed through the popular press. What is disclosed are the underhanded methods used by an elite professional group (doctors) to achieve medical control and dominance over mental health care.

4.1: The malice of ΙΑΤΡΟΣ.

From early 1846, rumours were circulating through the community of the mistreatment of patients at Tarban Creek Asylum. A former patient (Mrs P.), charged she had been cruelly treated and this aroused public concern. On May 6th an anonymous report sent to the Colonial Secretary, damned the institution for its inefficiencies stating there was poor patient classification, lack of cleanliness, no amusements or employment for patients, lack of proper ventilation and (implied) excessive use of restraint (although the report noted only eight patients were under some form of restraint). The report further alleged;

The ward attendants were not checked when encouraging the patients in their delusions. Even the Matron was guilty of the same misgovernment. As long as this system is pursued, no continued improvement can be expected… A medical man of firmness yet amenity is required to conduct the establishment and induce the attendants to follow a more consistent course.¹

¹ Bostock, op. cit., pp.92-94.
Governor Gipps, whose term of office was soon to expire, referred the matter to the Legislative Council. On May 26th Charles Cowper moved that appointment of a Select Committee be established:

…to enquire into the management and conditions of the Lunatic Asylum, Tarban Creek… and report whether the system therein adopted required modification and how far the buildings are suitable or sufficient for the proper treatment and classification of the inmates.²

Seizing the moment, The Sydney Morning Herald from May 29th, published a series of letters to the editor under the heading of “The Lunacy Bill”. Obviously written by an erudite – if not verbose, and at times pompous medical man (Dr Francis Campbell),³ the correspondent used the non-de-plume “ΙΑΤΡΟΣ” (the Greek word for doctor). ΙΑΤΡΟΣ was probably encouraged by events in Britain, where the medical profession had been making considerable inroads ensuring the medical dominance of mental health care. For example, by 1846, the Lunacy Commissioners, many of whom were doctors, had developed a “steadily growing hostility to non-medically run asylums.”⁴ Further, in a preview of events in Colonial New South Wales;

With the help of elite sponsorship, the asylum doctors were now able to drive competing lay people out of the same line of work, and to subordinate those who stayed in the field to their authority.⁵

ΙΑΤΡΟΣ’s first letter began “GENTLEMEN, - It must fill every philanthropic bosom in the colony with unmingled pleasure to reflect that there is a prospect of some systematic and searching enquiry to be made into the conditions of the

² Ireland, op. cit., p.285.
⁵ Ibid.
Asylum at Tarban Creek, on behalf of the wretched lunatics.” He then praised the Governor for placing the matter before the Legislature. Next articulated a mischievous, veiled and savage attack upon the administration of the asylum, though cleverly, never once directly referring to Digby. The attack was allegorical; referring to the Scottish novelist and surgeon “Smollet” (sic), and noting that his satirical and humorous writings had (in the past) exposed abuse within English institutions (including asylums):

The most flagrant acts of injustice and oppression were perpetrated in those days in perfect security… by every petty tyrant and monopolist who had the pretext of a shadow of power to eclipse his enormities, or a mockery of justice to defend him; representatives of majesty were seldom cited before higher authorities than their own, to give an account of their stewardship, and the sores spread until Smollet arrested their progress by opening the eyes of a drowsy government.

may have seen himself as a new Smollett, opening the eyes of government. Referring to Pinel and Samuel Tuke, then gave a short history of the removal of restraint from the mentally ill, and by citing the British Lunacy Commission of 1844, implied that the use of restraint at Tarban Creek Asylum was abusive and not in keeping with modern asylum methods. then acknowledges that the buildings of Tarban Creek were as good as the circumstances of the colony would allow, but cleverly criticises its management;

…the greatest efforts of the friends of humanity are still wanted to place them in that position which will conduct most to the care of the curable, and the comfort of those in a state of settled dementia.

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6 Sydney Morning Herald, 29 May 1846, p.3.
8 Sydney Morning Herald, 29 May 1846, p.3. 
9 Ibid.
The letter concludes with suggestions for the Legislative Council to contemplate. The most essential; “the chief medical officer should be a magistrate, and should have the whole medical and moral control of the establishment, with a principal superintendent under him, and responsible to him for every act of his office.”

Further, the role and functions of these senior officers should be clear to avoid friction. Additionally, the buildings of the asylum need to be upgraded and lastly, the legislature (and the public) is advised;

…the first object in the confinement of lunatics within the walls of a specific building, is their cure; and the second, when the first is impossible, is their careful, humane, and healthful nursing, almost with the scrupulous attention paid to children.\(^\text{10}\)

It is plain that ΙΑΤΡΟΣ was demanding the asylum be brought under medical control, and that Digby (as principal superintendent) should be responsible to a doctor in everything he did.

The second and very lengthy letter of ΙΑΤΡΟΣ was published on June 2\(^\text{nd}\) and began;

GENTLEMEN, - I repeat here, and if I write fifty letters on the subject, I shall consider it my duty to repeat in every one of them, - that the first object in placing lunatics within the walls of an hospital is their cure; and the second, when the first is impossible, is careful, humane, and healthful nursing,...\(^\text{11}\)

In this preface, ΙΑΤΡΟΣ used the term “hospital” rather than asylum, which inferred a place for the (medical) treatment of the sick. Asylums were merely places of confinement. ΙΑΤΡΟΣ then went on to create the concern and condemnation of the public with half truths and lurid accounts of the abuses and

\(^{10}\) Ibid.
\(^{11}\) Sydney Morning Herald, 2 June 1846, p.3.
atrocities, committed upon the mentally ill, that had occurred in the public and private madhouses of Britain and Ireland and even when patients were privately managed at home. Never once referring to Tarban Creek Asylum, IATROΣ, anticipating a similar outcome from any inquiry or report into that asylum, wove examples of investigations into places of abuse that had exonerated or even praised their proprietors or managers.

This was designed to sow the seeds of doubt should the inquiry into Tarban Creek Asylum not demonstrate abuse, or offer criticism of its management. Once again IATROΣ extols the virtues of Pinel in removing restraints from the mentally ill. This ignored the fact that Pinel removed *chains* from his patients but continued to employ strait waistcoats and other devices to control them. The public were thus reminded that Digby employed restraints at Tarban Creek Asylum. The judicious use of restraints by Digby was not the issue, it was the fact they were used, thus IATROΣ’s reference to them in his examples of abuse, implied that abuse may be occurring at Tarban Creek Asylum.

IATROΣ’s third letter appeared on June 8<sup>th</sup> and was prefaced in a similar vein to his second. IATROΣ discusses the proper (medical) classification of patients. Regarding the stages of madness, he discusses only two; acute mania and chronic “confirmed insanity”. He notes that much is to be made of this distinction “because under ‘energetic and timely treatment’, acute mania of less than 12 months duration is reckoned curable in 70% of cases.” IATROΣ then cleverly refers to St Luke’s Hospital records to support his claim. This was where Digby had come from, could IATROΣ also have some connection with it? He stated that

asylums should have separate buildings to cater for various types of patients, and especially noted that those recently admitted should be housed away from longer term patients (they were the most likely to be curable). ΙΑΤΡΟΣ also suggests asylums should be no larger than 100 beds (and in his final remarks):

…one hundred being the utmost that one superintendent can manage with any hope of success – and two superintendents, I mean two with undefined functions, and powers, and rank, is an outrage on common sense, and the strongest drawback on good government.\(^{13}\)

ΙΑΤΡΟΣ was clearly stating the asylum should have only one superintendent and he had already made it clear in his first letter, that the superintendent should be a medical man.

In his fourth letter published on June 12\(^{th}\), ΙΑΤΡΟΣ discusses his ideas for the design of the ideal asylum. It should be sited near a source of wholesome fresh water (the supply of fresh water had been an ongoing problem at the Tarban Creek Asylum). He suggests a commanding place with the buildings having large windows without bars, so that patients can take in the views. Windows should be shuttered to allow for the darkening of the apartments, but also to prevent moonlight from entering “…as the mischief they occasion is extremely injurious in some forms and stages of mania.” ΙΑΤΡΟΣ later goes on to state, “this caution is not founded on the superstitious and absurd motion (sic - notion?) of lunar influence inducing or aggravating the disorder,” and says he has “solid reasons, not necessary to discuss here.”\(^{14}\) The buildings should be crescent shaped and arranged back to back so that the noises of clamorous patients would

\(^{13}\) Sydney Morning Herald, 8 June 1846, p.1.
\(^{14}\) Sydney Morning Herald, 12 June 1846, p.3.
be directed away from the institution. He wants large rooms painted in a colour to suit the type of patients to occupy them, as well as attention paid to ventilation and central heating for the winter months. ΙΑΤΡΟΣ finishes by stating the perimeter walls of the institution should not be of stone but rather open timber palisades; “It will remove the appearance, and consequently the suspicion, of imprisonment, and every notion of restraint…”

In this letter, ΙΑΤΡΟΣ did not hint at criticism of Digby (except perhaps to gently remind the public of Tarban Creek’s use of restraint). He notes the ancient idea of the moon’s influence over the behaviour of the mentally ill is absurd – but also suggests there is some reason to be concerned, without elucidating why. Perhaps he wasn’t sure himself? Many of the practical ideas contained within this letter were feasible and affordable, and have much to recommend them; it seems that ΙΑΤΡΟΣ had made something of a study of good institutional design.

ΙΑΤΡΟΣ’s extremely lengthy fifth letter, published June 15th, completely departs from his previous four. Instead of veiled criticisms or practical ideas, he presents a fanciful paradise or Garden of Eden for lunatics. “I would erect a little Republic after the model of the Elysium of Homer and Virgil, but furnished with the tangible elements of a terrene paradise.” He describes a spiritual therapy to impress upon the minds of the patients, the principles of order, reason, beauty and peace. This would require “beautiful and correct models of works of art, towers, temples and palaces, perfect and in ruins; landscapes of varied views… gardens and farms in all states of cultivation.” He believed this would “…pour

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15 Ibid.
16 Sydney Morning Herald, 15 June 1846, p.3.
its calming and peaceful influence over the troubled minds of the insane.” Later he remarked,

Let no one think lightly of these views. Let no one imagine that my republic is a mere Utopia… The time will come when the cure, not the imprisonment, of the maniac, even here in New South Wales, will be the policy of the statesman and the duty of the physician…

ΙΑΤΡΟΣ’s extravagant portrayal of his “republic” for lunatics, appears to be the description of a grand estate of the English upper class. These estates were (and are) the very antithesis of the harsh Australian landscape and may have struck a chord in a public that still saw itself as essentially British. The landscape elements he describes were utilised by the famous 18th century landscape designer, Lancelot (Capability) Brown. Perhaps ΙΑΤΡΟΣ was familiar with Brown’s work; he was the designer of the gardens of Blenheim Palace, the Kew and Stowe Gardens and Warwick Castle. ΙΑΤΡΟΣ had already made clear that the head of the asylum should be a doctor, and perhaps he fantasized that the (medical) superintendent represented some sort of squire of a grand estate, who could govern those under him in the manner of a benevolent English gentleman.

The sixth letter of ΙΑΤΡΟΣ was published on June 17th 1846. Perhaps sensing the public were not as concerned as he hoped (there were no published letters by others expressing concern about the asylum’s management), or that his criticisms had become excessive, ΙΑΤΡΟΣ prefaced his last composition with;

GENTLEMEN, I have exceeded the limits I had originally prescribed to this subject. When I commenced these letters my purpose was to make only a few unconnected remarks on one or two important topics relating to the maladministration of Lunatic Hospitals in

17 Ibid.
general, in order to rouse the sympathy and call the attention of your readers to a subject of great and momentous interest to the whole community, involving, as it does, all that is most precious and ennobling in human nature. I knew that enquiry into the state of the establishment at Tarban Creek was in contemplation…and I knew at the same time that it was just as possible as not, that if professional evidence should not be considered necessary, the very objects of the enquiry might be defeated… the crying evils, so clamant indeed, as to be heard at the gates of Heaven, imploring mercy and reform, might be passed over without sufficient investigation at all. It is thus that abuses are perpetrated.\textsuperscript{19}

IΑΤΡΟΣ goes on to state he did not intend to “impute” blame on the current administrators of Tarban Creek, “the whole evil is to be traced originally and fundamentally to the nature of the institution itself.”\textsuperscript{20}

IΑΤΡΟΣ then discusses the causes of insanity. Prefaced by the following paragraph and demonstrating some of his most flamboyant prose yet, it leaves one wondering about IΑΤΡΟΣ’s own personal demons;

Mania results so frequently from mental molestation that it establishes one of the great facts of our moral condition – that the same fountain from which we drink our purest and sweetest enjoyments may, by the slightest excess, become the source of our bitterest misfortunes: and this most important truth, alas! Is but too often exemplified in the fate of the most exalted and gifted minds… that in those conditions… characterised by a highly excitable sensibility, an over anxious solicitude to fulfil the most sacred duties – the too eager pursuit even of virtue and happiness, may in one moment: make havoc of the highest endowment of our nature. Oftener… this deplorable bereavement originates from baser sources.

Beings of imitation, and slaves to our evil passions, whilst we would seek happiness, …by contently imitating the mere wisdom, or the mere folly of those who have both proceeded us, and who at present surround us – envy, pride, ambition, avarice, and a cohort of vile and

\textsuperscript{19} Sydney Morning Herald, 17 June 1846, p.2. 
\textsuperscript{20} Ibid.
sensual appetites, allure us from the only path which leads with safety to happiness, and persuades us with the voice of syrens [sic] that the surest road to earthly felicity lies through vice, folly, depravity, immoral habits, the gorgeous illusions of wealth, grandeur, falsehood, and all the fiery sacrifices which we burn ...on the altar of Moloch. Add to these a more guiltless race of causes, but as numerous as the leaves of Autumn, which arises from the very nature and necessities of social and civilized life. They adhere to us like shadows: go where we will, they cross our path: they haunt us in our closets, they modify our dreams by night, they gnaw our heartstrings by day: they even violate and embitter the tranquil sweets of home and the sanctity of the domestic hearth.\textsuperscript{21}

ΙΑΤΡΟΣ then clarifies the causes of mania;

- \textit{Constitutional or hereditary taints.}
- \textit{Physical.} “The physical causes most productive of mania, are vicious indulgences generally, and these are by far the most influential and the most frequent.”\textsuperscript{22} Excessive alcohol consumption (particularly in the lower classes); sensuality and immoral habits (especially the \textit{secret vice}, [masturbation] – which led to the lowest form of insanity – dementia); accidents and injuries; and hereditary taint.
- \textit{Moral.} “Among the more immediately exciting of the moral causes, may be reckoned sudden shocks given to the feelings from grief, joy, the unexpected loss or acquisition of fortune, disappointed ambition, long intense and perplexing combinations of thought, the dread of poverty or ruin, and the passion of avarice… which are more or less frequent causes of this melancholy disorder.”\textsuperscript{23}

\textsuperscript{21} Ibid.  
\textsuperscript{22} Ibid.  
\textsuperscript{23} Ibid.
IΑΤΡΟΣ finishes this letter with a dire warning;

...insanity is increasing in alarming proportion; and the chances of recovery decreases rapidly every month that passes without treatment.24

Throughout the weeks of IΑΤΡΟΣ’s public criticisms, observations and fantasies, Digby appears to have maintained a (dignified) silence. Had Digby attempted to comment upon or refute IΑΤΡΟΣ publicly, then the press would have possibly reported it. A public squabble between the two would no doubt have been encouraged. One can only imagine how the Digbys must have felt.

Although the Legislative Council announced an Inquiry into Tarban Creek at the end of May 1846, they were slow to initiate it; the Select Committee having met only once in June. On September 4th, the Editorial of the Sydney Morning Herald questioned the Legislature’s delay, complaining that:

…as long as the Council sat, we thought we had reason to hope that both a minute and comprehensive inquiry would be made into what, according to universal report, appears to be a highly inefficient, disgusting, and irrational system of general treatment of the insane, as at present pursued in that establishment. – Not only did we expect this preliminary step to be taken in the importance of an important public duty, and in the reform of a crying abuse; ...we even hoped… that an actual revolution would have been commenced in the entire policy of this Institution. …the sudden prorogation of the Council, swamped for the time, the anxious hopes of many a philanthropist, and left the friendless maniac to continue mortifying in the endurance of abuse, mismanagement, and suffering. …Most of the harsh and pernicious relics of the mechanical system of curing insanity are said to be had recourse to there, on the most trivial and unnecessary occasions, in all their pristine diabolical details. We are not sure that we may include the actual whip; but we cannot discover what distinction in effect, there is between the application of the lash and a blow of the fist…25

24 Ibid, IΑΤΡΟΣ’s italics.
25 Sydney Morning Herald, 4 September 1846, p.2.
IATΡΟΣ’s work was well done. The Herald’s claim of “universal report” appears to be fictitious – no correspondence by others was published by the newspaper (nor found elsewhere); the newspaper’s claim was based largely on the letters of IATΡΟΣ. There was probably rumour and innuendo fuelling discussion in some quarters of colonial society, but on the whole, widespread outrage and concern simply did not occur. IATΡΟΣ stated in his last letter, that he knew an inquiry into the Tarban Creek Asylum had been initiated, partly the result of a former patient’s claims of abuse and an anonymous report, also claiming abuse and mismanagement, sent to the Colonial Secretary. However, in the absence of any substantive evidence of abuse and mistreatment, and before the Inquiry had taken any substantial evidence, one of the colony’s most influential newspapers had declared Digby’s management of Tarban Creek, and the treatment of its patients, “inefficient, disgusting and irrational;” a place of “crying abuse… mismanagement and suffering.”

The public were left in no doubt that what the asylum needed was IATΡΟΣ, who would cure the curable and ensure that the incurable spent their days in an “asylum paradise.”

Joseph Digby could take no more. He wrote to the new Governor, Sir Charles Augustus Fitzroy, protesting “the gross misstatements, falsehoods and cowardly innuendos… as are stated in the Herald of the 4th inst. – trusting H.E. the Governor will cause immediate enquiry to be made into these charges…”

Fitzroy replied (in effect) that Digby should ignore the newspaper article, he had recently personally visited the asylum and was satisfied with the manner by

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1 “Universal report” is a euphemism for gossip.
26 Ibid.
27 Ibid, op. cit., p.94.
28 Digby to Colonial Secretary, 8 September 1846. Cited in Bostock, ibid, p.98.
which it was conducted. In a classic case of trial by media and despite the inquiry that was to follow, the Digbys’ fate was already sealed.

4.2: The Select Committee on the Lunatic Asylum Tarban Creek 1846.

The Select Committee was composed of seven members of the Legislative Council with Sir Charles Cowper appointed as Chairman. Committee members were all prominent citizens in colonial society; there were two wealthy pastoralists, a solicitor, the Colonial Secretary (Sir Edward Deas Thompson), a gentleman of independent means, a banker and Dr William Bland. Bland (noted in chapter 2), had been transported to New South Wales after killing an opponent in a duel. He was the first resident medical officer appointed to the Castle Hill Asylum in 1814. There had been antagonism between Bland and that asylum’s non-medical superintendent, which was only alleviated after Bland received a pardon, in 1815, and left to set up his own private medical practice in Sydney. He was now one of the wealthy elite of the colony.

The Select Committee first convened on June 1st 1846 and had taken some evidence. However, they had not met again for three months prompting the Sydney Morning Herald’s Editorial comments of September 4th. Stung into action, the Committee reconvened on September 10th and over six days during September and October, examined ten witnesses. Of these, five were doctors – it was inevitable therefore, that the Select Committee’s findings would be heavily medically biased.

Ibid.

The first witness examined (June 1st) was the Visiting Magistrate, Captain Joseph Long Innes. He was questioned as to his role and duties, upon which he produced a letter from the Colonial Secretary which stated, the Visiting Magistrates “will have no power to interfere in the treatment of patients, but should report anything of doubtful propriety, countersign all requisitions and estimates, and examine all accounts.”

Regarding the asylum, Innes reported it was very overcrowded with 146 patients accommodated in a building intended for 80 with further increases anticipated. He also felt a second asylum was needed which could take the chronic or incurable cases. He stated conditions within the asylum were reasonable, commenting that patients’ diets were excellent, and the place was remarkably clean, considering that the patients did most of the cleaning. Concerning the occupation of patients, Innes noted, they could work “whenever they will” and that some books and reading material were supplied – although he felt a proper library would be of benefit to some of the patients. Asked about his views concerning the use of restraints, Innes’ answers were tentative, he indicated that restraint was not excessively used but he felt if more keepers were employed, it could be used even less. Asked for his opinion regarding the curative methods employed at the asylum, Innes was evasive saying he was not competent to give an opinion. Innes was pressed on this point and replied, “I would rather leave that to properly qualified persons – medical men.”

Later, he was asked about the curative effects of restraint, Innes stated, “That is a question for a medical man…” further adding, “from my general experience, I should say these restraints have a tendency to irritate the mind.”

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32 Ibid, p.2.
33 Ibid, p.3.
Innes, when asked his opinion of Mr and Mrs Digby, stated he had every reason to be satisfied with them, he observed, “they are decidedly kind to the patients; over and over again, in my hearing, the Superintendent has given the strictest instruction to the keepers never to use the slightest violence.” Innes further stated, “…those who are capable of judging exhibit the greatest confidence in him.”

This evidence was taken three days after ΙΑΤΡΟΣ’s first letter to the Sydney Morning Herald; ΙΑΤΡΟΣ’s influence upon the Inquiry’s proceedings was not yet fully realised. As publication of the entire series of ΙΑΤΡΟΣ’s letters, and the Herald’s subsequent damning editorial had not occurred by the first day of the Inquiry, Innes was probably at a disadvantage. As the first witness, he was probably not aware of what subsequent witnesses would say, especially if their testimony, and indeed the foci of the Select Committee, was influenced by ΙΑΤΡΟΣ’s criticisms. For the Digbys, perhaps the most damaging part of Innes’ testimony involved his evasion of questions associated with treatment and restraint at the asylum. Innes stated only properly qualified persons – medical men, could answer the Committee’s questions, thus implying that Digby, as a non-medical person, was not qualified.

Apparently not quite satisfied with Innes’ testimony, the Select Committee recalled him on September 29th. Innes was now more assertive in his views. Questioned about Joseph Digby’s record keeping, Innes informed the Committee no records of the use of restraints were kept. He did note that such records as were kept were freely open to him to inspect on his visits, except Digby’s

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34 Ibid, p.4.
35 Ibid.
personal diary. Innes agreed a “very meagre” amount of information was available and indicated that this aspect of the asylum’s management needed reform. Then, in contrast to his evidence of June 1st, Innes became very critical of Digby and accused him of resenting any interference in the asylum’s management, by the Visiting Magistrate. Further, in a booming echo of Sir William Ellis’s 1838 criticism of Digby’s lack of (medical) qualifications, Innes was asked directly if he believed that a person who was not a doctor, was fit to administer the asylum. Innes tellingly replied,

I have turned the matter over in my mind – have conversed with many persons upon the subject – and I think that the head… ought to be a medical man of high standing and character and one who has made that branch of the profession his particular study.

Regarding the Superintendent (Digby), he should be under a “Governor” of the Asylum (a medical man) “…to act as Steward and his wife as Matron; the Steward should superintend the executive part of the asylum and see that the prescribed treatment was fully carried out.” There should also be a subordinate medical officer to assist the asylum’s Governor, and attend to minor duties that the Governor would not.

Given the turnaround of Joseph Long Innes’ opinions, it is impossible to believe he was uninfluenced by the events which occurred between his two Select Committee interviews. Innes no longer implied Digby was unqualified to administer the asylum, he directly stated it. Clearly Innes was influenced by others, as he acknowledged he had “conversed with many persons upon the

36 Ibid, (Second Session) p.25.
subject.” Who these “many persons” were is unknown, and the Select Committee did not ask; could these “many persons” include members of the medical profession, or even other witnesses?

The second witness to give testimony was Dr William Dawson, the new Deputy Inspector General of Hospitals, and a recently appointed Official Visitor to the asylum. He gave evidence after Captain Innes on June 1st. Dawson was definite in his views; he stated, the head of the establishment must be a medical man, as only a medical man could properly record the symptoms, and appearance, of patients on admission to the asylum. Further, only a medical man could properly record the patient’s progress and their treatment, both physical (restraint) and medical.

Regarding the use of restraints, Dawson believed that the doctor, as head of the asylum, “should not be a common medical man; he should be a good physician, something of a scholar, a man of the world and possessing considerable conversational power and tact, so as to be able to lead the minds of the patients from their diseased trains of thought, to more healthy ones.” Dawson also complained of poor record keeping, which prevented him (thereby excusing him from having to express an opinion to the Select Committee), from discerning the merit of Digby’s treatment and management of the patients. Whilst acknowledging the poor resources and inadequate buildings, Dawson stated his opinion that the asylum was not a curative establishment (because it did not have a doctor at its head), and there were insufficient occupational and recreational diversions for the patients.

38 Ibid, (First Session) p.6.
Dawson was also critical of the system of patient classification which was divided into only four divisions; male, female, more violent and more tractable. Dawson also implied Digby was not as co-operative as he should be with the Official Visitors. In spite of his criticisms, Dawson stated his belief that Digby was a humane man, and mindful of the asylum’s shortcomings, the patients’ diets were good, and the institution was kept scrupulously clean.40 In offering this compliment Dawson implies Digby has his uses - as a servant of the establishment, but not as its chief administrator.

Dawson’s testimony is not surprising. Like his predecessor, Dr J.V. Thompson, Dawson would like to have brought the asylum under his control. Thompson failed in his attempt during 1839, but succeeded in having a resident medical officer appointed (none had been appointed to an asylum since the dismissal of Parmeter from Castle Hill twenty years earlier). Dawson, if successful in having a doctor placed in charge of the asylum, might reasonably expect the asylum to come under his purview, as the Deputy Inspector of Hospitals, and Head of the Colonial Medical Service. He must have been disappointed when the latter was not realised – the administration of mental health care remained outside the Colonial Medical Service (and its subsequent manifestations), until its tentative and progressive amalgamation with Department of Health, in the early 1960s.41

On September 16th and 18th, Joseph Thomas Digby gave evidence to the Select Committee. Digby was the first person to give evidence following the full publication of ΙΑΤΡΟΣ’s correspondence, and the damning editorial of the

40 Ibid, pp.5-6.
Sydney Morning Herald. Questioned regarding the use of restraint, Digby explained it was seldom used except for short periods, for violent or suicidal patients. Digby then showed the Committee “a strong leather belt, with a handcuff attached to it on each side, covered with soft leather” and stated, “I scarcely use any other than this.”

Digby was questioned about the complaints of the former patient (identified previously as “Mrs P.”). Digby stated that during her admission he was unaware of any complaints, either from her or her relatives. He told the Committee, far from expressing any concern about Mrs P’s treatment, her husband and brother-in-law had given him and Mrs Digby small presents for their attention and kindness towards Mrs P.

Questioned about his authority verses that of the medical officer of the asylum, Digby was clear; he did not feel bound to be guided by the medical man in the general moral management of the asylum, although he deferred to the doctor in matters concerning the medical treatment of patients and special diets. He said that they generally acted together “…he has to attend to the medical, I to the moral treatment of the patients.” Digby was forced to acknowledge he never received formal instructions on exactly how to manage the asylum, the implication being, he took charge and presumed his authority over the doctor. Questioned about his role, Digby told the Select Committee he had daily supervision of the patients and staff, in consultation with the medical officer. He also held full responsibility for the moral treatment of the patients as he

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42 Evidence, (Second Session) op. cit., p.10.
43 Ibid, p.15.
possessed “better knowledge of the party.””\textsuperscript{45} Digby denied the doctor should examine patients on admission, “unless they were reported to have any sores or bruises, and then for my own security he is brought to examine them.”\textsuperscript{46} As noted earlier, Digby gave responsibility for the examination of patients on admission, to the keepers (and nurses); any anomalies were to be reported to both Digby and the doctor.

Digby informed the Select Committee that he was responsible for classifying the patients, without consultation with the doctor, and he was later to say that classification wasn’t difficult “after seventeen years of experience.”\textsuperscript{47} The Select Committee continued to question Digby on the doctor’s role: Digby made it clear that the medical officer was “responsible… only for the proper discharge of his medical duties,” adding that the doctor’s duties were drawn up by former Governor, Sir George Gipps.\textsuperscript{48} Digby told the Committee, “neither is of liberty to give directions to the other,” except when it involved medical treatment, and when this occurred, Digby felt “…bound to attend to such orders.”\textsuperscript{49} When pointedly asked by Committee member, Dr William Bland (whose previous difficulties with the non-medical Superintendent of the Castle Hill Asylum made his Committee position questionable), “You do not view insanity as being a malady to be treated by medicine?” Digby replied “Not by medicine entirely, but by a judicial combination of medical and moral treatment.”\textsuperscript{50}

\begin{footnotesize}
\textsuperscript{45} Ibid.
\textsuperscript{46} Ibid, p.10.
\textsuperscript{47} Ibid.
\textsuperscript{48} Ibid, p.12.
\textsuperscript{49} Ibid.
\textsuperscript{50} Ibid.
\end{footnotesize}
In response to questioning about the facilities of the asylum, Digby reported the establishment really only had the capacity for 100 patients, and suggested extensions were necessary to accommodate 100 more. If enlarged, the patients could be classified into four classes; “quiet, convalescent, idiotic and dirty, and refractory, both on the male and female side.” Poor drainage was a problem, but Digby informed the Select Committee that £700 had been allocated to undertake remedial works. Digby noted he had problems with the general maintenance of the asylum, as only a few patients were willing to work, and these patients had done most of the jobs necessary to keep the asylum in repair. Apart from jobs to occupy patients, other diversions included fishing, boating and reading, with Digby stating that a library of two or three hundred light and amusing works would be desirable.

Digby was also questioned about the duties of his wife in her role as Matron of the asylum. “Her duties are similar to mine; she goes round the wards every day, generally with the medical officer, and attends to the comfort and employment of the female patients. She has also management of the household affairs of the establishment.” Unfortunately, Susannah Digby’s physical and mental health was in a “deplorable” state at the time of the Inquiry. This is not surprising, given she had not fully recovered from her accident (the fall from a horse in 1844), compounded by the added stress of the public attacks and scandal initiated by ΙΑΤΡΟΣ. Visiting Magistrate, Captain Innes, in a letter to the Colonial Secretary, reported on her condition and it was expected that “in a reasonable period (she would) be able to re-assume (sic) her duties as Matron.”

51 Ibid.
52 Ibid, pp.11-12.
53 Ibid, p.11.
Dr Thomas Lee was examined by the Select Committee on October 25th. Dr Lee was the asylum’s resident medical officer, appointed in September 1840 following the death of the first medical officer, Dr McLean. Asked about his working relationship with Digby, he informed the Committee he was “told by the Colonial Secretary to keep on good terms with Mr Digby.” His role included; “Physician, Surgeon, Apothecary and Dispenser.” Lee claimed his work was double that of McLean because of the increase in patient numbers. He was given no assistant and in England and Ireland, such a range of duties would not be expected of one man. His daily routine included; seeing to every patient, providing medicines as required, and attending to any medical needs. He undertook a daily round of the asylum with Mr Digby, but had no share in the moral management of the asylum. This responsibility, he reported, was entirely Mr Digby’s. The Select Committee asked, “Your treatment is for the bodies of the patients, and not for the minds?” Lee responded, “Not for their minds, except so far as the bodily ailments of the patients affect their minds.”

Lee was also questioned about his record keeping; he told the Select Committee that whilst scanty due to his workload, he fulfilled all the requirements expected of him by the Government. Nevertheless, Lee was forced to confirm that the only records required by the Government were the reports and returns sent in by Digby. Lee, in support of his limited record keeping, referred to his medical work at institutions in Ireland, “In neither of these institutions have I been required to keep a detailed account of the cases which had come under my care.”

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54 Ibid, Innes to Colonial Secretary, 12 September 1846, Appendix to Report (preceding Minutes of Evidence).
55 Ibid, p.16.
56 Ibid, p.17.
Dr Lee was also questioned on the fitness of the asylum staff (which was in transition to being fully staffed by non-convicts). Asked if the “habits and manner of the nurses … afford grounds for the assertion … that their treatment of patients is not only coarse, but cruel and inhuman,” Dr Lee replied;

> It is my opinion that it is not true generally; there may be probably a single blow or push given by some of those ruffians who came to us from Norfolk Island to be keepers; in fact we ourselves were hardly safe with them. Until lately, we had no under keepers or nurses who were not convicts, some of them doubly convicted.\(^{58}\)

Lee reported that recently, two free under keepers had been employed and the situation had improved. He further told the Select Committee, that the keeper’s salaries were insufficient as “the duties are extremely disagreeable as well as hazardous, as they have to take away all the filth from the beds, and, I have seen them sick for forty-eight hours in consequence; therefore the reward should be considerable.”\(^{59}\) Asked if it would be better if a “very inferior person” might be employed at a cheaper rate to deal with the “menial work” and if an increase in the number of keepers would be an “advantage” to the asylum. Lee replied, “I think so.” However, he also advised the Committee that;

> The keepers require to be persons of great prudence, mildness, and sobriety, and they should be strong, as when a patient sees himself surrounded by several strong, muscular men, he is frequently overawed, and will not be so violent as when he sees only a single keeper not so strong.\(^{60}\)

\(^{57}\) Ibid, p.16.  
\(^{58}\) Ibid, p.20.  
\(^{59}\) Ibid.  
\(^{60}\) Ibid.
Dr Lee and Joseph Digby were the only employees of the asylum to be examined by the Select Committee. Clearly he felt overworked, which gave him something of a reason (apart from it never being required by the Government), for not keeping detailed case notes on the patients. His defence of the keepers and nurses was admirable and creditable, perhaps he saw them as his colleagues in the work they were all employed to do. In defending them, he reinforced the need to employ free persons as keepers and to do away with the remnants of convict labour at the asylum, upon whom he laid the blame for any perceived blemish on the keeper’s and nurse’s work.

If one of the outcomes of the Inquiry had been (as suspected), predetermined in favour of a doctor as head of the asylum, it might be expected that the Committee would press Dr Lee for his opinion on the matter (which they did not). As resident medical officer of the asylum, it would be reasonable to expect Lee would gain the most from Digby’s removal. It appears Dr Lee was not party to any possible secret machinations or perhaps he was seen as too close, or too supportive, of Digby. Further, it is probable Lee was not the doctor wanted as head of the asylum. This is borne out by the testimony of a later (non-medical) witness, who, when asked if Lee was fit to take charge of the asylum, indicated he didn’t wish to express an opinion as “he [Lee] is a very old man.”\footnote{Ibid, p.29.} This unflattering non opinion put paid to any thoughts that Lee could run the asylum. None of the medical men called to testify before the Select Committee, were asked for their opinion of Lee’s competence to administer the asylum – the doctors were not required, it seems, to criticise their own.
Reverend George Turner - Official Visitor and local Anglican Clergyman to the asylum, gave testimony to the Select Committee on September 29th. The Select Committee’s pre-occupation concerning Digby as the medically unqualified Superintendent of the asylum, and its apparent presumption that a doctor should be in-charge, now became more obvious. Rev. Turner was asked;

What is the result of your observation in reference to the system of placing the Institution under the superintendence of a non-professional man and placing a medical man in the institution merely as a medical attendant - Do you or do you not think it would be better for the Institution to be under the direction and control of a medical man?

Turner responded by saying he felt unqualified to give an opinion, however, he could express the opinion of the Lunacy Commissioners in Ireland: “…it is not desirable that medical men should be Superintendents.”

Turner’s response was in marked contrast to other witnesses (before and following his examination). The Select Committee were not happy with Turner’s answer and continued to press him on the matter, telling Turner eminent professional men had advocated putting medical men at the head of asylums. Turner was undeterred, he again confessed to be unqualified to judge but added, “[it did not] necessarily follow because a gentleman may be a medical man, that he is also acquainted with diseases of the mind.” The Select Committee reworked the question a further eight times, and probably to their chagrin, Turner remained constant in his opinions, for example,

“…there are many afflictions of the mind, in fact, the majority of them which do not require the assistance of a medical man daily.” [and], “…insanity itself comes under the cognisance of the

63 Ibid.
superintendent, who in treating the disease of the mind combined with the medical man who treats the disease of the body."  

Regarding diseases of the body which also affected the mind, Turner stated, “If the medical man discovered such disease, he should treat the patient, having satisfied the Superintendent of the disease.” Further, Turner said, “I think medical men are, in many cases, less qualified to treat diseases of the mind than others; their whole studies have been directed to physical and bodily disease, not mental.”

Evidently, Rev. Turner was not supportive of the appointment of a Medical Superintendent, nor could he be pressured into changing his opinion. Turner’s reference to the Irish Lunacy Commissioners, demonstrates he possessed some knowledge regarding the treatment and care of the insane. Whether or not Turner had become acquainted with the subject in preparation for the Inquiry is unknown. Turner, irking the Committee with his resistance to their pressure, added to it by enthusiastically praising the Digbys’ management of the asylum. He told the Committee the Digbys were attentive to their duties, “much excessive kindness on the part of the keepers, and great forbearance is observed.” Further, “I can only wonder that the establishment is so well conducted.” That Turner was a supporter and friend of Digby cannot be denied. In fact, later when another controversy erupted (after the inevitable appointment of a Medical Superintendent over the asylum occurred), Turner and Digby were accused of colluding, to make trouble for the Medical Superintendent.

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64 Ibid.
68 Bostock, op. cit., p.124.
On October 1st 1846, three witnesses appeared before the Select Committee in comparatively quick succession. Mr Hutchinson Hothersall Browne; – the first Visiting Magistrate appointed to Tarban Creek Asylum (Captain Innes’ predecessor), was the witness who implied Dr Lee was too old to administer the asylum. With Browne, the Select Committee’s now familiar preoccupation with the need to appoint a doctor as Superintendent of the asylum, was reinforced. Asked to provide his opinion regarding having Digby in-charge over a medical man, Browne was unequivocal, “I should say it was detrimental to the advantages that might be derived from incarcerating people in that place for the purpose of their recovery.”

Browne added, “Tarban Creek under proper superintendence would be an excellent asylum.” He also stated that Digby understood the asylum treatment of lunatics but, “I think under a good medical officer, you could not appoint a better man … a man of Digby’s standing should be, “under the Superintendence of a doctor.”

