At a cost of 198,334 pounds, the Kew Asylum was the most expensive asylum ever built in Victoria. It was originally designed to house 600 inmates, including 40 paying patients. By 1871, the intake of patients began, with most of them being directly transferred from Yarra Bend. In 1872, the Kew Asylum was officially gazetted as an institution, and it was considered fully occupied, even though construction had still not been completed. It is also important to note at this point that Yarra Bend was not closed down as planned when Kew was finished, but continued in its more or less original form until it was eventually closed in 1926. For a time, Yarra Bend and Kew were often considered as separate parts of one asylum. There were, of course geographically close, they shared a water supply, and patients were often transferred from one to another, once it became apparent that Yarra Bend was not about to close. They were sometimes even referred to collectively as The Metropolitan Asylum.

In June 1873, all remaining patients were transferred from the Carlton Asylum to Kew.

In January 1874, as construction work continued, there were 812 patients registered at Kew. Bath houses, sculleries and farm buildings were added to the complex as well as the outside wards for the male and female sections. Admissions continued apace, and by

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61 According to Dr. Dick's assessment in 1884: 'the Kew Asylum for buildings, fittings, boundary walls, fencing, and laying on services of gas and water cost 198,334 pounds compared to Ararat 128,222 ... Beechworth 166,403'. (Source: Zoë Commission VPP 1884 vol.4, p.12).

62 At the end of 1873 the number of male inmates was 323 and the number of female inmates was 313, a total of 636 occupying accommodation which according to the Annual Report, VPP 1874, vol.2, p.17 was 'capable of taking 600'. During the time of the first Superintendent Alexander Robertson it very quickly became overcrowded and by the end of 1875, just three years after opening, it was already vastly in excess of this with 500 males, and 420 females resident. (Source: Annual Report 1875, VPP 1876, vol.2, p.5).

63 The reasons behind most of the transfers remains obscure, but transference from asylum to asylum within the state (or colony) was a common practice. Some patients went from Yarra Bend to Kew, to Beechworth or Ararat in the course of their institutional lives.

64 According to Sylvia Morrissey in her History Honours thesis, University of Melbourne, 1988, 'The Asylum and the Community: the Relationship between the Suburb of Kew and the Kew Asylum', p.20 Yarra Bend was originally known as The Metropolitan Asylum, a name which the incumbent Kew Council wished to transfer permanently to Kew Asylum when it opened in 1872. They petitioned the Chief Secretary to this end. Although reference was sometimes made to the Metropolitan asylum, as I have noted, Kew Asylum (later Hospital) was the official title, and certainly the name by which it became popularly, until it was changed to Willsmere in 1960.

65 Pratt, Passages of Time, p.49.

the close of 1875 the asylum accommodated 920.\textsuperscript{67} When Robertson, the first superintendent, retired in 1877 there were 980 patients in residence.\textsuperscript{68} The largest number recorded at the institution occurred in 1889 when there were 586 males and 449 females.\textsuperscript{69}

\section*{Behind the Grand Facade}

\subsection*{The Earliest Revelations}

For four years, the Kew Asylum maintained a self-assured silence behind its imposing facade. In 1876, however, it was forced to reveal that its internal condition was a pitiful affront to the outward ostentation. The major source of revelations about the nature of life behind the asylum walls was an official inquiry which had been initiated by a sudden and suspicious death at the asylum. The number of complaints and queries that were aired, particularly about staff neglect and ill-treatment of patients, turned it into a major investigation of the asylum and its administration. \textit{The Inquiry into Matters Concerning the Kew Asylum}, as it was called, is detailed in subsequent chapters with regard to treatment of patients and general conditions at the asylum. However, certain situations clearly arose at least partly because of the nature of the original plans, and construction of the building.

Possibly the most devastating revelation to emerge from the Inquiry was an indication of the disillusionment of some doctors with the grand asylum design. The large monumental asylums, of which Kew was such an outstanding example, had already

\begin{itemize}
\item \textsuperscript{67} Annual Report 1875, \textit{VPP} 1876, vol.2, p.5.
\item \textsuperscript{68} Annual Report 1877, \textit{VPP} 1878, vol.2, p.15.
\item \textsuperscript{69} Annual Report 1889, \textit{VPP} 1890, vol.3, p.5. The Annual Report for 1910 shows 1343 patients registered at the asylum. However 173 of the males and 139 females were in the 'Idiot Asylum' (later known as Kew Cottages). There were 492 males and 375 females in the main building. (Source: \textit{VPP} 1911, vol.2, p.5)
\end{itemize}
began to fall into disrepute as the expected cures for insanity had not eventuated. They had become known as ‘barrack or block style asylums’, because of their perceived resemblance to other stockade-like establishments. Rather than distinguishing them from prisons, their outward appearance seemed to reinforce the similarities between them. One of the first and most significant people to express misgivings was the first superintendent at Kew, Dr. Alexander Robertson. He voiced the opinion, after three years at Kew, that the ‘smaller the asylum the better’.\textsuperscript{70} Robertson continued:

the general concurrence of modern opinion is that the use of large asylums for the cure of the insane is a mistake. ... It has been well said that a magnificent asylum for the insane means, and must ever mean, the crowding of cases together which ought to be kept apart.\textsuperscript{71}

The smaller single storey dwellings such as those comprising Yarra Bend, which had been condemned as unsightly and inappropriate 20 year previously, were favourably reconsidered. Now named ‘cottage style asylums’ they were seen by many to be the preferred option.

As Robertson’s following comment reveals, however, there was an ironic result of the enormous expenditure outlayed in building Kew and other large asylums. These larger asylums, expensive as they were to build, were still cheaper to run and maintain than any detached cottage system would ever be. ‘There is,’ he stated, ‘only one ground on which you can encourage the large asylums - that is the ground of economy.’\textsuperscript{72} The Board of the Inquiry agreed. Among their 30 or so recommendations regarding the treatment of patients at Kew they announced that a system of small individual cottages was the preferred option in dealing with the insane.\textsuperscript{73} However, they added pragmatically, that as

\textsuperscript{70} Kew Inquiry, VPP 1876, vol.3, p.90.
\textsuperscript{71} ibid.
\textsuperscript{72} ibid.
\textsuperscript{73} ibid., p.91.
Kew Asylum already existed and had been achieved at great expense, it could not be abandoned.