Asked if Digby should be looked after, Browne said, “I think having been left so many years to himself, he fancied himself supreme.” Asked whether, if the institution was under a medical man, it would be necessary to pay the Superintendent and Matron so highly? Browne was blunt, “(there was) no necessity to give the present salary.” Interestingly, Browne admitted to conflict between himself, as the asylum’s first Visiting Magistrate, and Digby, who had questioned his official functions. Browne believed he should make reports on his observations and listen to patient complaints (indicating he heard many of unkind treatment on the part of the keepers), but he found it “extremely difficult to

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69 Report of the Select Committee on the Lunatic Asylum Tarban Creek, op. cit., (Evidence), p.27.
71 Ibid, pp.28-29.
obtain correct information.”⁷² Here, Browne was suggesting things were being kept from him (thus, he couldn’t prove abuse).

Browne clearly thought Digby had risen well above his proper station in life. The Digbys’ salaries were quite high for the time as at their appointment, Governor Bourke (as noted previously), did not want them to become “discontented and induced to leave their employment for more profitable occupation.” In his testimony, Browne articulated a possible course of events which might have solved a potential problem. How to get rid of Digby in a relatively clean manner. There was no evidence presented to the Select Committee which could have provided a reason for Digby’s dismissal. If Digby were placed under the supervision of a doctor however, and also had his income reduced, Digby might well become discontented, resign his position and quietly go away.

The next to give evidence was Dr Arthur Savage; – Royal Navy Surgeon, Health Officer for the Port of Sydney, and one time unpaid visitor to the asylum. Dr Savage’s response to the Select Committee’s ubiquitous question of who should be in charge of the asylum, elicited a predictable answer. “A medical man of first rate talent, ought to be place at the head of the establishment, with first rate salary and appliances; one who has made this branch of disease his particular study.”⁷³ Savage believed a medical man would treat cases of insanity more thoroughly than a non-medical man, and he suggested the first rate salary should be in the order of £600 – 700 per annum (more than twice the Digbys’ combined salary). Savage also believed the Medical Superintendent should have an

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⁷³ Ibid, p.29.
assistant medical officer under him, to undertake the more menial medical tasks
such as dispensing medications.\textsuperscript{74} Savage was not only suggesting that a very
highly paid doctor be placed in charge, but that this doctor should not even have
to do the work then currently undertaken by the asylum’s resident medical
officer. As for Joseph Digby’s role under a medical man, Savage replied, “(he
should be)...a sort of head overseer.”\textsuperscript{75}

Savage was much less concerned about the keeping of medical records, “I think
it is very convenient for a man to dot it down, though a very extensive practice
might be carried on without it.”\textsuperscript{76} Savage’s response is curious, other witnesses
viewed the asylum’s record keeping as inadequate, and even though what was
officially expected was done - it was a convenient criticism of the Digbys’
management of the asylum. Perhaps Savage was not as attentive as he might
have been to the record keeping requirements of his own position, as a doctor in
Government employment. In this regard, a public statement by Savage insistent
on the proper keeping of medical records at the asylum might have attracted
criticism of his own laxity; the facts of this matter remain unknown.

Mortimer William Lewis, the Colonial Architect, was the third witness to appear
on October 1\textsuperscript{st}. He was largely questioned about the design and facilities of the
asylum. Lewis noted that the design was based on the asylum at Dundee
(Scotland), “being the most simple, and affording the greatest accommodation in
airy grounds, and the best inspection in a small compass” (that is, it was easy to
keep an eye on the patients).\textsuperscript{77} Lewis told the Select Committee he originally

\begin{itemize}
  \item \textsuperscript{74} Ibid, p.30.
  \item \textsuperscript{75} Ibid, p.29.
  \item \textsuperscript{76} Ibid, pp.29-30.
  \item \textsuperscript{77} Ibid, p.30.
\end{itemize}
designed the asylum to accommodate sixty patients in cells, and those of a superior class on the upper floor of the main building.\footnote{Ibid.} Lewis acknowledged complaints that the asylum was overcrowded, but downplayed insufficient room in the sleeping arrangements as, “a deficiency.”\footnote{Ibid.} Implying that overcrowding could be resolved, Lewis noted that the addition of a third floor to the buildings would double the accommodation the asylum was originally designed for.\footnote{Ibid, p.31.} In this statement, Lewis was not entirely honest. As Lewis stated, the asylum was designed to accommodate sixty patients, double that equals 120; however, at the time of the Inquiry the asylum already accommodated 135 patients.\footnote{This observation was made by Curry, who further states, the lack of proper consultation between hospital (Government) architects, with those who provide patient care, has been a continuing problem until the present day. See Curry, G. \textit{The Select Committee on the Lunatic Asylum Tarban Creek, 1846: The Medicalisation of Mental Nursing in New South Wales}. M.A. Thesis, University of Sydney, Department of History, 1989, pp.70-71.} Under further questioning, Lewis conceded the number of patients accommodated in the asylum exceeded the sleeping accommodation, but he thought, “…the men’s rooms and yards are ample enough, if no further classification (that is; greater separation of different types of patients) be required.”\footnote{Report of the Select Committee on the Lunatic Asylum Tarban Creek, op. cit., (Evidence), p.31.} This may have been true at the time, as in 1841, as previously noted, Governor Gipps permitted the roofing over of two of the men’s yards.

The last two witnesses testified before the Select Committee on October 14\textsuperscript{th}. First to give evidence was Dr Patrick Hill; - Royal Navy Surgeon In-Charge of the Hospital at Parramatta, and the Female Factory - now housing invalid and lunatic convict women (he was also the former visiting medical officer to the Liverpool Asylum). Dr Hill was asked to report on the state of those patients who had recently been transferred from Tarban Creek to the Female Factory. He told...
the Committee he had received twenty one patients so far; there was no evidence of abuse, and they were all in “good, robust, bodily health.” Questioned on their mental state, Hill observed, they were all incurable, “in a state of idiocy or fatuity.” He recalled that some of the patients had formerly been confined and under his medical care, at the Liverpool Asylum, and some had been confined at the Castle Hill Asylum before that. The Committee were interested in Hill’s opinion on whether or not those patients, that he had formerly treated, now showed any sign of improvement. Hill replied, “No, they are just the same now as they were when they were at Liverpool.” On questioning, Hill told the Committee that some of the patients had arrived from Tarban Creek Asylum under “mild restraint”, and some still required restraint “to prevent their doing mischief to themselves or the other patients.” Hill believed restraint should be used as little as possible. Asked if he thought restraint was appropriately used at Tarban Creek Asylum, Hill said he had only visited it once and very few patients were under restraint; “I think… not above two.” However, he did note the very overcrowded conditions of the establishment.

Curiously, Dr Hill was not asked to give an opinion on whether or not a medical man should be put in charge of the asylum, nor did he offer one. As the former Visiting Medical Officer to the Liverpool Asylum, perhaps his views were known. No evidence has been found to suggest he had any complaints about his previous role and position; Hill never appeared to want more than he had. As noted in chapter 3, however, Hill was quite consumed in his pastoral interests,
and cheese making. Of note, the questioning of Hill about any improvement in patients during their time at Tarban Creek Asylum, and his answer that there was none, may have weighed against the Digbys’ management and treatment. For instance, might medical treatment have produced better results?

The last witness to be called by the Select Committee was Dr James Eckford; Colonial Surgeon In-Charge of the Liverpool Hospital. On the question of whether or not a doctor should be in charge of the asylum, Eckford claimed patients frequently suffer an organic disease which may be the remote cause of their insanity – “the proximate cause being some exciting passion of the mind.”

Eckford believed a medical man should be in charge as only he would be “acquainted with the remote causes of insanity, which may arise from an organic disease of the brain, liver, or heart.” To support this contention, and as proof that a doctor should head the asylum, Eckford informed the Select Committee that he had conducted post mortems on lunatics;

I have opened every insane person who has died under my charge, and I have never found a case where there has not been organic disease either of the brain, heart or liver, affecting in a great measure the blood vessels of the brain, which clearly shews (sic) that a medical man should be in charge of lunatics.

In relation to a medical man being in charge of an asylum, Eckford further claimed;

It is usual at Home, and I would prefer it; my reason is this, that the man who is totally unacquainted with the remote causes of insanity, …might, when a man is violent, become alarmed, …keep him under restraint when it was not necessary; but the medical man who would know that the patient was labouring under organic disease, would only impose slight restraint for a short period, and when …alleviated by the remedies employed, he would be liberated.

87 Ibid, p.34.  
88 Ibid.  
89 Ibid. p.35.  
90 Ibid.
Underlining this statement, Eckford said, “A medical man would do by medicine which a non medical man would do by restraint.” Eckford was asked if he ever utilised restraint and he replied,

“Only to prevent onanism [masturbation] at night – if a man is plethoric and violent I have recourse to bloodletting and other remedies to reduce his full habit of body, and I find he soon becomes a different man.”

Eckford further told the Committee that when Digby first arrived in the colony, he had shown Eckford a number of manacles he brought with him from St Luke’s Hospital (presumably the apparatus Digby had shown the Committee during his evidence). Eckford told Digby he could not see much use for them, as patients at Liverpool, “when they had been very violent, we had chained them to a log by the ankle, or imposed some slight restraint upon them.” Eckford told the Committee that his method of medical treatment, with the help of a clergyman during intervals when the patients were lucid, “would tend much to their recovery.” He claimed several of the patients (male convicts), sent to him from Tarban Creek, would soon be ready for discharge. Under him, “they are becoming more sane, and their acts more rational.” Dr Eckford also complained that the lack of proper case notes from the Tarban Creek Asylum, made it difficult to properly treat the patients transferred to him – presumably a case history allowed Eckford the opportunity to diagnose the organic cause of the patient’s insanity more quickly than his own observations. Asked if the treatment (he provided) was beyond the ability of a non-medical man, Eckford was

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91 Ibid.
92 Ibid.
93 Ibid.
94 Ibid.
emphatic, “Clearly, and therefore I recommend a medical man [as
superintendent].”95

Eckford’s evidence was noted in the Select Committee’s recommendations,
“Such evidence is, in the opinion of (the) Committee, conclusive that the chief
authority of the Institution should be vested in a duly qualified medical man.”96
Following its Inquiry into the Tarban Creek Asylum, The Select Committee
made seven recommendations.

4.3: The Select Committee’s recommendations.

1: Head of the Institution.

The Select Committee recommended, “It appears… indispensable that the head
of the Institution should be a Medical Man; and they desire to express their
opinion that until a professional man of ability, and experience in the treatment
of insane persons, is placed in charge, the asylum cannot be satisfactorily
conducted as a Sanatory Establishment.”97 The Committee suggested a liberal
salary for the position. They saw no problem in placing a doctor over Mr Digby,
“as the duties of steward or keeper would, to be effectively performed, occupy
the whole of his time.” The Physician in charge was also to be provided with a
Medical Assistant.

It was inevitable that the Select Committee would recommend the appointment
of a Medical Superintendent. The question of the qualifications of the person
who should occupy the most senior position in the asylum was a preoccupation
of the Committee from the beginning – even before the full public exposure of

95 Ibid.
96 Report of the Select Committee on the Lunatic Asylum Tarban Creek, op. cit.,
(Recommendations), p.3.
97 Ibid, p.3.
ΙΑΤΡΟΣ’s letters in the press. To what degree this had been pre-determined is unknown. However, it does seem probable that this question had already been decided before the testimony of the first witness was taken. ΙΑΤΡΟΣ may have been privy to this, and his role may have been to acquaint the public with the benefits of the idea, prior to, and during the Committee’s evidence taking. It could be suggested that the Select Committee’s findings were not based purely on the evidence obtained during the Inquiry; and the heavy bias towards medical witnesses (five of the ten who gave evidence), would seem to confirm this.

2. Keepers and Attendants.

The Committee recommended there should be an increase in the number of keepers and attendants, before a system of non-restraint could be introduced. Moreover, a better class of persons than have been hitherto employed should be placed in these positions.

The Committee’s Report observed, “Rumours unfavourable to the character of the Institution have obtained some currency, founded… upon a belief that the conduct of the keepers and nurses has been occasionally harsh and unfeeling… in some instances not without foundation… [we] yet venture to hope (that in some cases these rumours) are exaggerated, and in others, altogether unfounded.”

The Committee noted the convict staff were being replaced with free persons, which would incur greater costs. The Committee did not however, recommend higher salaries for the keepers and nurses – which had been suggested by Dr Lee in his testimony.

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98 Ibid.
3. *Inspection.*

The Committee believed the mode of official inspection was a failure. They recommended that the English system be adopted, whereby a Board of paid Visitors (or Commissioners) should be appointed. This Board should be Chaired by the Principal Medical Officer of the colony. In this regard, the Government was strongly urged to cause a Bill to be drawn up, for presentation to the Legislative Council, before the next sitting.

The Committee noted that the distance of the Asylum from Sydney had previously created some problems for the Official Visitors. It was also noted that some conflict between Mr Digby and the Visiting Magistrate, about responsibilities and powers of the Visitors, had occurred. The Committee were of the opinion that once a Board of Visitors was properly set up, and its responsibilities legally clarified, then the position of Visiting Magistrate could be dispensed with.


The Committee recommended that besides the clauses of an Act governing the duties of Official Visitors, and the reports required from them, other clauses should require the keeping of books for the public records, viz:-

1. Register of Patients.
2. Medical Register.
3. Case Book.

Commenting on the lack of such records as, “so obviously an irregularity” that the notice of it by the Committee would induce the Government to immediately
require the officers of the asylum, “to commence a system of books and records as herein described.”


The Committee noted that many of their recommendations could not be carried out until the asylum was enlarged. In this regard, the Committee suggested: yards should be enclosed and wings erected, drainage should be improved, better ventilation should be provided in the dormitories, and proper heating in the winter. In addition, more room would be required for the increased number of staff to be accommodated, however (for the present), if a new store was erected outside, the cellars would become available for that purpose. The Committee also noted that accommodation for the better class of patients would not incur any cost, as “the erroneous impression under which the rooms intended for them have been otherwise appropriated will be corrected.”

Overall, the Committee was of the opinion that the buildings at the Tarban Creek Asylum were inadequate as they did not provide for the suitable classification of patients, and as they stood, were not adequate to accommodate the population. Accordingly, the Committee felt an increase in the accommodation was “absolutely required.” The accommodation for staff, in the cellars (for the present), probably seemed appropriate to the Committee; the majority of staff were seen as mere servants. The area intended for the superior class of patients, and described as “otherwise appropriated”, were the apartments of the Digbys. They were expected to find somewhere else in the establishment in which to live.

99 Ibid, p.4.
100 Ibid, p.5.
101 Ibid, p.3.

The Committee noted that funds had already been voted by the Legislative Council, to enclose the grounds for recreational purposes. This would allow convalescent and harmless patients to take exercise under proper surveillance. The Committee also hoped a moderate sum would be made available, to establish a library, so that patients might borrow books under proper supervision.

7. Funds.

The Committee reported that a considerable sum would be required to carry out and complete the recommended changes. Whilst the Committee could not accurately estimate the amount needed, it suggested between £8,000 and £10,000 would be expended over the following three years. The increased annual expenditure, to make the necessary changes in the management of the asylum, was estimated at between £1,000 and £1,500. The Report concluded, “(the Committee) express their earnest hope that the Council will not hesitate to supply the funds, when satisfied that the expenditure is indispensable to provide adequately for the comfort or restoration of this unfortunate class of our fellow beings.”

4.4: Sequela of the Select Committee’s report.

The Report of the Select Committee was tabled in the Legislative Council however, discussion of it was postponed until the next year. On May 12th 1848, the Select Committee’s Chairman, Sir Charles Cowper, moved that the report be sent to Governor Fitzroy. During the debate, it was noted that the Select Committee had found no evidence of cruelty, abuse or maladministration, and

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102 Ibid, p.5.
some members of the Council criticised the Select Committee’s poor treatment of Digby and Dr Lee. The Attorney General was particularly concerned and expressed his view that Digby and Lee had a right to complain of the spirit of the report in regard to them. Cowper retaliated by stating that Lee had shown by his evidence, “so great amount of imbecility, as to prove that he was not qualified to hold any position of responsibility.”

Cowper also said Digby had displayed certain arrogance; his manner suggesting he did not feel he was answerable to the Select Committee. As for Digby’s and Lee’s poor treatment by the Select Committee, Cowper claimed “the officers of the Institution had been treated with the greatest kindness, tenderness and consideration”

On the motion to refer the Select Committee’s Report to the Governor, the Council was divided, and the motion passed by a majority of just one.

The concerns raised regarding the treatment of Digby and Lee, by nearly half the members of the Legislative Council, appears to have unnerved Digby’s antagonists. For instance, in what can only be seen as their official organ, The Sydney Morning Herald, a lengthy editorial appeared a few days later. This editorial utilised a transcript of the Select Committee’s evidence to attack Digby, Lee and Reverend Turner. The editor(s) again rehashed some of the complaints of the Committee, such as poor record keeping, inadequate accommodation and the use of restraints. But they went further, manipulating and twisting the words of Digby, Lee and Turner, with what can only be described as outrageous and libellous comments and interpretations. These were designed in the hope of smothering any sympathy for Digby and Lee that may have been developing in

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103 Sydney Morning Herald, 13 May 1847, pp.2-3.
104 Ibid.
105 Sydney Morning Herald, 18 May 1847, p.5.
public opinion. For example, Digby’s statement concerning the gifts given to him and Mrs Digby, for their good treatment of Mrs P. by her relatives, was reinterpreted as; gifts given in the hope that the Digbys would treat Mrs P. better in the future, than they had in the past.

Regarding the Rev. Turner’s statement, that the keepers demonstrated great forbearance in their dealings with the patients, the editorial sarcastically asked, “But in what respect did the keepers forbear? Did they forbear to strike the patients?” The editorial also openly questioned the qualifications of Digby, the medical competency of Lee, and in effect, dismissed Turner as someone who didn’t know what he was talking about. The editor(s) included in the diatribe, claims that cruelty did exist at Tarban Creek Asylum (despite no such finding by the Select Committee), and concluded with the inevitable call for a doctor to be put in charge as the only remedy for the ills of the establishment.

Digby tried to defend himself, he wrote to the Governor refuting the (most damaging) evidence of Dr Eckford. Digby pointed out that Eckford had only visited the asylum twice, and that he had never shown him any manacles; unless Eckford was referring to the leather restraint belts that were in use (these belts had leather wristlets that restrained the arms of the patient to the waist). Digby further reported that Eckford’s implications that restraint was abused at the asylum, were based on conversations with one of the convict keepers (one of the “ruffians” from Norfolk Island whom Lee had referred to in his evidence), who had been transferred to Liverpool Hospital with the convict patients. Digby then pointedly referred to Eckford’s form of mild restraint which he said he would

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106 Ibid.
107 Ibid.
adopt at Liverpool Hospital; “It was to have a sort of pound built with high
slabs… and when a patient became troublesome, to chain him to a log.” Digby
was now clearly out of favour with the Governor, who in a short reply told
Digby, he felt his remarks to be “extremely unbecoming.”108

Dr Lee also attempted to defend himself, he complained bitterly to the Governor
of his treatment during the Inquiry. He noted that contrary to the complaints of
some witnesses, he kept such records as were required of him by the government.
Referring to H.H. Browne’s statement in evidence, that he did not wish to give
an opinion of Lee’s competence because he was a very old man; Lee averred,
“the answer is that of a person wishing to hurt, yet afraid to strike.” Lee also
accused the Inquiry’s Chairman (Cowper) of prejudice against him, and of using
his influence to prevent Lee from undertaking a review of his evidence.109 It was
of no use - Lee was to be disposed. Later in the year, Lee was informed he was
considered too old to take on the position of Medical Superintendent (he was 74),
and his services were no longer required. Dr Lee did not readily accept this
situation, and in frustration wrote an impassioned letter to Governor Fitzroy,
expressing his disappointment. He further pointed out that he was entitled to a
gratuity for the loss of his position. The Governor was not moved by Lee’s letter,
pointing out that the,

irritable and improper tone in which it is written is quite
sufficient proof of his unfitness for any office requiring
temper, forbearance and discretion… and that, if no other
reason existed, it would fully justify this Government for
removing him from further employment.110

108 Digby to Colonial Secretary (with Governor’s annotation), 11 May 1847. Cited in Bostock, op.
cit., pp.110-111.
109 Lee to Colonial Secretary, 8 May 1847. Cited in Bostock, pp.112-113.
110 Lee to Colonial Secretary, 12 January 1848. Cited in McDonald, p.287.
Like Digby, Dr Lee could not be dismissed for any wrongdoing. The Select Committee Inquiry’s main criticism of him was his lack of record keeping, but he had done all that was expected of him by the Government. His only taint was his age, and Browne’s one crafty statement averring to this, proved his undoing. No doubt under extreme pressure, a very frustrated Lee responded to this particular criticism in perhaps an understandably emotional manner. In doing so, Lee provided a more convenient reason why he should be dismissed.

During this time and until the end of 1847, Joseph Digby continued to superintend the Tarban Creek Asylum. Some of the improvements to the institution, recommended by the Inquiry, were undertaken. Advertisements for tenders to rectify the drainage, improve ventilation in the cells, and enclose the yards appeared in the Government Gazette. The last of the convict keepers were replaced with salaried staff and the number of keepers and nurses were increased. Digby also persuaded Governor Fitzroy to import new “Hydrostatic Beds,” for bedridden patients, from the manufacturer in England. Four beds were ordered at a cost of £13 each.111

4.5: Further trouble for the Digbys.

During August 1847, scandal erupted again at the Tarban Creek Asylum. Elias Hobbs, Principal Turnkey of Darlinghurst Gaol, alleged he found staff intoxicated when delivering insane prisoners to the asylum. In particular, he pointed to the asylum’s clerk (Flemming) and Mrs Digby. To examine Hobb’s claims, a Board of Inquiry was ordered by Governor Fitzroy. Joseph Digby informed the Inquiry that he knew of the clerk’s alcohol consumption, saying the

clerk was in the habit of taking spirits as well as laudanum to relieve his pains (Flemming suffered from severe rheumatism), but he had never known him to be so intoxicated as to prevent him from performing his duties.112 The Board of Inquiry did not accept this explanation, and Flemming was dismissed from service. Regarding Mrs Digby, the Board exonerated her, mainly on the evidence of George Frederic Isaacs. His statement, although helpful to Mrs Digby, was not at all flattering to her:

I have frequently seen Mrs Digby, in the last eight years or nine years; I have always considered her weak of intellect; about three years since she fell from her horse, and her memory has become more defective, and her mind more weak; her appearance has been that, at times, which a stranger might have supposed to have arisen from intoxication, but I have never seen her take anything likely to produce intoxication, and I think from having so often seen her, she could not have been in the habit of drinking, or could not have been otherwise than a sober woman without my knowing it.113

The Board wanted to question Mrs Digby, however, Joseph Digby would not allow it due to his wife’s delicate state of health. Apparently, Mrs Digby’s head injury resulted in a permanent disability, and given the stresses of the previous year (perhaps not surprisingly), Mrs Digby’s health had not improved. Soon after this Inquiry, Mrs Digby resigned her position as Matron (as noted in the previous chapter), and a Head Nurse was appointed to take up most of her duties.

By November 1847, Governor Fitzroy decided to reorganise the Tarban Creek Asylum’s administration. A Medical Superintendent would be appointed, and Digby would be demoted to Steward, under the authority of the Medical Superintendent.

112 Sydney Morning Herald, 30 September 1847, p.2.
113 Ibid.
4.6: The medical profession’s coup d’état.

In the *Government Gazette* of November 26\textsuperscript{th} 1847, an advertisement appeared under the auspices of Dr Dawson, calling for applications for the position of “Medical Superintendent of the Lunatic Asylum.”\textsuperscript{114} The advertisement made clear,

> “It is indispensable that the applicant be a legally qualified Medical Practitioner in New South Wales; that he shall have practised the three branches of the Medical profession, viz, Medicine, Surgery, and Midwifery, during at least, the last five years… It is desirable that he be a married man, above thirty years of age, in sound health, of good moral character, and free from infirmities of temper.”\textsuperscript{115}

The salary was stated to be £400 per annum, with a residence, light, fuel and provisions. “If the candidate have a family, he should state for how many he will require accommodation.” The interviews were to take place on December 13\textsuperscript{th}, and the candidate should be prepared to take up the position on January 1\textsuperscript{st} 1848.

The *Government Gazette* of December 28\textsuperscript{th} 1847 carried the following announcement:

> His Excellency the Governor has been pleased to appoint Francis Campbell, Esq., M.D., to be Superintendent of the Lunatic Asylum at Tarban Creek, to take effect from the 1\textsuperscript{st} of January, 1848.\textsuperscript{116}

Campbell’s appointment was greeted with enthusiastic support in the press. One editorial effusing;

> By, and with, the advice of the Medical Board, Dr F. Campbell has been recommended for the office; and we do not recollect any appointment which has given such universal satisfaction. Mercy, wisdom, and humility will now step in where chains and cruelty so long have exercised their iron sway.\textsuperscript{117}

\textsuperscript{114} *Government Gazette*, 26 November 1847, p.1347.
\textsuperscript{115} Ibid.
\textsuperscript{116} *Government Gazette*, 28 December, 1847, p.1.
\textsuperscript{117} Reform at Tarban Creek. *Heads of the People*, 18 December 1847, p.68.
Again, without any substantive evidence of cruelty and abuse, Digby’s administration was publicly and maliciously defamed. Perhaps it was hoped that Digby would solve the problem of his existence at the asylum, by simply resigning and going away. However, Digby was tenacious; he was not going to give up that which he had worked for so long. Digby continued to hold on, in the face of public and official denigration and humiliation. This particular editorial, with its reference to the Medical Board, provides evidence (if any more were needed), that there existed a conspiratorial collusion between members of the Medical Profession and the popular press - it was published December 18th, ten days before the appointment was officially announced in the Government Gazette; and just five days after interviews for the position of Medical Superintendent of the Lunatic Asylum took place. This article also publicly revealed that Dr Campbell was ΙΑΤΡΟΣ, effusing that he;

> As one of the most learned of our literati, whilst his ability in his profession, and his proverbial kindness and humanity, pre-eminently qualify him for the duties of an office, which, we may observe, has been created through his own means.\footnote{Ibid.}

### 4.7: Dr Francis Campbell takes control.

Francis Campbell (1798 – 1877) was born in Belfast; he studied at Glasgow University (M.A., M.D., 1829) and at Edinburgh (L.R.C.S., 1829). He married Selina Porter, probably in 1829, and fathered at least eleven children. He practised medicine in London before migrating to New South Wales, arriving in September 1839. Campbell then set up a medical practice in Sydney, later moving to Morpeth in the Hunter Valley, to take up a land grant. Apparently not
content (or unable) to make a living as a farmer, he opened a medical practice in Maitland (near Morpeth) during 1842. During 1845, Campbell returned to Sydney, where he again practised medicine, obtaining an honorary position on the medical staff of the Benevolent Asylum. He was also appointed as Physician to the Oddfellows Medical Institute, an appointment he resigned on becoming the Medical Superintendent of Tarban Creek Asylum.\textsuperscript{119}

Taking up his appointment at the asylum on January 1\textsuperscript{st} 1848, Dr Campbell very quickly issued a new set of Regulations. These regulations covered all categories of staff; there were also rules for the patients, and rules for visitors. Campbell’s rules were to remain in force until at least 1863.\textsuperscript{120} In reference to the main care providers of the patients, Campbell does not refer to keepers (males) and nurses (females) in his rules, but rather uses the non-gender term \textit{attendant}. This term was to be utilised to describe both genders of asylum carers of the insane, until the late 19\textsuperscript{th} century (males continued to be referred to as \textit{attendants} until the mid 1950s). Campbell posted sixteen rules for the attendants, and these were significantly different to those issued by Digby in 1842 (noted in chapter3). All of Joseph Digby’s rules were concerned with patient care and comfort and included procedures to be followed in the event of a patient requiring restraint. On the other hand, Campbell’s new rules included some of those issued by Digby (in most cases paraphrased or changed slightly), however, Campbell’s rules began with orders to regulate the movement of staff, the issuing of fines for mistakes and concluded with rules demanding staff obedience to superior officers.

4.8: Regulations for the Guidance of Attendants, 1848.

1. They are to be at all times in the Asylum, and each at the post or duty assigned to him.

2. None shall leave the Asylum without the written permission of the Superintendent or steward, which written permission shall, on the return of each attendant from leave, be deposited with the steward or the clerk, who shall write on it the hour at which it was given to him.

3. The attendants shall call the patients, and shall assist them to rise, and dress, and wash themselves.

4. One attendant in each division shall, at the appointed hours, go to the kitchen for the breakfast, dinner, and supper of the patients.

5. At least one attendant shall be present at every meal hour to divide and distribute the food, and watch over the conduct of the patients during their meals.

6. Such proportion of the attendants as the Superintendent thinks fit shall remain in the Asylum to clean the day-rooms and the mess utensils belonging to their several divisions, and to perform any other necessary duty. The remainder of the attendants shall accompany the patients to the airing or working grounds.

7. Every attendant especially those under whose immediate care for the time the patients are, shall keep a watchful eye over them. It is their duty to prevent violence, and to soothe the temper of such as are likely to be roused. Remembering always that the insane are without reason, the attendant should conduct himself kindly to them, speak mildly, and never in an angry tone; and if he has occasion to interfere, his manner should be gentle and calm, but determined, without hurry.

8. The attendants must never, for any purpose, threaten, swear at, or strike a patient, or of themselves apply restraint of any kind. If it be necessary to overcome a violent refractory patient, the attendant should not attempt it alone, but should ask for assistance; or if the case of emergency should arise, rendering it
necessary for the safety of the patient or others to apply restraint, it must be immediately reported to the Superintendent or the steward.

9. The attendants of each division must observe the patients carefully, so as to report daily to the Superintendent, the state of the appetite, the nature of the excretions, the habits of each patient and any mark they may detect in the person.

10. All patients employed inside and outside the walls of the Asylum must be strictly watched by the attendants in charge of them, and they are on no account to leave them a moment without first putting them under the charge of a responsible person; and before returning to their wards their persons strictly examined, in order that nothing of an injurious nature may be conveyed therein.

11. No attendant or other servant to shew [sic] the patients to any person whatever, without being so ordered by the Superintendent or steward; and no attendant, while on duty in the airing yard of the refractory ward, must leave it, even to go into the mess-room, except in case of emergency.

12. If any patients should escape from the attendants in charge, they will have deducted from their pay not exceeding £1 for the first offence; £2 for the second; and they will be discharged for the third offence. Females 15s. for the first offence; 30s. for the second; and for the third to be discharged.

13. All plates, cups, spoons, &c. to be scoured and kept clean; and all articles of clothing, furniture, &c. given into the charge of the attendants, and shall be mustered on the first day of each month; and if destroyed through negligence, or want of proper precaution, the value of each article shall be deducted from their pay.

14. Each attendant to bring to the steward for inspection, all worn-out articles of clothing and other stores every Saturday forenoon, in order that they may be replaced.

15. The attendants are to be clean and neat in their persons and conduct themselves with regularity and decorum and civility to each other, and in respect to the officers of the Asylum.
16. These instructions are only for the general guidance of the attendants, and not to supersede or prevent their obeying implicitly, and without hesitation, whatever orders or instructions they may receive from the Superintendent and the steward; and though they will be more immediately under the direction and control of the steward, they are to remember that he is carrying into effect the orders and wishes of the Superintendent.\textsuperscript{121}

These regulations were probably posted for show, and were primarily meant to demonstrate Campbell’s complete control of the asylum, including its staff.

Campbell (as ΙΑΤΡΟΣ), had made claims of cruelty and mistreatment of the patients by the staff, and could claim to be addressing the problems by referring to the new rules. Further, it is likely that the majority of the attendants were illiterate, thus the regulations must have been transmitted to the staff verbally.

Whilst on the surface there is much that is creditable; such as, approaching the patients in a civil and kindly manner (implied in rule 8), and maintaining patient privacy (implied in rule 11), there are other expectations which in modern times, necessitate considerable education, training and experience. For example, the expectation attendants soothe the temper of patients who may become violent, and set firm behavioural limits (implied in rule 7). It can also be noted that Campbell, who put himself up as the liberator of the insane from cruel restraint, felt it necessary to include a rule about when restraint could be used, and who could authorise its usage. Perhaps Campbell wanted it known that he, as well as Digby, could authorise the application of restraint (even if it was not to be used).

The draconian nature of Campbell’s regulations cannot pass without comment. The attendants became almost as much prisoners of the asylum as the patients,

\textsuperscript{121} Ibid.
having first to obtain written permission to leave the establishment, and upon
return, having the time recorded. The Superintendent was not just controlling the
attendants’ working time, but also their off duty time. The introduction of fines
against the attendants if a patient absconded, and the expectation that damage to
asylum property would be paid for by levying the attendants wages, were very
harsh financial penalties for what sometimes may have been unavoidable
incidents/accidents, although their imposition implied such incidents/accidents,
were the result of frank negligence on the part of the attendants. This control of
the attendants off duty time, and the fines for (perceived) dereliction of duty,
became features of staff regulations well into the twentieth century (as will be
seen in later chapters).

Another feature of Campbell’s printed regulations is the denigration of Joseph
Digby’s role as Steward. This is implied throughout the text by Campbell’s usage
of the upper case “S”, when referring to his own position “Superintendent,” and
lower case “s” when referring to Digby’s position “steward.” This is in contrast
to later Rules and Regulations where, when reference is made to any senior
officer of the asylum, upper case letters are always used.122 Campbell also firmly
places Digby in a subservient role to himself in Rule 16, where, regarding the
Steward it states, “he is carrying into effect the orders and wishes of the
Superintendent” (implying the steward had no authority to issue orders in his
own right). This was probably part of Campbell’s desire to make clear to the
staff; he was now the master of the establishment. Campbell underscored his
status as master by relieving Digby of all responsibility for the moral

122 Hospital for the Insane Gladesville, *Rules for the Attendants, Nurses, Servants, and Others.*
Government Printer, Sydney, 1885.
management of the patients. Campbell made it known he considered Digby’s role as akin to *servant*, instructing Digby to undertake such duties as; the issuing of rations, cutting of bread and supervising the patients at meal times. Before long, the relationship between the two men deteriorated (awkward from the beginning as Digby was aware his nemesis ΙΑΤΡΟΣ, was Campbell himself), and an air of suspicion, hostility and ill-will developed and festered.\textsuperscript{123}

At the end of 1848, Campbell presented his first Annual Report.\textsuperscript{124} In this report, Campbell glorified his cures. He claimed that the large majority of the 155 patients cared for at the asylum at his appointment, were “chronic cases”, however, he had cured 17, discharged three as improved, and held hopes of cure or improvement for 31 others. From a total of 55 patients admitted during the year, 14 were discharged cured, and another 31 were probably curable. Campbell claimed, in regard to the chronic cases, the percentage of cures would have been better if treated properly at an earlier stage of their disease. Campbell also reported he had completely removed the use of restraints;

\begin{quote}
The revolution commenced with the immediate expulsion of that greatest disgrace of the exploded system, those ready engines of conquest, cruelty and terror, the Coercion Chairs, Strait Waistcoats, Muffs, Leglocks, Handcuffs, Collars and all the remaining apparatus.\textsuperscript{125}
\end{quote}

In regard to Campbell’s removal of restraints, a later commentator observed during Digby’s administration, the use of restraints was so small “that it must have been physically impossible for the patients to be festooned with so much detention hardware.”\textsuperscript{126} Campbell was not entirely honest in his claim of total

\textsuperscript{124} Dr Campbell’s Annual Report 1848. Cited in Bostock, op. cit., pp.113-117.
\textsuperscript{125} Ibid, p.115.
\textsuperscript{126} Ibid.
non-restraint, he continued to employ “crib rooms” (box-like restraint beds), for the “aged, infirm, diseased and mindless persons of dirty habits” and for the frantic patients who were incontinent of urine or faeces.\textsuperscript{127} For “maniacal patients,” Campbell employed seclusion (apparently Campbell did not view this as a form of restraint), which he claimed produced “magical effects” on their minds, and they soon learnt self-control.

At the end of his report, Campbell proudly proclaimed:

\begin{itemize}
    \item those attendants who were formerly in the habit of having recourse to mechanical coercion on every emergency, frequently indeed when there was no emergency, and who long retained a strong leaning to the old, ready methods of quieting a patient, entertained also the utmost contempt and distrust of milder methods, have repeatedly confessed that they can manage the patients much more easily than formerly.\textsuperscript{128}
\end{itemize}

The attendants and nurses would have told Campbell what he wanted to hear, their livelihoods depended on it. There is little doubt, the consequence of dissent would have been dismissal from service. Indeed, this was to be Joseph Digby’s fate.

\textbf{4.9: The events leading to Joseph Digby’s dismissal.}

Inevitably, in March 1849, the tension between Digby and Campbell erupted and became the subject of gossip among asylum staff. Apparently, avoiding even speaking to one another, they were exchanging heated letters, with Digby informing Campbell he should not interfere in the affairs of the Steward.

Campbell let Digby know in no uncertain terms that he expected to be obeyed. Campbell stated he was responsible for all matters regarding the asylum, noting

\textsuperscript{127} Ibid, p.116.
\textsuperscript{128} Ibid, p.117.
caustically, “these responsibilities embrace everything connected with the establishment – from a man to a rat.”129 Campbell then wrote to the Governor and formally charged Digby with insubordination. Another Board of Inquiry was established to examine Campbell’s claim, resulting in an official reprimand of Digby. However, Campbell did not escape censure, Governor Fitzroy noting Campbell was not always tactful, and had displayed outbursts of temper towards Digby. 130

Peace between Digby and Campbell was always unlikely as they had probably acquired a hatred for one another. Their rancid relationship became public property during March 1850, when an article appeared in the press charging Campbell with inefficiency. The article claimed that in Campbell’s fetish for removing restraints, the patients lives were being put at risk. Further, patient complaints were being suppressed and their spiritual needs were neglected. The article also pointed to staff dissatisfaction, due to the heavy fines imposed on them for alleged breaches of duty.

It was clear someone was leaking information to the press. Campbell approved of a staff meeting on April 11th, where the officers and attendants were pressured to disclose the disaffected person(s) identity. They all denied having given information to the newspaper131 but, when asked to sign declarations they had not been responsible for the leak – Joseph Digby refused to do so. 132

Criticism became more serious when on June 13th 1850, Rev. Turner wrote to the Sydney Morning Herald. Turner said he had officiated at the internment of two

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129 Campbell to Digby, 18 March 1849. Cited in McDonald, op. cit., p.291.
130 McDonald, ibid.
131 Ibid.
asylum patients, and implied they had died directly as the result of Campbell’s imposition of non-restraint at the asylum. Turner stated, “I merely mention the fact, that not having been restrained, they either voluntarily deserted, or were dragged out of their beds by some violent patients, and, being enfeebled by disease, were incapable of raising themselves from the cold stones, on which one of them absolutely perished.” He also clearly stated he received this information from the asylum’s Dispenser, and called for an inquiry by an independent board of visitors. Campbell was furious, unlike Digby, who had kept a dignified silence whilst being slurred by IATROΣ, Campbell responded publicly and viciously. Campbell wrote to the Herald on June 15th, giving explanations for the deaths of the patients.

However, when referring to Turner, Campbell described him as “this reverend advocate of chains, belts, &c.”, and “reverend dictator”, terminating the diatribe with, “the assertions of this clergyman are Jesuitical, malignant, false, and slanderous.”

Immediately following Campbell’s response was a letter from the asylum’s Dispenser, H.D. Leslie, who denied having spoken directly to Turner but implied Turner had listened in on a private conversation between himself and Mr Digby. A few days later, Digby denied Leslie’s claim stating, “the facts related by Rev. Turner… were communicated [to him] by Mr Leslie, and not by me, on our way to the Burial Ground.” Digby, in rejecting Leslie’s version of events, stated “[it was] in every respect, a fabrication of his own flighty imagination.”

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133 Sydney Morning Herald, 13 June 1850. p.3.
134 Sydney Morning Herald, 15 June 1850. p.5.
135 Ibid.
136 Sydney Morning Herald, 18 June 1850. p.3.
Leslie was subsequently dismissed from his position for his reported remarks to Turner. The erstwhile supporter and organ of ΙΑΤΡΟΣ, the Sydney Morning Herald, in an editorial on June 20\textsuperscript{th}, attacked Campbell’s malicious criticisms of Rev. Turner, pointing out “that plain naked fact is, that a man did die unattended, that another did perish upon the cold stones.”\textsuperscript{137} The editorial concluded by calling for (yet another) inquiry into the asylum.

On July 1\textsuperscript{st} 1850, a Medical Board of Inquiry convened to investigate the deaths of the two patients.\textsuperscript{138} The Board heard evidence from Digby about the continuing overcrowding of the establishment, which resulted in two patients sharing a cell (except if this posed a difficulty, for example, Digby noted that a particular male patient was not allowed to share a cell as he was caught on two occasions, committing unnatural acts with other males). Digby told the Inquiry that since the appointment of Campbell, he had been barred from contributing to the moral management of the asylum’s patients, being ordered to concern himself with other (more menial) duties. Digby was asked if the system of non-restraint had contributed to any accidents or injuries. He told the Inquiry that apart from some slight injuries, he knew of four cases of serious injury, one of which resulted in a death. In this instance, on May 23\textsuperscript{rd} 1849, a maniacal patient fractured the skull of another patient with a chamber pot. The injured patient died six or seven weeks later. In a further session of evidence taking, Digby was asked whether he considered the attendants and keepers humane and kind to the patients. He stated he did not believe that any acts of wilful cruelty were ever committed against the patients by the attendants, and as far as he could judge, the

\textsuperscript{137} Sydney Morning Herald, 20 June 1850. p.2.
\textsuperscript{138} Colonial Secretary to Government Medical Adviser - Report of the Board of Inquiry on the Lunatic Asylum Tarban Creek. N.S.W.L.C. V.& P., (Second Session), Vol. II., 1851, pp.583-584.
attendants acted with kindness and demonstrated great forbearance. Digby was asked if he could identify the person responsible for leaking information to the press (the original article published in March, which in effect led to the current Inquiry). Digby was evasive in his responses however; evidently the Committee believed (as will be seen later), he was probably the informant.

Dr Campbell was questioned about several aspects of the asylum and its management (including the occupation of the patients, cure rates, the patient’s diet). However, he was also questioned about his system of non-restraint. Campbell noted that non-restraint was being practised in England, in more asylums than not. He conceded that accidents and injuries do occur (to both patients and attendants), but did not believe injuries occurred in any greater numbers than in places that used restraint. Campbell was asked if he thought the number of attendants at Tarban Creek Asylum were sufficient to manage a system of non-restraint. He replied that they were, but he would like to have male and female night-watch attendants, especially to care for cases of severe illness. The Inquiry subsequently recommended the appointment of extra attendants and nurses to ensure a night-watch could be instituted.139

The Medical Board of Inquiry’s Report laid the blame for the deaths of the two patients squarely on conditions at the asylum. The Report noted, due to the overcrowding, there was no room to enable an infirmary to be set up, which was absolutely necessary to properly care for patients enfeebled by disease or sickness. The Board also came to the conclusion that the two patients had been neglected in their last hours - however, this was entirely due to insufficient staff

139 Ibid.
numbers. It could not be expected that attendants perform night duties attending
the sick, while at the same time, carry out their other regular work during the
day. The Board recommended steps be urgently taken to remedy both
problems.\textsuperscript{140}

Whilst the Medical Board of Inquiry was charged to examine the circumstances
surrounding the deaths of the two unfortunate patients, perhaps the real reason
for establishing the Inquiry may be seen in its final recommendations. The vexed
question of the disposal of Joseph Digby was solved. The Medical Board
recommended to Governor Fitzroy, that Digby should be summarily dismissed,
claiming his continued presence at the asylum would be disruptive to its proper
management. However, as a concession to his long service, the Medical Board
also recommended that Digby be granted half of his yearly salary (£100) upon
leaving. The Board also recommended that Digby’s replacement’s salary should
only be £100 per annum (25\% of Dr Campbell’s salary).\textsuperscript{141}

Joseph Digby’s dismissal did not result from proven allegations of cruelty to
patients, mismanagement, or indeed any other crime. We are left to conjecture
that either Digby’s honesty and integrity (he gave information to the press and so
was unable to sign a statement saying he did not) or, his refusal to be accused
and overborne by Campbell by signing such a statement led to his downfall. On
the other hand, it is clearer that Digby, as a man without wealth or of the ruling
class, was seen as acting above his station in giving orders to medical men and
being in charge of an institution over which doctors felt they had the claim.

Perhaps, during Digby’s time in the colony, many factors came into play,

\textsuperscript{140} Ibid. pp.2-3.
\textsuperscript{141} Ibid.
nevertheless, the Governor subsequently dismissed Joseph Digby and shortly afterwards, he and Susannah returned to England.


The innuendo and half truths that had been perpetrated, and continued to be perpetrated against Joseph Digby by Francis Campbell were of such depth that it transcended a generation. The son of Francis Campbell, W.S. Campbell, later reinforced the untruth that Joseph Digby’s administration of Tarban Creek Asylum was one of disorder and patient abuse. Writing in 1919, W.S. Campbell noted;

At the time, and before my father took charge of the lunatic asylum, Tarban Creek, the condition of the inmates was deplorable … The previous year an enquiry was held in connection with reputed abuses at the institution, and these being substantiated, my father’s appointment followed…. The opposition to his humane efforts was marvellous, and he had a struggle, a very hard one, indeed, to accomplish his aim.143

Written as an article for the Journal of the Royal Australian Historical Society, W.S. Campbell’s comments attempted to ensure historians would believe that his father, Dr Francis Campbell, was the first and foremost reformer of lunacy services in colonial New South Wales. However, as will be seen in chapter 5, Dr Campbell’s twenty year administration of Tarban Creek Asylum, did not result in the promised improvements in mental health care.

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1 My emphasis – this claim was patently untrue. As has been seen, W.S. Campbell’s father’s allusions of abuse at the asylum, in his erstwhile guise as ΙΑΤΡΟΣ, were not found by any Inquiry to have any real substance.

Chapter 5.

The more things change – the more they stay the same: 1850 – 1868.

(Alphonse Karr, ‘Les Guêpes’ 1849)

This chapter examines mental health care in colonial New South Wales during the two decades following the medical profession’s appropriation of formal control of services. Improvements in treatment and care for the insane promised by the medical profession, are never realised. This was partly due to the medical profession’s inability to find a cure for insanity but also due to government indifference towards the needs of the mentally ill. This chapter also explores the significance of this period regarding the ways the medical profession began to extend its dominance over everything associated with asylums, including the working and private lives of the staff. The dominance over attendants of the insane will be shown to have been achieved by the imposition of official rules and regulations, as well as an Act of Parliament. Through such mechanisms of control, dissent, in relation to the medical superintendence of asylums, was not tolerated from any working class subordinate.

5.1: The establishment of the Parramatta Lunatic Asylum.

As previously noted (in chapter 4), during the period covering the struggle between Joseph Digby and Francis Campbell for control of Tarban Creek Asylum, urgent relief of overcrowding at the institution necessitated the removal of convict patients to other existing establishments. These establishments had been earlier built and reserved as places for the confinement and/or care of the convict population. Thus, from 1846, the Parramatta Female Factory and the Convict Hospital at Liverpool, were convenient receptacles for the confinement
of lunatic convicts. However, the medical care of lunatic male convicts, under Dr
Eckford at the Liverpool establishment, was to last barely two years. Male
lunatic convicts were then transferred to the Female Factory (in 1848), forming
an institution which survives to the present day as Cumberland Hospital.

Colonial Secretary’s Office,
Sydney, 28th December, 1849.

INVALID ESTABLISHMENT,
PARRAMATTA.

His Excellency the GOVERNOR directs it to be
notified, for general information, that a
portion of the Invalid Establishment at Parra-
matta, (formerly the Female Factory,) has been
appointed a public Asylum for the reception and
custody of lunatics.

By His Excellency’s Command,
K. DEAS THOMSON.[sic]

Through this notice in the Government Gazette, colonial society was informed
that the former, notorious, female convict prison was to become a public lunatic
asylum.

The Female Factory was constructed during the governorship of Lachlan
Macquarie to receive and accommodate newly arrived convict women. Opening
in January 1821, it was designed to house 300 women prisoners, who could be
assessed for their suitability for placement in a variety of assigned positions
within the colony. It was also utilised to detain and punish women, considered
refractory by the governing authorities, and as a dumping ground for (often-
abused) women, unfortunate enough to become pregnant. Paternity of the

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children was sometimes the result of liaisons with male convicts and poor settlers, but probably just as often was the result of seduction or rape by the women’s masters. The pregnant women, now not as useful as servants, and a greater expense with another mouth to feed (or sometimes to disguise paternity), were returned to the Factory; often on trumped up charges or complaints from their masters (or mistresses). The children could stay with their mothers until age four, when they were sent to government orphanages. Also, the Factory became in effect, Australia’s first matrimonial agency, where settlers and emancipated male convicts could visit and woo a wife.

At the Factory, women could also be subjected to a variety of abuses, at the hands of the warders, and several riots occurred there during its history. Built to accommodate 300 women, further extensions (including a 72 cell penitentiary block) were required to ameliorate gross overcrowding, but by 1842, the Factory accommodated 1,203 women, and their children, in deplorable conditions. All of which along with the previously noted abuses and violence, would likely predispose women to mental illness. The end of transportation to New South Wales saw the need for the Factory diminish, and by the mid 1840s – operating like a benevolent asylum, the Factory only accommodated aged infirm, invalid and lunatic convict women. Nevertheless, this change of role for the Female Factory did not happen overnight.

Upon the opening of Tarban Creek Asylum, in 1838, and possibly in a bid to relieve overcrowding at the Factory; eleven lunatic convict women were transferred to the Tarban Creek Asylum. Ironically, gross overcrowding at Tarban Creek Asylum resulted in the transfer of all lunatic convict women back
to the Factory in 1846 - the male convicts were transferred to the convict hospital at Liverpool. During 1847, Governor Fitzroy agreed to proposals to make the Factory a receptacle for lunatic convicts (and ex-convicts),\textsuperscript{146} with male convict lunatics transferred from the Liverpool Convict Hospital in March 1848;\textsuperscript{147} prior to Liverpool’s conversion into a Benevolent Asylum for pauper infirm and aged men. The Female Factory thus became an institution for the long term care of chronically mentally ill convicts.

However, continued overcrowding at Tarban Creek Asylum resulted in the need to transfer chronic non-convict patients to the Factory, and to do this, it was necessary, in 1849, to declare the Factory a \textit{public} lunatic asylum. Tarban Creek Asylum was then supposedly freed up to become a \textit{curative} establishment, the Parramatta Lunatic Asylum an establishment for the incurable.\textsuperscript{148}

From 1846, Dr Patrick Hill was appointed Government Medical Officer at Parramatta. This role encompassed the Superintendency of infirm and invalid convicts within all institutions at Parramatta, including the General Hospital and particularly the Female Factory. He also held appointments as Honorary Medical Officer of the General Hospital and Visiting Medical Officer of Parramatta Gaol and the Protestant and Roman Catholic Orphan Schools. Additionally, he served as Magistrate to the Tarban Creek Asylum and held the office of President of the New South Wales Medical Board. Dr Hill (as noted in chapter 3) was also busy managing his substantial pastoral interests and producing cheese.\textsuperscript{149} His attendance to all these appointments must have been limited, and he was

\textsuperscript{146} McDonald, D.I., \textit{This essentially wretched asylum: The Parramatta Lunatic Asylum 1846-1878}. \textit{Canberra Historical Society Journal}, 1977 (September), pp.52-69.
\textsuperscript{148} McDonald, (1977), op. cit.
\textsuperscript{149} Brown, K.M., \textit{Medical Practice in Old Parramatta}. Angus & Robertson, Sydney, 1937, pp.55-56.
particularly reluctant to accept the transfer of acute and manic lunatics from Tarban Creek Asylum to the Factory, as due to his absences, it would be hard to treat them. Hill wanted only the “Imbecile, Idiotic and fatuous” who could be easily accommodated and fed, “which is almost all that can be done for them.”

Dr Hill’s concerns, about difficulties associated with the care of acute and manic lunatics, were realised in May 1849, when a male patient sent to cut up wood, in a work gang, suddenly cleaved the skull of another patient with his axe before the keeper could move to stop him. At the Coroner’s Inquest the keeper was exonerated from blame; however, the Coroner hoped new arrangements would be made to render such future accidents impossible.

Hill was appointed Medical Superintendent when the Parramatta establishment was opened as a public asylum at the end of 1849 (a legacy of ΙΑΤΡΟΣ’s earlier criticisms of the non-medical administrative arrangements at Tarban Creek Asylum) and tenure lasted until his death in March 1852. The Female Factory’s last administrators, Edwin and Elizabeth Statham, were re-appointed to the Asylum in their previous positions of Storekeeper (with duties equivalent of Tarban Creek Asylum’s Steward) and Matron respectively. Following her death in office on January 8th 1864 - aged only 42, indicative of her status and perhaps reflecting her family’s pride in Elizabeth Statham in her official role, her gravestone was inscribed for posterity; “She was for many years Matron of the Lunatic Asylum at Parramatta.”

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150 Hill to Colonial Secretary. Colonial Secretary’s Papers - Letters received, Lunatic Asylums 1848 – 73. S.R.N.S.W.,4/7183.
152 Grave monument: Elizabeth Statham (Row G No. 2). All Saints Cemetery Brickfield St, North Parramatta, New South Wales.
Generally, little is known about the early (nursing) carers of the lunatics at Parramatta Asylum. There were some salaried personnel, but the majority were probably assigned convicts whose sentences had not been commuted or expired (known as “lifers”). Unlike Tarban Creek Asylum, where assigned convicts were removed from the staff, there were still convicts employed at Parramatta until at least the late 1850s. In 1858, it was reported that nine of these “nine penny men” (so-called as they were paid 9d. a day), had been recently transferred from the Parramatta Lunatic Asylum to the Macquarie Street (Parramatta) Benevolent Asylum, with another twelve remaining on the lunatic asylum’s staff. Also, patients whose mental state had improved but were waiting for discharge, were employed as attendants, especially during the labour crisis caused by the gold rush in the early 1850s. Further, two former patients were reported to have remained on staff as attendants, in 1855, and a former female patient was employed as a private servant at the Medical Superintendent’s home. Staff of the asylum were also assisted by less disturbed patients and the employment of patients as carers continued until at least the mid 1860s, when it was noted that a “lunatic” woman was being utilised as a “nurse” to care for the “idiotic children.”

Dr Hill’s successor, Dr Richard Greenup, was appointed very soon after Hill’s death in 1852. Greenup was the second son of an English Squire and arrived in

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154 Ibid.
156 McDonald, (1977), op. cit., p.54.
the colony with his wife Jane, and their family, in April 1850. He secured their passage by working as Surgeon-In-Charge of the immigrant ship *John Knox*. Greenup appears to be the first doctor in New South Wales appointed to treat the mentally ill, who had previous experience in an asylum (at Calne in Wiltshire, England). Greenup’s period as Medical Superintendent is said to have been characterised by his apparent kindness and concern for patient welfare. The asylum staff were directed to treat the patients with respect and to allow them as much freedom as possible. Greenup also gave public lectures at the Parramatta School of Arts on such topics as, “Atmosphere”, “Ventilation”, and “The Character of Napoleon Bonaparte.”

Insight into Greenup’s character and sense of authority can be found in a letter he sent to the Colonial Secretary, soon after his appointment to the Parramatta Asylum. Complaining about the inclusion of a doctor to the Asylum’s Official Visiting Board, Greenup protested;

> I am nominally and virtually the head of the establishment to whom every appeal is made and whose decision is final. This will not be the case if another medical man is required to visit at least once a month investigating every point of my duty and making monthly reports to the Government. It requires little knowledge of human nature to see that all real authority will at once be transferred to the influential visitor… (it) will give to him regular and systematic control over the establishment which has hitherto been vested in the regular Superintendent.

Dr Greenup’s protestation fell on deaf ears; the Colonial Secretary replied he could not accede to Dr Greenup’s objections. Greenup’s fear that his authority at the Parramatta Asylum would be undermined, by the appointment of a doctor to

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158 Brown, op. cit., p.57.
159 Ibid.
160 Greenup to Colonial Secretary, 3 July 1852 (with Colonial Secretary’s annotation). *Colonial Secretary’s Papers – Letters received, Lunatic Asylums*, S.R.N.S.W., 52/5636.
the Official Visiting Board, was perhaps hypocritical, as he himself was an Official Visitor to the Tarban Creek Asylum. Greenup’s position of Official Visitor to the Tarban Creek Asylum was later queried in a Legislative Council Report of 1855, where it was observed;

The present system of inspecting the Asylums by the Official Visitors appears to us objectionable. It must be an invidious duty for any medical man, having necessarily no professional status above the officer whose acts he may have to consider, to report any neglect or irregularity… The fact of the Official Visitor being himself at present in direct charge of one Asylum renders his inspection of the other still more questionable.\textsuperscript{161}

In relation to the Superintendency of lunatic asylums, Richard Greenup had one thing in common with Francis Campbell; neither would tolerate any dissent from their subordinates. Each believed their social position gave them absolute authority to direct those beneath them. Whilst Campbell’s method in disposing of critics and dissenters was discussed in chapter 4, Greenup (as will be seen later), whilst not as reactionary as Campbell, found ways to remove dissenters from his ranks. However, if with the disposal of Joseph Digby, Dr Francis Campbell hoped his idea of establishing a utopian paradise for lunatics would be realised, he was to be sorely disappointed.

5.2: Paradise lost - the Tarban Creek Asylum.

Digby’s successor, John Hayborne, was appointed to Tarban Creek Asylum in November 1850, at a salary of £120 per annum, with his wife appointed as head nurse at £50 a year. This represented a significant saving as Joseph and Susannah Digby’s combined wage was £300 per year. Hayborne, appointed by Campbell,  

\textsuperscript{161} Commission of Enquiry on Lunatic Asylums (Report), op. cit., p.9.
was an alcohol abuser and lasted in the position only two years. His eventual
disposal was not the result of inefficiency or conflict with Campbell, but due to a
fatal seizure brought on by a drinking binge, almost exactly two years after his
appointment. Hayborne’s replacement was James R. Firth; he too was soon to
prove a problem at Tarban Creek Asylum, and later was the centre of a major
scandal at the Parramatta Asylum.

Meanwhile, work commenced to enlarge Tarban Creek Asylum, which despite
the establishment of the Parramatta Asylum, continued to suffer from
overcrowding and poor accommodation for the staff. Campbell, dissatisfied with
the progress, requested the Colonial Architect (always under pressure to keep
costs down) to arrange for repair and re-gravelling of the airing yards which were
in a deplorable state. The Colonial Architect’s reply suggesting some patients
could be employed to rectify the yards and reminding Campbell that such
maintenance work was frequently undertaken by patients at the Parramatta
Asylum, angered Campbell. He retorted that the yards were never properly
constructed and were now beyond repair; he wanted them flagged with stone. He
further pointed out there were very few patients willing and able to do the work,
and resented the insinuation that he allowed his patients to be idle.

In July 1854, Campbell sought and was permitted a six months leave of absence
to recover from ill-health brought on by the “consuming anxieties” of his
position. He recommended Dr George Walker, the asylum’s dispenser for the
previous twelve months, act in his stead. Soon after taking up duty, Dr Walker

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162 McDonald, D.I., Dr Francis Campbell and the Tarban Creek Asylum, 1848 – 1867. *Journal of
163 Ibid.
164 McDonald, (1967), op. cit., p.234.
wrote to Henry Parkes, liberal reformer and Member of the Legislative Council, alleging the Government Medical Advisor, Dr O’Brien, was neglecting his duties. Further, Walker claimed, the mentally ill taken into custody by the police, were confined too long in gaol before transfer to the asylum. Walker also alleged that whilst confined in gaol, lunatics were subjected to cruelty and abuse and often arrived at the asylum with serious bodily injuries.\(^{165}\)

Henry Parkes, eager to embarrass the Government, raised the matter in the Legislative Council on September 7\(^{th}\), and the Colonial Secretary was forced to agree to investigate the claims. Unsatisfied and probably knowing any investigation would take too much time, Walker next aired his allegations in the popular press. For this, Walker attracted a reprimand from the Colonial Secretary who warned that should he persist, he would be dismissed. James Firth, the asylum’s Steward, coming to the defence of Walker, injudiciously wrote to the Government Medical Advisor (Dr O’Brien), saying that if Walker felt compelled to resign for his own self respect, then Firth too would resign.\(^{166}\) The Government Medical Advisor referred the letter to the Colonial Secretary, who gave a reply that stunned Firth and Walker; they were informed their resignations, “virtually tendered,” had been accepted.\(^{167}\) Parkes again raised Dr Walker’s allegations in the Legislative Council on November 17\(^{th}\), and queried the Colonial Secretary’s treatment of both Walker and Firth. The Colonial Secretary was forced to admit neither Walker nor Firth had actually resigned, but their actions amounted to the same thing. Despite leaving the Tarban Creek Asylum, both officials continued to work in the public service (probably with the

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\(^{167}\) Colonial Secretary to Government Medical Advisor, 8 November 1854. ibid.
support of Parkes). Walker became the Medical Officer of the Hyde Park Benevolent Asylum, whilst Firth, was soon re-employed at Tarban Creek Asylum as Clerk, and was later to be appointed as Storekeeper (Manager), of the Parramatta Asylum.

Parkes also raised the complaints of a former detainee, Charles Gaunt, who claimed he was cruelly abused whilst at the Darlinghurst Gaol. Gaunt was confined at the Gaol after a drinking binge on July 7th, and locked in a cell with three convicts and a lunatic. Gaunt alleged the gaol warders goaded the lunatic into attacking him, which resulted in considerable injuries. Gaunt further claimed the gaol doctor ignored his requests for treatment and his plea not to be sent to the asylum. Six day later, Gaunt, chained to the lunatic who had assaulted him and “forced to walk the streets of Sydney like a felon,” was transferred to Tarban Creek Asylum, where at least his injuries were treated. He was soon found not to be insane and discharged from the asylum. On November 18th 1854, Parkes put further pressure on the Colonial Secretary with an article in the Empire, a newspaper of which he was the proprietor.

Parkes then continued his attack in the Legislative Council on November 24th, succeeding in having another Commission of Enquiry appointed. The Commission’s object was to “Enquire into the present state of the several [there were only two] Lunatic Asylums in the Colony… with special reference to the classification of patients therein… to their medical treatment… and the means of security and protection afforded them.” These were the same issues the

168 The treatment of lunatics in Darlinghurst Gaol. Empire, 23 November 1854, p.5.
169 The word "Enquiry" rather than "Inquiry" was used in the title of the Commission.
government had inquired into, nine years earlier, during 1846. Evidently, removing a non-medical man and replacing him with a doctor to superintend the asylum, had not produced the changes which were anticipated.


The report of the Commission of Enquiry, where it was critical - especially of Tarban Creek Asylum, concerned the same problems raised in every Inquiry since 1846 (the Parramatta Asylum attracted little criticism). The colonial government’s continuing poor response and ad hoc approach to the needs of the mentally ill, ensured not just a lack of real improvement, but on some issues such as asylum facilities (which impacted on patient classification, occupation and accommodation), a definite deterioration had occurred.

On the question of treatment and patient classification (the Commissioners put these issues together), they found, “as far as we can judge it [treatment] is as good and as well adapted to the benevolent purposes of these institutions as is compatible with the means at the disposal of the medical officers.”171 The Commissioners recognised that the two asylums were quite different due to the different types of patients admitted. They were particularly critical of the facilities (but not the care and treatment) at Tarban Creek Asylum, which did not allow for the proper classification of patients. In particular, they criticised the admission of criminal lunatics, who because of inadequate space, were not kept separate from other patients. The Commissioners recommended that all criminal patients should be removed to the Parramatta Asylum (a former prison), where they could be kept apart from other patients. Poor facilities at Tarban Creek

171 Ibid.
Asylum were blamed for the lack of amusement and proper occupation of the patients. The facilities were also to blame for the continuing poor accommodation for patients, and it was observed that the buildings were already in a state of disrepair. The Commissioners thought that a sum of approximately £50,000 would be needed to rectify the problems, in fact, they felt a wholly new asylum would need to be erected.

Regarding complaints of cruelty the Commissioners reported,

We do not find the charge supported by the evidence before us… all that we heard on this point is, that tenderness and humanity are generally exercised and no needless severity or harshness used… There is no doubt that patients have been found suffering from external personal injuries; but we think it likely that in many cases these have been inflicted by their own efforts in some maniacal fit, or have been the accidental result of the resistance and necessary force which has been used in repressing their violence… reliance cannot safely be placed upon the statements of persons who have been insane, as to the treatment they received during their lunacy; it being well established that many things, which were undoubtedly delusions of the patients when insane, are often even after perfect recovery still looked upon by them as realities.172

The Commissioners’ finding that patient complaints of ill treatment were only the result of delusion, is unfortunate. Essentially, in the Commissioners’ judgement, lunatic patients’ testimony should not be believed unless there existed corroborative evidence. Though injury to patients is not a straightforward or simple issue, it would be difficult to counter any force or violence on the part of attendants if patients, whether acutely ill or not, were never to be believed in this matter.

Meanwhile, at the Tarban Creek Asylum, Dr James MacNish (the Assistant Medical Officer) replaced Dr George Walker as Acting Superintendent (under the supervision of Dr Richard Greenup, in his capacity of Official Visitor). Mr Robert Lakin was appointed as Steward in place of James Firth. Lakin, who had never worked in an asylum, commenced his duties on November 14th, but was never given a statement of what those duties entailed. Assumed he was responsible for the proper management and distribution of government stores, sent for the use of the establishment, Lakin quickly became concerned about what appeared to be misappropriation of the stores; in particular, he suspected Francis Campbell’s family were drawing supplies to which they were not entitled. Dr Campbell had gone away during his leave of absence, leaving his wife and family at the asylum. Lakin, unsure of himself in his new career, at first suppressed his suspicions, later worrying he might have to account for the stores, eventually raised the matter with Dr MacNish (Acting Superintendent). MacNish appeared to do nothing and when Campbell’s wife became aware of Lakin’s concerns, a veritable war of words erupted between the two. On January 10th 1855, Robert Lakin was dismissed from his position,

“without any cause having been assigned… and notwithstanding repeated applications for an investigation into the circumstances of the case, the Government have refused to afford him any satisfaction or information.”

Lakin petitioned the Legislative Council and a Parliamentary Select Committee of Inquiry was established to investigate his complaints and accusations.

Specifically, Lakin claimed the Campbell family were misappropriating soap, washing soda and blue, and expected the asylum’s laundress to wash their

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clothes (there were thirteen Campbells living at the asylum). Lakin also believed the Campbell’s were using firewood sent for the asylum’s use, and were taking meat from the kitchen meant for the patients. A number of senior asylum staff were called to testify and (perhaps not daring to do anything else), were supportive of the Campbells and critical of Lakin, accusing him of a variety of offences including assaulting a patient. Five patients were called to testify and they refuted the claims of Lakin’s harshness towards patients, indicating he had shown them nothing but kindness.\textsuperscript{174} The Matron, Mrs Jane Manson testified she had trouble obtaining candles for her own use from the asylum store, as Lakin demanded proof of her entitlement. Mrs Manson also intimated that Lakin sexually harassed the female attendants and said he brought the institution into disrepute, – “Indeed I considered the respectability of the Institution compromised in having such an illiterate person as second officer.”\textsuperscript{175} The Select Committee did not bother to seek corroborative testimony from any of the female attendants - Mrs Manson’s word was enough.

Mrs Campbell was also called to testify, she said she did not understand why Lakin refused to allow her soap, washing soda and blue, or allow the asylum’s laundress to do the family’s washing. She claimed after all, it had been allowed since the day the family came to live at the asylum. Mrs Campbell flatly denied misappropriating fire wood and meat and indicated she found Lakin’s behaviour impertinent.\textsuperscript{176}

\textsuperscript{174} Select Committee on Robert Lakin’s Petition (Minutes of Evidence). \textit{N.S.W.L.C.V. & P.}, Vol. 3, 1855.
\textsuperscript{175} Ibid, (Minutes of Evidence Manson, J.), p.17.
\textsuperscript{176} Ibid.
Ultimately, the Inquiry dismissed most of Lakin’s accusations, except on the issue of the misappropriation of soap, washing soda and blue. Whereas other asylum staff found guilty of any minor infraction, let alone misappropriating stores, were liable to summary dismissal, Campbell and his family were excused;

The consumption of the laundry articles is admitted, and, though there is no proper regulation sanctioning the privilege, it appears to have been authorized by Dr Dawson [verbally, years before]… the regulations of the asylum… are not sufficiently clear and explicit respecting the matters which have been under investigation. A public officer, placed in circumstances so trying and difficult as is Dr Campbell, ought not be annoyed by having any privilege called into question, to which he is entitled.\textsuperscript{177}

The conclusions of the Select Committee are not really surprising. The ability of Campbell (with the help of his influential class of friends), to overcome scandal and criticism and to dispatch his critics, has already been shown. The manner of Lakin’s dismissal, which apparently came as something of a surprise to him, demonstrates the lengths those in authority would go to protect their own interests. Lakin had reported his concerns regarding the possible misuse of asylum stores to the Acting Superintendent, Dr MacNish. He, unaccustomed to managing an asylum and not sure how to handle the situation, passed it on to Dr Greenup, the Official Visitor. Dr Greenup, a Medical Superintendent himself, would not have felt comfortable with the notion of a subordinate officer questioning the privileges of his superiors. He was also in close and supportive contact with Mrs Campbell, who sent to him several letters making a variety of complaints about Lakin’s behaviour.\textsuperscript{178} It appears Greenup, possibly to make an

\textsuperscript{177} Select Committee on Robert Lakin’s Petition (Report). ibid, p.1.
\textsuperscript{178} Selina Campbell to Medical Advisor to the Government. (Appendix copies of letters), ibid, p.11.
example of Lakin, whilst reinforcing the authority of the Medical Superintendent over subordinates, decided to dispose of the troublemaker.

Dr Greenup wrote to the Colonial Secretary, outlining complaints about the Steward but particularly emphasising Lakin’s alleged discourteous/uncivil behaviour towards Mrs Campbell. The Colonial Secretary replied, “His Excellency trusts he may hear of no incivility or neglect on the part of the Steward towards Mrs Campbell, as, if he do, he will feel himself bound to relieve Mr Lakin from his appointment.” This apparently was all Greenup needed, at the next indication of unhappiness from Mrs Campbell, Lakin was summarily dismissed. Greenup was questioned at the Select Committee Inquiry about the circumstances of Lakin’s dismissal and perhaps fearing criticism of the manner of Lakin’s removal, embellished the reasons;

There were great complaints about him, for incivility to Mrs Campbell’s family, and he was reprimanded for that. He was not a good-tempered man, and he was complained of, to me, for speaking harshly to patients… His temper was very bad; and he quarrelled with Dr MacNish… Dr MacNish made so strong a complaint to me… [and] seeing he was altogether an unfit man, I represented it to the Government, and he was dismissed.

Lakin was naive. Evidently he did not know that challenging the authority of the Medical Superintendent (let alone Campbell or his family), was not appropriate for someone of his class (and a subordinate). With the exception of Lakin, the senior staff of the asylum were appointed by Campbell, and they would not have survived had they ever shown anything but complete loyalty to him. Dr Greenup, whilst not under Campbell’s authority, was of the same social and professional

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179 Greenup to Colonial Secretary, 27 December 1854, (Appendix). ibid, p.6.  
class and that status (and authority), had to be protected from the aspirations of subordinates.

Whilst Greenup’s opinion of his own authority as Medical Superintendent has previously been exposed, he was more measured in response to critics and was not above manipulating circumstances to maintain his authority. For example (at a later date), Greenup dismissed one of the senior attendants at Parramatta Asylum for allegedly striking a patient. The attendant, Christopher Diamond, denied the assault and alleged to a Parliamentary Inquiry that Dr Greenup disposed of his critics by bringing false charges against them. Diamond stated he was really dismissed for contradicting Greenup in evidence, during a very public libel suit.182 This suit was a consequence of allegations by a patient against Greenup for wrongful incarceration, resulting in the patient’s supporters and detractors engaging in a public verbal dispute. Greenup testified that the patient was insane at the time, but Diamond testified he had not observed behaviour consistent with madness, whilst the (now former) patient was incarcerated at the Parramatta Asylum. After the court’s judgement, attendant Diamond was called into Greenup’s office and summarily dismissed.183 Dr Greenup denied Diamond’s claims. He acknowledged Diamond had been a good attendant and had never previously ill-treated a patient, but insisted at the Inquiry, on this one occasion, Diamond did indeed behave cruelly towards a patient. Greenup then scornfully suggested Diamond might find better employment as a gaol warder and added, this would be “an advancement” from being an attendant.184

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182 See Scott v. Hanson & Bennett. Empire, 1 December & 2 December 1862.
183 Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Diamond, C.), 1863-64, op. cit., pp.944-945.
184 Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Greenup, R., - recalled 20 April 1864), 1863-64, op. cit., p.989.
of evidence from another attendant, Luke Dunn,\textsuperscript{185} corroborating Diamond’s allegations, he was not re-instated to his position. In this way, a Superintendent’s (and doctors) power over subordinates (including attendants) was made manifestly plain - as it was between Campbell and Digby. Thus class, position, status and power/authority to influence people of similar backgrounds, repeatedly resulted in discrimination and injustice toward those not sharing such backgrounds, for example, Digby, Lakin and Diamond.

5.4: Staff loyalty to the Medical Superintendent.

The absolute loyalty of asylum attendants (and servants) towards their superiors, established by Campbell and reinforced by Greenup, was expected by Medical Superintendents well into the 20\textsuperscript{th} century. To underline this expectation, the initial management and control of complaints (or dissent) of subordinate staff by the Medical Superintendents, was eventually enshrined in law. Regulations under Section 177 of the Lunacy Act 1878 included;

\begin{quote}
Any proceeding on the part of attendants, nurses, artisans or servants in the nature of or intending to a combination for any object connected with their duty, position, rate of salary, or a charge against a superior, taken without the knowledge of the Medical Superintendent or the Officer in charge, is prohibited.
\end{quote}

The Medical Superintendent or Officer in charge will forward any representations made to him in writing, and duly signed by attendants, nurses, artisans or servants, respecting their duties, position, &c., to the Head of the Department; and no attendant, nurse, (artisan) or servant will address the Head of the Department or any Officer in other Departments of the Public Service except through the Medical Superintendent or the Officer in charge.\textsuperscript{186}

\textsuperscript{185} Ibid, (Minutes of Evidence Dunn, L.), p.951.
\textsuperscript{186} Regulations under Section 177 of the New South Wales Lunacy Act 1878. (42 Victoria No.7), Supplementary Gazette No. 810, 3rd December 1895, p.2.
Therefore, whilst not able to completely suppress complaints, Medical Superintendents were given opportunity to keep them in-house. If the complainant persisted, the Medical Superintendent had advanced warning and could prepare a defence. It also provided opportunity to gather incriminating evidence against the complainant, providing potential grounds for dismissal. In combination with past events, this law made it evident that attendants and nurses wishing to remain employed, had to remain silent. Later, upon the commencement of formal education for attendants and nurses, of the insane, part of the first lecture was devoted to *Loyalty to the Institution and its Officers*.\textsuperscript{187}

Attendants and nurses were advised;

> Loyalty to the officers under whom you work is an [sic] essential for success. That institution works best in which the nurses and attendants are able to admire and respect those with whom and for whom they are working. If you cannot praise you can be silent. Criticism of those who are placed over you, whether delivered in or out of the hospital, can do nothing but harm, and in the majority of instances it will be as worthless as harmful. You will be neither in a position to appreciate the difficulties under which your superior is acting, nor to judge of his reasons.\textsuperscript{188}

The comment stating criticism, *in the majority of instances it will be as worthless as harmful*, was already seen to be true, for example; Lakin and Diamond’s experiences. Attendants and nurses were also subject to regulations under the Lunacy Act and as they were informed of the expectation of their complete loyalty in their first lecture; there was no excuse for ignorance on the matter. Several decades prior to the passage of this Act however, "gold fever" was to have a dramatic impact on the staffing of lunatic asylums.

\textsuperscript{188} Ibid.
5.5: A labour crisis: all that glitters ...

During 1851, the first of a series of major gold finds in New South Wales and then Victoria, which lasted until the 1870s, created a severe shortage of labour. Thousands of workers, weary of poor pay and conditions, abandoned their employment and joined tens of thousands, seeking riches in the gold fields. In the cities, businesses were forced to close and newspapers reduced their size, or closed forever, as their staff departed for the gold fields. Even ships were stranded in harbour after crews abandoned them. Banks became short of cash as people anxious to buy provisions and equipment to take to the diggings withdrew money. Whilst ultimately the vast majority of these “diggers” did not find financial independence (in fact most found hardship, destitution, sickness and death), the few who gained unimaginable wealth, spurred others on. The population of New South Wales and especially Victoria, increased dramatically, swelled by immigrants eager to find their own pot of gold. In the decade from 1852, almost 300,000 people left Britain alone, in the quest for instant wealth.189

Workers engaged in the government’s employ also abandoned their jobs, including asylum attendants and servants. The government attempted to curtail the outflow by asserting the Crown’s right under common law to all deposits of gold in New South Wales, declaring that no man could dig without permission. This involved purchasing a license in advance which was given only to those who could prove they were “not improperly absent from hired service.”190 The price of the license was set at thirty shillings, thought to be sufficiently high to be

190 Kociumbas, op. cit., p.303.
unaffordable to most labourers and lower ranked workers. However, it was not enough, public servants continued to abandon their employment and the government was forced to increase wages in an attempt to stem the flow.