There were other compelling reasons for Kew Asylum to be maintained in its original form. By its design in the barrack style it facilitated a most important facet of moral management—the requirement of surveillance. The long continuous connecting corridors and outside covered walkways enabled the doctors to move rapidly from one section of the building to another in order to observe the inmates at any time. This design, plus the implementation of glass windows in the doors of many of the single rooms made quick and unexpected observation possible. More important than the real possibility of the superintendent appearing suddenly for an inspection was the constant knowledge that it could happen at any time with little or no warning. Assisted by the continuous presence of the attendants, this system was intended to produce an ‘atmosphere of restraint’ without the necessity of real physical restraint involving the use of strait-jackets, camisoles, and other restrictive clothing. As described in other chapters, these devices were not completely abandoned for some time, however. Although the annual report of 1889 claimed that ‘seclusion and restraint [had been] largely abandoned’, 74 isolated incidents of their use were chronicled until at least 1907.

The windows in the asylum were generally left unbarred to further eliminate the feeling of imprisonment. However, their smallness made any escape difficult, with the added disadvantage of rendering the rooms even more gloomy than they would have been if they had been larger and barred. Although opinion was divided about the architectural style and outward appearance of the asylum, both critic and advocate of the barrack plan were less than complimentary about the interior of Kew and its furnishings.

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Internal Problems

During the Inquiry, several problems were aired that were directly attributed to the inadequate supply of fresh water. A former attendant and a former patient both testified that the flannels used in the bathrooms were 'filthy' and that 'lice were transferred from one patient to another'. 75 Ward E, in particular, was 'in a dirty condition'. 76 Besides the undeniable tardiness of attendants, the unreliability of the water supply hindered any efforts at hygiene. There were six underground tanks capable of holding 70,000 gallons on the site. Presumably for the sake of economy, Kew shared its water supply, which was pumped from the Yan Yean reservoir, with Yarra Bend. As Kew was set on much higher ground the water was more likely to end up in the tanks at Yarra Bend. This situation was exacerbated because the pipes to Yarra Bend were made wider than the extension to Kew. 77 During the winter months, sufficient water was pumped to both establishments, but during summer the supply to Kew often dried up completely. Another important effect of inadequate fresh water and a considerable impediment to hygiene was that the closets (or toilets) were found to be 'not cleanly'. 78 To add to the discomfort of patients, there was often no paper supplied in them which meant that 'patients often had to tear their clothes' to use instead. 79

Besides the lack of proper sanitation, the other acute problem was that the design of the building exacerbated the inconvenience caused by overcrowding. Although the Board of the Inquiry were generally satisfied with the state of the sleeping accommodation with 'horse-hair mattresses in many cases' the large wards often had as many as 27 patients sleeping in them. This meant that noisy patients were inclined to disturb others. 80 The

75 Kew Inquiry, VPP 1876, vol.3, p.43.
76 ibid.,p.55.
78 ibid.,p.82.
79 ibid.
80 ibid., p.81.
original plan had been based on the amount of air that would enter the rooms with ‘from 30-40 ft. of fresh air passing into each room per minute ... in bedrooms about 600 cubic feet of space [was allowed] for each patient.’  

This was apparently insufficient. In 1876 the Board of the Inquiry declared that it was ‘impossible to get pure air enough for every patient to breathe’  

82 A visiting journalist described a more obvious lack of space just prior to the inquiry:

At the entrance there is a large dormitory, which was originally built as a day-room ... but owing to the number of patients is now filled with beds ... in the cells the beds are laid on the floor. The rooms are very crowded, the beds seeming far too close together.  

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Ongoing Problems

In 1879, the Victorian Branch of the British Medical Association (BMA) authorised the council of the association to visit and report upon the condition of Kew and Yarra Bend asylums. Its specific task at Kew was to ascertain whether the improvements suggested by the Board of Inquiry three years previously had been carried out. Although they were impressed with the splendour of the structure, they reported that:

the internal appearance and arrangement would do little credit to a workhouse. The walls are rough, the bare bricks showing through the paint, while pictures or other decorations are rarely seen in any of the rooms ... the want of passages all along the

82 Kew Inquiry, VPP 1876 vol.3, p.80.
83 Quoted in Best Overend and Partners and Lewis, Conservation Analysis, p.208.
building for dormitory purposes makes it necessary to pass through one room in
going to another. 84

They too concurred that the worst aspect was that the complex was much overcrowded,
with recalcitrant patients and the more tractable all in together. They declared that although
it was originally designed for 600 it was habitually crowded with anything up to 1,000
patients. The report described how extra space for beds was created. The method was
simple and effective, but lacking in consideration of the inmate’s comfort or privacy:

A room now filled with fourteen or seventeen, or thirty beds has been got by
throwing down the passage wall and seizing the passage as part of the room ... the
effect ... is to render the isolation of noisy and unmanageable patients an
impossibility. 85

The most telling indicator of the lack of space was the fact that two patients were
compelled, despite their protests, to sleep in the earth closets, a situation which must have
been particularly objectionable, given the state of the closets. In spite of this, the members
of the council amazingly concluded that as regards the general order and administration of
the place they had every reason to be satisfied.