In the asylums the effect was dramatic. At Tarban Creek Asylum,

> The wages are so small and the accommodation for attendants so deficient in comfort that none but persons thoroughly in want of a shilling would engage… [the Superintendent having to accept] the garbage of humanity [as attendants].

Government bureaucracy only worsened the situation. Early in 1854, Dr Campbell had forwarded, via the Government Medical Advisor, a request to the Colonial Secretary to increase the attendants’ wages; it was not until July the wage increase was authorised. In the meantime,

> the attendants were receiving so small a salary that we could not actually get men worth an iota to come as keepers. I have known as many as two keepers drunk on their beds… and Dr Campbell, the Steward, and myself (the Dispenser - Dr Walker), had to perform the duties of ordinary keepers… Dr Campbell dared not dismiss them, because they were better than none, and he could get no others for such low wages.

At the Parramatta Asylum, Dr Greenup, in addition to having to utilise convicts (as already noted), was forced to employ recovering patients as attendants. The Parramatta Asylum also found itself employing people, who formerly, would not have been considered for positions. In 1863, Master Attendant Michael Prior observed, a better class of applicants for positions of attendant would occur, if the wages were improved. He stated, the attendants currently employed were

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191 Walker to Parkes, 24 August 1854. op. cit.
“mostly ignorant people; and when there is any disturbance they do not use discretion, but brute force.”\textsuperscript{193} Edwin Statham (the Storekeeper), was more optimistic;

We have had, I may say, to manufacture the attendants. We have some who have been with us many years, who originally were not of such a class as we should have selected, but it was difficult in the gold times to get attendants; these men have got into our mode of working, and they do exceedingly well.\textsuperscript{194}

Evidently, some applicants once considered unsuitable for the position of attendant, responded positively to being \textit{manufactured}, presumably through guidance, discipline and on-the-job training. Nevertheless, attendants’ wages did improve during the gold rush period. In 1847, ordinary (non officer) male attendants earned £30 per annum, whilst females received £18.\textsuperscript{195} By 1855, males earned between £35 and £40, and females £25 to £30, depending on seniority.\textsuperscript{196}

In contrast, at the same time, ordinary police constables (on foot), in addition to rations and having their uniforms supplied, were earning around £100 per annum. Mounted police received a further £30 for forage for their horse and yet policemen deserted the ranks when a new gold strike became public.\textsuperscript{197} By the mid 1860s, ordinary male attendants’ wages were between £67 and £72 per annum - in contrast with the annual wage of an ordinary gaol warder, which was approximately £120.\textsuperscript{198} Female attendants’ wages, noted as between £40 and £50 per annum, whilst increased, did not keep pace with their male colleagues.\textsuperscript{199}

\textsuperscript{193} Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Prior, M.), 1863-64, op. cit., p.944.
\textsuperscript{194} Ibid, (Minutes of Evidence Statham, E.), p.927.
\textsuperscript{196} Commission of Enquiry on Lunatic Asylums. (Appendix), 1855, op. cit., p.45.
\textsuperscript{197} Progress Report from the Select Committee on Retrenchment in the Public Expenditure. (Minutes of Evidence McLerie, J.), Government Printer, Sydney, 1858, p.68.
\textsuperscript{198} Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Prior, M. & Greenup, R.), 1863-64, op. cit., pp.944 & 989.
\textsuperscript{199} Ibid, (Minutes of Evidence Dunn, L.), p.951.
Thus, even though attendants’ wages had increased, complaints about poor pay continued.200

Government workers in what might be regarded as comparative employment (the police and especially gaol warders) earned considerably more than asylum attendants. This may be explained by colonial society’s fear of criminality as it had not long shaken off the burden of convict transportation. Perhaps the government anticipated the general public’s need to feel protected. Certainly, with so much wealth being generated by gold discoveries, criminals were plentiful. The police and gaol warders maintained the law and incarcerated felons and were therefore, symbols of the government’s effort to provide and ensure public security. To keep them reasonably content in their work, the government was forced to pay high wages.

On the other hand, lunatics and invalids, perhaps the most underprivileged and undervalued members of society, were kept out of sight and out of mind; which may explain the government’s chronic apathy concerning the improvement of asylum conditions and services. Asylum attendants, doing the work once given only to convicts and recently described as having been drawn from an undesirable class (*the garbage of humanity*), probably also attracted the taint and stigma of their necessary association with lunatics. Thus they were more easily downgraded in terms of salary and working conditions, by a government which knew their plight would not attract too much public interest or concern.

In 1858, the government, always eager to control costs (particularly in light of the inflation caused by the gold rush), established a Parliamentary Select

200 Ibid.
Committee to inquire into ways in which money might be saved in government
services and institutions. The Medical Superintendents of the Tarban Creek and
Parramatta Asylums, were called to testify. Both Campbell and Greenup
assertively argued there was no wastage in their respective asylums. On the
question of salaries for senior staff, Dr Campbell suggested downgrading the
position of Steward, which he said did not require an educated man to fill. An
unsurprising opinion given the trouble caused to Campbell, by almost all
incumbents occupying that position since its inception.

Campbell told the Select Committee, he would rather have a position for a clerk
than a Steward, which was a more nebulous position in nature. He stated he was
overburdened by clerical duties, and wanted the position of Clerk to be second
only to his position, with a salary of £150 per annum. To pay for this
reorganisation, Campbell suggested abolition of the Master Attendant’s position,
which, he stated, was “not very useful to me… [although the incumbent was] a
very trustworthy man… would be a very good doorkeeper or messenger.”201 The
Master Attendant’s salary of £90 could then be utilised to offset the cost of
employing a clerk, the rest made up by “several small reductions necessary to be
made to equalize the pay of some of the attendants.” This would, Campbell
continued, “effect a saving in the end of £3 to the revenue.”202 In is unclear what
Campbell was thinking when making his statement as Tarban Creek Asylum’s
cost estimate for the year was between £9,000 and £12,000.203 Campbell’s
suggestion to dispose of the Master Attendant’s position and replace it with the

201 Progress Report from the Select Committee on Retrenchment in the Public Expenditure.
202 Ibid.
203 Ibid, p.113.
new position of Clerk, was possibly a hope or wish; he wanted someone whose role, in effect, would be to assist him.

Following Dr Campbell’s suggestion, Dr Greenup was questioned regarding his Master Attendant (who received £130 per annum), and asked if he would recommend abolition of the position. Greenup defended the Master Attendant; “I have the sole and unassisted medical charge of 525 patients, and I try to see every day every one of them, and if I have entirely to depend on my own eye, you may think what time it would take.” And further, “…the only way I can get through attending to 525 patients – [is] by making everybody attentive to their business. My great help on the male side is, of course, the master-attendant.”

When asked if he could reduce his staff, Greenup explained that due to the large increase in patient numbers at the Parramatta Asylum, he was forced to ask the government for permission to hire even more attendants.

Unfortunately, in the few years following this Inquiry, cost saving resulted in government reluctance to authorise the employment of additional staff. Thus, by the early 1860s, due to this and poor working conditions, gross understaffing was endemic at the asylums. The attendant: patient ratio was 1:20 at Tarban Creek Asylum and 1:22 at Parramatta Asylum, whilst in England and parts of Europe, the acceptable standard was 1:10. Not only did this place considerable work strain on the attendants, it also resulted in the curtailing of important activities such as patient occupation and amusement. When questioned about the severe

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204 Progress Report from the Select Committee on Retrenchment in the Public Expenditure. (Minutes of Evidence Greenup, R.), 1858, op.cit., p.125.
205 Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Campbell, F.), 1863-64, op. cit., p.891.
shortage of attendants at Tarban Creek Asylum, and why he had not lobbied for more, Campbell replied;

I have never wished to trouble the government when I have been able, by any self sacrifice, or by any other means; carry on the duties of the asylum.  

It is unclear from his statement whether or not Campbell’s reference to *self sacrifice*, meant his own or his attendants. In either case, as the following evidence notes, it was not he who suffered under the persistent and extremely poor working conditions.

At the Parramatta Asylum, working conditions had deteriorated so much that by 1863, notwithstanding the expectation of complete loyalty to the Superintendent and the institution; the attendants, during an Inquiry, raised a range of serious complaints.  

These complaints included;

- low wages – said to be less than labourers;
- heavy fines if a patient was injured during a shift;
- extremely long hours – on duty up to 16 hours in 24, in one instance an attendant claimed he was put on duty for 17 hours and then was called up again within an hour;
- having to buy their own clothing which was often damaged by patients whilst on duty, and not replaced;
- very poor rations – only given bread and tea for breakfast and supper;
- forced to sleep in the dormitories, with the patients, as separate staff accommodation did not exist (except of course for the officers);

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208 Ibid, (Minutes of Evidence Parramatta Asylum attendants).
• not allowed out of the asylum at night or in off duty hours – only permitted out during the day for 3½ hours in 48;
• only allowed out of the asylum for two days in every three months - and sometimes had to wait four to five months before being allowed out;
• The Superintendent (Dr Greenup) indulged his favourites among the staff;
• Dr Greenup ignored the attendants’ concerns, unsympathetically indicating they could resign if they did not like the work.

These issues caused some disquiet among the attendants and two years previously, as a body, they discussed writing a petition airing their complaints; which the Superintendent should then have passed onto the Colonial Secretary. However, the attendants were told by the doctor (Greenup), “it was no use,” in effect telling them they were wasting their time.\textsuperscript{209} This implied Greenup had no intention of allowing the complaints to be forwarded, and perhaps fear of retribution prevented the attendants from persisting in the matter. Despite airing their complaints at the Inquiry, working conditions and wages for attendants was to remain very poor for a number of years. For example, 13 years later in 1876, a Board of Visitors Inquiry noted the staff did not have proper facilities for preparing meals or enough time to eat during their breaks. The Board observed, “In regard to the accommodation for the attendants, it is in rather worse condition than when the Board reported in 1870.”\textsuperscript{210} They found neither provision made for sitting rooms for the attendants, nor any means of recreation for either male or female attendants. The Board particularly condemned the continuing practice

\textsuperscript{209} Ibid, (Minutes of Evidence Dunn, L.), p.951.
\textsuperscript{210} Board of Visitors Report Concerning Conditions of the Lunatic Asylum Parramatta. \textit{N.S.W.L.A.V.& P.}, Vol. 6, 1876-77, p.94.
(especially in the female division), of forcing a number of attendants to share the
dormitories with patients. The Board recorded, the attendants sharing of space
with the patients;

[which] combined with the long hours, probably accounts
for a fact we have long regretted to observe, namely, the
rapid deterioration in the health of young women after
first entering upon their duties.\(^{211}\)

Of the male attendants’ accommodation, the Board of Visitors found, “the
wretched accommodation… mitigates very seriously against the chances of
getting a superior class of men.”\(^{212}\) On a slightly more positive note, the Board
found no complaints regarding the number of attendants, and married attendants
were now permitted to sleep out of the asylum for one week in three. The Board
recommended improvements for the accommodation of attendants, and whilst
extensive additions to the asylum during the 1880s ameliorated conditions for
male attendants, a separate nurses’ home for females was not constructed until
1899.\(^{213}\)

Following the Report of the Committee of Enquiry of 1855, the Government
provided money for capital improvements at the two asylums. Following this
increased funding, Dr Campbell, referring to Tarban Creek Asylum
enthusiastically noted, it was “to the honour of the Government which has of late
enlarged and endowed it with unprecedented liberality.”\(^{214}\) At Parramatta
Asylum, part of the former Governor’s Domain, across the river from the
asylum, was granted to the institution to establish a farm for the occupation of

\(^{211}\) Ibid.
\(^{212}\) Ibid.
\(^{214}\) Campbell to Colonial Secretary, 18 July 1863, Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Appendix), 1863-64, op. cit., p.838.
patients. Extensions were also begun in 1861 to provide accommodation for criminally insane male patients, who were now admitted to Parramatta rather than Tarban Creek Asylum.\textsuperscript{215} The government had also commenced negotiations to purchase a property adjacent to the Parramatta Asylum for future, further extensions.\textsuperscript{216} In spite of the improvements, both asylums were the objects of severe criticisms during early 1863, in particular, following a visit from Bishop Willson.

5.6: Yet another Inquiry: The Select Committee on Lunatic Asylums, 1863 - 64.

The Catholic Bishop of Hobart, Dr Robert William Willson, visited both the Tarban Creek and Parramatta Asylums and what he saw appalled him. Bishop Willson, a social reformer, was an outspoken critic of the official treatment of colonial society’s underprivileged and outcast; particularly convicts and the mentally ill. Prior to his appointment as Bishop of Hobart, Willson had for twelve years been a member of the Executive Board of Management of the Nottinghamshire (England) County Lunatic Asylum, and in 1839, obtained a license to convert his own home into a private lunatic asylum. After his arrival in Tasmania, Willson was a foundation member of that colony’s Board of Commissioners, overseeing mental health care, where his reformist zeal brought about many positive changes. Moreover, after exposing and lobbying against the abuses committed by the island’s authorities, Willson’s concern for the plight of convicts resulted in the closure of Norfolk Island as a penal settlement. His reforming activities had won public praise in both England and the Australian


\textsuperscript{216} Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Minutes of Evidence Statham, E.), 1863-64, op. cit., p.936.
colonies and his work was already well known in New South Wales prior to his visit.\textsuperscript{217}

Following his visit, Bishop Willson wrote a letter to the Colonial Secretary, condemning both the colony’s Asylums. Bishop Willson described the Parramatta Asylum as “a frightful old factory prison… with its doleful cells and its iron bar doors, even for women,”\textsuperscript{218} (it was bad enough that lunatic men were kept behind barred doors, Willson was appalled that the women were also).

However, despite the poor physical facilities, the Bishop was much more positive about the care given; “great cleanliness and order were evident in every part; no doubt the best is done for the patients.”\textsuperscript{219} Regarding Tarban Creek Asylum, Bishop Willson drew particular attention to its facilities. The asylum was;

so gloomy, and so ill-constructed for proper classification and in fact so ill-adapted for the humane, wise and truly economical system now everywhere carried out both in our native land [England] and on the Continent of Europe... High walls with no sight of green trees, no flowers, no human beings seen…\textsuperscript{220}

The Bishop went on to criticise the lack of a proper infirmary, no Chapel or large room where amusement of the patients could occur. On the outside;

From the rocky and sterile nature of the adjoining ground there is want of out-door employment in gardening or farming occupations.\textsuperscript{221}

Indicative that the Bishop was not being critical of Campbell personally, or his treatment and care per se, Willson noted;

\begin{itemize}
  \item \textsuperscript{218} Bishop Willson to Colonial Secretary, 25 July 1863, Select Committee of Inquiry into the Present State and Management of Lunatic Asylums. (Appendix), 1863-64, op. cit., p.836.
  \item \textsuperscript{219} Ibid.
  \item \textsuperscript{220} Ibid, p.833.
  \item \textsuperscript{221} Ibid.
\end{itemize}
If Dr Connolly or Bucknill or Tuke were to supersede Dr Campbell even his efforts must be paralysed in such buildings.222

Dr Campbell, evidently had prior knowledge of some of the Bishop’s criticisms, and in his usual style, decided to pre-empt the Bishop’s letter by submitting one of his own, to the Colonial Secretary, a week in advance of the Bishop’s. Campbell repudiated the Bishop’s opinions as though they were intended as a personal affront to him, attacking the Bishop for;

denouncing the management, the treatment, the structure, the site and the character [of Tarban Creek Asylum] in such a tone of dogmatism as will no doubt lead to the general belief that all that he asserts must be true.223

Campbell then denigrated the Bishop’s record as a reformer, presenting instead his own credentials for the title. Indicating his reforms were superior to the famed “Connolly, Bucknill and Tuke” in England, Campbell grandiosely added (in part);

I have the unspeakable satisfaction of having thoroughly and demonstrably gained the advantage over the most enlightened of British Superintendents and placed the Asylum over which I preside in a loftier position in regard to Government and the treatment of lunatics than the most advanced and favoured of European asylums.224

Later, Campbell was severely and very publicly ridiculed and criticised, for these and other self-promoting and self-congratulatory remarks, by the editor(s) of the Sydney Morning Herald.

The government was embarrassed by the claims and criticisms of Bishop Willson, and in its usual response, announced an Inquiry. This Inquiry was given

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222 Ibid.
223 Campbell to Colonial Secretary, 18 July 1863. ibid, p.838.
224 Ibid.
to a Select Committee of the Legislative Assembly, and charged to *Inquire into the Present State and Management of Lunatic Asylums*.

The Select Committee heard evidence criticising the physical conditions at both asylums. In spite of some government spending in recent times, the problems were more or less the same as those exposed in every Inquiry since 1846, for example; overcrowding, lack of proper classification of patients, poorly designed buildings, poor siting of the asylums. However, the actual care and treatment of the patients was considered adequate.

Whilst Parramatta Lunatic Asylum had its farm for the occupation of patients, there was little progress in outdoor occupation at Tarban Creek Asylum. Parramatta also seems to have put more effort into other areas of patient occupation and amusement. For example, the Storekeeper boasted of a large group of female patients, escorted by attendants, taken into the town for public celebrations upon the marriage of the Prince of Wales. He also detailed the variety of activities (games) offered, and of allowing musically trained patients to play instruments.  

> In this regard, Dr Greenup noted the difficulty of motivating patients, “Lunatics require more to be led to amusement than to amuse themselves,” and in a rare acknowledgment of the ordinary attendant’s role in moral therapy, Greenup stated, “they are the leaders in amusement.” Greenup also stated that more could be done, if he had additional and “the proper kind of attendants.”

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227 Ibid.
Regarding the amusement of patients at Tarban Creek Asylum, Dr Campbell whilst supportive of the “cheerful amusement,” was quite opposed to dancing and provided a moralistic condemnation of it;

I do not like exhibitions: I have always set my face against exhibiting that most appalling of all calamities to which flesh is heir to, the public gaze.\textsuperscript{228}

In relation to the attendants, during the course of the Select Committee Inquiry, a number of complaints regarding poor wages and conditions were aired by male attendants (no women at all were called to testify during this Inquiry), principally from the Parramatta Asylum.\textsuperscript{229} The violence of patients and potential for injury to attendants working with the violent mentally ill, received scant, but at least some recognition during the Inquiry. For example, one attendant told the Inquiry he had been required to defend himself against an assault by knocking the attacking patient down. Interestingly, in this instance, and prior to the assault, the patient indicated to the attendant;

…he might kill me and I would get no law, as he had a doctor’s certificate; and that if he broke away, and killed all the people in the Colony, he could not be hanged.\textsuperscript{230}

The threat of serious injury or worse, through patient violence, was a constant occupational risk for asylum attendants. And, whilst injuries to attendants caused through violence rarely found exposure in official reports, the murder of two attendants at Gladesville Hospital for the Insane could not be ignored. In 1884, Senior Attendant Robert Colvin died of peritonitis caused by being kicked in the abdomen by a patient. It was recorded that his wife received a “liberal sum” in

\textsuperscript{228} Ibid, (Minutes of Evidence Campbell, F.), p.895.
\textsuperscript{229} Already referred to elsewhere in this work.
compensation. In 1889, Attendant Hubert Small died when his skull was fractured by a patient wielding a broom. Small was a young unmarried man and no report of compensation, apart from an offer of condolence to his parents, appears to have been made. Neither case caused concern or a public uproar (unlike when Dr Greenup was murdered in 1866 – see later in this chapter), these accidents, as they were referred to, were considered the occupational hazards of attendants working with the insane.

Perhaps differences in the way officials and the public viewed and responded to the death of an attendant, as opposed to a medical superintendent, relates to the class, position and status of those people. A doctor was considered of greater social value than an attendant and, after all, a significant minority were, members of society’s elite. On the other hand, the attendant was merely one of a multitude of ordinary workers and “accidents” were a commonplace occupational occurrence of the working class, and also inevitable, due to poor working conditions endured by most 19th century workers.

Following the 1863 Inquiry, the situation in regard to the asylums and to the care and treatment of the mentally ill remained much the same. There was no immediate overt change in government policy. However, as later events may show, notions regarding a reformation of mental health care services may have germinated, or were given new impetus, in the minds of some of those governing the colony.

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5.7: Restraint versus non-restraint in New South Wales Asylums.

It has already been noted that the Parramatta Lunatic Asylum became a receptacle for patients considered incurable, many of whom were convicts or ex-convicts. The patients at the Parramatta Asylum were observed to be much quieter than those at Tarban Creek Asylum, which was said to be due to their being “in a more uniform condition of passive imbecility, and rarely subject to maniacal excitements.” Further, the patients at the Parramatta Asylum were described thus, “a very large proportion of the inmates… have been convicts, and accustomed therefore to discipline and regularity.”

In contrast to Dr Campbell’s treatment philosophy of non-restraint at the Tarban Creek Asylum, mechanical restraint formed a significant part of the treatment provided at Parramatta. Dr Greenup had few qualms about the use of restraint at the Parramatta Asylum. He informed the Commission of Enquiry in 1855, that he generally followed the practices of his predecessor Dr Hill, with one exception – he did not confine violent patients perpetually to their cells; he allowed violent patients to walk about airing yards wearing mechanical restraint. In pointing out inconsistencies with the non-restraint method, Greenup stated;

> At Hanwell, one of the model lunatic asylums in England, they always shut up refractory patients in cells, and still they say that is the non-restraint system; and it is not restraint, it is simply taking them away from doing mischief.

Greenup also told the Commissioners that violent behaviour could result in the patient being placed in a restraining belt, described as being a leather belt with handcuffs attached. This was exactly the same restraint used by Joseph Digby

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234 Ibid.
236 Ibid.
at the Tarban Creek Asylum and which, in 1846, resulted in so much criticism from the medical profession. However, the “belt” was not the only mechanical restraint employed at Parramatta Asylum; patients could be handcuffed, strait waistcoated and even “fastened to a post” to prevent self-injury. At the 1855 Commission of Inquiry, there was no criticism of Dr Greenup’s use of restraint (it should be noted that three of the five Commissioners were doctors). It can only be assumed that when applied on the orders of a doctor, mechanical restraint was treatment, but when applied by a medically unqualified person (like Joseph Digby), it was inhumane and cruel.

The use of mechanical restraint seems to have continued unabated until the appointment of Greenup’s successor, Dr Edward Waldegrave Wardley, on June 1st 1867. Dr Wardley was promoted from his position as Assistant Medical Officer of the Tarban Creek Asylum, and as such, had been working under Dr Campbell and was experienced in the non-restraint system of treatment. Wardley was appalled at what he found at Parramatta Asylum. Writing to Mrs Jane Manson, Matron of Tarban Creek Asylum, within the first week of his appointment, Wardley wrote;

Abuses/the accumulation of years/I can see plainly enough will have to be swept away, and I have already made a beginning in regard to the non medical treatment of the Patients. I found one Max Cameron… in solitary confinement with his arms pinioned just sufficiently to allow him to walk in solitude up and down a corridor… I immediately ordered him to be set at liberty and allowed the full use of the yard… He could hardly on the first day regulate the motion of his arms so as to feed himself… [In the imbecile ward] [I] found a ‘frightfully dangerous’ individual with his arms pinioned to a waistbelt, I ordered them off instantly… On the female side I found a fine young woman strapped to the post… [and] ordered that it be

237 Ibid.
discontinued… [I] found the abomination repeated the next morning… [I] then found little Sarah Smith the deaf and dumb girl who was so mischievous at Tarban hobbled and with her hands confined – [I] expressed my utter abhorrance [sic] of all such practices and remarked generally on them … The work to be done here will be liking [sic] sweeping out the Aegean [sic – Augean?] Stables… of course we must expect a great deal of combination against their reform. It will require discretion to deal with but by the help of that steady determination we shall let some daylight in.

Wardley told Matron Manson of the attendant’s objections to his freeing of the patients, from restraint, noting only one, James Firth the Storekeeper (and former Steward of Tarban Creek Asylum), supported his actions from the beginning. Wardley insisted on the implementation of non-restraint methods, however, whilst he had the authority to insist on its implementation, he knew the staff were not altogether supportive. At an address given before the Philosophical and Literary Society of Parramatta in 1871, Wardley attacked the “inhumanities” of the old system of restraint and wondered how medical men of the past could condone it. Regarding the subordinate members of the Asylum’s staff Wardley stated;

Sub-officers and attendants would, I believe, almost to a man, whatever their verbal declarations might be, readily retrograde into the old system, because it lessens their trouble and responsibility. Their bent, from this feeling therefore, is to exaggerate the violence of the aggressive and magnify the danger of their injuries to others; and if a superintendent were not fully known to hold the non-restrictive principle inviolable, he would be misled by their representations, and there would soon be the plentiful supply of belts, manacles, fetters, straitwaistcoats, and muffs, in the wards, which was the disgrace of asylums in the days of our fathers.

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238 Wardley to Manson, 7 June 1867. (Typescript – original not sighted), Cumberland Hospital File, Parramatta Heritage Centre.
239 Wardley, E., *Some Phases of Insanity and its Treatment, Popularly Considered.* (Read before the Meeting of the Philosophical and Literary Society of Parramatta), John Ferguson, Sydney, 1871, pp.20-21.
Wardley’s public attack on the “old system” was in response to a softening of official attitudes against the use of restraint, in part due to a voluminous report written by Dr Campbell’s successor, Dr Frederic Norton Manning, at the Tarban Creek Asylum. Dr Manning was requested by the colony’s Colonial Secretary, Henry Parkes, to visit a variety of asylums around the world, and prepare a report to advise the Government on the best way to establish a comprehensive lunacy service for New South Wales.

Manning visited asylums in Britain, Europe and the United States, and wrote a report which was essentially a comparative analysis of asylum construction, management, staffing, and methods of treatment, observed during his visits. Manning presented his report in 1868, and whilst not openly advocating the re-introduction of mechanical restraint, he presented a variety of arguments for and against its use, collected from Medical Superintendents around the world.\(^{240}\)

Manning found that most objections to restraint came from British authorities and advocates of its use came from the United States. Concerning the British objection to restraint, Manning observed;

> During the last few years there has been a certain reaction in the feelings of superintendents of asylums on this subject; in quite half of the asylums visited, although restraint was not practised, its advantage in certain cases was distinctly admitted; and it does not now meet with the all but wholesale condemnation which it was accorded to it some years ago.\(^{241}\)

Manning reported that the use of seclusion for violent patients (in padded cells where available) was almost universally used in the asylums he visited, but he especially noted Dr Kirkbride’s (Superintendent of the Pennsylvania Hospital)


\(^{241}\) Ibid, p.119.
views on seclusion. Kirbride was an advocate of mechanical restraint but opposed to seclusion;

“Seclusion is always bad; no teaching by means of the senses is going on the while, and patients who have bad habits almost always practise them when in seclusion.”

Included in the discussion of restraint was the medical use of cold and warm baths and shower baths (which were applied to patients whilst locked in specially constructed cabinets). Manning found the use of shower cabinets relatively common (but not universal) in Britain and Europe but, “In America its use has been totally abandoned, owing to the strong prejudice felt against it by the public, and its liability to abuse.” Manning, demonstrating his open mindedness, concluded his discussion;

It is not a little curious that, owing more or less to popular clamour, and to a fear of the abuses to which they are liable; mechanical restraint has been virtually abandoned in Great Britain, and the shower bath has ceased to be used in America, and so a mode of treatment, useful in a certain number of cases, is lost to the Physician in each country.

In spite of Wardley’s (and earlier Campbell’s) insistence on non-restraint methods in the two asylums then extant in New South Wales, mechanical restraint stealthily crept back into use. Manning was later to become Australia’s first Inspector General of the Insane, controlling lunacy services in New South Wales until the end of the 19th century. In Manning’s official Annual Reports, numerous examples of his observations (during asylum visits) of the use of mechanical restraint (principally camisoles), which he did not in principle object

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242 Ibid, p.121.
244 Ibid.
In an attempt to prevent abuse of restraint, attendants were not permitted to “place a patient in mechanical restraint except by medical authority.” By the mid 1880s, in cases of emergency, attendants were given the authority to seclude violent patients without a prior order from the doctor; in a sudden access of violence the attendants may, for the safety of the patient and the protection of others, place the patient in seclusion, but they must, in this and in all other instances in which force is used, at once report the fact to the Chief Attendant.

The use of mechanical restraint continued in New South Wales mental health facilities until the mid 1960s, and apparently in some places a little longer. It was reported as late as 1970; although the majority of such devices are now of historical interest, the wide use of camisoles persisted almost to the present time, with occasional use still occurring... in spite of much administrative and clinical improvement in psychiatric hospitals in recent years, the use of camisoles or straitjackets has persisted so long.

Nevertheless, by the mid 1860s, the Medical Superintendents of the colony’s two asylums were becoming quite elderly (Greenup was born in 1803, Wardley in 1798). For both, the prospect of retirement in the next few years may have been anticipated. However, a tragedy would end the life of Greenup, and Campbell doggedly held on until wearied by years of constantly battling government inaction, compounded with public criticism, he sought retirement.

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246 Ibid.
247 Ibid.
5.8: The end of the old guard Superintendents.

In July 1866, Dr Greenup met his tragic death at the hands of a criminally insane patient, James Cameron. Indicative of Greenup’s medical treatment, Cameron had developed delusional ideas regarding the use of the “lancet” (a bleeding instrument), which Cameron believed was associated with the “black arts” (witchcraft). During his morning round on July 17th, Greenup approached Cameron in the yard of the criminal ward and inquired about his health. Greenup stated to Cameron, “You look rather pale this morning – rather greenish.” Cameron replied, “You don’t see any green in my eye,” then quickly drew a large pair of scissors from his clothing and plunged them into Greenup’s right side. It happened so quickly, Greenup at first didn’t realise he had been stabbed, and (probably in shock) denied to the Master Attendant Michael Prior, that he was hurt. However, Greenup was seriously injured; the scissors had penetrated the abdominal wall and the great omentum, and severed a coil of the small intestine. In spite of the attendance of some of Parramatta’s best doctors, Dr Richard Greenup died on the afternoon of July 20th, from generalised peritonitis.

The scissors used in the attack were normally kept on a nail in the lower attendants’ room, and just how Cameron obtained access to them was the subject of speculation at the Coroner’s Inquest. In piecing the circumstances together, it was concluded that a key to the attendant’s room, was left in the pocket of a coat hanging in a corridor. Cameron was presumed to have taken the key and obtained the scissors, whilst washing the walls of the corridor on the morning of the

249 Sydney Morning Herald, 16 August 1866, p.8.
250 Murderous attack upon Dr Greenup. Sydney Morning Herald, 18 July 1866, p.5.
251 The death of Dr Greenup – Inquest on the body. Sydney Morning Herald, 20 July 1866, p.5.
assault. Without apportioning blame to any particular person, the jury at the
Inquest criticised the “carelessness in the custody of the key.” Greenup
himself, however, was viewed as contributing to his own death. For instance, an
account of his funeral and obituary was published in the popular press, and
reinforcing the notion that lunatics were dangerous, it commented;

…those who knew him best testify to his considerate and
humane disposition, which led him to be too trustful even
of men such as those who are confined in the criminal
division of the asylum – a confidence which has
eventuated in his untimely decease.

In contrast, Dr Francis Campbell’s departure from lunacy services (in view of his
personality and reactive disposition), was somewhat sedate. The year following
the Select Committee of Inquiry of 1863/64, Campbell’s administration of
Tarban Creek Asylum came once again under public scrutiny. In response to a
leaked report from the Tarban Creek Asylum’s Board of Visitors, critical of the
facilities at the institution and suggesting the construction of a new asylum, the
popular press supported the Board’s recommendations. In a series of editorials
beginning in August 1865, the *Sydney Morning Herald* bemoaned the situation of
patients confined within stone walls:

Where they see nothing of the beauties a few hundred
feet distant from them;— no verdant sward – no river with
its life and movement, greets their eyes. They are
neglected and forgotten.

Excusing Campbell, the editorial attacked the prison like, overcrowded
conditions and blamed the government for not finding the resources necessary to
improve the asylum. The editorial called on the colony’s wealthy elite to create

252 Ibid.
253 The Late Dr Greenup. *Sydney Morning Herald*, 23 July 1866, p.4.
254 *Sydney Morning Herald*, 23 August 1865, p.4.
and contribute to a private charity, which could philanthropically fund better services (or a new asylum) for the mentally ill. However, one week later, a subtle change in tone of the Herald’s editors regarding Campbell was evident. Critical that nothing had changed at Tarban Creek Asylum for years and calling for the construction of a new asylum, the editors observed that a new asylum with new officers appointed, would be of no use if the system stayed the same. Implying Campbell was old fashioned, the editors stated;

The treatment of the insane in all civilised countries has undergone as great a revolution as any branch of science. It requires a new course of study in the profession.

In acidic and sarcastic prose, equal to Campbell’s own offerings as IATROΣ, the Sydney Morning Herald’s editorial on the following day, clearly demonstrated Campbell’s standing had plummeted. Lamenting the state of mental health services in the colony it stated, “All we have to boast of is, says the Sydney Empire, is one asylum for incurables, and another for making incurables.”

Attacking Campbell directly and personally, the editorial cited a letter written to the Colonial Secretary by Campbell (July 18th 1863 - noted previously), in response to Bishop Willson’s criticisms two years earlier. The following excerpt from this very lengthy editorial demonstrates the tone of the piece:

…we shall now extract, for the amusement and edification of our readers, this hero’s estimate of himself. It would appear that the world has hitherto been most culpably ignorant of the existence of a mighty benefactor, who, long patient under cruel neglect, at last comes forward and “fearlessly vindicates his own claims to the rank of a successful reformer second to none in Christendom, though the Bishop may think otherwise.” We confess with sorrow that we can find no excuse for so

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255 Ibid.
256 Sydney Morning Herald, 1 September 1865, p.4.
257 Sydney Morning Herald, 2 September 1865, p.8.
258 Ibid.
natural a thought in the Bishop. Distant as it is our misfortune to be from the newly-risen prophet, we can put forward a sort of plea of justification for our ignorance... It is but one more instance, we fear, of that perversity of human nature, whereby it happens that a prophet ever is without honour in his own country. Dr Campbell must console himself... (as others have done) by appealing to an enlightened posterity and future ages. It matters not much that some quacks, well skilled in thrasonical boasting, have made this appeal also, and that vainglorious madmen commonly do so... we have done with this melancholy exhibition of overbearing conceit and arrogant puerility, the extravagance of which is not less pitiable than it is ridiculous.

Ironically, this was the newspaper once so effectively used by Campbell to attack his predecessor Joseph Digby. Now, it turned on Campbell and he found himself defending his own reputation. Why the Sydney Morning Herald, a previous supporter of Campbell, now turned against him is unclear. No dramatic change occurred in the government, and at the Herald, the only major change was the admission to the firm of Edward Ross Fairfax, the youngest son of the proprietor, John Fairfax, in 1865.\(^\text{259}\) However, Edward Fairfax does not appear to have exerted any great influence over the newspaper during this period.

Campbell wrote to the Colonial Secretary (the letter occupied a full six pages of the Legislative Assembly’s Journal), attempting to defend himself whilst attacking the Board of Visitor’s Report. Within the letter he noted the Herald had in the past supported and praised his efforts.\(^\text{260}\) The controversy soon settled and for the next two years, Campbell presided over Tarban Creek Asylum without any major issues presenting themselves. During July 1867, Campbell wrote to the Colonial Secretary giving notice of his resignation, which he wished to take


\(^{260}\) Campbell to Colonial Secretary, 18 September 1865. *N.S.W.L.A.V.& P.*, 1866, Vol. 4, p.9.
effect after a full twenty years of service (December 31\textsuperscript{st} 1867).\textsuperscript{261} For the remaining years of his life, Campbell resided not far from Tarban Creek Asylum at Hunters Hill, where he became involved in local politics. He died October 19\textsuperscript{th} 1877 aged 79 years.

Despite giving administration of the colony’s lunatic asylums to doctors, there was little advancement in the care of the mentally ill during the almost two decades from 1850. The utopia for lunatics envisaged by Dr Campbell, was not established and the opening of a new asylum at Parramatta did not alleviate overcrowding. The majority of attendants continued to be drawn from the lowest social class, and they continued to be subjugated through the class distinctions of those who believed they were their superiors. Perhaps the one notable reform of this period was the introduction of the non-restraint system of care. Dr Campbell introduced non-restraint methods into the Tarban Creek Asylum in 1848, whilst attempting to demonstrate the gulf in philosophy of care between himself and Joseph Digby. Subsequently, Campbell’s medical assistant, Dr Wardley, introduced non-restraint into the Parramatta Asylum in 1867. However, this reform would soon be swept away and nearly a century would elapse before non-restraint methods returned to mental health care facilities in New South Wales. Nevertheless, the problems extant during the decade prior to 1850, remained unsolved, and for much the same reasons as before, that is; the lack of proper resources and planning for services by government, which resulted in an ad hoc approach and temporary solutions to problems, when public disquiet and concern was raised.

\textsuperscript{261} Campbell to Colonial Secretary, 4 July 1867. Colonial Secretary’s Papers – Letters received Lunatic Asylums, S.R.N.S.W., 67/7453.
Dr Campbell’s successor, Dr Frederic Norton Manning, was eventually to
dominate lunacy services in New South Wales in the last twenty five years of the
nineteenth century. It was Manning who would initiate reform of the colony’s
mental health services, leaving a legacy that survived until the final quarter of the	twentieth century.
In this chapter, reforms and improvements in mental health care and services following the employment of Dr Frederic Norton Manning as Medical Superintendent of Tarban Creek Asylum are examined. Also, the early development of the future profession of mental health nursing is explored including the profession’s adoption and use of methods contained within the philosophy of Moral Treatment. Following an Inquiry into corrupt officials at the Parramatta Lunatic Asylum, the government finally decides to establish a Department of Lunacy, wholly concerned with the development of services for the insane. Dr Manning is appointed as Head of the new department and begins to introduce the reforms he first articulated in 1868, including promoting the notion of scientific treatment of the insane. Through his reforms Dr Manning succeeded, in a sense, to bring method into madness.

6.1: Enter Dr Frederic Norton Manning.

Despite the medical profession’s dominance over lunacy services from 1848, the following two decades did not see any substantial improvement in mental health care. Evidently, replacing the first experienced carer of the mentally ill (Joseph Digby), with the learned (though inexperienced) Dr Francis Campbell, had not yielded the promised results. By 1868, despite the establishment of another lunatic asylum at Parramatta, this time with a learned and experienced doctor in charge (Dr Richard Greenup), overcrowding persisted as a major problem. This was in part due to the colony’s increased population; but also, the promised alleviation of mental illness (or cures) through medical treatment, did not
eventuate. These issues, combined with government inaction and reluctance to properly resource services, and the inability of asylum superintendents to attract enough and/or a better class of applicants for attendants’ positions, effectively prevented any real progress.

The man who was to dominate and change mental health services in the late 19th century, Dr Frederic Norton Manning, first arrived in New South Wales in 1864. At the time, Manning was serving as a Royal Navy Surgeon on the *H.M.S. Esk*, which was visiting Sydney before proceeding to New Zealand where it took part in the Maori War. Manning brought with him, letters of introduction in which he was described as highly distinguished in the medical profession. With his gentlemanly manners and interesting conversation, he quickly impressed some of the colony’s elite.  

After seeing active service in New Zealand, and on its return journey to England, the *H.M.S. Esk* revisited Sydney in June 1867. Dr Manning took the opportunity to visit the Colonial Secretary, Henry Parkes, who saw an urgent need to reform lunacy services. Parkes had already begun to reform general health care services and had written to Florence Nightingale, requesting her to send a party of trained nurses to improve nursing care at Sydney Hospital.  

Parkes invited Manning to Superintend the Tarban Creek Asylum, as the incumbent, Francis Campbell, had just given notice of his intention to retire at the end of the year. Manning accepted the appointment, but as he had to wind up personal affairs in England, he would not be able to commence his duties until the following year. Manning returned to England aboard the *H.M.S. Esk*.

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3 See Chapter 7.
however, prior to departure, Parkes commissioned Dr Manning to visit as many asylums as possible in Britain, Europe and the United States.\textsuperscript{4} Parkes instructed Dr Manning to;

\begin{quote}
…direct your inquiries in these visits to the principles on which the buildings have been erected, and the sanitary precautions adopted in their construction. You will carefully observe the different methods of treatment, and obtain statistical evidence of the results in separate cases… You will examine the working of different systems of management and discipline, and endeavour to ascertain the effects of the different forms of administrative organization on the condition of the patients, and in relation to efficient supervision and economy of expenditure…
\end{quote}

You will obtain… copies of all regulations, dietary scales, and reports. …and the end to which all this information is to tend is “a reorganisation of the lunatic asylums of the Colony on the basis of a correct knowledge of the improvements carried out under more favourable circumstances in other parts of the World.”\textsuperscript{5}

Manning returned to New South Wales, submitted his report to the government and as formally appointed to the position of Medical Superintendent of Tarban Creek Asylum on October 15\textsuperscript{th} 1868.\textsuperscript{6}

\textbf{6.2: Manning’s Report on Lunatic Asylums.}

During a period of six months, Manning visited an extraordinary number of asylums around the world. In England he visited 25, in Scotland 9, the United States 14, France 9, Germany 4, Belgium 5, Holland 1 and New Zealand 1; a total of 68 asylums worldwide. As might be expected, given his commission and the number of asylums visited, Manning’s Report was extremely detailed and lengthy and made a multitude of recommendations framed as “suggestions.”\textsuperscript{7}

\begin{itemize}
  \item \textsuperscript{4} Obituary, Frederic Norton Manning. op. cit.
  \item \textsuperscript{5} Manning, F.N., \textit{Report on Lunatic Asylums}. Government Printer, Sydney, 1868, p.i.
  \item \textsuperscript{6} McDonald, op. cit., p.192.
\end{itemize}
Manning’s suggestions provided the blueprint from which the pattern of lunacy services was to develop well into the twentieth century. The Report is too extensive to be covered in detail in this work, broadly however, Manning recommended the construction of new asylums on abundant land, with patient populations limited to around 400 to 500 each, but never to exceed 600. This number was exceeded - the perennial problem of overcrowding was to remain a major problem throughout the 19th century. He also suggested a Board of Inspection to administer the asylum system, but the government did not wish to reduce parliamentary authority so the Board was never created. However, Manning’s recommendation that the government establish an Inspector of the Insane, who possessed legal and executive powers over the asylums, was later adopted. Indeed, when the position of Inspector of the Insane was introduced eight years later in 1876, Manning was appointed as the first incumbent in the position.

Manning was extremely critical of both existing asylums in the colony. Referring to the Parramatta Asylum he stated, “The buildings ... are utterly and completely unfit for the purpose for which they are at present employed…. No amount of money or skill can avail to render (it) a fit residence for the insane.” At the Tarban Creek Asylum, Manning criticised the lack of facilities and the isolated site as visitors found access very difficult. He recommended the construction of a new asylum for Sydney, sited closer to the city, following which Tarban Creek Asylum was to “be put to some useful purpose, as a Destitute or benevolent

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Asylum, the sooner it ceases to be a residence for the insane the better.”\textsuperscript{10} Whilst too extensive to cover the entire report in detail, it is Manning’s recommendations concerning attendants, which is most relevant to this work.

6.3: Recommendations concerning attendants of the insane.

Manning believed there should be one Chief Attendant or Supervisor for each sex,

\[ \text{to exercise a general oversight of all the patients and their attendants, and form a medium of communication between them and the medical and other officers of the institution.} \textsuperscript{11} \]

He recommended the careful selection of candidates for these senior positions, “\textit{to secure the services of persons possessing tact, intelligence, and, above all, a special acquaintance with the insane}.” Manning further urged “they should receive liberal remuneration and good treatment.”\textsuperscript{12}

Concerning the employment of ordinary attendants Manning stated,

\[ \text{[It] will depend no small part of the success of the institution, and every care should be taken, to secure the services of young, active, and intelligent persons, to instruct them in the duties of their office, and to induce them to remain in it. A fair education is indispensable.} \textsuperscript{13} \]

In this regard, Manning wanted literate attendants so they might be trained in their special duties. He observed, “Your first attempt ought to be to cure your keepers; you need not proceed to your patients till you have done so.”\textsuperscript{14} By this, Manning meant it was necessary to ensure attendants and nurses were competent to manage patients properly and their competence to manage the mentally ill

\textsuperscript{10} Ibid, p. 161.
\textsuperscript{11} Ibid, p. 205.
\textsuperscript{12} Ibid.
\textsuperscript{13} Ibid.
\textsuperscript{14} Ibid.
depended on education and training. Manning realised that without this education and training, attendants and nurses were merely turnkeys and the potential for patient recovery depended on staff having some therapeutic knowledge.

Manning also recommended that attendants be supplied with good food, have comfortable and well-furnished bedrooms and reasonable periods off duty, away from the asylum. Nevertheless, he believed strict discipline was necessary and fines should be imposed for some offences, for example, negligence of duty. However, he also warned that a system where fines were enforced for minor offences “is liable to prove irritating to the attendant.”\textsuperscript{15} The proportion of attendants to patients was fixed by most authorities at 1:10, however, Manning believed 1:12 or 14, was quite acceptable. He further recommended the introduction of uniforms, “not suggestive of the police or the prison,” but “some quiet dark colour, relieved by white cuffs and collar, and made as becoming as possible for the women.”\textsuperscript{16}

Manning also said an efficient night watch was necessary, to guard against accidents, minister to the sick, calm the noisy and raise those patients who were incontinent. He observed, not only the comfort of the patients would be ensured but, the ordinary attendants will secure sound sleep …If the attendants are disturbed repeatedly at night, they will, in all probability, be irritable and inattentive during the day, and so utterly unfit for the special character of their work.\textsuperscript{17}

\textsuperscript{14} Ibid.
\textsuperscript{15} Ibid, p.206.
\textsuperscript{16} Ibid.
\textsuperscript{17} Ibid.
Manning’s “suggestions” appear to be the first clear and coherent attempt in Australia, to define the minimum standards expected of applicants for attendant positions. To reduce employee turnover, Manning also recommended attendants’ working conditions be improved as he recognised a certain investment was necessary to retain good staff. Manning’s expectation that attendants be better educated (than previously), prior to taking positions, as well as trained afterwards, shows he felt attendants and nurses might be moulded into semi-skilled or perhaps quasi professional workers, which would raise them above the lower order of labourers. Moreover, introduction of a new and standard uniform would set attendants apart and identify them as a unique body of workers. However, despite recognition of the importance of attendants’ work and their role within asylums, Manning was also very clear about the attendant’s place in the asylum’s hierarchy. For example, Manning stated categorically, the best managed asylums were those “in which the physician is the superintendent, one and supreme … and in which the appointment and dismissal of all attendants are delegated to him.”\(^{18}\) Clearly Manning, like most other doctors of his era, believed a doctor was the master of all workers in his domain and subservient to his authority as the *one and supreme*. It was during Manning’s incumbency as Inspector General of the Insane, that expectations of complete loyalty to the asylum (complainants could not bypass the Superintendent), were enshrined in the Lunacy Department’s regulations.\(^{19}\)

Despite all of this, the government did not immediately act on Dr Manning’s suggestions to improve the colony’s lunacy services; it was be several years

\(^{18}\) Ibid. p.79.  
\(^{19}\) See Chapter 5.
before some of the recommendations were initiated. In the meantime, Manning took up his appointment at Tarban Creek Asylum and began his reforms.

6.4: Dr Manning’s ten year medical superintendency of Tarban Creek Asylum.

On October 15\textsuperscript{th} 1868, Dr Manning, as the new Medical Superintendent, made his first (night) inspection of the Tarban Creek Asylum. What he found greatly disturbed him and apparently he never forgot it. Nearly thirty years later, he related his experience,

\begin{quote}
I picked my way, armed with a big bunch of some twenty heavy keys, some of them formidable weapons, and a lantern (for there was neither lamp or gas-jet in the place), among the patients spread out on the floor of every room, without bedspreads, and as thick as they could lie. I confess that my heart sank within me.\textsuperscript{20}
\end{quote}

What confronted Manning shocked him and he was determined to institute reforms. One of his first, was to successfully lobby the government for a name change of the institution and on January 22\textsuperscript{nd} 1869, the Tarban Creek Asylum was gazetted the Hospital for the Insane Gladesville (hereafter Gladesville Hospital).\textsuperscript{21} In doing this, Manning was publicly proclaiming the institution was a curative establishment; as a hospital, it was a health facility where medical treatment could be expected to occur. Further, now defined as a hospital, there could be no question of the supremacy of the doctor in determining what would, or would not, be done.

Around the same time, Manning’s predecessor, Dr Francis Campbell, spent the first few months of his retirement writing a very lengthy account (occupying 13 pages of the Legislative Assembly Votes and Proceedings) of his twenty-year

\textsuperscript{20} Australasian Medical Gazette, Vol. XVII., 21 February 1898, p.78.
\textsuperscript{21} New South Wales Government Gazette, 22 January 1869.
superintendency, which was published in the parliamentary papers in 1870.

Campbell’s report, extolling his own virtues whilst blaming others for any faults at Tarban Creek Asylum, can be assessed from the following excerpt:

  through my own personal energies alone, [I have achieved] … tantamount to conversion of a hell into a heaven for that isolated portion of the human brotherhood whom it has pleased God to bereave of all that is transcendent in man, and all that makes his life worth the tenure.\textsuperscript{22}

It is impossible to reconcile Campbell’s heaven with what was perhaps more accurately assessed by Dr Manning in his first Annual Report and printed within the same parliamentary papers.\textsuperscript{23} Manning reported the establishment was grossly overcrowded, 420 male and 230 female patients, with insufficient space in the day rooms to accommodate them (650 patients were being accommodated in an institution adapted for 300 or 350 at most). The beds in the dormitories were less than a foot apart and approximately 150 patients were forced to sleep on the floors.

Every patient was bathed once a week, with up to three patients using the same water. The shower baths were as much utilised by the attendants to punish patients as to clean them, forcing Manning to introduce special bathing rules. The toilets were primitive and stank abominably. There were no decorations of any kind in the wards or dayrooms. Recreation and amusement for the patients was insufficient and there was nowhere within the buildings that might accommodate these important activities.

\textsuperscript{22} Hospital for the Insane, Gladesville. Report of Dr Campbell, Late Superintendent. \textit{N.S.W.L.A.V.& P.}, Vol. II., 1870, p.604.

Concerning the patients’ diet, Manning reported the food was appalling with the meat being cooked by 10.30am and reheated before being served at 1pm - “The whole process of serving and eating the dinner is simply filthy and more fitted for pigs than human beings.” The buildings were rat-infested and rat nests were exposed when anyone trod through the rotten floorboards. Lighting was by dismal lamps and only sufficient “to make darkness visible”. The four padded rooms (two for each sex) had deteriorated to such an extent they were completely unusable. The conditions he said were little better for the attendants.

Accommodation for the staff was appalling, for example, the Matron had only one dark room, partitioned across the middle, where she lived, slept and worked. The proportion of attendants was much below that of almost every large asylum Manning had visited in early1868. They wore no uniforms, were untidy in appearance and several of the most senior were almost illiterate. Manning could find no set of the asylum’s rules posted within the establishment, nor could he find copies anywhere.  

Based on the problems and inadequacies laid out in his report, Manning made what he felt were 43 very urgent recommendations. These recommendations included the purchase of an adjoining estate to enlarge the grounds, there; a farm or other occupational and diversional activities could be carried out. He wanted new recreation rooms and workshops built, as well as new bathrooms and laundry facilities. The appointments of artisans, such as a carpenter, blacksmith, tailor and boot maker to the staff were also suggested. They, in turn, could both help with repairs and supervise the patients in occupational activities. New and

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24 Ibid.
better accommodation for the staff, including fit and proper mess-rooms for attendants was requested. Further, new locks should be fitted throughout the institution to be opened by one general key, as it required over twenty different keys to open the existing locks throughout the establishment.\textsuperscript{25} The general or “G” key became standard in all mental health hospitals and are still used in some facilities to this day.

Over the following decade, Manning, bit by bit, was able to correct many of the deficiencies he reported in 1870. Unlike his predecessor, Dr Campbell, Manning’s reports were pragmatic, never verbose or loaded with decorous prose, and reasoned arguments and/or statistical information supported his contentions. He also persuaded the Colonial Secretary to allow his annual reports to be printed and sold to the public (prior to 1870, the reports were sent only to the Colonial Secretary, from 1870 they were printed in the parliamentary papers). This allowed interested citizens to know what was occurring within the hospital thus demystifying, to some extent, mental health care. Also, from time to time, newspapers printed extracts of his reports, which helped to garner public support for many of his reforms. For example, in 1874, the \textit{Sydney Morning Herald} published Manning’s 1873 report, in its entirety, in which Manning lamented the gross overcrowding of exiting asylums;

\begin{quote}
No one, without being intimately acquainted with asylum management, can imagine the difficulties, the dangers, the relaxation of order and discipline, caused by overcrowding; and it is only persons who have been in charge of institutions of this character who can understand how disheartening it is to a superintendent to see his means of restoration and cure gradually curtailed, until he is left with little or no resources beyond food and
\end{quote}

\textsuperscript{25} Ibid.
physic. The overcrowding … has not only taxed the
ingenergies of the officers and staff to the utmost, but has
seriously interfered with the comfort, the health, and the
recovery of the inmates.26

Manning however, was quite politically astute, following his criticism of the
overcrowded conditions, he congratulated the government for moving to rectify
the situation;

It is with great satisfaction that I have learned that the
Government has purchased a site for a new hospital. The
estate at Callan Park possesses many of the requisites for
the site of such an institution. Its proximity to Sydney, its
ready accessibility both by land and water, the fine and
varied view… and the facilities for water supply are all
great advantages.27

In this way, Manning was applying pressure to ensure the government moved
quickly to build the new asylum. Consequently, by 1876, the old mansion of the
estate was fitted out to accommodate patients and initially operated as a wing of
Gladesville Hospital. In 1877, construction commenced on the Callan Park
Hospital for the Insane (hereafter Callan Park), designed to be very large, it
wasn’t finished until 1885. Nevertheless, Callan Park was the first planned and
purpose built asylum constructed in colonial New South Wales for forty years.28

Before this, in the mid 1870s however, Manning’s reforms at Gladesville
Hospital had borne some fruit. For instance, Dr A.R. Urquhart, Physician
Superintendent of the Murray Royal Asylum, Perth (Scotland), toured Australian
asylums and visited Gladesville Hospital in 1877. He later wrote an article
describing the institution which was published in 1880. Whilst Urquhart

26 Hospital for the Insane Gladesville. Sydney Morning Herald, 22 April 1874, p.9.
27 Ibid.
recognised some problems, for example, the amount of bushland nearby which
allowed patients to hide after escape, overcrowding, scantiness of furniture and
lack of dayroom space, he also praised some of the other services and amenities
of the institution. The rocky and sterile grounds complained of by Bishop
Willson in 1863 were now,

highly ornamental, and pleasant with ferneries and
rockeries, and green walks and orange trees. At the foot
of the garden a spacious bathhouse has been staked off
from the river, so as to exclude the sharks that swarm
beyond…. – terraces of vines and orange trees taking the
place of virgin bush. This is the result of the work of
male patients, an average of fifty being so employed out
of a population of 300. The airing courts are extensive
and pleasant… Here too, are many pets – kangaroos,
emus, tortoises, birds… in aviaries. These form one of the
special features of Gladesville…

The Steward’s stores and kitchen block have lately been
repaired, remodelled, and enlarged. The laundry is very
complete… A sewing room has been formed out of a
cellar, and here a full complement of female patients
work.

The diet scale is most liberal, more meat being set down
than seems necessary… Dances, theatricals, and other
amusements are held weekly, and occasional picnics and
water parties are given.29

Urquhart also reported some interesting observations concerning the staff:

Salaries of officers are pretty much the same as at
Melbourne and Brisbane, but the attendants are not quite
so well paid, while the number is quite as large. The latter
are liberally treated with regard to leave, rations, &c., and
of course are all trained in the asylum. All officers are
subordinate to the Medical Superintendent, and all
servants and attendants are appointed and discharged by
him.30

29 Urquhart, A.R., Three Australian Asylums. The Journal of Mental Science, Vol. XXV., No. 112,
January 1880, pp.480-489.
30 Ibid.
It would appear Manning instituted the recommendations, outlined in his 1868 report, to improve the working conditions of attendants. For example, the liberal leave provisions and better food. However, it seems the attendants’ wages (a government prerogative) could have been improved. It is also clear that Manning’s notion of the Medical Superintendent as the one and supreme, in regards to administration of the establishment, and particularly in the hiring and firing of staff, was firmly in place.

Manning zealously pursued his reforms and whilst not able to solve every problem besetting Gladesville Hospital, he apparently initiated more improvements in ten years than occurred in the previous twenty. A further tribute to Manning’s abilities is evidenced by the absence of any major scandals at the former Tarban Creek Asylum, or for many years subsequently. Unfortunately, this could not be said of elsewhere, with a series of shocking public scandals at the Parramatta Lunatic Asylum during 1876. Possibly more than anything else, it was these scandals which provided the impetus for reform of the colony’s entire mental health service – beginning with the 1876 Select Committee Inquiry.

6.5: Sex, lies and murder - The Select Committee Inquiry into Parramatta Lunatic Asylum 1876.

The murder of a patient, Peter Westmeyer, on July 8th 1876, began a series of investigations into the administration of the Parramatta Lunatic Asylum. These investigations revealed an entrenched culture of corruption, neglect and laxity involving the asylum’s staff, including at the highest level. Westmeyer was found dead at 8.00am, within a locked dormitory, which had been visited around one-hour earlier, when attendant Peter Latham delivered clothes and ordered the patients to dress. Latham then left the patients unattended in the locked room.
Upon his return, Latham found Westmeyer already dead and with a serious head wound. The other patients upon questioning, would, or could not, reveal how Westmeyer died or who perpetrated the murder. A Board of Visitors Inquiry found; The injuries which caused the death of Peter Westmeyer did not result from an epileptic or other form of convulsive seizure or from any attempt at suicide and were probably produced by his head being brought into violent contact with the framework of one of the iron bedsteads.\textsuperscript{31}

Following inquiries, the Board also found that senior attendant Peter Latham had neglected his duty, on this and many other occasions, and this neglect was known to 1st class senior attendant John Veitch. Both were subsequently dismissed from service. The Board also condemned the asylum’s physical condition which had contributed to a culture of laxity;

\begin{quote}
The present absence of strict discipline has always existed more or less, and that the very old and dilapidated condition of a large proportion of the buildings and yards, the absence of necessary accessories, and the general unfitness of the establishment for the purposes of a Lunatic Asylum, have a demoralizing effect upon the patients and attendants, are a source of danger, are incompatible with the degree of discipline which ought to exist … and [incompatible] with the comfort, healthy occupation, and tranquillity demanded by common humanity.\textsuperscript{32}
\end{quote}

Despite the Inquiry, however, the perpetrator of the crime was never identified.

The Parramatta Asylum was currently under the administration of Dr Charles Taylor, who replaced Dr Wardley following his death in September 1872. During 1876, Dr Taylor took nine months leave, from the end of January, to visit England and he left the asylum in the charge of the Assistant Superintendent, Mr

\textsuperscript{31} Board of Visitors, Report concerning conditions of the Lunatic Asylum Parramatta. \textit{N.S.W.L.A.V. & P.}, Vol. 6, 1875-76, p.96.
James Firth. Firth was the former steward of Tarban Creek Asylum, whose resignation from that position in 1854, has already been noted in chapter 5. It would appear Firth was soon re-employed at Tarban Creek Asylum as the Clerk, and in 1865, was promoted to the position of Storekeeper (the equivalent of Steward) at the Parramatta Asylum, upon the retirement of Edwin Statham. During 1868, this position was redesignated as Assistant Superintendent, enshrining Firth as the asylum’s second-in-command.\(^{33}\)

Rumours of staff corruption and intrigue became the subject of gossip and conjecture, of the citizens of Parramatta, and were reported in most of the colony’s newspapers. Much of the public conjecture was apparently fuelled by the local Member of Parliament, Mr Hugh Taylor (no relation to Dr Taylor). Hugh Taylor pressed for a Parliamentary Inquiry and consequently, August 8\(^{th}\) 1876, a Select Committee (Chaired by Hugh Taylor) was appointed to examine conditions at the asylum. Hugh Taylor was probably motivated by ill will towards Firth because, as a local butcher, Taylor wanted a contract to supply meat to the asylum and Firth resisted his representations. In this matter, Taylor himself was not acting entirely ethically; Members of Parliament were expected to have no personal interests in regard to government contracts.\(^{34}\)

### 6.6: A system corrupt – the allegations against the asylum officials.

In his capacity of Assistant Superintendent, James Firth organised a system and culture of corruption within the asylum, with methods akin to modern perceptions of organised crime syndicates. Accusations levelled at Firth included

\(^{32}\) Ibid.
\(^{33}\) Select Committee on the Lunatic Asylum Parramatta. (Minutes of Evidence Firth J.), _N.S.W.L.A.V.&P._, Vol. 4, 1876-77, p.850.
theft of asylum stores and livestock; theft and misuse of equipment; misuse of staff labour for his own benefit and profit; and withholding money from some of the attendants’ salaries.

Firth was also accused of sexual misconduct towards female patients whilst pretending to examine them (a completely inappropriate activity as Firth was not a doctor). It was further alleged that an attendant found Firth having “connection” in *flagrante delicto*, with a female attendant on the floor of his office.\(^{35}\) This female attendant (Mrs Russell), was later “compelled to leave” because she was pregnant.\(^{36}\) Intrigue deepened, as it was alleged a newborn baby’s body was found in the asylum’s cesspit, and Firth or his cronies covered up the matter.\(^{37}\)

To cover his corrupt behaviours, Firth bribed and cultivated some of the ordinary attendants (thus making them complicit) with minor privileges, such as allowing them to consume beer and food meant for the patients’ use, and selling hats to them from the asylum’s storeroom at very cheap prices. Attendants who complained or didn’t agree with Firth, were threatened with dismissal on false charges (some were actually dismissed and others resigned).\(^{38}\) Firth’s hold over the staff, however, apparently began whilst Dr Wardley was Medical Superintendent. It was alleged Dr Wardley was an alcoholic, and kept in a state of “imbecility and somnolency” through constant drinking, with Firth accused of keeping Wardley well supplied with brandy from the asylum stores.\(^{39}\) By

\(^{35}\) Select Committee on the Lunatic Asylum Parramatta. (Minutes of Evidence Penno, T.), ibid, p.807.

\(^{36}\) Ibid.

\(^{37}\) Ibid.

\(^{38}\) Ibid, (Minutes of Evidence), pp.803-885.

\(^{39}\) Ibid, (Minutes of Evidence Prior, M.), p.821.
keeping Wardley intoxicated and out of the way, Firth was able to completely manage the institution with “No check on him at all.”\textsuperscript{40} Because the Board of Visitors always notified the asylum before their visit, “Everything is prepared for them … to look in apple pie order.”\textsuperscript{41}

Firth maintained control of the asylum after Wardley’s death, by bringing the Master Attendant, John Brown, into his confidence. Brown appears to have acted as Firth’s deputy, in the ring of corruption. Brown also exploited his position and was accused of theft of asylum equipment and of persistently stealing the patient’s food for his own family’s use. Brown was also in the position to keep Firth well informed of the opinions and grumblings of the attendants, thus ensuring dissenters could be quickly dealt with.\textsuperscript{42}

John Brown was appointed to the position of Master Attendant after the previous incumbent, Michael Prior, was promoted as the first Superintendent of the Newcastle Asylum for Idiotic and Imbecile Children, which opened in December 1871. The Newcastle Asylum didn’t need a doctor in charge – \textit{idiot}s and \textit{imbecile}s were known to be incurable and only required containment. The Newcastle Asylum was established in the old military barracks, specifically to reduce overcrowding at the Gladesville and Parramatta institutions.\textsuperscript{43} \textsuperscript{44}

Formerly a policeman, Prior was for 17 years the Master Attendant at the Parramatta Asylum, enjoying the confidence and praise of Dr Greenup.

Following Greenup’s murder in 1866, Dr Wardley took over management of the

\textsuperscript{40} Ibid, p.822.
\textsuperscript{41} Ibid.
\textsuperscript{42} Ibid, (Minutes of Evidence).
\textsuperscript{44} Select Committee on the Lunatic Asylum Parramatta, (Minutes of Evidence Prior, M.), pp.820-823.
asylum, joining his former colleague (Firth) from the Tarban Creek Asylum. Prior quickly became aware of Firth’s corruption and behaviour, and as Prior had a personal friendship with the Colony’s then Premier, Sir Charles Cowper, he informally told Cowper of his concerns. Prior pleaded to be given another government position away from the asylum and Cowper obliged by giving him the position at Newcastle.45

The Select Committee was critical of Prior, because, even though he knew of the asylum administration’s corruption five years previously, he had not made an official report. Prior’s excuse was, “who could I have reported to?” Further, when asked if he was “afraid” to make a formal report, Prior stated, “Most likely I was,” adding, “I did not wish to be dismissed.”46 Clearly, Prior did not believe he could act against the Medical Superintendent, and his assistant, and not suffer serious consequences. The supremacy of the Medical Superintendent was well and truly instilled in the asylum’s subordinates, even to the extent that a very senior officer felt at risk if he dared criticise the administration. This was a legacy of the conflict between Digby and Campbell, more than twenty five years previously at the Tarban Creek Asylum.

Prior was right to be afraid. For instance, following his transfer to Newcastle and while seeking to recover salary owed him from the Parramatta Asylum, Prior wrote to Dr Manning complaining of Wardley’s behaviour (including an accusation that Wardley was an alcoholic) and asking Manning to intercede to recover the money. Manning was incensed, evidently Prior did not know that Manning and Wardley had been very close friends with Manning saying of

45 Ibid.
Wardley many years later, “than whom a better man never lived.” Manning referred the matter to the Colonial Secretary to investigate but also recommended Prior be dismissed from service. As it happened, Prior discovered Firth was the person responsible for withholding the money, and subsequently withdrew his charges against Wardley. However, the damage was done. Prior had criticised a Medical Superintendent and the withdrawal of charges was interpreted as trouble making by the authorities. Prior was severely punished for his actions, he was disrated and sent to the Biloela Asylum (a small benevolent asylum situated on Cockatoo Island), which was in the process of being closed, upon which Prior was made redundant. He was recorded as “living on his wits” in 1877. The message again was loud and clear, subordinates, no matter how senior or how far away, did not criticise Medical Superintendents, especially if they wished to remain in government service.

Nevertheless, how all this corruption could occur for the previous 4 ½ years without Dr Taylor knowing (he denied any knowledge of it), was a matter of conjecture. Dr Taylor, it seems, was drawn into the habit of borrowing money from Firth. When questioned about this, Dr Taylor firmly denied he felt any “obligation” to Firth, but admitted Firth sometimes treated him, “as uncivilly as he dared.” It seems Firth was able to sense weaknesses in others and set them up, exploiting those weaknesses. Had the scandal not erupted at that particular time, Dr Taylor may have found himself inexorably entangled in Firth’s corrupt enterprises and rendered completely impotent as Firth’s superior and the asylum’s administrator. Dr Taylor informed the Select Committee that upon his

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return from leave (which he cut short on hearing of the scandal), he found the asylum in a state of “disorganization” with “the attendants’ minds… largely disturbed by matters arising out of this inquiry; some have resigned and others seem disposed to resign.”

Dr Taylor further reported the asylum had become a house divided;

for there are a large number of the men who are disorganized in whom I can place no confidence. There are some who call themselves “Firth’s” men, who are interested in his affairs and welfare.

During the course of the Inquiry, Firth was suspended from duty; however, he was constantly coming to the asylum and making contact with his supporters. It was reported to Dr Taylor that Firth had said, “I am coming back again, it will be all right here again, or something of that sort.” Dr Taylor also stated that Firth kept a set of asylum keys to enter whenever he liked, and refused to give them up until Dr Manning spoke to him. Firth’s purpose, Dr Taylor stated, was “to degrade me in my office, and that was the deliberate intention, no doubt.” Firth was probably also attempting to keep track of who was saying what and perhaps he hoped to influence the testimony of the attendants, before they were called to give evidence. The Select Committee was critical of Dr Taylor for not exercising his authority to keep Firth away from the premises.

6.7: In the wake of the Select Committee Inquiry.

Following the Select Committee Inquiry, several attendants were dismissed from service – including the Master Attendant, John Brown. James Firth, despite being accused of a number of illegal activities, was also dismissed, on the charge he

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50 Ibid, p.880.
51 Ibid.
52 Ibid, p.881.
illegally kept back part of the salaries of two attendants. He appealed to the Executive Council of Parliament, claiming he was not guilty of the charges preferred against him, “beyond having exposed myself to censure for neglect.”54

On April 4th 1877, (now Sir) Henry Parkes, the colony’s Premier as well as Colonial Secretary, was very clear in his response,

The case appears to me to be sufficiently clear … to justify the conclusion that it is my duty to recommend Mr Firth’s removal from the Public Service…. There is conclusive evidence… of a defective comprehension of official duties and responsibilities, and a perverse spirit of insubordination, which would render him incompetent to fill the important position he has, I fear to the injury of the Institution, so long held.55

Despite the public uproar over the mismanagement and criminal activities at the Parramatta Asylum, exposed by the Select Committee Inquiry, Dr Taylor survived in his position. He seems to have been excused for not knowing of the corruption being perpetrated around him, largely because the entrenched perverseness of his officers was of such a devious nature and had existed for so long. Firth’s administrative control over the asylum was also partly due to the government’s inaction concerning the appointment of an assistant medical officer.

Unlike Tarban Creek Asylum, the Parramatta Asylum employed only one doctor, the Medical Superintendent, who not only administered the institution, but was also solely responsible for the medical care of (at that time) 773 patients.56 Dr Taylor had, during the previous two years, pleaded for medical assistance, a plea

55 Ibid, Minute of the Colonial Secretary.
that went unanswered.\textsuperscript{57} It is not hard to imagine Firth, firstly with Dr Wardley and later with Dr Taylor, offering to remove much of the burden of administering the asylum, allowing the doctors more time to undertake any necessary medical care. Being second-in-command and with more administrative authority than perhaps his position normally would have allowed, it was relatively easy for Firth to abuse and exploit his power and position, whilst controlling what was brought to the attention of the Medical Superintendent(s). Following the Inquiry, at which public attention was brought to Dr Taylor’s pleas and complaints, the government allowed the employment of an Assistant Medical Officer at the Parramatta Asylum.

\textbf{6.8: The attendants’ culture of silence.}

The culture within the ranks of attendants would probably also have contributed to Firth’s control and exploitation of the asylum. As a group, the attendants and their work (and indeed lives), were heavily regulated and under the strict authority of the asylum’s officers, and in defence, they probably tended to band together. From the days when the colony was a penal settlement (particularly in the working class), a culture developed, rooted in the convict experience, where one did not inform on another. The attendants, whose work had its roots in the era of convict labour, and was ranked low in terms of occupational status (and probably as much as any like group), maintained a culture of \textit{see no evil, hear no evil} and especially, \textit{speak no evil}. Not only could an informer expect the wrath of Firth or his cronies, he might well have been ostracised by his workmates. A Medical Superintendent of Callan Park observed this culture of silence, 60 years

\textsuperscript{57} Ibid, p.88.
later. When attempting to check abuses; he had to quietly recruit informers on the
staff as;

Naturally life would have been unlivable [sic] for them
amongst the rest of the staff were it known that they had
given information about their fellows.\textsuperscript{58}

So powerful was the culture of silence, that still much later, in 1961, a Royal
Commission into Callan Park found need to criticise “The Wall of Silence”
which continued to exist in that (and probably every other) institution;

A disturbing feature … is not the number of alleged or
proven cases of ill-treatment but the lengths to which
some of the staff will go to prevent the truth coming out.
Men who would not themselves be guilty of wrongdoing
are evasive and unwilling to assist investigation of the
misdeed of others.\textsuperscript{59}

There was possibly also a further reason why the attendants in 1876 kept silent –
many of them were not guiltless, and there had been accusations of cruelty
towards patients aired during the Inquiry. Within the walls, the culture of the
asylum was all pervasive and consuming, with even those attendants who were
naturally kind and honest, being drawn into activities which they might have
ordinarily avoided and of which they were ashamed. This is illustrated by a
commentator, who co-incidentally during 1876 (in an early example of
investigative journalism), wrote of his experiences working as an attendant in the
Kew Asylum of Melbourne;

I write with much reluctance… Not with the intention of
discovering abuses have I acted the part of a spy on their
actions. I had no wish to discover faults, but I must write
a truthful account of what I saw in the asylum… The
attendants are kind sometimes, but it is the kindness of a
gaoler…. The patients are prisoners, and the habit of

\textsuperscript{59} McClemens, J., \textit{Report of the Honourable Mr. Justice McClemens Royal Commissioner into
commanding and ordering them about as much grows on one. I found my charges were so used to this harshness of tone that I was almost compelled to adopt it, and many times discovered, to my disgust, that I was myself lapsing into a habit of bullying the patients. The promiscuous “clouting” with which the troublesome patients are treated begins with a gentle tap, given as a reminder, and ends in a smart blow.\footnote{60}

In Dr Taylor’s \textit{Annual Report} of 1876, he was forced to admit the situation regarding male attendants at the Parramatta Asylum was less than ideal;

> Whilst I am disposed to believe that most officers and attendants… discharged their duties with zeal and fidelity, I am nevertheless compelled to withhold that broad expression of general confidence in those under my control, which I have hitherto so cordially afforded.\footnote{61}

However, the entrenched corruption did not extend to the female division of the asylum and Dr Taylor was very particular in his praise of the female staff:

> The female division, surrounded by many inconveniences and wants, bears nevertheless ample testimony to the care and humanity exercised by the female attendants over their patients. I cannot speak too highly of the Matron’s efficiency and the ready obedience and good conduct of those under her control.\footnote{62}

The Matron, Mrs Jane Burn, occupied the position since the death of Elizabeth Statham in 1864. During her administration of the female division of the asylum, which lasted until 1892 (28 years), there was never a hint of impropriety or corruption on her part. In fact, to the end of the 19\textsuperscript{th} century, the senior female staff and the divisions under their control, were never subject to public scrutiny through major inquiries and were rarely called to others to testify. The near

\footnote{62} Ibid.
absence of opinion by female attendants in this work is noteworthy, and they were rarely given the opportunity during public inquiries to voice their views or describe their work.

Most information existing on this issue is from the very occasional mention that female attendants received in annual and even more rarely, other official reports (for example, the Board of Visitors Report of 1876). The good record of the senior female officers of the Lunacy Department was sullied in 1900, when the Matron of Callan Park, Mary Ann Fairbairn, was found to have misappropriated food and medical comforts intended for both the nurses and patients. Further, she was also found guilty of persecuting a young nurse, whose complaints led to the inquiry. Miss Fairbairn resigned in an attempt to save face, however, a newspaper let the public know in the most personally insulting and disparaging terms (perhaps in vitriol especially reserved for women who were seen as deviant), what she had done;

Matron Miss Fairbairn has sent in an application to resign… this malicious perverter of the truth as well as misappropriator of other people’s food, this vindictive vestal virginal virago firebrand Fairbairn of Callan Park.64

Throughout the inquiries of 1876, the Parramatta Asylum and the sordid behaviours said to be occurring there, featured prominently in most of the colony’s newspapers.65 However, in a reasoned article, the Sydney Morning Herald demanded,

It is more than time that the policy of patchwork, which has so long been followed in this colony, in making some sort of provision for the insane should be abandoned, and

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63 Referred to in the previous chapter.  
64 Callan Park. The Truth, 22 July 1900, p.2.  
65 See Edwards, G., op. cit.
the whole question should be dealt with in a comprehensive manner, with a view to the requirements of the future, and in light of the best information that can be brought to bear on the subject.\textsuperscript{66}

The paper went on to praise the reforms of Dr Manning, at Gladesville Hospital, and concluded by stating the problems of the asylums would only be solved, by boldly entering upon a comprehensive scheme, which would produce immediate relief and benefit, and admit of systematic expansion to meet the requirements of the future – requirements that will certainly increase, and will have to be met, with system or without system, efficiently or inefficiently.\textsuperscript{67}

In this way, the newspaper combined Dr Manning’s name, and work, with the notion that a comprehensive system of managing mental health care in New South Wales, was now absolutely essential. The key to providing comprehensive mental health care was to develop a discrete centralised administrative structure (a separate government department) to plan and coordinate all of the colony’s lunacy services.