The most flattering appraisal came from Dr. Moore in 1886. He described the interior as
spartan, but basically clean, functional and comfortable. He noted that all the rooms were
‘well ventilated’ and the ‘beds are very comfortable, and, like everything else all through
the asylum, scrupulously clean ... each bed is provided with a straw under-mattress, a
firm hair mattress and the requisite number of sheets and blankets’. As regards decor, he
considered that the few pictures on the walls of the day rooms ‘might with advantage be
increased’. Nevertheless, Moore felt that the few that were there helped to alleviate ‘the

84 Quoted in Brothers, Victorian Psychiatry, p.100.
85 ibid.
dullness which necessarily attaches itself to very large poorly furnished rooms. The
sameness of the dormitories is relieved by painting the walls in lively colours'. 86 Even
the bathrooms he proclaimed as adequate. ‘The baths are of wood, and, being kept well
cleaned, are quite dry and smooth, and free from anything approaching greasiness’. 87

There is no indication in either report that any great improvement had taken place since
the 1876 Inquiry, with the possible and important exception that more attention was paid
to basic cleanliness. The overcrowding was still a problem, and no structural
improvements had occurred, nor had anything been done about the overlarge dormitories.
Also in 1886, another report noted:

the original plan showed the building projected by a man who knew the
requirements of a hospital .... but it had been destroyed by someone who had struck
out the dividing walls ... thereby converting single rooms into large dormitories. 88

However, the optimism that had characterised the first years of Kew Asylum’s
operations had by now all but vanished. The expected cures had not eventuated within the
monolithic structures. Any inspection had become merely a cursory gesture at the
maintenance of an institution that had by the mid 1880s become something of an
embarrassment, and was regarded as simply a drain on the community’s resources.

**The Economic Limits of Compassion**

The Board’s findings in 1876 did not make an end to the debate regarding the barrack
versus the cottage system and it became a contentious issue for many years. Supporters
of cottages continued to gather support. However, in defending the system they were

86 Moore, ‘Notes of a Visit to the Kew Asylum’, *AMJ*, vol.viii, no.3 (March1886), p.98.
87 ibid.
ever mindful of the financial considerations of such a scheme which would have meant, among other things, a much larger staff of attendants, with the accompanying costs that this would entail.

Another major inquiry was instigated in 1884. The main reason behind this inquiry appeared to have been a general unease with the ever increasing asylum populations. Lasting for two years, this inquiry was officially *The Royal Commission on Asylums for the Insane*, but became known as the Zox commission after its chairman, Ephraim Zox MLA, a prominent businessman and philanthropist with a particular interest in organised charity. More extensive than the Kew Inquiry in that it dealt with all the asylums in the state, it followed the format pioneered by the earlier inquiry. It also expressed similar concerns about the size of asylums, the treatment of inmates and the general maintenance of institutions.

By this time, however, the earlier optimism about discovering cures had all but evaporated, and the discussion surrounding insanity was couched almost solely within a framework of economics. In its initial report the committee recorded that:

> We believe that a grave error has been committed in the erection of enormous buildings on the block plan, and that the cottage system should have been in the

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89 Richard Kennedy in his work on organised charity in colonial Melbourne describes Zox as one of two gentlemen who, by their ubiquitous presence on charitable committees, provided the Society[ of Charity Organisation] with considerable opportunity for exerting influence’. He also attributes Zox, a somewhat flamboyant figure, with an intense conservatism painting him thus: ‘Ephraim Lamen Zox, a stout man sporting abundant whiskers and moustache, was a familiar bell-topped figure in Collins Street where he operated as a financier. Born 50 years earlier in Liverpool, Zox came to Melbourne in 1852 and later set up as a clothier in Elizabeth Street. From 1877 to 1899 he represented East Melbourne in The Assembly and there became a spokesman on philanthropic matters. He chaired the [Royal] commission in 1884–1886 and sat on numerous charity committees. Zox’s courtesy and good nature won him a Pickwickian reputation, but his intense political conservatism set a firm boundary to his good works; in the nineties he opposed both the income tax and female suffrage’. Beneath his niceness there was little evidence of intellect, and his commitment to Organised Charity was of the unthinking sort that regarded its class doctrines as natural truths’. Zox was a crony and supporter of Premier Gillies, leader of the Conservatives who established the Charity Commission in 1890, which Zox chaired. R. Kennedy *Charity Warfare: The Charity Organisation Society in Colonial Melbourne*, Hyland House, Melbourne, 1985, p.90.
past, and certainly should be in the future, more generally adopted. The erection of huge piles of buildings at Kew, Ararat and Beechworth has added a permanent tax to the country without any equivalent advantages. 90

More pragmatically, even bitterly, the Board lamented: we cannot help regretting the enormous sums expended in building the asylums at Kew, Ararat and Beechworth ... it is hard to say why the dwellings of lunatics should cost such extravagant sums as were lavished on the edifices in question.91 Whereas the opponents of cottages usually argued that they were more expensive to run in terms of staffing requirements, the Inquiry argued that they were cheaper to build in the first place than large asylums. The commissioner’s eventual conclusion echoed that made by the Board of the earlier Inquiry, in that although ‘the evidence is overwhelmingly in favour of the cottage or village plan it is too late now to speak with regret about what is done. We have costly barracks at Kew, Beechworth and Ararat, and they must be utilised.’92

In 1888, the editorial of the Australian Medical Journal made an impassioned plea for better treatment for the insane with regards to accommodation, coming out strongly in favour of the smaller style asylums. According to the article:

the main contention against the cottage system appears to be that it does not permit of adequate attention and supervision [but this was] merely a question of expense ... it is incumbent on those who believe in the cottage idea, to speak out in defence of their views.93

The article countered the cost factor by claiming that: even from a commercial aspect, no expense should be spared in the treatment of acute cases, with the view of preventing

90 Zox Commission, VPP 1884, vol.4, p.19.
91 ibid.
92 ibid.
them from lapsing into the chronic class, and becoming a permanent burden on the State.94 There were still those that continued to defend the large institutions as the appropriate venues in which to implement the new ‘scientific’ techniques. Dr. Moore sounded a positive note on his visit to Kew in 1886. ‘In England the asylums old and recent, are on the Barrack plan’, he commented, ‘as also in this colony, where the results of treatment are so good’.95 Dr. Manning also continued to defend the large asylums. In 1888, he stated that he believed they were ‘unfairly called barrack buildings.’96 This spirited defence of large institutions soon faded however as there was little indication that patients were more likely to recover in them than in the smaller asylums. The noble intentions of providing a beautiful environment had clearly been forgotten as economic considerations overtook the discussion on the most suitable accommodation for the insane. Arguments about barrack versus cottages appeared less to do with the well-being of asylum inmates than symptomatic of doctor’s frustration with the failure of medical science to offer any definitive cures for insanity.