\textbf{6.9: The problem of government administration of lunacy in the late 19\textsuperscript{th} century.}

Contributing to the problems, and therefore, the subsequent inquiries into the colony’s lunatic establishments throughout the 30 years following the construction of Tarban Creek Asylum, was the bureaucratic and centralised administration set up in the colony’s earliest days. The then penal settlement’s Governors, eager to maintain absolute authority, ensured that the Colonial Secretary's Department brought government business to their attention. In time, particularly after establishment of the colony’s Legislative Council, the Colonial

\textsuperscript{66} Sydney Morning Herald, 12 September 1876, p.2.
\textsuperscript{67} Ibid.
Secretary’s Department acquired more or less autonomous control of the asylums. As more asylums were established, the Colonial Secretary’s department maintained control over them; the asylum administrators operating with little reference to each other. The Colonial Secretary also had administrative responsibilities over a plethora of other activities and competing interests. Thus, the office simply did not have the time or resources to concentrate on particular issues, especially those not commonly affecting the citizens of the colony. Whenever the issue of the insane was raised, a temporary solution was usually all that was necessary to allay disquiet for a while and hence the ad hoc nature of the development of lunacy services.

When the Colony was granted self-government in 1856, a model of the bicameral Westminster Parliamentary system was adopted. The Legislative Council became the Upper House and reverted to membership by appointment of the Governor, the elected or Lower House, the Legislative Assembly, became the actual governing body of New South Wales.68 The office of Colonial Secretary was made a ministerial portfolio, and because it had so long enjoyed substantial executive authority over government business, it was regarded as the most important portfolio in the Government. Thus, most of the leaders of various governments of the colony in the 19th century (variously known as Prime Minister or Premier – Premier is used in this work), were keen to take up the portfolio of Colonial Secretary.69 But the essential problem remained unchanged; a very busy politician did not have time to closely oversee lunacy services. The solution – to increase the bureaucracy and create a new

69 Ibid, pp.46-47.
department under the Colonial Secretary’s purview, which could more closely monitor the expansion and development of services. To achieve this, there would need to be a Department Head who would oversee lunacy services and be directly responsible to the Colonial Secretary’s Department,\(^7\) the first of these, was Dr Frederic Norton Manning.

6.10: The appointment of an Inspector General of the Insane; the first step in developing a comprehensive mental health service.

Only six months before the scandals at the Parramatta Lunatic Asylum became public, the government decided to act on the question of the future of mental health services in New South Wales. The first step was to create the position of Inspector of the Insane, who would have under his charge, all of the institutions where lunacy services were provided. This was a recommendation made by Manning in 1868 but at the time ignored. Dr Manning’s reforms at Gladesville Hospital and Manning’s efforts to ensure public exposure of those reforms ensured he was seen as the logical choice for the new senior government position. On January 13\(^{th}\) 1876, in addition to his position as Medical Superintendent of Gladesville Hospital, Manning was appointed Australia’s first Inspector of the Insane\(^7\) (later Inspector General of the Insane).

Over the next 18 months, Manning urged a review of lunacy laws and contributed to a new Act, which was passed in the Legislative Assembly in late 1878, coming into operation on March 1\(^{st}\) 1879. The *Lunacy Act 1878* was entitled “An Act to consolidate and amend the Law relating to the Insane.”\(^\) Generally, this Act made legal provisions for the means by which a person could

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\(^7\) *Government Gazette*, 14 January 1876, p.161.

\(^7\) *Lunacy Act 1878* (42 Victoria No.7), p.7.
be declared insane, the legal status of patients and the procedures for admitting and discharging patients. It also established the office of the Master in Lunacy, to manage “the estates of Insane Persons and Patients” - removing this authority from the Supreme Court. More importantly (from the perspective of the development of comprehensive mental health services), Part VI. Of the Act, established the office of an Inspector General of the Insane. This inaugurated the Lunacy Department of New South Wales and enshrined the Inspector General as the Head of the Department, with a wide range of responsibilities and powers over mental health care. In keeping with Manning’s view that institutions accommodating the mentally ill were medical establishments, the Act formally made lunatic asylums, Hospitals for the Insane. Of note, part IX of the Act, made provision for penalties for asylum staff who mistreated patients;

Any superintendent officer servant or other person employed in any hospital for the insane licensed house reception-house hospital for criminal insane public hospital or gaol who shall strike wound illtreat [sic] or wilfully neglect any insane person or patient confined or detained therein shall for every such offence be liable to a penalty not exceeding twenty pounds or to imprisonment for any period not exceeding six months.

In this way, it was no longer left entirely in the hands of the Medical Superintendent to punish abusers of patients; the legal penalties were severe enough to make abusers consider the potential serious consequences, before committing an offence. This provision had good and bad points; Medical Superintendents would not be able to summarily dismiss staff on unsubstantiated charges as the offence was reportable and substantive evidence would be

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73 Ibid, (Part VII.), p.28.
required. However, if the abuse of patients was already kept quiet by staff, the penalty for offences drove abuse even more deeply underground.

Manning held the designation Inspector of the Insane, in addition to his position as Medical Superintendent of Gladesville Hospital. The fact that the scandals at the Parramatta Lunatic Asylum erupted only six months after his appointment, demonstrated that it was impractical for the Inspector of the Insane to oversee all lunacy services, as well as administer a large institution. The new designation of Inspector General of the Insane, at the Head of a new government department, removed the incumbent from close association with any individual institution and subsequently, Manning gave up the superintendency of Gladesville Hospital. Further, the offices of the new department were established in the city, away from any asylum, the Inspector General was thus seen as having no allegiance to any particular asylum. Dr Manning claimed he had not sought the position of Inspector General of the Insane, which he occupied until 1898, as “he would no longer be in direct contact with patients.” Nevertheless, during his long term in office, Manning oversaw a considerable expansion of services, and by the close of his tenure, the colony boasted six public hospitals for the insane, two private licensed houses, and a reception centre at Darlinghurst. However, the perennial problem of overcrowding continued, due to the increased general population and the government’s inability or reluctance to provide funds to keep pace with growing needs. Also, Manning had several times since 1868, recommended the building of more institutions, particularly in country areas, and they were eventually established in the first three decades of the 20th century. Manning’s

76 Ibid, (Part IX. 179), p.42.
reforms and career are two extensive to be covered in this work; it is his early work to reform (mental) nursing services through Lunacy Department regulations which are of relevance.\textsuperscript{78}

6.11: Regulation of nursing services for the insane.

Manning, as the head of the Department of Lunacy, exercised total control of the Hospitals for the Insane in the colony, which included all staff who worked within them. He was also responsible for hiring and firing senior officers, including Medical Superintendents, Master Attendants and Matrons. Naturally, Manning employed likeminded people and so was able to (in time); fill the department with senior officers who would willingly co-operate with his and/or institute their own reforms.\textsuperscript{79}

Manning was particularly keen to change the existing culture and working status of the attendants.\textsuperscript{80} To do this, he encouraged, as much as possible, the employment of applicants who satisfied the requirements laid out in his 1868 report; that is, intelligent, educated and empathetic people. As the Matrons of old asylums retired and new positions were created with additional institutions, Manning ensured the positions were filled and occupied by general trained nurses.\textsuperscript{81} In this regard, Manning experienced the benefits of having a trained nurse as Matron whilst he was in charge of Gladesville Hospital. When Jane Manson retired from Gladesville Hospital after twenty five years service, in


\textsuperscript{79} \textit{Australasian Medical Gazette}, Vol. XVII, 21 February 1898, p.78.

\textsuperscript{80} \textit{Hospitals for the Insane, Rules for the Attendants, Nurses, Servants, and Others}. Government Printer, Sydney, 1908.

1873, she was replaced by Mary Bland – one of the early graduates of the Sydney Hospital nurse training programme, established by Lucy Osburn in 1868. It is also worth noting that Manning referred to female attendants as nurses in his reports and correspondence. The term attendant, describing both male and female staff, replaced keeper (male) and nurse (female) during Dr Campbell’s time. Male staff continued to be called attendants until 1960.

Manning, now at the head of a centralised administration over the Hospitals for the Insane, began to standardise the responsibilities and duties of all staff, from the Medical Superintendents to the Servants. By the mid 1880s, the erstwhile list of duties which could previously be posted on noticeboards was replaced by a Rulebook of 45 pages. These rulebooks were individualised for each institution and carried the name of each institution’s Medical Superintendent as author. However, they were almost identical in presentation and content which suggests the guiding hand of Manning and in 1908 the pretence of individualised rulebooks for the various institutions was abolished. The rulebooks, given to all staff on commencement of duty and expected to be returned when they resigned, were standardised as the Rules for Hospitals for the Insane.

Whilst far too extensive to detail in this work, some of the rulebook’s contents are worth noting. The Introduction contains an early form of mission statement and philosophy of care:

...[name]... Hospital has been established and is maintained for the treatment of persons suffering from

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82 Sinclair, E., Hospital for the Insane, Gladesville, Rules for the Attendants, Nurses, Servants, and Others. Government Printer, Sydney, 1885, p.5. & Godson, E., Hospital for the Insane, Parramatta, Rules for the Attendants, Nurses, Servants, and Others. Government Printer, Sydney, 1885, p.5. & Blaxland, H., Hospital for the Insane, Callan Park, Rules for the Attendants, Nurses, Servants, and Others. Government Printer, Sydney, 1886.

83 Hospitals for the Insane New South Wales, Rules for the Attendants, Nurses, Servants, and Others. op. cit., 1908, frontispiece.
defect or disease of the brain affecting their mental powers. All persons engaged in its service must therefore constantly bear in mind that it is a hospital, the object and aim of which is the recovery of those whose recovery is possible, and improvement and amelioration in condition of those whose disease is of an incurable nature.

Whether the patients belong to one class or the other they are equally held to be not responsible for their words and actions, and require to be treated with the greatest consideration, sympathy, and forbearance by those who are placed in charge of them.  

The rulebook also noted that the recovery of patients depended on the manner in which staff performed their duties; “It is a great mistake to suppose that these duties are of a light or easy character, or can be performed in a routine manner.” The expectation that attendants and nurses view patients as individuals and modify their own behaviour and responses toward the patients accordingly, is outlined as one of the attributes considered necessary to be a good attendant or nurse;

The essential qualities in an attendant or nurse are patience, gentleness, and firmness, with constant perseverance in all efforts to induce the patients to work, join in recreation, to take food and medicine considered necessary, and to perform in a proper manner the duties of every-day life. It is absolutely necessary that attendants and nurses should observe the peculiarities and character, and take personal interest in the patients under their care, since it is only by becoming acquainted with their habits, tendencies, eccentricities, and delusions that they can manage them properly or can hope to adapt themselves so as to influence them for good.

In this statement, albeit without the vocabulary of similar modern care concepts, nascent notions of individualised patient care can be seen. For example, the attributes of the good attendant or nurse include; observe the peculiarities and

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85 Ibid.
86 Ibid.
character [of the patient] and become acquainted with their habits, tendencies, eccentricities and delusions and where the attendant or nurse should adapt themselves so as to influence [the patients] for good and manage them properly, can be seen to relate to the modern concept of developing therapeutic interpersonal nurse/patient relationships. This in turn, involves mental health nurses engaging with and identifying each patient’s personal strengths and needs, and then developing individualised nursing actions/interventions (in collaboration with the patient), to best meet those identified needs.

What is not articulated (but expected in modern mental health nursing care) is the concept of evaluating the efficacy of the nursing actions. However, it is likely the attendants and nurses would informally evaluate the patient’s mastery of the task at hand, and would change the task accordingly, based on the performance of the patient. Attendants and nurses would have also provided the doctors with verbal reports of the patient’s progress. Further, the modern behavioural concept of modelling is clearly articulated in the Rules;

Example is better than precept, and it will be found that attendants and nurses who are industrious and painstaking themselves will most readily obtain willing help from the patients, whilst those who merely direct work to be done without assisting will find that they cannot induce the patients to occupy themselves.87

The vulnerability of patients is considered; the attendants and nurses are counselled,

The patients are separated from home and relatives, are in a dependent position, and often incapable of protecting themselves, so that any unkindness towards them is peculiarly cowardly and heinous.88

87 Ibid, p.5.
Attendants and nurses are further warned that any inappropriate behaviour on their part will make their work all the more difficult. “All roughness of demeanour to patients… will lead to irritation, annoyance and resentment.”

The rulebook outlines general rules for attendants and nurses, including restrictions on fraternisation between male and female staff; prohibitions on alcohol consumption and bad language (swearing); fines for neglect of duty (particularly in relation to the escape of patients); the regulation of tobacco to patients; the importance of patient confidentiality; restrictions on the use of mechanical restraints; the supply and care of uniforms; fire regulations; the importance of the patient’s religious beliefs and the prohibition on attempting to alter patients’ religious beliefs.

All attendants and nurses, when first engaged, were put on probation for a period of three months (the Medical Superintendent could extend this probationary period if he wished), so their suitability for the work could be assessed. Once permanently engaged, attendants and nurses were issued with uniforms which had to be worn at all times whilst on duty, and given up upon leaving employment.

Also, apparently for the first time, the expectation that each ward’s senior attendant or nurse would keep certain records is articulated, for example, Diet Lists, Laundry Lists, Store Requirements and Equipment Inventories. Further, these rules also demand the keeping of a 24 hour Daily (Ward) Report, which was delivered to either the Chief Attendant’s, or in the case of female wards, the Matron’s Office by 8am every morning. The Daily Report Book might best be

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89 Ibid.
90 Ibid, p.15.
described as consisting of two pages of printed questions, in a written answer format, which the senior attendant or nurse filled in on a daily basis at the end of the shift. Information such as bed and patient numbers; patients receiving “special care, Treatment or Control,” and the particulars of that special care; “special Instructions by Medical Officer(s)”; the use of seclusion or restraint; any injuries or accidents; patient transfers and admissions; “names of Staff on duty”; and a breakdown of “Patients occupied in various activities” (patient numbers involved and at what specific activity, for example, on the farm, in the laundry, assisting on ward) were included. Although not of the same formal prescriptive format, a shift report is still expected in most mental health care settings to this day and the required information generally remains the same. Above all, Rule 1. reinforces the authority of senior officers and the Medical Superintendent;

The attendants are required to yield the most strict, prompt, and constant obedience to the orders of the officers of the establishment. Any attendant will be liable to instant dismissal by the Medical Superintendent for being intoxicated, for striking, ill-using, or neglecting any of the patients, or for any act of insubordination or misconduct. 

Manning also regulated the working hours of Attendants and Nurses, with alterations to the “hourly routine” and “the hour at which the attendants’ and nurses’ day duty ceases” being made, and depending “entirely on the arrangements which may be best for the welfare of the patients.” The duty hours of the attendants and nurses were somewhat regimented, with a prescriptive timetable of what would be done, at particular times of the day. The

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93 Ibid, p.41.
various institutions within the Lunacy Department produced similar timetables of duty hours; an example from the Parramatta Hospital for the Insane follows:  

Hours to be Observed in the Hospital for the Insane, Parramatta.

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94 Godson, E., Hospital for the Insane Parramatta: Rules for the Attendants, Nurses, Servants, and Others. Government Printer, Sydney, 1885, p.41.
The attendants’ and nurses’ Leave of Absence was also regulated:

The attendants will have leave of absence on one week day a month, on Sunday in rotation, and from 6.30 to 10 p.m. in summer, and 6 to 10 p.m. in winter.

The nurses will have leave of absence on one week day a month, on Sunday from 9 a.m. to 10 p.m. in summer, and from 9.30 a.m. to 10 p.m. in winter daily.

The night attendants and night nurses will have leave of absence on one week night, and one Sunday night a month, and from 1 to 6 p.m. in winter, and 1 to 6.30 p.m. in summer. … [The hours of other categories of staff are listed hereafter with even less time allowed].

Leave of absence for fourteen days in each year, under such restrictions as may seem to the Medical Superintendent to be necessary, will be granted to such indoor attendants and nurses as have completed one year’s service. … [other categories of staff were only allowed 7 days].

In case of illness, 3 days’ sick leave on full pay may be allowed; after that time the Medical Superintendent will engage such assistance as may be necessary to carry on the work of the Hospital, and the expense must be defrayed by the absentee.

It is curious to note that at Parramatta, leave of absence for (female) nurses was greater than that of (male) attendants. Moreover, when comparing the hours allowed at the other two Hospitals for the Insane (Gladesville and Callan Park), the nurses and attendants received exactly the same (as the male attendants of Parramatta). There is one plausible explanation for the discrepancy relating to female nurses at Parramatta, their accommodation was extremely poor (as noted in chapter 5 – they slept in the wards with the patients), therefore they were granted extra time away to compensate them for such poor living conditions.

95 Ibid, pp.36-37.
It is also interesting to note, that attendants and nurses were granted 14 days (recreation) leave per year. However, this was only granted at the discretion of the Medical Superintendent (who could impose restrictions), presumably if he was satisfied that the time would be properly utilised. This is borne out, when 16 years later, Dr Manning (who had by then retired), was asked to prepare a report for the government concerning shortening the attendants and nurses hours of work (from averaging more than 10 per day to 8), and increasing their leave of absence. Manning generally did not believe it was necessary to reduce the hours of duty which by then totalled 56 hours per week. He noted the hours were long, however, attendants and nurses did not have to work exposed to the weather, nor did it involve exhausting manual labour. Further, their work;

> involved no continuous mental or physical strain, and there are times of comparative leisure and relaxation,… the whole character of the duties is that of domestic service, rather than ordinary labour.\(^97\)

Regarding holiday leave, Manning left no doubt it was to the attendants’ and nurses’ detriment if they were allowed too much. He claimed,

> the attendants and nurses [will] find too much time and too many holidays on their hands which they cannot pass profitably, and which involve an expenditure which they cannot afford.\(^98\)

Clearly only those with resources and therefore, unlike those in *domestic service* (poor, working class people), could profit from holidays and reasonable periods away from work.


\(^{98}\) Ibid.
From the rulebook, another largely unrecognised aspect of the work of attendants and nurses in the late 19th century can be discerned; their role as the agents of moral treatment within hospitals for the insane.

6.12: The Moral Treatment of patients in the work of attendants and nurses.

The history of psychiatry tends to be the history of the medical treatment of insanity. However, an unrecognised component of 19th century mental health care, is the role of attendants and nurses in the continuance of some of the methods utilised before the advent of the scientific medical treatment of lunacy; namely, Moral Treatment.

Moral treatment paid full attention to patients as persons and belonged more to the humanitarian liberal movement than to medical science.99

Pre-scientific methods of managing the insane contained in the philosophy of moral treatment “lacked a well developed ideological rationale,”100 but it did have an aim: “to arouse the faculties of the patient’s mind.”101 Moral treatment was thus concerned with stimulating and correcting the mind rather than repairing the brain. The mind, having no physical substance, could not be examined or dissected, and thus was of less concern to doctors than finding physical evidence of pathology of the brain (or other organs), which might cause insanity and/or respond to medical treatment.

Medical Superintendents, involved with treating and managing the insane, recognised the importance of purposeful activity and amusement for the patients, but perhaps rather than viewing it as treatment in its own right; saw it as a

101 Anonymous, Moral treatment in America. op. cit., p.469.
method to assess the patient’s progress under medical treatment. This they did, by noting the patient’s degree of motivation and involvement in these activities.

Medical Superintendents also valued moral treatment as;

- a method to occupy the patient’s time,
- a way to distract patients from their mental machinations,
- a means of contributing to the economy of the hospital.  

Indeed, Medical Superintendents were happy to accept community praise for the results of patient (and attendant and nurse) labour. For example, the Medical Superintendent of the Parramatta Hospital for the Insane, was lavishly commended for the gardens of the establishment;

[It is] one of the show-places of Parramatta; and this is not at the expense, but the material benefit of the patients… Dr W.C. Williamson, may honestly claim that he has more than fulfilled his predecessors’ highest ambitions. He has turned the grounds into beauty-spots. Knowing well how occupation in the preparation of attractive landscapes is as beneficial as the contemplation of them, he has achieved a two-fold triumph: he has given pleasant employment to his patients and – incidentally, as it were – he has made the surroundings of the old [Female] Factory a joy to the eye.  

Naturally, other than possibly directing, Dr Williamson did not do any of the work to establish the gardens, it was achieved through the labour of patients under the supervision (and labour) of attendants and nurses. The rulebook articulated an expectation that the ordinary attendants and nurses would employ patients to assist in the work of the wards, observing “Idleness and listlessness

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among patients often indicate indifference on the part of attendants.\footnote{104}

Moreover, the rulebook also described the duties of other categories of workers employed in the Hospitals for the Insane; for example, artisans, boot-makers, needlewomen, laundresses, gardeners and farm hands who were regarded as attendants and who were also expected to employ patients. A daily record of attendance and the work performed by patients was expected to be kept.\footnote{105} At issue here, is not the fact that considerable work was done, or who claimed the credit; but rather how the patients were induced to perform the work.

Mentally ill people can be unco-operative and difficult to motivate. The days of enforced (convict) labour under the lash were long over, and whilst there were incentives to encourage patients to be usefully occupied; for example, extra rations of food and tobacco, patients could not be forced to consistently co-operate if they did not wish to do so. To “encourage the patients to occupy themselves, - the men in gardening, cleaning the wards, and other suitable employment, - the women in washing, sewing, and other occupations suitable to their ability,”\footnote{106} attendants and nurses must have utilised interpersonal skills. As noted earlier, attendants and nurses were expected to become acquainted with the individual patient’s habits and tendencies and to adapt themselves to better manage the patient. In modern mental health nursing, and akin to the previous notions, is the concept of treating patients as individuals who are best assisted by the nurse who assumes a variety of roles, within a therapeutic relationship, that can help develop the patient’s abilities. Thus, it can be argued, patients were induced to do the work, by attendants and nurses who knew them well, utilising

the (therapeutic) relationship(s) which developed between them. In this way, moral treatment flourished, despite the rise of scientific medical treatment of insanity, it quietly continued, inherent in the work of attendants and nurses.

The attendants’ and nurses’ intimate knowledge of their patients, later received acknowledgment from Dr Arnott at Callan Park (writing of his experiences in 1925). He observed that “patients didn’t complain even when very ill,” but the nurses and attendants “knew instinctively if they were so.”107 This was not *instinct*, but rather occurred as the result of *knowing* the patient(s). Whilst Dr Arnott saw his comments regarding the attendants and nurses instincts (a primitive sense) as complimentary, when describing the acquisition of a similar skill by doctors, he described it as *intuition* (a sense gained from years of experience).108 Thus, the same skill was given a higher status when practised by doctors, compared with attendants and nurses.

Even so, the belief that insanity was the result of physical pathology was exalted during Dr Manning’s control of mental health services in the last quarter of the 19th century. Consequently, Manning saw another role for attendants and nurses, as assistants to doctors in their scientific management of the insane.


Frederic Norton Manning has been described as “the head of a small group of alienists who worked in the colony’s asylums.”109 A near contemporary source defines an *Alienist* as “One who treats mental diseases” and *Alienism* as “The science of mental disorders.”110 The key words here are *treatment* and *science*,

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108 Ibid.
109 Garton, op. cit., p.38.
which with disease, were the bywords of the medical profession’s claims to pre-
eminence and monopoly over the care of the insane.\textsuperscript{111} Medicine had become
concerned with identifying the physical causes of disease, and medical treatment
consisted of physical remedies, a physical cause and effect, which could be
measured and thus scientific. In the early days, when applied to the mentally ill,
scientific treatments were largely unhelpful and often detrimental, however as
time progressed, the notions of the alienists evolved into the modern concepts of
biological psychiatry. In turn, biological psychiatry has gained ever increasing
credence, particularly following the introduction of electro-convulsive therapy
and especially the psycho-active drugs (which are the mainstay of psychiatric
treatment today). Manning’s commitment to the \textit{scientific} treatment of the insane
was expressed by him in no uncertain terms, during an address he gave to the
Intercolonial Medical Congress of 1888;

\begin{quote}
The study of insanity has heretofore not been as scientific
and accurate as is desirable … [because doctors were
overworked] … they cannot undertake the pathological,
the microscopical, and the scientific therapeutical work
which should be steadily progressing in every hospital.
… I would urge a more liberal, and more accurate, and, in
some cases, a more continuous employment of drugs.…
Among other things, our hospitals should be great fields
for brain surgery, the brilliant results attending which are
of the greatest interest and importance.\textsuperscript{112}
\end{quote}

Linked to the scientific treatment of insanity was the need to systematically train
the attendants and nurses, ostensibly to act as assistants to the doctors in their
quest to conquer insanity by scientific means. This training and education is the
topic of the following chapter.

\textsuperscript{111} For an account of the adoption of \textit{Alienism} by medical practitioners managing lunatics see,
Scull, op. cit., pp.165-185.
\textsuperscript{112} Manning, F. N., Address in Psychological Medicine. \textit{Journal of Mental Science}, Vol. XXXV.,
No. 150, July 1889, pp. 149-178.
Chapter 7.

The origins and early development of mental nurse training in New South Wales.

This chapter is devoted to the origins and development of mental nurse training and education. The employment of general trained nurses as matrons of the hospitals for the insane in the last quarter of the 19th century, although unacknowledged, is speculated to have contributed to the formal introduction of training for mental nurses. The first textbook for mental nurses is reviewed and the early development of the training curriculum is revealed. Because of the importance of the origins and early development of mental nurse training to the history of the profession, an epilogue extending the primary period of this work’s focus, beyond 1901 to 1926 is included. The epilogue charts the early resistance to recognition of mental nurse training, by Australia’s first professional nursing organisation, the Australasian Trained Nurses’ Association, concluding with the establishment of the New South Wales Nurses’ Registration Board in 1926.

7.1: Background review.

Governor Bourke’s request to Lord Glenelg, in 1837, for a suitable married couple to be sent from England to manage the new Tarban Creek Asylum, was the earliest attempt to deliver specialist care to the insane in New South Wales. Despite criticism by Sir William Ellis, of the selection of non medical personnel for this position, the appointment of Joseph and Susannah Digby to the Tarban Creek Asylum in 1838, was precisely because they were knowledgeable and experienced in the care of the mentally ill. It can be assumed that the Digbys

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imparted whatever experiential knowledge they had acquired, *viva voce*, to the staff under their control. This aspect of the Digbys’ tenure seems to have earned belated acknowledgement by the Inspector General, Eric Sinclair, who noted in 1908 that the training of mental nurses was “instituted as far back as 1837.”

Sinclair, one of the progenitors of the systematic training of asylum nurses in the 1880s, began his career as Assistant Medical Officer at the Gladesville Hospital for the Insane, in early 1882. Despite the passing of thirty-two years since the departure of the Digbys, it is possible that through oral tradition and/or the direct recollections of senior asylum staff, Sinclair learnt of the Digbys’ attempts to train attendants.

In 1868, the appointment of Dr Frederic Norton Manning as Medical Superintendent of the Tarban Creek Asylum, and his commissioning by the colonial government to tour and examine asylums in America and Europe, was to result in considerable reform of lunacy services in Australia. Norton Manning’s 1868 *Report on Lunatic Asylums*, compared overseas mental health services with those offered in the colony, and made numerous suggestions for improvement. This report, whilst not offering specific details, also recommended that “no exertion should be spared” in the training of attendants. However, before training, the report stressed the importance of employing young people who possessed *tact, intelligence, and, above all, a special acquaintance with the insane.* This recommendation was influenced by problems associated with the employment of many unsuitable people over the years, which in turn, led to carers of the mentally ill being earlier described as *mostly ignorant people; and*
when there is any disturbance they do not use discretion but brute force.⁶

A decade later in 1879, when Norton Manning was appointed the colony’s first Inspector General of the Insane, he effectively used his position to influence and direct considerable reform, including professionalisation of the nursing care of the insane.

Whilst the conduct of attendants and nurses was already heavily regulated by the rules of the establishment, the efficient functioning of an asylum would have necessitated some training and education for novice members of staff. Dr Francis Campbell, of Tarban Creek Asylum, without providing details, claimed to have trained staff in their special duties in 1863.⁷ At the same time, Edwin Statham of the Parramatta Lunatic Asylum, referred to the manufacturing of unsuitable employees into efficient attendants.⁸ This suggests that whilst systematic education does not appear to have been established, at least some form of on-the-job training took place. Up to the mid 1880s, the only mention of formal training relates specifically to the formation of fire brigades within some of the asylums.⁹

For attendants and nurses to be competent assistants to the doctors, in the treatment of the insane, some knowledge and instruction must have been imparted. Medical officers probably outlined their expectations on an ad hoc basis, when the assistance of attendants and nurses was needed. In the absence of recorded evidence of formal education and training, it is likely that knowledge

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⁶ Select Committee of Inquiry into the present State and Management of Lunatic Asylums (Minutes of Evidence Prior, M.), N.S.W.L.A.V.& P., Vol.4, 1863-64, p.944.
⁷ Ibid, (Minutes of Evidence Campbell, F.), pp.891-892.
was also imparted by more senior attendants to their juniors, by learning between each other, and by reinforcement through their own work and practical experience.

As noted in chapter 6, Dr Manning was convinced mental illness was an organic disease, which required and might respond to medical treatment under the direction of a doctor. Manning had already redesignated the lunatic asylums as hospitals for the insane, and as such, those workers who had most contact with patients, and who could provide the best assistance to doctors, would logically be nurses. Florence Nightingale’s reforms of general nursing were well known, and Manning saw her reforms as a model for the reformation of the carers of the mentally ill. In fact, in his correspondence and reports, he had already begun to officially refer to female attendants as nurses. Manning did not have to look very far to observe the Nightingale system in action, as a number of her sisters had been at work in Sydney, since 1868.

### 7.2: General nurse training - the Nightingale system introduced into New South Wales.

When the colony was founded in 1788, the British Government made no provision for civilian staff to assist surgeons in their medical tasks, so convicts were the source from which labour was supplied to maintain the colony. However, hospitals (and asylums) were staffed with least desirable convicts, considered unsuitable for other work essential to the colony’s survival.¹¹

Following the cessation of convict transportation in 1839, labour for hospital

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¹ It is beyond the scope of this work to examine in detail the work of Florence Nightingale or the early development of general nurse training in N.S.W. - except where it may have influenced mental nursing, a brief overview of its broadly accepted origins is all that is necessary.

staffing came from the poorest classes of society, as it was not fit employment for anyone who could find other means of support. As a result, in the mid 1860s, care provided in general hospitals had improved little from the earliest days of the colony. Also, people requiring medical care, if they had the resources, avoided public hospital treatment. In this way, both staff and patients tended to come from the most disadvantaged (working) classes.

In July 1866, Henry Parkes, the Colonial Secretary, mindful of the need to improve health services, wrote to Florence Nightingale:

> The Government of this Colony is desirous of engaging the services of four ladies who have received an efficient training as nurses in some well managed English Hospital. These trained nurses are required for the Sydney Infirmary, where proper apartments will be provided for them by the time of their arrival in the Colony, but it is desired that in the performance of their duties in this institution they shall become the hospital instructors of such other female attendants as may from time to time be placed under their superintendence. In other words, it is hoped that a nursery for hospital attendants will thus be established from which similar charitable institutions in the country districts may be supplied.

> As the Minister under whom public charities are placed I do myself the honour of applying to you to ask your benevolent assistance in the selection of these nurses.12

Nightingale replied three months later, noting she was satisfied with his plans and suggesting six, rather than four nurses be sent. The extra nurses were viewed as necessary by Nightingale, to counter the influence of medical officers and make the task of the Lady Superintendent a little easier.13

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12 Cited in McDonnell, F., Miss Nightingale's Young Ladies. Angus and Robertson, Sydney, 1970, p.3.
On Friday March 6th 1868, Nightingale’s nursing sisters disembarked in Sydney under the Superintendence of Miss Lucy Osburn, the Sydney Morning Herald simply reported that “the Lady Superintendent and six nurses” had arrived on the *Dunbar Castle*.14 Three days later the Herald informed the public that;

> Miss Osburn and six trained hospital nurses arrived…
> This staff of nurses was sent for from England some months ago; they have been trained by Miss Florence Nightingale, and it is anticipated that they will prove of the greatest value to the Sydney Infirmary, where they are to be employed.15

Miss Osburn was evidently quite unimpressed with conditions at the infirmary. She was also not entirely happy with her apartments, as the sanitary condition of the establishment left much to be desired, and she described the rat infestation as “evil.”16 In a lengthy letter to Nightingale, Mary Barker (one of the original sisters), wrote extensively of the conditions;

> The wards was [sic] in a very rough, dirty state, I never saw such a place, I am afraid it is out of my powers to give you anything like a good description, I suppose it had been cleaned up for our reception, and no doubt they thought it was very beautiful …when the Lady Superintendent took me through the wards before I went on duty, I was quite ashamed for her to see it, for there was dirty old gowns, skirts and shawls hanging all round the beds, and old rags and rubbish crammed or stuffed in every place... and the Patients looking so miserably dirty.17

Barker’s description of the appalling conditions of which she was “ashamed” and over which she had no previous control, must have been the more unsettling, given she believed there had already been a recent attempt to clean up.

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14 *Sydney Morning Herald*, March 6 1868, p.4.
15 *Sydney Morning Herald*, March 9 1868, p.2.
16 Osburn to Nightingale, 26 February 1868. B.L., Add. Mss. 47757 ff 101-104.
17 Barker to Nightingale, 30 May 1868. B.L., Add. Mss. 47757 ff. 235-236. (NB. Spelling and grammatical errors, e.g. no full stops, abound in the letter).
Nevertheless, the physical conditions described by Barker were matched by her description of the staff:

The Nurses were dressed in all colours with old jackets and old gown skirts in rags all round the bottom and the largest crinolines I ever saw no caps and not a bit of apron... their hair... in all cases looking as if it had not been combed for a week, I think the scrubbers at St Thomas Hospital were a respectable class of women in comparison... women who consider themselves good Nurses, would let their patients lay in their beds unmade for weeks and not even wash their hands and faces for the same length of time, with this excuse, the doctor says that he or she is not to be disturbed... it was necessary to wash the patients and have them lifted into a clean bed, the old bed was quite rotted away and good mattresses in the same condition... They are so lazy, that when they see a patient covered with bed sores and vermin, it is looked upon quite as a matter of course in the colony.  

As a pioneer in sanitary reform, Nightingale would have empathised with the nurses in Australia, having earlier seen and experienced similar situations in her work. She had sent these nurses to the colony specifically to change such conditions and reform nursing and nursing care. Moreover, if this was the state of the colony's major public hospital which was under the control of the medical establishment, then conditions within the asylums might not be expected to be any better. However, evidently they were. At the Select Committee of Inquiry on Lunatic Asylums in 1863, Bishop Willson commended the (nursing) care stating “Great cleanliness and order were evident… no doubt the best is done for the patients.”

Through sanitary reform and especially nurse training, Miss Osburn and her nursing sisters, after many trials and tribulations, did influence improvements in

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18 Ibid.
health care. Lucy Osburn remained at the Sydney Infirmary until 1884\textsuperscript{20} and at
least four of the sisters who originally accompanied her to Australia, became
matrons; three of other hospitals and one of a benevolent asylum. These sisters,
and soon afterwards others trained by some of them in the Nightingale system of
nursing, introduced the system into the other colonies, establishing the
Nightingale tradition throughout Australia.\textsuperscript{21}

However, there was no pioneer of education and training for attendants and
nurses, or at least no one accessible to Dr Manning. Nor was there a suitable text
yet extant, which might form the basis for formal education of carers of the
mentally ill. Subsequently, Dr Manning lent his support to one of the Lunacy
Department’s young and ambitious medical officers, who had decided to write a
textbook suitable for use by the colony’s attendants and nurses working with the
insane.

7.3: Lectures on the care and treatment of the insane - a textbook for the
training of mental nurses and attendants.

In 1885, Dr William Cotter Williamson of the Parramatta Hospital for the Insane,
wrote what appears to be the first textbook for attendants and nurses published in
Australia, Lectures on the care and treatment of the Insane. This book consisted
of ten chapters set out as lectures, presumably as an aid to those providing the
lectures and also as a text for attendants and nurses to peruse at their discretion.
The lectures appear to be the first attempt to set out a standard minimum
knowledge base for attendants and nurses employed in the asylums of New South
Wales. Dr Williamson’s book was prefaced by Dr Norton Manning, and he notes
that whilst there were many publications for hospital nurses, there existed only

\textsuperscript{20} McDonnell, op. cit., p.100.
one “tiny and very insufficient” handbook for asylum attendants (although he later noted that as Dr Williamson’s book was going to press, the British Medico-Psychological Association published a handbook). Norton Manning stated he was “anxious” to write such a book, but “when Dr Williamson early in this year undertook the task I gladly accepted his offer.”\textsuperscript{22} This is evidence that Williamson required and received the Inspector General’s sanction and the book was probably written in consultation with him. Their (and perhaps others’) combined experience would have informed Williamson of what was needed to create useful asylum attendants and nurses.

The book’s first lecture was concerned with reinforcing the rules and regulations of the institution and the authority of senior officers. It began with the personal qualities expected of attendants and nurses especially emphasising the need for patience and forbearance when dealing with patients. There was a heavy emphasis on obedience and discipline and it states the orders of senior officers must be obeyed, whether “you think them right or not.”\textsuperscript{23} An appeal to the Medical Superintendent was allowed, but only after the order was carried out. Order, regularity, punctuality and personal neatness receive special mention. There is a demand for loyalty to the institution and its officers, with specific warnings against gossiping and grumbling which are described as “evil,” and could lead to the public disgrace of the uniform and institution.\textsuperscript{24} Courtesy to patients, leading by example, avoidance of ridicule and minimal reinforcement of the patients’ symptoms, were the final points outlined in this lecture.

\textsuperscript{22} Williamson, W.C., Lectures on the care and treatment of the Insane. Government Printer, Sydney, 1885, p.3.
\textsuperscript{23} Ibid, p.7.
\textsuperscript{24} Ibid, pp.9-10.
Lectures II. to IV. were chiefly concerned with mental disease; their classification, symptoms and nursing management. Emphasis was also given to the need for nursing observation, what to note and report to medical officers, including physical illness and pain that may “not be complained of but should be watched for.” Subjects covered included: idiocy and imbecility, mania, melancholia, dementia, general paralysis, delusions, hallucinations, illusions, epilepsy, hysteria, fainting, apoplexy, suicide, self mutilation, homicide and choking.

Lecture V. discussed the use of mechanical restraint and seclusion, food refusal and artificial feeding. The use of mechanical restraint is noted to have “diminished very considerably during past years... Experience has proved that its use is required very occasionally.” Both mechanical restraint and seclusion were to be used only in emergency and required the sanction of a medical officer.

Lectures VI. to IX. highlight physical illness and symptoms, especially those that might be regularly encountered or must be identified and managed urgently within a large and confined population. In particular, Lecture VI. described first aid techniques, including the treatment of various types of haemorrhage, wounds, burns and scalds, bed sores, contusions, sprains and the emergency management of accident victims. Lecture VII. described various types of bandages and bandaging, the administration of medicines, liniments, poultices and their preparation, fomentations and enemata. Lecture VIII. examined infectious diseases that might spread rapidly through an institution. Diseases of special

26 Ibid, p.33.
concern included phthisis or consumption (wasting of the body associated with tuberculosis), smallpox, typhoid and scabies. The importance of managing patients with “dirty habits” (incontinence) concluded the lecture.

Lecture IX. discussed bathing, beds and bedding, and patients clothing. Regarding bathing, Williamson points out the necessity of patient cleanliness and notes that during the process, an opportunity existed for attendants to examine the patient's bodily condition and whether any injuries were evident. Patients, except those who were frequently incontinent, were expected to bathe “at least once a week.”\textsuperscript{27} The shower (regarded as a form of shock treatment\textsuperscript{28}) was utilised for therapeutic purposes only and “should not be given as to frighten the patient, and as a rule the exact duration will be stated in the medical order, but in no case should exceed fifteen seconds.”\textsuperscript{29}

The last lecture (X) emphasised the therapeutic importance of occupation, amusements for the patients and religion. Williamson does not ascribe any particular benefit from a divine source, but rather religion is seen as important in order to encourage patients to “exercise their own wills for good or evil.” Even patients without religious beliefs should be encouraged to attend church services as this was “useful for discipline.”\textsuperscript{30} Night nursing and special duties completed the lecture, with a special note that on the approach of death, the patient must under no circumstances be left alone to die.

\textsuperscript{27} Ibid, p.63.  
\textsuperscript{29} Williamson, op. cit., p.63.  
\textsuperscript{30} Ibid, p.71.
Attendants and nurses spent the most time with patients, were the most intimately involved with their daily lives, and were in the best position to observe and report their observations to the medical staff. Much of the subject matter presented in the lectures was recognition of the importance of nurses and attendants as front line carers of the mentally ill; albeit their role being framed as assisting medical staff.

Dr Williamson’s book found favour in the British Medico-Psychological Association’s (B.M.P.A.) organ, *The Journal of Mental Science* (April 1886), where a review of his book concluded with “Dr Williamson has done well to omit all description of the anatomy and physiology of the brain in a book intended for the use of attendants and nurses.” It would appear the medical profession felt it necessary to protect what it saw as its own specialist knowledge and not surprisingly, Williamson’s first chapter was given praise;

> The advice given in the opening lecture on obedience and discipline, personal neatness... is very good, and the comfort of all asylums would doubtless be promoted were such advice universally followed.

It might be assumed from this that discipline, and the obedience of attendants and nurses, were traits necessary for the comfort of doctors as it would keep their subordinates in check. In fact, there was evidently some disquiet amongst the B.M.P.A. membership regarding the systematic training of asylum staff. For example, in an article published in the journal only three months later, Dr E.G. Shuttleworth, who had organised St John Ambulance classes for staff at the Royal Albert Asylum, Lancaster (England), found it necessary to defend the

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32 Ibid.
systematic training of attendants and nurses. He acknowledged “some objections” had been aired which included, “a little learning is a dangerous thing” and “subordinates might be apt to apply their ‘little learning’ independently of the medical officer.” However, Shuttleworth was able to report that events had “not justified any such prognostication,” adding that trained asylum staff, far from being tempted to exceed their duty, might actually be of value in carrying out the instructions of the medical officers.

Disquiet concerning nurse education was not confined to mental health services. In 1897, *The British Medical Journal*, reviewing the development of nursing during the reign of Queen Victoria, was compelled to complain of the “overtraining of nurses.” In moderation, the training of nurses was praised, however the increase in nursing theoretical knowledge was criticised as the nurse’s work was “essentially practical... The nurse’s function is to be the doctor’s hands and eyes: when she assumes the functions of his brain she has mistaken her place and the result may be disastrous.” Further, “it seems that the training should fit the nurse to be the doctor’s handmaid.” In the United States, this contention had already been eloquently expressed. For instance, in the *Medical Record* in 1892, it was stated that “the best nurse will be the woman who closely follows in the footsteps of the Great Physician.” Evidently, specialist knowledge was the key to power, and the medical profession knew this and did not wish to share it.

34 Ibid, p.201.
35 Ibid.
7.4: The systematic training of mental nurses begins.

From 1886, Dr Williamson’s book was supplied to all attendants and nurses on commencing duty in New South Wales Asylums. During 1887, Drs Sinclair and Chisholm Ross gave a special course of lectures to nursing staff, at Gladesville Hospital, with Dr Williamson examining candidates who completed this course. Those who passed received a Certificate of Efficiency - the first formal recognition of mental nurse training in Australia. In 1888, Norton Manning reported that lectures at Gladesville were continuing and that he, himself, had conducted the written and viva voce examinations. Further, he observed he was “not a little gratified to find how marked an extent the nurses had profited by the instruction given them, and to realise how their usefulness was increased by the knowledge so gained.” Norton Manning also reported he was negotiating the placement of asylum nurses in a general hospital setting, to supplement their training and knowledge of “such maladies as are only occasionally seen in hospitals for the insane... but [they] should be competent to deal with.” So confident was Norton Manning that the training of mental nurses would not merely succeed but flourish, that he predicted, Within another decade no attendants or nurses will be employed in State Hospitals for the Insane in these colonies, except as probationers, who have not gone through a systematic course of training and instruction in their duties, and received certificates of fitness for their special work.

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40 Ibid.
As can be seen, Norton Manning not only expected mental nurse training to soon spread throughout New South Wales, but believed that every other Australian Colony would quickly follow suit.

It is unknown why Gladesville Hospital, in particular, was selected as the site of Norton Manning’s experiment in the training of mental nurses. For instance, by the mid 1880s there were several large public asylums existing in New South Wales, most notably, the recently completed showpiece of the Lunacy Department, Callan Park at Rozelle. Possibly Norton Manning felt a personal attachment or loyalty to Gladesville, borne out by his wish to be interred there after his death. Gladesville was the first purpose built asylum in New South Wales and the first to employ staff experienced in the care of the mentally ill. It also provided Norton Manning’s first official appointment, which led to his now powerful position in government service.

Norton Manning undoubtedly influenced changes in the care of the mentally ill during his tenure at Gladesville, and he had intimate knowledge of the staff and workings of the asylum. He had been in the position to exert influence over staff appointments and was now, and had been since 1878, the authority under which senior appointments were made. It is unlikely that anyone who was not like minded or supportive of Norton Manning, would have found advancement within the Department of Lunacy. In this regard, Norton Manning readily acknowledged the work of medical men who advanced the education and training of mental nurses; Eric Sinclair, Chilsholm Ross and William Cotter Williamson - all of whom rose to become Medical Superintendents under Norton Manning’s administration. However, there was one appointment, that of Mrs Bessie Ann
Simpson as Matron of Gladesville in 1881, that has never received the attention it perhaps deserved.\textsuperscript{42}

7.5: Bessie Simpson - An unrecognised influence on mental nurse training?

Bessie Simpson (nee Chant) was one of the Nightingale nurses who arrived in the colony with Lucy Osburn in 1868. Mrs Wardroper, Superintendent of the Nightingale School at St Thomas’s Hospital London, in recommending Bessie Chant accompany Lucy Osburn, noted “Mrs Chant is really an amiable woman, extremely kind, almost to a fault, to her patients.”\textsuperscript{43} However, Bessie’s behaviour, including making “desperate love” (apparently kissing) to a patient in the accident ward, became the talk of the hospital - among staff and patients alike.\textsuperscript{44} She was to cause Lucy Osburn many problems as the result of her amorous dalliances with at least two patients - one of whom, William Simpson (a stoker on the railways), she secretly married on 15\textsuperscript{th} November 1869, two weeks before leaving the hospital’s service.\textsuperscript{45}

Thus, Bessie was the first of the Osburn group to leave her vocation and upon returning to it, was also perhaps the last to leave. Given the circumstances (Bessie was pregnant), her departure was greeted with relief by Osburn. She wrote to Florence Nightingale outlining Bessie’s behaviour and feared that the scandal, if it got out, would bring ruin upon the work of the Nightingale nurses.\textsuperscript{46} Evidently, whilst the scandal was known to people at the Sydney Hospital, it was not taken up by the press or public - Lucy Osburn and her

\textsuperscript{43} MacDonnell, F., op. cit., p. 9.
\textsuperscript{44} Osburn to Nightingale, 2 December 1869. B.L., Add. Mss. 47757, ff. 123-124.
\textsuperscript{46} Osburn to Nightingale, 24 March 1870. B.L., Add. Mss. 47757, ff. 127-132.
nursing sisters (and indeed Bessie) were spared widespread public humiliation over the affair.

In spite of her behaviour, Bessie’s nursing work was apparently well regarded by Osburn. In 1873, Osburn “forgave” Bessie and she assisted the married couple by successfully lobbying for a better position for William with the railways.\textsuperscript{47} She also directed private nursing of surgical cases to Bessie, who could earn £2 or £3 per week when work was available.\textsuperscript{48} However, by 1881, Bessie was widowed with at least two children, and needed full time employment to support herself and family.

Having applied for the position, on 17\textsuperscript{th} June she was appointed Matron of Gladesville Hospital for the Insane. In taking up the position, Bessie replaced Mary Bland, one time probationer of Lucy Osburn and the first trained general nurse to occupy the position of Matron of a hospital for the insane in Australia. Bessie’s salary was £120 per annum and she was provided with living quarters, light, fuel and rations.\textsuperscript{49}

Bessie Simpson’s earlier behaviour had not drawn wide public attention, but was likely to have been, at least for a time, the subject of gossip among the relatively small nursing and medical circles of the colony. Although possible, given the passage of more than a decade since the event, it is unlikely Norton Manning was ignorant of the affair, especially as he had employed and worked with the former probationer, Ms Bland. In applying for the position, Mrs Simpson would have had to reveal when and where she gained her training and experience, and a

\textsuperscript{47} Osburn to Nightingale, 12 May 1873. B.L., Add. Mss. 47757, ff. 140-145.
\textsuperscript{48} Ibid.
\textsuperscript{49} Shultz, op. cit., p.196.
check of her credentials would also have potentially revealed her past. Lucy Osburn was still Lady Superintendent of the Sydney Infirmary at the time of Bessie Simpson’s appointment, and had she been disposed to, could have sabotaged the appointment. It has been observed moreover, that Osburn often expressed very negative comments about her colleagues; “Gossipy and scandalous comments about the nurses abound, including unverified scandals many years after they had left the hospital.”

However, this was probably not the case with Bessie Simpson, Lucy and Bessie had reconciled and become firm friends; Lucy helped Bessie after the scandal and Bessie named her daughter “Lucy Osbourn Simpson.” It seems likely therefore, that Lucy Osburn probably downplayed or kept silent about Bessie’s earlier behaviour.

Notwithstanding, Norton Manning was prepared to give Mrs Simpson a chance. Yet more importantly, perhaps she had something to offer, a rare commodity he would find difficult to acquire elsewhere - a trained nurse with experience in the training of other nurses.

A matron predisposed toward and supportive of the training of mental nurses, would make the task of reform much less onerous for the doctors. For instance, there was much less need to convince a trained and experienced person, with influence and authority, of the desire for and benefits of change. Moreover, Bessie was able to assist by imparting her knowledge, and was already practised in and able to demonstrate many nursing procedures to the female staff under her control. This contention is supported, for when the systematic training of mental nurses was introduced at Gladesville, the training of female staff commenced one

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51 Lucy Osbourn Simpson 24 January 1872. (Birth certificate), N.S.W. Registry of Births, Deaths & Marriages, Reg. No. 1872/016091.
year earlier than that of male attendants. It was recommended that training
“begin with the nurses, and as soon as they are on an established basis, extend
the system to the men.”52 Further, the first recorded evidence (found) of the
matron’s involvement in mental nurse training occurs in 1911 (three years after
Bessie Simpson’s retirement). The matron provided practical demonstrations to
nurses, for example, in bandaging, temperature and pulse taking, bed-making,
sponging and packing – all basic general nursing skills.53 It seems unlikely that
the matron’s assistance in nurse training began in 1911, especially as Bessie
Simpson had been employed at Gladesville for most of the previous 30 years – it
must be probable that Bessie inaugurated the matron’s role many years earlier.

Dr Eric Sinclair, Medical Superintendent of Gladesville from October 1883,54
later advocated the establishment of medical wards within asylums. He suggested
the systematic education and training of nurses might be,

supplemented by special training in a ward, moulded
more after the style of a general hospital... the possession
of such a ward will allow of the training to be carried out
to a pitch of perfection, impossible without it.”55

Sinclair believed all new staff should be placed into this ward and “each would
remain there till he or she had become a nurse, and had hospital methods
thoroughly drilled into him [sic].”56 Although there is a dearth of direct
evidence, it cannot be mere coincidence that the first asylum with a hospital
trained Matron, would be the first to introduce systematic training also based on

52 Williamson, W.C., The training of nurses and attendants in hospitals for the insane. Intercolonial
Medical Congress of Australasia Transactions of the Second Session, Stillwell and Co.,
Melbourne, 1889, pp.892 & 893.
53 McDouall, H.C., The Training of Mental Nurses. Australasian Medical Congress Transactions
55 Sinclair, E., The extension of hospital methods to asylum practice. Intercolonial Medical
Congress of Australasia Transactions of the Second Session, Stillwell and Co., Melbourne, 1889
p.896.
56 Ibid.
hospital methods. Accordingly, Matron Simpson, through her necessarily close professional and administrative association with the Medical Superintendent, may have been instrumental in influencing his opinions.

In this regard, it is ironic that in her private correspondence to Nightingale, Lucy Osburn, apart from expressing concern about Bessie’s personal behaviour, had only ever criticised her nursing work once, and this concerned the training of nurses;

S. [Sister] Bessie is somewhat supine, does little towards training nurses, but she pleases the doctors and keeps out of flirtations and as long as she does this I am fain to be satisfied.\(^{57}\)

Bessie Simpson remained Matron of Gladesville Hospital for the Insane, until her retirement in 1908 (26 years) and apart from her pension was well rewarded, as was usual, for her long service. On the February 20\(^{th}\) 1908, she wrote to Florence Nightingale (who had recently been conferred with the Order of Merit by King Edward VII):

Dear Miss Nightingale

As one of your old probationers (who is some thousand miles away) will you allow me to congratulate you and express my great pleasure at the high honour Our Gracious Sovereign has conferred on you.

I am one of the pioneer nurses who came to the colony with Miss Osburn in the year 1867. Out of the number I am the only one left in Australia.

I must tell you a little about myself. After some years of hospital work I married, and shortly afterwards death intervened and I went back to my profession, taking up Insanity. I have been Matron of the Gladesville Hospital for the Insane twenty six years, only retiring last month,

\(^{57}\) Osburn to Nightingale, 8 October 1869. B.L., Add. Mss. 47757, ff 119-122.
having reached the specified age of retirement. The Government granted me nine months leave of absence on full pay and a gratuity of £190.

Believe me Gratefully your old Probationer Bessie Simpson (nee Chant).

This letter suggests Bessie had not been, if ever, in personal contact with Nightingale - at least not since leaving Lucy Osburn’s group. Whether or not she was aware that Osburn had informed Nightingale of her erstwhile, scandalous behaviour is unknown. There is no evidence that Bessie ever sought any special recognition; perhaps she felt it better to work behind the scenes, given the patriarchal nature of nineteenth century society and the institution she served. This contention may be borne out in Bessie Simpson’s own words. In 1911, Bessie was interviewed for a newspaper article about Lucy Osburn’s work. Regarding Osburn, Bessie stated,

[She was] a very clever woman – too clever to have to work with men, for they like to manage everything themselves, and in a hospital there is no doubt this should be done – the women officials must be under the doctors.

On the other hand, the lack of direct acknowledgement of Bessie Simpson by Norton Manning, may reflect the possibility that he didn’t comment on her because he saw no reason to. She was doing her work in a satisfactory manner, in effect, what was expected of her - no more, no less. Norton Manning rarely acknowledged anyone in his reports - except medical officers. However, other senior subordinates might be acknowledged upon their transfer or retirement - if they had, in his opinion, excelled in their duties or remained in service for an extraordinary length of time.

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Nonetheless, having a trained nurse in the matron’s position was seen as beneficial as from the mid 1880s, all new female appointments were given to trained nurses in New South Wales Hospitals for the Insane. Upon Bessie Simpson’s retirement in 1907, the Inspector General (then Dr Eric Sinclair) simply recorded her retirement in his report and noted she was replaced by Ms Newton, the former Matron of the Newcastle Asylum.

Whether Bessie Simpson contributed to the systematic training of mental nurses is unknown, however, if she did (and it seems she may have made at least some contribution), she received little recognition. Given Bessie was a woman, a nurse and of the working class, this lack of recognition may not be surprising.

Charged with the success of the training programme at Gladesville Hospital for the Insane, Dr Manning wanted to extend it to all institutions under his control. As noted earlier, Manning ensured that new appointments to positions of Matron were filled with trained general nurses, and gradually training programmes were established at every Hospital for the Insane in New South Wales.

7.6: Systematic mental nurse training fully established in New South Wales.

At the 1889 Intercolonial Medical Congress of Australasia, Dr Williamson delivered a lengthy address promoting the benefits of training nurses and attendants of the insane. He (perhaps mindful of Bessie Simpson?) acknowledged the work of Lucy Osburn and the Nightingale nurses twenty years previously, calling the experiment “a nucleus from which nursing reform might

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60 Shultz, B., op. cit., pp.320-326.
62 Williamson, W.C., The training of nurses and attendants in hospitals for the insane, op. cit., p.890.
be extended in the mother colony.” Subsequently, he said, an appointment to the nursing staff of New South Wales hospitals was the object of keen competition, with the list of applicants much greater than could be accommodated: “Trained nursing in short, has now been elevated into a profession.”

Williamson then posed the question,

If the nurse of the sick of a physical disease is so much improved by training, how infinitely more important is it that those who are to minister to a mind diseased should have special training?

Williamson was also critical of medical officers who, in the past, ignored the contribution of nurses and attendants in the recovery of patients. Moreover, not only was training of great benefit to the insane, there was also considerable personal gain for the nurse. This, he said, was especially true for women, whom might find future independence in employment outside the hospital and whose skills would be a “priceless boon to herself as well as those around her.”

Trained nurses might find employment in private practice, especially for patients of their own sex, and trained males would be very useful in military health care. In a rare acknowledgement, Williamson said, “men are quite as capable of becoming good nurses, as those of the gentler sex.”

Williamson also outlined the course provided at Gladesville which consisted of lectures given twice per week by medical officers. Male and female staff were lectured separately, the objective being “to teach the staff how to nurse the

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63 Ibid.
64 Ibid.
65 Ibid.
66 Ibid.
67 Ibid.
patients without taking on themselves any authority in the matter of
treatment.” The course was of two years duration, the first year was devoted to
medical/surgical nursing and elementary anatomy and physiology, with practical
tutorials offered in the wards on Saturdays. If the student passed both the written
and oral examination, they could progress into second year, which was
concerned with mental nursing proper.

Elementary anatomy and physiology of the brain, and theory concerning the
operation of the mind and will, was discussed, with practical tutorials involving
direct patient contact to illustrate points. If the student passed the examination
following these lectures, they could sit a further examination involving all
subjects given in the two years, and be awarded the Certificate of Efficiency on
passing. Discussing his examination of the Gladesville nurses in 1887,
Williamson stated, Without hesitation I affirm, that they would have well
compared with any body of nurses who had received a similar course of training
in a general hospital. Their accuracy of knowledge, zeal, and evident wish to
learn was as creditable to themselves as to the medical officers who had taught
them. Williamson added that he hoped in future, hygiene and cookery might
be included in the course. He concluded his address by expressing the hope that
training would begin in all hospitals for the insane throughout the continent.

Dr Williamson’s hopes were at least realised in New South Wales, as Frederic
Norton Manning’s report for 1893 noted that all major hospitals for the insane
were conducting nurse training courses. Also, mental nurses were able to spend
three months at the Coast (Prince Henry) Hospital, to gain experience in medical

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68 Ibid, p.893.
69 Ibid, p.894.
nursing care. In 1895, a supplementary set of regulations under the New South Wales Lunacy Act of 1878, made it mandatory for attendants and nurses to undergo training. These regulations outlined minimum requirements for the appointment of staff, including an expectation they were “able to read and write well.” Upon appointment, attendants and nurses were made probationers for one year and were required to attend lectures given by medical staff. They were also expected to pass “the necessary examinations, failing which their services will be no longer retained.” In their second year of appointment, attendants and nurses had to attend the senior course of lectures and pass the examinations, after which they were entitled to salary increases and promotion within the Lunacy Department.

Dr Williamson’s earlier belief that training could provide the nurse with future employment independence, may also have been realised. In 1896, for example, Norton Manning complained there was a high wastage of nurses due to poor salaries;

a wholesale loss of members of staff, selected for their special qualifications and trained for their special duties, caused considerable embarrassment to the Medical Superintendents in charge - embarrassment, which was not lessened by the paucity of suitable applicants for the vacant positions.

From December 1904, the training of mental nurses was increased from two to three years, and the third year included those topics suggested by Dr Williamson in 1889. A 1908 notebook, for instance, recording the content of third year

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72 Ibid.
lectures and written by a nurse who trained at Parramatta, demonstrates that cookery and hygiene were quite lengthy topics. Moreover, the diet of individual invalid patients was *prescribed* by doctors, cookery was not merely a domestic duty, it had a theoretical component and was a technical nursing action - in a similar manner as modern pharmaceutics are managed by nurses. Basic neurology and potential mental and behavioural symptoms were also described, as well as issues, physical and mental, associated with women’s reproductive health. Hygiene was also considered vitally important, with special procedures outlined to disinfect areas contaminated by infectious disease and the treatment of human parasitic conditions. Special instruction on the management of an outbreak of fire within the hospital was also included.\(^7^5\)

Providing lectures on the topics of hygiene, the management of infectious disease, and fire, recognises problems associated with large numbers of people living in very close proximity. The physical wellbeing and safety of patients (and staff), was a primary responsibility of the Medical Superintendents. A major calamity therefore, could feasibly end the career of a lax administrator, while the training of staff reduced the risk of disaster. Training also served the purpose of devolving some responsibility from the administrators, to those of lower rank. Once procedures had been articulated, for example, it was the responsibility of staff to follow them; any deviation could provide opportunity for disciplinary proceedings or to apportion blame.

The defining of carers of the mentally ill as nurses, and their subsequent education and training, was instigated by the medical profession. This resulted

\(^7^5\) Bergin, C., *Third year nursing lecture notes 1908*, (Courtesy of her grandson Michael Cleary).
from the complete dominance, by doctors, of the treatment of insanity and the administration of asylums. In this way, the medical profession’s control over other asylum staff was secured by their moves to train and define them (as nurses). This was not uncommon however, as nursing was already subordinate to medicine, and was seen to be so since Florence Nightingale’s time.76

Recognition of the significance of doctors to mental nurse training and education, is exemplified by the Norton Manning Medal. By 1908, for example, the nurse who obtained the highest aggregate result state-wide, from the three examinations during training, was awarded the Norton Manning Medal by the Department of Mental Hospitals.77 This prize, a gold medal, was instituted as a memorial to Norton Manning following his death in 1903, by the Department of Mental Hospitals.∗ Later, and until the transfer of nurse education from hospitals to universities, in the mid 1980s, this prize was awarded to the psychiatric nursing candidate who obtained the highest mark in the state registration examinations.

As can bee seen, the systematic training of mental nurses commenced and became fully established in all of the Hospitals for the Insane of New South Wales, within a period of seven years from 1886. However, early attempts to gain external recognition of the newly emerging nursing specialty, occurred within the decade following Australia’s Federation in 1901. The issues

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77 Rules for the Attendants, Nurses, Servants and Others, Hospitals for the Insane N.S.W. Government Printer, Sydney, 1908, p.12.
∗ In spite of considerable research, exactly when this prize was first awarded has not been discovered. It is hypothesised the records, which were apparently maintained by the N.S.W. Health Department until the mid 1980s, are stored and awaiting cataloguing by the State Records of N.S.W.
associated with the struggle for external recognition, fall well beyond the nominated timeframe of this work.

Nevertheless, the story of the early training of mental nurses seems incomplete without describing the events leading to the recognition of the specialty of mental nursing.

7.7: Epilogue 1900 – 1926; the external recognition of mental nurse training and the profession of mental nursing.

The further development of mental nurse training was advanced by Australia’s first professional association for general nurses. The Australasian Trained Nurses Association (A.T.N.A.) was formed in 1899, and resulted from discussions between senior nurses and members of the medical profession. The purpose of the association was to promote the desirability of qualified, trained nurses to the public and prospective employers, thus limiting the work prospects of untrained nurses. To this end, the A.T.N.A. established the first Register of (general) trained nurses in 1903.\(^{79}\)

The Association’s inaugural President was Dr Manning, and there were two Matrons with mental nursing experience on the first governing council.\(^{80}\) Despite this representation, it took another twelve years before the A.T.N.A. recognised mental nurse training. The A.T.N.A.’s. organ, *The Australasian Nurses’ Journal*, on February 15\(^{th}\) 1911, provides some insight into this delay;

> At the inauguration of the Association it was suggested that special provision should be made for Mental Nurses, but it was considered that the time was not then ripe to warrant such a step, as the supervision and training were in no way complete.\(^{81}\)

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\(^{80}\) Shultz, op. cit., pp.349-350.

The article went on to say standards had improved, “with the result that the training here in the Government Mental Hospitals is acknowledged to be second to none in the world by those competent to judge.”

Curiously, the A.T.N.A’s Minute book does not record any discussion at the inaugural meeting, about mental nurses or nursing. Perhaps it wasn’t seen as important enough? However, the Association did allow legally qualified Medical Practitioners to join. The first recorded mention of mental nurses occurred on August 9th 1905, when Ellen Gould, former Matron of Sydney Hospital and now Matron of the Rydalmere Hospital for the Insane moved;

That when a trained nurse has also obtained a State certificate for mental nursing, such certificate shall be mentioned among her qualifications as published in the Register, and after a little discussion this was carried.

Therefore, once registered as a general nurse, mental nurse qualifications would also be noted in the Register. It was a small step, but Miss Ellen Gould managed to provide an opportunity for mental nurses. However, for the Australasian Nurses’ Journal to say (in 1911), that mental nurse training remained incomplete, for the previous twelve years since A.T.N.A’s inception in 1899, was clearly incorrect; as the period of training for mental nurses had increased from two to three years in 1904. It is perhaps more probable that the hierarchy of the A.T.N.A., a body dominated by general nurses, were exercising professional control; mental nursing was not considered real nursing. Indeed, unlike general nursing, mental nursing was regarded as degrading work and had not achieved

82 Ibid, p.38.
83 A.T.N.A. Minute Book 1. 1899-1905. M.L. (Special Collections), Mss. 4144 MLK 2665, (Inaugural Meeting) 4 August 1899.
84 A.T.N.A. Minute Book 2. 1905-1908. M.L. (Special Collections), Mss. 4144 MLK 2665, 9 August 1905.
public recognition as an honourable, noble or dignified occupation. Furthermore, “General nurses had always regarded mental nurses as professionally inferior, partly because their educational program was less rigorous.”\(^{85}\) The antipathy of general nurses towards mental nursing, however, was not a phenomenon restricted to New South Wales. The founder of the Royal British Nursing Association (R.B.N.A.) and close associate of Florence Nightingale, Mrs E. Bedford Fenwick, vehemently opposed the admission of mental nurses into her organisation. Writing in 1896 she said;

Those who contend that a Nurse cannot be considered “trained” without a basis of practical experience and theoretical knowledge in general Nursing of the sick … will agree that no person can be “trained” who has only worked in Hospitals and Asylums for the Insane…. the scheme proposes to open the Register of Trained Nurses to men as well as to women; and, considering the present class of persons known as male attendants, one can hardly believe that their admission will tend to raise the status of the Association; while we foresee considerable trouble for the Executive Committee, from such members.\(^{86}\)

Moreover, Bedford Fenwick, and a group of associates, sought to link the cause of nursing to women’s suffrage and there was apparently no place for (working class) men in her political aspirations. Her enmity in turn, resulted in the erosion and eventual elimination of support for the membership of mental nurses to the ranks of the R.B.N.A.\(^{87}\) The B.M.P.A., which had lobbied for recognition of the training of mental nurses in Britain, was outraged;

Apparent misunderstanding and gross misrepresentation have been in the air. The old, old story of the inferiority of asylum nurses has been retold; the echoes of the bad old times have been re-echoed … It would seem that the


work of the Medico-Psychological Association and its most active members for the last decade is as naught…. Ignorance cries aloud in the market-place, naked and unabashed.\textsuperscript{88}

In New South Wales, there does not appear to have been such heated public debate, the A.T.N.A. was somewhat more discreet. Discussion regarding the admission of mental nurses to their Register, at least in the first few years, was simply not minuted (as evidenced by the claim that discussion occurred at the inaugural meeting – which was not minuted). Following Miss Gould’s motion for mental nursing qualifications to be noted in the Register, \textit{only after} the nurse qualified as a general nurse, the next minuted issue involving mental nursing occurred a full five years later, in October 1910:

\begin{quote}
Nurses Drummond and Southwell, holding certificates from the Lunacy Department, asked whether registration as Obstetric nurses would debar them from taking mental cases, It was decided that it would not debar them.\textsuperscript{89}
\end{quote}

In November 1910, perhaps indicative that some quiet lobbying had been occurring behind the scenes, Dr Dansey suggested the A.T.N.A. should consider establishing a Register for mental nurses as,

\begin{quote}
The training in Government Hospitals was now of a very thorough character and covered 3 years. It would be an advantage to medical men to know which mental nurses were certified.\textsuperscript{90}
\end{quote}

Evidently, the first recorded discussion regarding the registration of mental nurses was motivated by, and for the convenience of, the medical profession, rather than to promote professionalisation of mental nursing. After more

\textsuperscript{88} The Registration of Mental Nurses. \textit{The Journal of Mental Science}, Vol. XLIII, No. 181, April 1897, p.328.

\textsuperscript{89} A.T.N.A. \textit{Minute Book 3. 1909-1913}. M.L. (Special Collections), Mss. 4144 MLK 2665, 7 October 1910.

\textsuperscript{90} Ibid, Minutes of Meeting 4 November 1910.
discussion over the next three months, it was decided to put the question to the A.T.N.A’s membership. At a special meeting of the A.T.N.A. called in March 1911, acceptance for the formation of a register for mental nurses was carried unanimously.\textsuperscript{91} This might also indicate that much more discussion occurred between members of the A.T.N.A., than was recorded in the Minute Book. The rank and file membership \textit{unanimously} accepted the proposal; perhaps they might have accepted it years before, if the A.T.N.A’s Council had sanctioned it.

It was resolved at the meeting, candidates for registration were to sit and pass a special examination, the first of which was held in August 1911, with twelve nurses sitting and passing.\textsuperscript{92}

The syllabus for the training of mental nurses (drawn up by a committee of doctors), was delivered through weekly one hour lectures, by medical staff, for approximately twenty weeks. The first year encompassed elementary anatomy and physiology, elements of medical- surgical nursing and first aid. The second year provided a more detailed description of the nervous system, elementary psychology, nursing management of the various forms of insanity, and nursing of the seriously (medically) ill. Third year consisted of instruction on general disease, symptoms of disease and “nursing treatment”, elementary hygiene concerning prevention of the onset and spread of communicable disease, ethics, and for female staff only, diseases of the female pelvic organs and post partum nursing.\textsuperscript{93} This formal instruction of mental nurses appears to be much more medically orientated than that outlined by Dr Williamson in 1885. By all appearances, only one third (second year) of the 1911 curriculum was devoted to

\textsuperscript{91} Special General Meeting. \textit{Australasian Nurses’ Journal}, 15 April 1911, pp.112-114.

\textsuperscript{92} Membership Examination. \textit{Australasian Nurses’ Journal}, 15 August 1911, p.276.

\textsuperscript{93} McDouall, H.C., op. cit., p.826.
the nursing care of the insane. The greater emphasis on medical rather than psychiatric knowledge, probably reflects expectations that carers of the mentally ill should appear to be nurses first and foremost. It might also reflect the relatively poor, or less certain knowledge base of psychiatry in comparison with other branches of medicine. Also, the 1911 syllabus demanded twenty hours of lectures, Dr Williamson described only ten lectures, taking about an hour each to deliver. 94 Thus, the 1911 syllabus possibly doubled the time for theoretical instruction.

Invalid cookery was compulsory in the 1911 syllabus, however, any marks obtained did not count towards the awarding of the Certificate of Efficiency (a separate ‘Invalid Cookery’ certificate was issued). In keeping with the medical profession’s positivist philosophy at the time, “cooking for the sick” was “posited as part of scientific housewifery.” 95 The training of nurses in the preparation of food, food’s use in various diseases and special dietary preparations for invalids, was “classed among the preventative medicines.” This was seen to be important as the appetite of patients, and whether or not certain foods could be tolerated or kept down, were indicators of patient’s health status and were recorded by nurses to be shown to the doctor. 96

The Matron gave tutorials and practicum on bed making, bandaging, observations and other basic nursing skills. The pass mark was set at 60%, failure in the first year resulted in dismissal from service. Second and third year failure

94 Williamson, W.C., The training of nurses and attendants in hospitals for the insane. op. cit., p.893.
96 Ibid.
resulted in no promotion until successful, and there was no limit to examination attempts. Nurses who successfully completed third year could assist in the practical instruction of probationers in the sick and infirm wards.  

The role of the A.T.N.A., as the nurses’ registration authority, came to an end in 1924. At this time, the government of New South Wales, established a statutory body to control the education and credentialing of all nurses in the state, and approve training courses offered at various hospitals.

After years of lobbying by the A.T.N.A., came the beginning of State registration of nurses under the New South Wales Nurses’ Registration Act of 1924, where four equal subdivisions of the Register: General, Mental, Midwife and Infants nursing were listed. At the end of 1923, of the 3,547 nurses registered by the A.T.N.A., only 34 were mental nurses - from a total of 910 in employment with the Department of Mental Hospitals. Whilst not compulsory, the vast majority of mental nurses were members of the Hospital Employees Union - a trade union. Moreover, the A.T.N.A. was a professional, not statutory body, and could not force nurses to accept membership. Also, given the A.T.N.A.’s initial reluctance to recognise mental nurses or their training, a very large proportion of whom were men, it is not inconceivable the organisation was perceived as unsuitable to represent their interests.

The A.T.N.A. had, for more than two decades, lobbied for the statutory regulation of nurses and in 1924, the Nurses Registration Act found passage

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97 McDouall, op. cit., pp.821-826.
100 History of the New South Wales Nurses' Registration Board. N.S.W. Nurses Registration Board, Sydney, 1989, p.27.
through the New South Wales Parliament. It is interesting to note that whilst New South Wales led Australian action to improve nursing standards, the New South Wales Government was one of the last in the British Empire to assume responsibility for regulating nursing practice.\(^{101}\) The 1924 Act included the establishment of a Nurses Registration Board (N.R.B.) of seven members, only three of which were nursing positions. These three positions represented general, mental and infants nursing, with the general and infants nursing positions filled by nominees from the A.T.N.A.\(^ {102}\) However, under the Act, mental nurses were given the right to elect, by ballot, their own nurse representative to the Board - a right not allowed the other nursing specialties for another 30 years; the first mental nurse representative was Mr H. J. Mitchell. The other four positions on the board were filled by medical practitioners and medical dominance of the Board was to continue until the mid 1950s.\(^ {103}\)

The 1924 Act also set down the minimum requirements considered necessary for hospitals to be recognised as nurse training schools by the Board, although the establishment of separate nurse education centres within mental hospitals did not occur until the mid 1950s.\(^ {104}\)

The Registration Board’s requirements for the recognition of hospitals (or institutions) as training schools for each of the (then) four specialty branches of nursing were virtually the same. However, there were differences in the annual reporting forms, based on the individual specialties prescribed curriculum.

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\(^{101}\) Ibid, p.25.
\(^{102}\) Nurses' Registration Act 1924 – Act: Regulations and Syllabus of Study. Government Printer, Sydney, 1929, p.3.
\(^{103}\) History of the New South Wales Nurses’ Registration Board. op. cit., p.34.
The minimum requirements for mental hospitals were:

1. The Matron and chief attendant are registered nurses with adequate hospital training.

2. The hospital has a daily average of not less than one hundred occupied beds.

3. (a) The period of training is at least three years.
   (b) In the case of a nurse registered by the Board as a general nurse, the period of training is not less than two years.

4. The prescribed systematic courses of instruction in theoretical and practical nursing are given during the period of training by the medical staff, and the matron (or chief Attendant) of such hospital, or by lecturers approved by the Board.

5. At the conclusion of each such course the management conducts examinations in the subjects prescribed for same, and at the conclusion of the final examination undertakes to furnish to each successful pupil nurse a certificate that she [sic] has passed such examination.

6. The staff includes at least two registered mental nurses with adequate hospital training actually engaged in nursing at the hospital.

7. Every pupil nurse is required –
   (a) To be at least eighteen years of age at the commencement of her [sic] period of training;
   (b) to undergo a period of at least three months probation; before completion of her [sic] period of probation to produce a certificate of education of the standard prescribed, and a medical certificate of her [sic] physical fitness.

8. The hospital is being conducted and managed in an efficient manner.

9. The management undertakes to forward to the Board during the month of January in each year an annual report in or to the effect of Form 3.105

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105 Nurses’ Registration Act 1924 – Act: Regulations and Syllabus of Study. op. cit., pp.16-17.