The Politics Of Neglect

Charity and Respectability

There was a belief held almost universally by doctors and administrators that insanity was a disease associated not just with poverty, but with the ‘unrespectable’ poor. Official government policy clearly associated lunatic patients with poverty and charity. This was emphasised in 1884 when Ephraim Zox was appointed Chairman of the Royal Commission. The philanthropic attitude he expressed not only encompassed notions

94 ibid.
about deserving and undeserving cases but was underpinned by assumptions about what the poor were capable of appreciating. As the Board to the Commission noted, ‘in dealing with a large number of pauper lunatics, and the great bulk of them are paupers - their actual wants and powers of appreciation should be regarded’. With this in mind, the Board concluded that ‘palatial residences equipped with Chippendale furniture would not make them happier or minister to the wants of minds diseased’. 97

These perceptions, when measured against the expressed needs for beautiful surroundings and grand buildings, although superficially contradictory, were perfectly consistent with the concept of moral management, within which space and cure were inextricably linked. The healing properties of internal space as articulated through moral treatment were more to do with an adequate supply of fresh air than modern notions of ‘personal space’ or even basic privacy. Nonetheless, the perceived need for 600 cubic feet of air for each patient, eccentric as it now sounds, demonstrates an awareness of the importance of spatial dynamics. This was also expressed through the importance attached to the beauty of landscape, and the feeling of openness that the low walls engendered. The logic seemed to be that the type of inmate who was resident would benefit from the beauty and healing powers of Nature, but would not be appreciative of expensive furniture or other sumptuous fittings because they were unused to such trappings in their pre-institutional life.

In their final summing up, the Board of the Zox Commission decided that the ‘majority of these people belong to the poorer classes, and if they were supplied with the most elegant surroundings, they would be unable, even in their lucid moments, to appreciate the refinements of better life.’ 98 Simultaneously, it was believed that the insane like the poor, should be helped, but not ‘spoil’ or overindulged. This would only encourage them to become more dependent. In 1888, Superintendent McCreery warned that making the

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97 Zox Commission 1884, VPP 1884. vol.1, p.19.
98 ibid.
asylums ‘too comfortable’ could lead, to an ‘increase in the number of people on the border land of insanity who are only too willing to hang about any public institution’. 99

These arguments conveniently justified a lack of expenditure that virtually guaranteed the neglect which dogged the asylum for most of its existence, despite the many design faults which were later discovered and remarked upon. An extensive report in 1905 concluded that the entire asylum was ‘wrongly oriented’. 100 It also noted that the walls of the airing courts were too high, there was a:

lack of day-room space ... defective laundry ... on both sides of wards there are heavy verandahs cutting out light and interfering with cross ventilation, the lavatory and bathing accommodation [remained] defective ... nurse’s quarters limited, ... mess rooms too small the workshops and sewing rooms[were] small and inconvenient. 101

In addition to these structural problems, the available space was not utilised to maximum advantage with ‘rooms which were originally intended as day rooms used as dormitories, and even the galleries are lined with beds at night’. 102

Reassessing the Position

Adding to the dilemma about the amount of expenditure that should be allocated to asylums was the weight of public opinion. There is no doubt certain members of the community, especially the local community, were affronted by the presence of the

100 This expression is not explained, nor is it used again. Presumably, it referred to the siting of the building. It was one of a number of negative statements. I include as indicative of the contrast between the early lavish praise and later suggestions there was nothing good to say about the asylum.
102 ibid.
asylum in their midst. At a council meeting in 1871, before the asylum was even completed, the mayor of Kew had complained that it would mean that they would have in their midst a ‘nice little colony of troublemakers’. 103 In 1887, members of the then Kew council petitioned for the removal of the asylum to a ‘more suitable locality.’ At the same time Dr. Neild ventured the rather unprofessional opinion that there were ‘as many lunatics outside the asylums as inside them’. 104 The rather obscure reason the council gave in defence of a relocation was that the railway line from Hawthorn to Kew was about to be completed and open to traffic. 105

In an article on taxation concessions in 1889, a local paper, the Lilydale Express speculated that the government had ‘a large asset in the shape of valuable land which it was proposed to sell at Kew and Yarra Bend lunatic asylums’. 106 The annual report on asylums for the same year also observed that ‘a scheme under which these asylums [Kew and Yarra Bend] would be abandoned appears to be seriously entertained by the government.’ 107 The following year, the Sydney journalist ‘Benvolio’ claimed that he had read of plans to ‘sell the whole property, and devote the proceeds towards the erection of a new asylum at Sunbury’. 108 He attributed the reason for this to the increased value of the land on which it stood, and expressed his disgust, claiming that ‘it is not a matter for congratulation that we as a civilized community, should allow such mercenary considerations as one afforded by a sudden and fictitious rise in the value of land to break up a charitable institution’. 109

103 Morrissey, Asylum and Community, p.50.
104 Evelyn Observer, 6 September 1887.
105 ibid.
106 Lilydale Express, 20 March 1889.
109 ibid.
In the 1906 Annual Report, the removal of both Kew and Yarra Bend was again seriously considered. According to Inspector General W. Ernest Jones, both asylums were considered to be inappropriate, Yarra Bend because it was a collection of 'worthless buildings', and Kew because it had become rundown and had structural problems. The only regret expressed by Jones was that 'it is not at all certain that it is good policy to throw away the 250,000 pounds or more that the hospital at Kew represents', adding inexplicably that 'the fate of the two asylums is more or less a common one'.

When after 12 months, nothing had been done, another report concluded that it was the possibility of closure which had 'inhibited any additional buildings or improvements [to either asylum]'.