* Form 3. outlined within the N.R.B. Regulations was essentially a declaration that the hospital was conforming to the requirements necessary to be a training school. It also listed the names of pupil nurses in each year and the number of lectures they had attended.
The Board’s use of the gender specific pronouns _she_ and _her_ in this document, possibly reflected the notion that not many males would seek registration, or wish to transfer to other nursing specialties. As noted earlier, once a mental nurse (male or female) gained their Certificate of Efficiency, they could work in any institution within the Department of Mental Hospitals, the Department did not make registration compulsory for trained nurses.\(^{106}\)

In 1924, the N.R.B. Regulations set out a syllabus of study for each division of the register, including mental nursing. For mental nurses, Year 1 consisted of Anatomy and Physiology, First Aid, Hygiene and General Nursing. This later component emphasised management of the physically sick, administration of medicines, observations, antiseptic principles, infectious diseases, dressings and applications. Year 2 concentrated on Bodily Diseases and Disorders, Anatomy and Physiology of the Nervous System, Elementary Psychology, the Subconscious or Unconscious Mind and the Causes of Nervous and Mental Diseases. Year 3 examined Signs and Symptoms of Nervous and Mental Diseases, Nursing Requirements in Special Forms of Nervous and Mental Diseases, Management of Wards, Nursing in Private Homes and Invalid Cookery.\(^{107}\) In comparison to the 1911 curriculum, there is a greater number of topics associated with mental nursing proper. However, given there is also an increase in formal lecture hours, it is possible the amount of general medical nursing instruction remained much the same – the extra hours devoted to mental nursing. In the N.R.B’s curriculum, mental nurses were expected to have

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\(^{106}\) _Rules for the Attendants, Nurses, Servants and Others, Mental Hospitals N.S.W._ Government Printer, Sydney, 1934, p.4.

\(^{107}\) _Nurses’ Registration Act 1924 – Act: Regulations and Syllabus of Study._ op. cit., pp.42-44.
attended a minimum of 36 hours of theoretical instruction over three years, compared with twenty in 1911 and possibly only ten (over two years) in 1885.

The N.R.B. expected theoretical instruction to be given by medical officers, Matrons or other approved lecturers, and the nurses were expected to pass all examinations based on the content of the lectures. 108 The N.R.B. conducted its first registration examination for mental, general and midwifery nurses in May 1926. 109 The Australasian Nurses’ Journal of June 1926, published the questions and answers of the first Board examination and this article may reflect the distance between mental nursing and the A.T.N.A., because while the Surgical, Medical, General, Midwifery and Infants Nursing questions and answers were published, there is no mention of mental nursing. 110

The formal education and training of mental nurses in New South Wales, has been charted from its beginnings in the mid 1880s, until the first nurses’ registration examination in 1926. It is clear that members of the medical profession (doctors) initiated and developed this formal education and training, on a model (the Nightingale system) which had already accepted the supremacy of doctors over other health care workers. Consequently, this ensured the continued subjugation of mental health carers and their work (defined by doctors as mental nurses and mental nursing), to the medical profession. However, acceptance of this new specialised branch of the nursing profession, by general and other specialist nursing groups, was reluctant, slow and ultimately incomplete.

Chapter 8.

Time present and time past ... are both perhaps present in time future ... and time future contained in time past.

(T.S. Eliot, Burnt Norton).

This chapter discusses the general findings of this work and identifies three dominant issues (from the past) influencing mental health nurses and nursing in the present. These three issues, Government (political) indifference regarding the needs of the mentally ill; Medical dominance of mental health care; and the Silencing of male attendants and female nurses, are discussed, thereby revealing their influences and potential implications for the future of mental health nurses and nursing. To close, limitations and strengths of the work are outlined and the potential for future research is addressed.

8. 1: Discussion of the general findings of the work.

The stated aim of this work was to provide the first step toward bringing to light an informed and cogent historical account of mental health nursing in colonial New South Wales during the period 1788 – 1901. This has been achieved - the work traces a foundational history representing an account of the development of mental health nursing care from the establishment of the colony in 1788, until the Federation of all Australian colonies to create a nation in 1901. Prior to undertaking this project, and when contemplating its purpose, I believed the work should have some practical applications, including the need to furnish the knowledge considered necessary to provide answers to some of the questions increasingly asked of me in my role as honorary curator of the Cumberland Hospital Museum (Glengarriff), as well as to address a gap in the knowledge of mental health nursing. In doing this, a platform for further research would also be
provided. Addressing an identified gap in the historical knowledge of mental health nursing would, in turn;

- provide a lineage for the profession of mental health nursing in New South Wales,
- illuminate the origins and development of mental health nursing practice(s),
- expose some of the problems of the past and how these were dealt with – possibly providing lessons for today, and
- at a practical level, simply and no less importantly, satisfy a need to know – in effect, to inform the present of the past.

In the following section, these points are briefly summarised and reviewed.

In tracing this history, the previously noted aim and purpose of the work were generally satisfied, a lineage (or at least the beginnings of one) for the profession of mental health nursing in New South Wales has been exposed. The early carers of the mentally ill were convicts, involuntarily co-opted to undertake the care of lunatics, who themselves were drawn from within the convict ranks. As the colony developed, Joseph and Susannah Digby, specialists in mental health care, were appointed to manage New South Wales' first purpose built asylum. As experienced keepers, they represented the colony's first true mental health nurses and whilst they eventually succumbed to the class distinctions of colonial society, through the medium of medical ascendancy, their work in the moral treatment of the insane lives on, somewhat unrecognised, in the work of their successors. Thus, a little of the origins of mental health nursing practice(s) has been revealed.

The origins of the work of mental health carers in New South Wales, is closely related to the lineage of the profession; it began and was firmly rooted in the
labour of convicts, later becoming very much an occupation of the working class. However, for several reasons, even for the working class, caring for the mentally ill was undesirable work. For example, the nature of the work, the extremely poor working conditions and emolument, the lack of training and career opportunities, societal stigmatisation because of close association with the insane. There was also the absolute authority and control of the medical superintendents over the carers’ working lives, and to a great extent, over their private lives (not least in terms of the time they were off duty and allowed out of the asylums, and what they could do within that time), meant the work tended to attract people who were often considered unsuitable by asylum medical superintendents. However, these were not issues and experiences that occurred in isolation in New South Wales, contemporaneously these same issues influenced the nursing carers of the insane in other countries and with similar consequences.¹

The difficulty in recruiting suitable applicants for positions of attendants and nurses, within asylums, became one of the excuses used by the medical profession for its inability to provide promised improvements in patient care, following its *raison d’être* and total authority over mental health services. Nevertheless, towards the end of the 19th century, the status of the nursing carers of the mentally ill was raised.

However, this did not occur because of the members of the new profession, rather, it was instigated by an increasingly powerful medical profession,

ostensibly to improve patient care, but it was also to create competent and subservient assistants for doctors. Thus the modern work of mental health nurses began, and was directed and developed, under the control of the medical profession.

Despite the historical significance of this event, it was probably inevitable as almost all official and political decisions made in colonial New South Wales were subjugated to the authorities of Great Britain. There, the medical profession had begun to assert its primacy over mental health care - it was only a matter of time therefore, before events in Great Britain would influence decisions taken in the colony. However, whilst the medical profession’s ascendancy took many years in Britain, it was rapid and complete within a very short time span (effectively three years 1846 – 1849) in New South Wales, reflecting the comparatively smaller and less complicated society and infrastructure then extant in the colony.

With the Digbys, an opportunity arose for carers of the mentally ill to develop a profession relatively free of the machinations of a rival group, however, as noted, this opportunity was undermined and eventually destroyed by members of that rival group - the medical profession. Whilst most of the Digbys’ early nursing successors were kept under control by the medical superintendents, a few, such as Christopher Diamond and Michael Prior, by asserting their rights, challenged the power of that authority, albeit with little success at the time. However, and particularly in these cases, their challenges reveal that whilst their labour and

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behaviour (to some degree) were controlled, their minds functioned independently of the authorities who sought to control them. These expressions of independence, from the lower ranks (and class), had to be dealt with quickly in order to maintain the authority and power of those drawn from the upper classes of society. The Digbys, Diamond and Prior (and without doubt others), were castigated and thus made examples of, to ensure that the natural order of class distinction and its power relationships were maintained by those who had the most to lose, should the order of class distinction collapse.

To maintain such authority and power, the medical profession later began to mould (through formal education/training) attendants and nurses of the insane into useful, but subservient assistants for its scientific treatment of madness. To do this, the medical profession used as its model, the system said to have been created by the famous reformer of general nursing, Florence Nightingale (herself from the upper class), thus laying the foundations of the modern profession of mental health nursing. Nightingale’s system of nursing had already accepted the authority of the medical profession, and so too, from its modern beginnings, mental health nursing was contrived to be subservient to medicine. In beginning this process, trained (general) nurses and in particular, Bessie Simpson, seem to have contributed to the early training of members of the nascent profession of mental health nursing, however, they received little or no recognition for their work, the credit being taken by doctors (for example, Frederic Norton Manning). Nevertheless, after education and training programmes for mental nurses were well established, it took some years before the professionalisation of mental health nursing was reluctantly acknowledged and recognised by the wider nursing profession. This professional discrimination had a lasting effect and has
not completely abated in modern times as “general nurses had always regarded mental nurses as professionally inferior… [and] mental nurses were not imbued with the tradition of self sacrifice that influenced general nurses.”

This history of (nursing) care, and of the carers of the mentally ill, has shed light on the personages and events of colonial times which shaped the development of mental health nursing in New South Wales. This has, to some degree, informed the present of the past; however, this history has also revealed that there is more to know. This is not a negative thing, as gaps in knowledge inspire a desire to know and search for more, thereby encouraging further research. Whilst compiling this history, it became evident that although there were many problems associated with the past care of the mentally ill, and with their carers, the causes of these problems related to three dominant issues. These issues remain pertinent to mental health nurses/nursing in the present and the issues in some cases, as seen in the past, may be outside the direct control of the profession. The three issues, which are discussed in the following sections, are:

1. Government (political) indifference regarding the needs of the mentally ill
2. Medical dominance of mental health care.
3. The silencing of male attendants and female nurses.

8.2: Government (political) indifference regarding the needs of the mentally ill.

With few exceptions, from the earliest days of the foundation of the colony of New South Wales, management of the mentally ill and who should care for them, was not an issue which occupied the minds of those in authority, at least not until specific circumstances demanded attention. In this regard, apart from Governors

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Lachlan Macquarie and Sir Richard Bourke, who both appear to have genuinely wanted to provide humane and appropriate care for the insane, others in government only acted when circumstances occurred that aroused societal concern or condemnation. This government indifference resulted in a long-term lack of service planning and insufficient resources. In turn, asylums suffered from poorly planned infrastructure, deteriorating conditions, chronic gross overcrowding, insufficient and sometimes inappropriate staffing, a lack of staff training and an inability to retain staff. Also evident, a pattern developed of government intervention usually occurring after Inquiries exposed deficiencies. A “boom and bust” cycle occurred, where resources were made available then the situation was allowed to deteriorate until another injection of resources was finally made.

This pattern of ad hoc problem solving remained almost constant throughout the 19th century, extending into the 20th century and up to the present day. For example, over the last century there were at least two Royal Commissions4 and several other major reports into mental health care.5 This suggests a significant and fundamental problem of the past, that is, government indifference and its ad hoc response to mental health services, remains a contemporary issue with serious implications for mental health care and nursing. Supporting this contention, for instance, is the very recent public disquiet regarding mental health services in New South Wales. The Auditor General’s recent Report

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criticised the current lack of emergency beds for the mentally ill, noting that the
government’s own target of 32 mental health beds per 100,000 population was
well below establishment and that resources were not equitably distributed across
the state.\textsuperscript{6} This reflects the same 19\textsuperscript{th} century issue of insufficient resource
allocation which resulted in the gross overcrowding of colonial asylums.

However, rather than allowing mental health services to become overcrowded,
the government has created a situation where service providers discharge patients
too early, ostensively to (already overstretched) community services, with the
purpose of vacating beds. Further, a system has developed where the mentally ill
are admitted to emergency departments of general hospitals, where they wait
until a mental health bed becomes available. The Auditor General’s Report
observes that this can take an inordinate amount of time and in some cases,
patients have walked out without ever seeing a mental health professional.\textsuperscript{7}

The government’s lack of forward planning and poor resourcing is also
impacting on mental health nursing - just as it did in the 19\textsuperscript{th} century, and the
issues and effects are remarkably similar. For instance, the issue of mental health
nursing work, education and training has of late come under public scrutiny;

\begin{quote}
it is nurses who provide most of the care. And in an
overburdened, under-funded system, too much
responsibility falls on their shoulders.\ldots
\end{quote}

Yet too few of the nurses are adequately trained,
especially given the responsibility falling upon them.

Psychiatric nurse training ended in most states in the mid
– 1980s. Since the early 1990s, across Australia, nurses
have been comprehensively trained in tertiary

\textsuperscript{6} Auditor General of N.S.W., \textit{Report into Emergency Mental Health Services}. Audit Office of
Morning Herald}, 26 May 2005, (on line edition),

\textsuperscript{7} Ibid.
institutions. Depending on the university they attend, their training in the complex range of psychiatric illnesses could be measured in days.\textsuperscript{8}

The paucity of mental health nursing theory provided in tertiary educational courses has received criticism from nurse researchers. One extensive survey of university undergraduate curricula across Australia,\textsuperscript{9} demonstrated (during the standard three year full-time course), that the teaching hours of mental health nursing theory ranged from 0 – 225 and clinical practice 0 – 200, or 0 – 15\% of the curricula. This was in contrast to the 33\% recommended for comprehensive nursing courses and expected by nurse registering authorities. This criticism of the education and training of mental health nurses is supported by the findings of a recent Commonwealth Inquiry into the nursing profession. This Inquiry noted that undergraduate comprehensively educated nurses do not receive adequate theoretical content and too little clinical teaching and placement in mental health nursing. The Inquiry recommended that additional theory and clinical experience were necessary to prepare nurses for work in mental health care settings.\textsuperscript{10}

As in colonial New South Wales, working conditions and remuneration continue to be issues of importance in mental health nursing today.\textsuperscript{11} Greater workloads, leading to deteriorating working conditions and dissatisfaction with salaries, have impacted significantly on the recruitment and retention of mental health nurses. Nurses, just as they did in the 19\textsuperscript{th} century in response to similar problems, are

\textsuperscript{8} Dowrick, S., An example to us all. \textit{The Good Weekend (Sydney Morning Herald)}, 12 March 2005, p.59.
walking away from the work. As a result, as shortages of nurses increase, those remaining are forced to take on greater workloads resulting in more and more nurses becoming dissatisfied and leaving. This negative cycle is currently a major industrial issue for the nursing profession at large, however, the shortage of mental health nurses has become critical. The New South Wales government’s response is an ad hoc promise to recruit a further 400 mental health nurses over the next two years. The question is, however, from where will these nurses be recruited? It has been recently reported that there is insufficient funding to ensure adequate university places in undergraduate nursing education programmes, thus it is anticipated that demand for nurses, which already grossly exceeds supply, will further widen over the next few years.

One possible response to the crisis of nurse shortages might be the employment of increasing numbers of lesser trained and educated people. This has already occurred in mental health nursing’s closest professional specialty discipline, developmental disability nursing, where increasing numbers of care assistants have, for many years, been employed in place of trained nurses. This situation resulted from recommendations made when developmental disability services were separated from health 20 years ago, where it was noted “it is inappropriate per se, for the developmentally disabled… to be cared for by a staff category identified as ‘nurses’.” Clearly, mental health nursing may well be approaching a critical crossroad and must be prepared to defend itself. If it does not, then the problems experienced in recruiting suitable and appropriately

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12 Ibid.
13 Lawes, A., They’re tinkering. Parramatta Advertiser, 27 April 2005, p.11.
trained staff during the 19th century, where it was said, “we could not actually get men worth an iota to come as keepers… [and we] dared not dismiss them, because they were better than none,”16 may echo deafeningly from the distant past.

Viewed against current circumstances, the knowledge this work has drawn from the past suggests T.S. Eliot’s words are true – time present and time past are contained in time future, and time future is contained in time past. A quote from an Editorial in the Sydney Morning Herald suggests so;

Mental health still suffers from a broad community prejudice, which has tangible results. The brutal truth is that governments allocate fewer resources to it because they know an uncaring electorate will let them do so.17

8.3: Medical dominance of mental health care.

It is not surprising that medical dominance of and authority over mental health services, and care, would impact on other health care providers such as nurses (and their role within that service). In this work, the actions and consequences of individual doctors operating to ensure the medical profession’s ascendancy over mental health care in 19th century New South Wales, was documented and examined. However, as noted previously, apart from the local consequences for (in particular) nursing carers of the insane, medical ascendancy and dominance of mental health care was a phenomenon already underway in Britain (thus directly influencing events in New South Wales), but also in Europe and North America. This phenomenon, driven by advancements in medical knowledge and influenced by the medical profession’s adoption of a positivist ideology, had

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16 Dr George Walker 1855 (see chapter 5 ref. 49).
successfully demonstrated cause and effect in many disease processes and towards the end of the 19th century, began to influence the profession of nursing.\textsuperscript{18}

In colonial New South Wales (as elsewhere),\textsuperscript{19} doctors involved in the treatment of the insane believed the same positivist methodologies, so successful in general medicine, would equally apply to madness. However, at the time, positivist treatment of the insane did not fulfil the hopes and expectations of medical practitioners.\textsuperscript{20}

During the early 20th century, described by one historian as the “melancholy years”\textsuperscript{21} for mental health care, positivist approaches gave way to psycho-analytical and psychodynamic theories, quickly developed and adopted by the medical profession thereby continuing its hold over mental health care. Nevertheless, hopes of a positivist breakthrough continued to exist, with experiments occurring in a variety of somatic interventions during the early to mid 20th century, for example, Fever Therapy, Insulin Therapy and the development of Electro-Convulsive Therapy.\textsuperscript{22} Furthermore, positivist hopes were encouraged and given impetus during the 1950s, through the emergence and early success of psychotropic drugs such as chlorpromazine (leading to the present attraction of biological psychiatry). The medical profession was again

assured of its ascendancy, not least because it had the exclusive rights to prescribe, vary and suspend medication.

During the course of this work, medicine’s ascendancy over mental health services was revealed. In turn, it is suggested that medicine's continuing ascendancy is achieved, in part, by the production of historical narratives tacitly informing other health care providers (and particularly society), of medicine’s importance to the past improvements and future development of health care. In this way, methods were provided through which medicine secured and maintained its power. For example, medical dominance of health care is perpetuated through historical narratives favouring medicine and medical advances, at the expense of other health care providers. This reinforces long held assumptions of the ‘natural’ order of the power relationships in health care, which places doctors and medicine at the top of the authority and power hierarchy. In this regard, traditional historiographies of health care often detail the supremacy of doctors and the role of medicine in the improvement and advancement of health care, particularly during and since the 19th century. For instance, Whig interpretations suggest that history is a history of progress, from a primitive or less developed past, to a more enlightened and better present. The present is explained in terms of the past, with the implication that the present is better than the past.  These Whig histories tend to be unquestioning chronological narratives, detailing the work of (great) medical men who struggled against the odds and succeeded.  To them goes the credit for advances in health care, while little or no recognition is given to those outside the

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medical profession who may have contributed to those advances. In this scenario, non doctors are deprecated for their backwardness or resistance, or given no mention at all. More recently, there have been attempts to address the silence/silencing of other health care providers in historiography (in particular nursing), by re-assessing and analysing their historical contribution to health care. Nevertheless, one generally cannot argue that advances in health care and treatment were largely the result of advances in positivist medical sciences, except perhaps in one major domain of medical treatment, the treatment of the mentally ill, more commonly known as psychiatry.

Traditional histories of the development of psychiatry, usually written by medical men, follow the same principles of traditional Whig health historiographies, that is, the pre-eminence of past doctors in the advancement and shaping of modern mental health care. In constructing these sorts of historiographies, alluding to advancements in the treatment and care of the mentally ill, the failure of the medical profession to provide the early promised cure for insanity is effectively covered over and, at the same time, any notion that others were (and are) significant contributors to mental health care is suppressed. Further, these historiographies downplay or ignore the role of alternative ideologies sometimes practised by other health care providers (for example, moral treatment - aspects of which were adopted and utilised by mental nurses laying the foundations of the concept of therapeutic relationships). In turn, such treatments are given little recognition or worth in relation to positivist

psychiatric treatment. These historiographies can thus be seen to glorify, justify and reinforce the need to maintain medical dominance of mental health care. Moreover, they continue to progress the notion that cure is possible and nigh. This aspect of medical dominance is beginning to be challenged or re-interpreted by nurses\textsuperscript{27} and others\textsuperscript{28}, which may see some of the weight of medical dominance lifted from the profession of mental health nursing.

Whig historiographies have also provoked a strong and often critical reaction from commentators both inside and outside the psychiatric professions; even if the role of nurses in these critical discourses is rarely mentioned, especially in regard to the patient’s experience. Moreover, it could be implied that mental health nurses and nursing have shared in the benefits of association with psychiatry and thus must also share the criticism. For instance, in social theory and anti-psychiatry discourses, where psychiatry is interpreted, for example, as a method of social control\textsuperscript{29}, mental health nursing may not be seen as a victim of, but rather viewed as a partner in, the medical profession’s dominance over the body and/or the mind. Thus, in defending the historical (and present) role of mental health nurses/nursing, nurse historians may also find themselves defending the psychiatrist’s role and by extension, psychiatry’s dominance over their work. This may be a potential pitfall when one attempts to rewrite the history of mental health nursing.


\textsuperscript{28} See for example, Skull, op.cit. & Porter, op.cit. & Smith, L.D., op. cit.

Whilst the medical profession’s (psychiatry) use of historiography to assert its
ermine and necessary control of mental health care required attention, there
are other aspects of this issue, which because they impact on the subordination of
nurses and nursing care in the present and the future, are also important to note.
For instance, in the present, the long history of the medical profession’s positivist
approach to knowledge development has influenced nursing practice and
research. This occurred because, rather than legitimising its own practice by
developing nursing knowledge, through which to inform practice, mental health
nursing borrowed knowledge from medicine/psychiatry. “Thus, the materialistic
medical epistemology was absorbed uncritically and became assumed psychiatric
nursing knowledge.”  

30 Also, in the recent past, the nursing profession in
“mimicking medicine,” flirted with logical reasoning and decision making via
the nursing process and nursing diagnosis movements. However, this flirtation
with positivist methodologies to inform nursing practice has not produced the
supposed benefits of professionalism, accountability and effectiveness.  

31 Further, the endorsement of evidence based practice (also borrowed from
medicine) to inform nursing work, according to one commentator, could be
detrimental to nursing and especially so for mental health nursing.  

32 This is
because the evidence favoured in evidence based practice is developed using
quantitative (positivist) research, whereas human relationships and human
experiences of illness/health, a domain of mental health nursing, do not lend
themselves solely to quantitative but also to qualitative methodologies. Thus,
evidence based practice arising from medicine, is unlikely to provide substantial

30 Horsfall, J., Psychiatric nursing: Epistemological contradictions. Advances in Nursing Science,
31 Geanellos, R., Nursing based evidence: moving beyond evidence-based practice in mental
32 Ibid.
and useful knowledge to inform mental health nursing. Just as importantly, continued reliance on models and knowledge developed by medicine will impede the professional development of mental health nursing, delaying its ability to extricate itself from the medical dominance of psychiatry.

Historically, the knowledge and practice of mental health nursing has been influenced by the philosophical and epistemological views of psychiatry – presently dominated by a biological worldview. However, biological psychiatry, which has gained popular acceptance through advances in modern psychopharmacological treatments, is said to be potentially incompatible with the philosophical and epistemological foundations of holistic mental health nursing practice.\(^{33}\) Thus, the current dominance of a reductionist “monotheistic biological worldview” of psychiatry, in which the causes of mental illness are “understood in terms of aberrant neurophysiological processes,” potentially undermines mental health nursing’s humanistic and psychosocial practice base;\(^{34}\) the origins of which can be found in nursing’s adoption and use of moral treatment during the late 19\(^{th}\) century and the influence of psychodynamic traditions of the early to mid 20\(^{th}\) century. Therefore, rather than focusing on interpersonal nurse-client relationships, the nurse’s role in biological psychiatry could be reduced to utilitarian approaches such as supporting, delivering and monitoring prescribed medical treatment, thus becoming seen (by patients) as merely “pill givers.”\(^{35}\) It would be ironic indeed if mental health nurses and nursing were to be dominated by biological psychiatry, as this would realise the


\(^{34}\) Fanker, ibid.

hopes of psychiatry’s 19th century ancestors of securing subservient assistants for medicine’s positivist treatment of the insane.

Of further concern is the perhaps inadvertent complicity of the nursing profession in reinforcing medical dominance of health care. For instance, recent nursing research revealed that current texts utilised extensively by tertiary nurse education courses, reinforce the subservience of nursing to medicine. This research found that the majority of nursing texts, by positioning medical representations of illness and pathology of disease in primary positions, before the person (patient) and nursing management, would in effect, socialise future nurse practitioners to see their role as naturally subordinate to medicine. The researchers recommended that nurse authors “must be active in the construction of… [nursing] knowledge,” which could be achieved by ensuring that nursing texts privileged the people (patients) who are the focus of nursing work and nursing work itself.36 Thus, by shifting the emphasis of medical knowledge to a supporting role, nursing texts could be released from the formal control of medical discourse and the medical dominance of nursing work would be addressed.

Changes in mental health nursing administrative structures in the last 40 years, for instance, the development of nursing management frameworks which removed the medical superintendents’ (thus the medical profession’s) power to hire, fire and discipline nurses, and changes to nursing practice, for example, from institutional to community care, may suggest nursing has been freed, to

some extent, from medical dominance.\textsuperscript{37} However, at the clinical workface, the
games played by nurses and doctors in clinical decision making, betrays just how
subservient the role of mental health nursing is to medicine. According to one
researcher, in these game playing situations, both nurses and doctors are “acutely
sensitive to each other’s non-verbal and cryptic recommendations,”\textsuperscript{38} where
nurses, when they desire a particular action from the doctor, disguise their
recommendation(s) within non-assertive interactions. On the other hand, the
doctor who seeks the advice or recommendation of the nurse, disguises the need
by avoiding an open request for an opinion. Following such interactions, the
nurse tends to terminate the situation by thanking the doctor “with a tone of
grateful supplication,”\textsuperscript{39} thus, reinforcing nursing’s subservient role.
Therefore, in relation to the issues discussed in this chapter, it seems almost
every aspect of mental health nursing (care), from practice and practice
traditions, research methodologies and epistemological bases, were historically
and are presently, significantly influenced and dominated by the medical
profession.

\textbf{8.4: The silencing of male attendants and female nurses.}

Because the origins of the work of attendants and nurses were firstly grounded in
the convict labour force and later became an occupation of the working class,
evidence of their (authentic) voices would be difficult to find. The very nature of
their origins tended to ensure that, on the whole, they were illiterate and thus
unable to leave for posterity their own perceptions and opinions. Occasionally,

\begin{flushleft}
\textsuperscript{38} Dhondea, op. cit., p.80. \\
\textsuperscript{39} Ibid. 
\end{flushleft}
something of the views of persons of this class has been recorded by someone else, for example, Joseph Smith’s recollections of the Toongabbie Government Farm which were recorded by Caroline Chisholm (chapter 2). As with much historical evidence, what was recorded may not be exactly what was said and further, in the aforementioned example, it was recorded 56 years after the events described. However, this account may be the only existing evidence of conditions under which convicts laboured, by someone who lived it at that particular time and place (i.e., not an official report by someone observing rather than living the experience of being a convict at the farm) and as such, is valuable.

Other evidence from illiterate persons can be garnered from official inquiries where oral evidence was written down and thus recorded, and upon which this work has heavily relied. This was necessary as no other recorded views of attendants was found, even those who were literate did not leave written information for posterity or future researchers (although letters or diaries, currently inaccessible to researchers may exist in the hands of a few descendants). Herein too lies a problem, only the voices of those interviewed at Inquiries are recorded and they represent a small percentage of the workforce. They may or may not have been honest, they may have had a personal or political agenda, they may have been too fearful to voice opinions that dissented from those in authority and they could only respond to the questions they were asked. This situation is further complicated by the culture of silence, which became an entrenched part of the attendants’ working lives, largely as part of their attempts to keep out of trouble and also to maintain some control within and amongst themselves (chapter 6).
As can be seen, the authentic voice of male attendants was reduced to a whisper; however, the voice of nurses (women) was almost completely silenced as in almost every Inquiry, the voice of nurses (women) was excluded. This may have occurred because of the idea that women belonged to a private sphere so it was considered “inappropriate for women to be named in [a] public document.”

Generally, however, it appears that women’s opinions were not valued or considered necessary and this may be the case when considering the issues under investigation in the majority of 19th century Inquiries into lunacy services in New South Wales. The Inquiries of 1846 and 1849 (chapter 4), for example, were concerned with the struggle over who should be in ultimate authority over the administration of Tarban Creek Asylum and this was a struggle between men. At that time, there was never any doubt about what the gender of the superintendent (or anyone in ultimate authority) should be – it was men’s business. At the 1855 and 1863 Inquiries (chapter 5), the issue of asylum administration (again men’s business), was investigated by a parliament which consisted only of upper class men, who did not appear to want or need the views of women.

Whilst the views of women were apparently not seen as relevant or important, there was at least one exception. During the 1855 Inquiry into the dismissal of Tarban Creek Asylum’s Steward, Robert Lakin, the matron, Jane Manson, gave evidence supporting the dismissal of Lakin. In this instance, the matron’s experience of attending on the insane would have been vastly different to the ordinary nurse and besides, she was very much speaking to an agenda. Manson was supporting Francis Campbell and particularly his wife, in her accusations against Lakin, where the complaints originated from an upper class woman,

supported by upper class men, who had to suppress the behaviour of a lower
class man who questioned their perquisites (chapter 5). Thus, Manson’s evidence
was useful to those in authority who wished to maintain their control over others
whom they saw as lower in station, exercising rights to which they were not
entitled.

The silencing of women can also be seen in the lack of recognition and hence the
devaluing of their work. For example, the probable contribution of Bessie
Simpson in the early development of mental nurse training at Gladesville
Hospital (chapter 7), was, at the time, never acknowledged by those in authority
— doctors who were men. However, there is a rare exception - the 1876 Inquiry
into the corrupt administration of the Parramatta Lunatic Asylum (chapter 6)
which did not call for women to give evidence. In this case, the skilful
management of the female division of the asylum by Matron Jane Burn, kept the
machinations of the corrupt male administrators largely from influencing her
staff of nurses (except one - Mrs Russell), and won (rare recorded) praise from
the Medical Superintendent, Dr Taylor.

Nursing, as an occupation, was (and is) traditionally seen as women’s work and
apart from attracting little recognition for the work, nursing also brought few
material rewards, particularly as the ideology of duty rather than rights developed
and prevailed. Moreover, as those who remained nursing over a lifetime often
found, at the end, little value was placed on their years of work and
experience. However, mental health nursing is somewhat different to general
nursing in one significant aspect. While women represented the bulk of the

41 D’Antonio, P., Revisiting and rethinking the rewriting of nursing history. Bulletin of the History of
workforce in general nursing, in mental health nursing, males represented at least and perhaps a little more than 50% of the workforce.\textsuperscript{42} Although not revealed in this work, overseas historical research has exposed an erstwhile neglected aspect of gender relationships within mental health nursing – the marginalisation of men. The development of nurse training in the late 19\textsuperscript{th} century resulted in this marginalisation of male attendants due to the defining of asylum work as being nursing work which, as noted previously, \textit{was seen as women’s work} thus feminising the role. There existed little social respect for male nurses and there seemed little value in obtaining qualifications when the unqualified male staff were doing work little different to the qualified. Male attendants were needed primarily for their physical strength (in order to manage/subdue difficult patients) and, within the asylums, males tended to gravitate towards artisan work which gave (masculine) legitimacy to their role.\textsuperscript{43} Historically in the New South Wales context, this issue may be evidenced by the fact that male carers of the mentally ill continued to be called \textit{attendants} until as recently as 1960.\textsuperscript{*}

Whilst there would be similarities in the experiences of colonial female and male mental health nurses, the experiences of women would have been different to that of men. This is largely because of poorer pay and conditions (as in the case of the Parramatta Lunatic Asylum), but further due to social strictures, where notions of respectability and subservience to men were placed on women during the Victorian age.\textsuperscript{44} This gives voice to feminist concerns regarding


\textsuperscript{43} Boschma, op. cit., pp. 176-179.

\textsuperscript{*} Noted in chapter 6, p.241.
women’s silence in history as an artefact of past patriarchal oppression; where women represented a class of their own, always below that of men, regardless of what social class (and occupation) to which they belonged. Because there is silencing of women, it is not possible to know what female nurses experienced or thought of their experiences, it is only possible to extrapolate their possible experiences from indirect evidence. For example, from reports of the extremely poor conditions under which nurses lived for years at the Parramatta Lunatic Asylum and which was recorded as impacting upon their health and decisions to leave the mental nursing workforce (chapter 5).

Perpetuating the historical silence of attendants and nurses are the Whig historiographies of psychiatry (as noted in the previous section), and histories purporting to be of nursing but ignoring mental health nurses and nursing (see chapter 1). However, this situation has begun to be addressed in works such as this, and in the relatively recent and increasing amount of research which has led to a number of histories written about, or involving, aspects of the history of mental health nursing itself. This is essential work for whilst in modern times, mental health nurses have been far from silent by way of significantly contributing to nursing research, knowledge and philosophy, they still know relatively little of their past. This is important as;

Having a history confirms the legitimacy of the service one provides; mere inclusion in the history of another group implies subordination.47

The three dominant issues discussed; Government (political) indifference regarding the needs of the mentally ill; Medical dominance of mental health care and, The silencing of male attendants and female nurses, were revealed to be historically embedded and currently influencing mental health nurses and nursing. It seems clear that mental health nurses will have to become more politically active, both within the nursing profession, and outside, if the three dominant issues exposed in this work are to be addressed. In my view, these issues are analogous to the laying and development of the first railway line in New South Wales – completed in 1855 and running between Redfern (Sydney) and Parramatta. In the 150 years since, the line has been widened, lengthened and branches have extended from it. The trains are powered differently from the original steam to today’s modern electric locomotives, and they have become larger, faster, shinier and more streamlined. However, although the ballast, sleepers and tracks have been replaced many times during the line’s existence, trains still traverse, backward and forward, comfortable but completely dependent upon the original base and corridor; like the first train in 1855. This is the way the tracks were laid so this is the way the trains will go, which is (presumably) an acceptable existence for mindless inanimate objects. The question is - will mental health nursing be willing to jump its tracks abandoning its base and corridor, to find alternative destinations or new ways to old destinations?

8.5: Limitations of the work.

Historical knowledge requires consideration not only of how documented evidence might be understood but equally, how the non documentation of evidence might be understood. For example, the seeming non-history of attendants and nurses of the insane in colonial New South Wales. Understanding this history requires inferences and analysis of the context of its occurrence. For instance, the convict roots and general illiteracy of attendants and nurses; their working class origins and subservience to upper class, authority figures; their overall poverty and hardship of life and their work during the rapid ascendancy of doctors (men) over attendants (men) and nurses (women), caring for the insane. Evidence about such people (the poor, illiterate and disenfranchised), and their history, is mostly written by others (and from their perspective) – the resourceful and well educated; those in the mainstream of society. History (and historical knowledge) therefore, is neither static nor complete, it remains a living document of the past which increasing evidence and insight continue to shape, enlarge and refine.

This work is a foundational history of the experience of attendants and nurses caring for the mentally ill in colonial New South Wales. It has been limited by the decision to examine an extended period (113 years), in a broadly chronological narrative where some exposed issues, for example, the wall of silence of attendants or the differences of the experiences of attendants and nurses based on gender inequalities, are left analytically under-developed. Also, whilst the work has uncovered some dominant issues which existed in colonial New South Wales, and which continue to have implications for modern mental health nursing, the time-frame of this research concludes a century before the
present thus leaving a substantial gap or distance between then and now.

Accordingly, while these dominant issues were present more than 100 years ago and continue to exist today, the factors that allowed these issues to remain unchanged and continue throughout the 20th century are unexamined and, therefore, unexplained.

Regarding the evidence upon which this work is based, and whilst this work has utilised a good proportion of primary material, most of this material is from the official sources of those in authority giving a perspective which does not, on the whole, provide a direct link to the felt experience of attendants and nurses of the insane. Thus, this work is limited by an inability to source the authentic voice of attendants and nurses, which may or may not exist, but which might be uncovered with further research. Therefore, the experience of attendants and nurses was interpreted (through empathising) and this is only one possible perspective. Moreover, how this history might be viewed by those who lived it, is impossible to know.

8.6: Strengths of the work.

This work is the first attempt to provide a cogent history of the early days of mental health care and the origins and development of mental health nursing in colonial New South Wales. Parts of this history had previously been recorded, piecemeal, leaving substantial gaps and a fragmented, poorly understood lineage for the profession of mental health nursing. The work has uncovered sources, issues and themes, which can now be further examined and interpreted and thus, it is a foundation upon which future historical research might be conducted. The narrative form of the work allows for an interesting story to unfold, which in turn
provides a wealth of information from a number and variety of sources, within a structure that is easy to read. The wealth of source material (evidence), combined with a descriptive-interpretative approach (which does not overwhelm the evidence), allows for ready access and re-interpretation from other philosophical and even personal positions (because I believe that “popular” history is often as valid and important as scholarly history and is probably read by more people).

8.7: Potential directions for future research.

Several potential directions for future research have emerged from this work and are listed below.

- The historical gap between the timeframe of this work and the present day (a time of accelerated professional development; more in the hands of nurses), should be undertaken to provide a better link between the past and the present.

- Research should be undertaken to illuminate the differences in the experience of male attendants and female nurses, perhaps utilising feminist or critical approaches.

- More difficult perhaps, but highly useful, would be research identifying the authentic voices of attendants and nurses of the past.

- The dearth of recorded information from the 19th and now probably early 20th centuries, serves as a reminder of the importance of recording the authentic voices of mental health nurses whilst we can. Thus, research utilising oral history methods could provide evidence not only for current research, but for future historical researchers.

- The lived experience of patients during this historical period would shed light on both the care and treatment of the insane from “below.” This could be achieved by examining patient records, files and letters held by State Records (and some remain at present within the older asylums – for example Kenmore Hospital Goulburn).
8.8: A final reflection.

When I first conceived of this project, and having no formal education in the researching and writing of “history,” I had little understanding of the nature of what I was embarking on. My early ideas concerned informing me of the past for the purpose of making me a better honorary “curator” of the mental health museum at Cumberland Hospital. However, during the process of researching and developing this work, I became aware of just how much the past really influenced the present, no less in my work as a mental health nurse clinician. For instance, I now have a keener view of the issue and use of power relationships, and how and why they exist in the administrative and indeed clinical decision making processes of modern mental health services. One thing I already know from this, I will find it impossible to remain silent any longer.

It is not to be rid of history that we study it, but to save from nothingness the past which would be swallowed up without it. We study history so that even these things which would be lost from the past may once again come to life in this all-important present, apart from which nothing really exists. In order that this particular human story may live anew, in all its individual and complete complexity, it is enough that we know it.

(Etienne Gilson, Heloise and Abelard). 48