In 1907, there was an outbreak of typhoid at Kew. This dramatic incident focussed attention on the institution again and caused Jones to observe that:

for years nothing has been expended on the hospitals for the insane [as they were by then known] ... repairs have been neglected, woodwork gone unpainted, water pipes unrenewed ... a good water supply and proper drainage have been omitted.

This was due he concluded, to the totally unforeseen circumstance that 'the number of insane increases in comparison more rapidly than the population of this state'. Such an admission would have been unthinkable 30 years earlier. Those who were destined to suffer the consequences of this curtailment of expenditure were generations of asylum inmates; for it was their world that was fashioned through middle class notions regarding the economic limits of compassion.

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111 ibid., p.27.
113 ibid.
Controversial since its inception, the Kew Asylum was built within the framework of the most optimistic perceptions of issues regarding mental health that has ever existed. The human misery and anguish with which it became seen as synonymous was never a part of the intentions of its creators, but stands as a monument to their failure to achieve their high-minded objectives. Nowhere is the frustration and disillusionment of the medical profession’s fruitless struggle for a definitive cure for madness more poignantly reflected than in the disintegration and neglect of the Kew Asylum. Ultimately, its spatial dynamics, which were deliberately fashioned as part of the rehabilitation of its inmates, merely exacerbated the misery behind its impervious facade.
CHAPTER 2

Life Inside the Walls of the Asylum.

The medical superintendent of an hospital for the insane is entrusted with the care and medical treatment of unfortunate persons who have been banished from the the world for the legal [their emphasis] reason that they are unable to take care of themselves or their property, or are dangerous to themselves or to others.

Australasian Medical Gazette 1883.¹

If an insane person is as well housed, as well fed and as well clad as he was in the days of his sanity, then the State has done as much for the sufferer as he could do for himself if he enjoyed his faculties unimpaired.

Final Report of the Zox Commission, 1886.²

The manner in which the Kew Asylum dominated the skyline and loomed over the surrounding landscape probably intensified speculation about the dark secrets that supposedly lay behind the barred windows and locked doors. That insanity, and the manner in which it was articulated through the appearance and operation of this particular asylum, occupied a prominent place in the imagination of colonial and twentieth century Melbourne is beyond doubt. A macabre fascination formed at least part of the reason for the many investigations of the asylum. These ranged from the official inquiry in 1876 through to the stream of tourists who filed through to peer into the dusty empty rooms during a public ‘Open Day’ in 1991, after the institution had been decommissioned and

closed. In between, there were a number of investigations, both official and more personal, which provide insight into the manner of its operation. During the time period which I discuss, in addition to official inquiries, there were at least two instances of journalists who wrote articles directly about the asylum, and many others concerned with the general notion of madness.

In popular Australian literature, the best known evocation of insanity was that drawn by Henry Handel Richardson in her classic portrayal of early Victorian life The Fortunes of Richard Mahoney. Walter Richardson, the father of Ethel Florence Lindesay Richardson (Henry Handel) is believed to have died from General Paralysis of the Insane (GPI), that is syphillis-induced insanity. Although she was too young to have witnessed her father's illness, Richardson vividly re-creates the symptoms and progress of the disease within her fictional character Richard Mahoney. With the nineteenth century novelist's concern for detail, Richardson also describes how her character entered a 'Melbourne public asylum', (popularly believed to be based on Kew). Although a work of fiction, it is interesting to observe how Richardson charts the gradual descent into madness, and finally the death of her protagonist, utilising the assumptions and nuances contained in the narrative of insanity as outlined by the contemporary medical profession. This work, probably more than any other, stands as an illustration of the relationship of medical discourse and the artistic imaginative response to insanity. With its emphasis on the tragedy of human existence, the novel in its portrayal of the asylum, is mostly concerned with the cruelties and inhuman treatment inflicted upon its fictional hero. Much of the incidental detail, however, replicates events depicted in everyday asylum life.

3 See the Age 4 February 1991, p.4.
5 See Richardson, Richard Mahoney, 'Afterword', p.838. Tertiary Syphilis (or GPI) was not uncommon among early asylum committals.
In producing this ethnographic interpretation of the asylum I have also drawn on some other, less orthodox sources. These include the contemporary works of the eccentric doctor Paul Ward Farmer, 6 and the journalist and ‘man about town’ Stanley James, better known to his readers as the Vagabond. 7 In utilising these tracts, I am well aware that both of these writers wrote for a specific audience and with a specific agenda, which no doubt coloured their accounts. The Vagabond was stimulated by his concern for social justice and a desire to entertain and titillate his readers with tales both literate and lurid. There is no doubt that he was conversant with contemporary notions of insanity and the insane. Nor was he lacking in compassion for his fellow-humans, and at least part of his motivation was to expose injustices and suffering in order that something might be done about them. The other motivating force behind the work of the Vagabond was his desire to distance himself from the type of person he found at Kew. In spite of his professing to share their destiny as he does in the opening paragraph of the Vagabond Papers, exclaiming that it is ‘not at all surprising that a vagabond should become a lunatic – gaols and asylums are his natural destinations’, 8 he is careful to picture himself as something quite different. He is, in fact, a gentleman of refined taste, widely travelled, and who ideally begins his day ‘awakened by the advent of two young gentlemen who have a friendly quarrel as to who shall wait on me’. 9

Undoubtedly the Vagabond’s writing was designed to appeal to the more conservative element in society who, like himself, would enjoy the vicarious experience of dwelling among the unknown and mysterious poor and unrespectable, much as they would enjoy a horror story. 10 For this reason, he tended to pursue the spectacular event and ignore the

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6 P.W. Farmer, Three Weeks in the Kew Lunatic Asylum, John J. Halligan, Alfred Place Collins Street Melbourne, 1900.
7 James, Vagabond Papers.
8 ibid., p.78.
9 ibid., p.82.
10 The 1877-1878 edition of the British medical journal The Journal of Mental Science reviewed the Vagabond’s report on Melbourne’s asylums from The Vagabond Papers thus: This book is written by one of those facile-penned gentlemen, who, having a talent and no money, wanted to put the former to usury, and the latter into his pocket, and so went into
more mundane aspects of asylum life and the more commonplace inmate. Nevertheless, his writing is detailed, descriptive and evocative and there exists no more vivid account of one person’s stay in an asylum at that time.

Paul Ward Farmer also had a particular reason for the production of a pamphlet on his experience at Kew. He sought, even more transparently than the Vagabond, to circulate his own ideas. As a member of the medical profession, he too would have been familiar with current notions about insanity, and was anxious to publicise what he considered their shortcomings. His style, however, was rather different from the Vagabond’s. He seemed eager to prove that the inmates of Kew had the potential to be ‘normal’. He also felt that their ‘cure’ could be affected by his own rather unorthodox methods. Farmer believed that a rearrangement of society could eliminate insanity altogether. Sustained by this belief, he found that most of the inmates were, like him, not insane, just misunderstood. ‘I was struck’, he exclaimed, ‘by the number of intelligent faces.’ He also dwelt more on the interesting rather than the ordinary, in particular those men and women whose illness appeared to mirror his own beliefs about insanity. Nevertheless, the portrayals of Farmer and the Vagabond are valuable as they form a useful counterbalance to the sometimes arid accounts contained in the annual reports and inquiries which expose at length the minutiae of asylum life.

Whether approached from these detailed accounts or from the more sensational perspective of a Paul Farmer or Stanley James, there exists a basic contradiction in the

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narrative of insanity with regard to the function of asylums. Andrew Scull explains it thus:

The creation of a network of institutions ... had drawn its legitimacy from the constantly reiterated contention that lunatics were sick and /or not responsible for their own actions. Yet if these vast asylums were to operate at all patients had to be made to conform to the rules of the institutions. ¹²

Notwithstanding this underlying paradox, or perhaps because of it, it was imperative that the asylum system create its own reality. Once established, the asylum gained its legitimacy from its inmate population. This population therefore had to be continually created and maintained.

Although cruelties and instances of outrageous denials of human rights were certainly uncovered at the Kew asylum, the most consistent and maybe the most debilitating feature of life there was the sheer monotony of everyday existence. Certain changes did occur as various superintendents sought to impose their own particular brand of order, therapeutic functions were re-evaluated and discarded and new ones taken up, and various administrative activities altered at times within the walls. There were, however, certain aspects of the asylum experience that remained sufficiently persistent to form an impression of everyday life there during the first 40 years. This chapter is a portrayal of the continuity of asylum existence as a background to the changes in events and personnel that are described in subsequent chapters.

Arrival

Admission Procedures

The American sociologist Erving Goffman invented the term ‘total institution’ to describe all institutions in which the goal is a total regulation of all aspects of the inmate’s lives. In *Asylums - Essays on the Social Situation of Mental Patients and other Inmates*, Goffman applies this particularly to mental asylums. There, the rituals and routines of the institution in themselves provide the means of depersonalisation and mortification of the patient as he or she is transformed into a ‘suitable’ inmate. Goffman proposes that this ‘total institution’, having first created a managed group separated from the rest of society, then creates its own hierarchy and social function. The first step in this depersonalisation begins with the admission procedures. In recording a patient’s life history, photographing and weighing up, the new arrival is ‘shaped and coded into an object that can be fed into the administrative machinery of the establishment.’ The admission procedures at Kew clearly followed a pattern that can be understood in terms of the process outlined by Goffman. According to the 1876 Inquiry:

on first entering the asylum the patient is taken to what is called the receiving ward... that he may be watched, and that it may be seen what is actually the matter with him, and whether he is capable of cure.

The major means of ascertaining this was by the collection of a variable amount of data on the patient being admitted. These details included such basic information as the age, sex, marital status and former address of the patient. Other, more personal details

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14 Goffman *Asylums*, p.18
15 ibid., p.16.
requested were the names of relatives or friends, the patient’s religion and occupation. They were also asked whether there were others in the family who had ever been classified as insane. Goffman suggests that this collection process in itself represents a ‘violation of one’s informational preserve regarding self’, because, ‘facts about the inmate’s social statuses and past behaviour – especially discreditable facts – are collected and recorded in a dossier available to staff’.

Around 1900, this process was extended with provision for a photograph of the patient to be included alongside the written information. Some individual case histories have notes written to the effect that the patient was too restless to have a photograph taken. Many are left blank and some do have accompanying photographs of what initially appear to be largely unexceptional men and women of the time. Yet these photographs do in themselves provide a catalogue of the depersonalisation of institutional procedures. There are young faces, old faces, sad faces, bewildered faces, and belligerent faces. Most are unsmiling, those that do smile do so with an air of defiance. Often the unwillingness of the participant to take place in the procedure is illustrated in the photograph by the depiction of a restraining, disembodied hand, presumably of an attendant, on the shoulder of the patient.

Confiscation of Goods

After information was collected and photographs taken, patients were then required to hand over their possessions. During the first two years of Kew’s operations, the nature of these possessions was also noted alongside the other information. Whether through lack of time as the numbers increased, or lack of interest on behalf of the staff, the habit of listing them in the case-books soon ceased. Presumably, however, the practice of confiscation still continued. It was noted in 1884 for instance, that:

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17 Goffman, Asylums, p.32.
A large number of the patients cannot wholly have lost the idea and the pleasure associated with possession of various articles of use and interest, trinkets and knives and other such things are all taken from patients when they enter the asylum.\(^\text{18}\)

As Mary, the wife of the fictional Richard Mahoney discovered, ‘his books and clothing were returned to her as ‘patients were not allowed any superfluous belongings’\(^\text{19}\). According to the case-books, many patients came to the asylum quite literally empty-handed as in most instances the admission form’s query about property is simply answered with the word ‘nil’.

Whether this is an indication of the poverty or otherwise of the patients, is difficult to assess as a great number of these early cases were transferred from Yarra Bend. Such inmates may have previously arranged for any possessions to have been handed over to family or friends long before they came to Kew. Alternatively, any property may have been lost among the institutional debris of their former residence. The sort of items that are listed are usually modest: small amounts of cash and keys are the most common, and often the men carry knives. However some descriptions suggest that the person deliberately gathered up precious, if meagre possessions on leaving their pre-institutional lives. Mary Slow, for example, came into the asylum in December 1871 carrying two boxes and one basket containing ‘articles of sham jewellery(sic) and hawker’s ware besides twopence ha’penny in cash’.\(^\text{20}\) Maria Hobbs, a servant, arrived the same month with ‘a letter, a pocket-book, three keys, as well as a broken brooch and a cookery book.’\(^\text{21}\)

\(^{19}\) Richardson, Richard Mahoney, p.802.
\(^{20}\) Public Records Office Victoria (PROV), Kew Asylum, VPRS 7397/P1 Case Books of Female Patients, 1871-1912, unit 1, p.15.
\(^{21}\) ibid., p.20.
These types of possessions carried into the asylum clearly meant something to the inmate, even if only to serve as a reminder of home. They sometimes also assumed an importance in the view of onlookers that prompted judgments to be made about the state of mind of the patient. Miss Jessie Cosh expressed just this concern about the eccentric collection that made up her cousin Mary Walsh’s luggage when she entered the asylum in 1912. Its inadequacy was, she felt, indicative of her relative’s incipient insanity. In a letter to the superintendent she described how Mary with her assorted collection of goods, arrived to visit her immediately prior to her entry into the asylum. These fragments caused her to surmise that ‘from what is in her baskets I think that she must have been insane when she left Adelaide’. She went on to add that they consisted of ‘a miscellaneous collection of lace, pieces of silk, rags and scraps such as might be used to make clothes for a doll only like a child would collect, even clothes pegs, bark bones, old broken lanterns etc’. 22 In spite of her censorious tone, Miss Cosh showed obvious concern for her cousin. She added that there were ‘muslin frocks and summer underclothing, also two coats (warm) belonging to costumes and one old skirt, woollen’, that she could send ‘if they’d be any use... along with some calico underclothing’. 23 In view of the fact that patient’s possessions were routinely confiscated, Miss Cosh’s kindly concern was, to a large extent, misplaced.

After surrendering their other possessions, incoming patients were required to change their clothes. Goffman categorises this divestment of clothing as the pivotal point in the beginning of the institutionalisation of the patient. ‘The admission procedure can be categorised as a leaving off and a taking on’, he claims, ‘with the mid point marked by a physical nakedness’. 24 At Kew, ‘patients when admitted come in their own clothing but afterwards dressed in conformity with the weather’. 25 This meant in effect, that they

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22 PROV, VPRS 7397/P1, Unit 20, p.184.
23 ibid.
24 Goffman, Asylums, p.18.
were usually dressed in ill-fitting, drab, but serviceable institutional clothing. The uniformity of this clothing served to underline the loss of individuality that the asylum imposed. The official visitors on an investigative tour in 1886 were moved to remark that they were ‘struck with the dull and unenlivening[sic] clothing of the patients at Kew,’ although they noted that the inmates sometimes continued to wear their own clothes. 26 Whether they were in fact their ‘own clothes’ was debatable, as all clothing, whether institutional or ‘private’, was gathered together to facilitate the laundry process and issued from a common stock. Even the clothes issued at the beginning of the week might not be the same ones individual inmates were wearing at the end of the week. As one of the reporters was to record in 1876:

Clothes are not to be taken into the dormitories but are left about the corridor.

Many of the patients knew where they had left their things but there (was) a general feeling of community apparel amongst them, and I noticed one man who hardly wore the same clothes two consecutive days.27

In his report on the ‘sharing’ of clothing that he also observed in American asylums, Goffman had a different evaluation. Far from interpreting this as evidence of the production of ‘community feeling’, he reflects that the ‘failure to provide inmates with individual lockers’ was a part of the process that ‘reinforces property dispossession’.28 Either way, in the words of Ethel Richardson, patients like the hapless Mahoney would ‘from now on wear the garb of [their] kind’. 29

26 ibid.
27 James, Vagabond Papers, p.109.
28 Goffman, Asylums, p.19.
29 Richardson, Richard Mahony, p.804.
First Impressions

After 1900, questions were posed upon admission about the patient’s pre-institutional life. This additional information required a certain amount of speculation on behalf of the persons answering them. These include such things as asking the ‘form of insanity... if disordered before... length of present attack ... cause of insanity and habits of life’. 30 From the answers to these questions, elicited from the accompanying officials or family and friends, combined with their own observations, doctors would attempt to construct a medical diagnosis. The most common ‘types’ of insanity diagnosed were mania, dementia, delusional insanity and melancholia. Mania and dementia were usually used to describe patients who were noisy and restless in behaviour, while melancholia and delusional insanity were the terms used for quieter, depressed, or withdrawn patients. Dementia was often added to a long term patient’s initial diagnosis.

A factor which remains largely unexplored in Goffman’s depiction of inmate life is that despite the uniformity and depersonalisation of the admission procedures themselves, the experience of arrival at the asylum differed between individuals according to their own expectations and severity of mental disturbance. Those who were severely depressed would have related differently to being admitted than those who were ‘furiously mad’. Patients arriving for the first time would have reacted differently than the many who had been institutionalised before. Many patients arrived weak with chronic physical illnesses, such as the final stages of syphilis or tuberculosis, heart disease, or dreadful infections exacerbated by their inability to care for themselves. Patients such as these may have viewed the asylum as a place wherein they could be cured of their afflictions, and may have approached it with optimism and hope. Alternately they may have been simply too ill to care. Some – especially women exhausted by the demands of children, years of illness or ill-treatment at the hands of brutal husbands – may have regarded the asylum as

30 These questions appear in all Case Books after 1900. PROV, VPRS 7397/P1 Units 13-21, and PROV, VPRS 7398/P1 Units 16-23.
a refuge from the outside world. Many others would have approached it with the fear and
dread that such places had created in the popular imagination. Even the very first glimpse
a future inmate had of the building was coloured by the perceptions they carried with
them of their future life in the institution.

Although there are no surviving accounts from patients of their very first impressions,
there are two published accounts which offer dramatically polarised versions of the
experience. Two contemporary writers, although they were never confined as patients,
offer us quite different impressions of their first glimpse of the asylum. The journalist
Stanley James, self-styled pursuer and advocate of what he termed the ‘bohemian
lifestyle’ and chronicler of the ‘low life’ of Melbourne spent two weeks at both Kew and
Yarra Bend asylums. James posed as an attendant in order to get an ‘undercover story’
for his newspaper. His first impression of the asylum as he recorded it in 1876 was that it
‘might be taken for a palace, its facade is imposing, the Italian towers break the
monotony of the architecture and it looks a far more stately building than Sir George
Bowen’s present abode [Government House]’.31

Another report, written by a (genuine) former attendant nine years later, painted a much
more dismal picture of the asylum. ‘The massive block of the Kew lunatic asylum first
rose upon my vision,’ he wrote. ‘Its three towers menace the heavens like jagged teeth
and its sad coloured front presents a grim, unfriendly aspect to the new comers.’32
Descriptions like these, for all their florid prose, do evoke powerful, if conflicting images
of the asylum. However, in all probability they would have borne little, if any,
resemblance to the feelings of patients whose physical health was so fragile that any
response to the appearance of the asylum would have been blunted, or exacerbated by the
reality of their own personal suffering.

31 James, Vagabond Papers, p.79.
32 Misquoted as Argus, 6 May 1885, p.4, in J. Millman, Origins and Development of Legislation
on the Treatment of the Insane in the Colony of Victoria in the period up to 1850-1900, MA
thesis University of Melbourne, 1972, p.40.
An article that appeared in the *Australian Medical Journal* in 1887 commented explicitly on the severe incapacity of some incoming patients. 'Some have to be carried into the hospital, they become inmates of the sick ward, and require nursing and feeding ... and are unable to assist themselves in the smallest degree ...'

The article concluded, with apparent irritation, that these patients could be housed in a Benevolent Asylum 'at much less cost to the State'. These patients whose physical condition meant they required extra attention were defined as 'objectionable inmates'. Unfortunately, for both the patients themselves and the medical staff, there were many of them.

Even quite young patients often came to the asylum in poor physical condition, if not actually suffering from any identifiable disease. A young woman called Edith Smith arrived on 28 May 1892. According to the charge attendant, Edith could not 'collect or express ideas' and had 'impaired memory'. If these rather vague utterances were less than illuminating about the patient's state of mind, it is clear from the remainder of the notes that her physical state was lamentable. A memo attached to her record revealed that the 19 year old woman was 'suffering from abrasions all over [her] back extending from shoulders to lower parts of back, a cut on abdomen two inches long, a few bruises on legs a few slight marks about the head'.

Whatever the cause of her injuries, Edith recovered sufficiently both physically and mentally to be allowed home for some months. When she returned, she was described as having regressed to being 'acutely maniacal', although she was in good physical health. In common with many other patients, Edith endured at least two admissions to the

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34 ibid.
35 PROV, VPRS 7397/P1, Unit 10, p.154.
36 ibid.
asylum, in rather different circumstances. It is a matter for speculation as to whether or not she would have experienced each one differently.

Besides physical condition, the manner of a patient’s actual arrival would have coloured each new-comer’s initial attitude to the asylum. The most potent demonstration of reluctant admission was the not uncommon spectacle of patients being dragged to the door of the asylum in restraints. In an article in the *Medical Gazette*, Dr. Downey explains that ‘it is common for us to receive patients strapped down in every conceivable way, and in some cases trussed up like fowls’. 37 Although Downey, who was Assistant Medical Officer at Parkside in South Australia at the time, was referring specifically to that institution, it was clear that a similar situation operated at the other asylums throughout Australia.

At the Kew asylum, this is most dramatically illustrated by the case of Fanny Barlow. Fanny was brought to the asylum from her home in Bendigo by a nurse and a friend in April 1905. Her admission papers recall how she was:

received tied up securely in blanket [ and that she] had camisole made of tick [strong cotton material] on, arms bound to side tightly by a broad strap, leather loops for arms, locked. Long sleeves tied round and round body. Ankles bound by leather anklets. 38

Not surprisingly, she also arrived ‘much exhausted, bruised and perspiring.’ 39 Although she appeared ‘maniacal on reception’, she became ‘moderately quiet after restraint removed’. 40 Fanny remained at Kew until August at which time she went home ‘on

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38 PROV, VPRS 7397/P1 Unit 15, p.20.
39 ibid.
40 ibid.
trial'. By mid-September her family began to suggest that they return her. This time, in order to avoid the excessive restraint of her first incarceration, her father decided to employ a form of trickery in order to get her there. He explained the method he proposed in a letter to Dr. Gamble, then superintendent at the asylum:

The difficulty of getting her back seemed to us an impossible task, except by force.
We have therefore decided that instead of attempting to drive to Kew direct from the station my daughter shall accompany her cousin to her house in Collingwood where it will be little trouble to convey her to the asylum.\textsuperscript{41}

Fanny was duly returned to the asylum on 14 October, after her family declared her unmanageable. Whether they had to resort to tying her up again is not recorded.

Another patient whose case earned some notoriety also felt that he had been a victim of trickery as well as force. He was Dr. Paul Ward Farmer, who was conveyed to the asylum in September 1899. In a pamphlet primarily designed to illustrate his rather unorthodox views, Farmer relates how he was abducted from the front of his house and taken to the asylum. ‘On the morning of 23rd September 1899, at noon,’ he wrote:

I drove up to my house in Collins St. in my carriage and noticed that the blinds were drawn. A friend of mine handed the coachman a piece of paper with an address on it, and immediately jumped in on one side and shut the door, while his groom jumped in on the other side, and did likewise, and on the carriage moved.' \textsuperscript{42}

On demanding an explanation, the doctor was told, ‘You would not take a holiday, and now we shall see whose will is the stronger, yours or mine. We are going to take you to Kew.’ Although he remonstrated with his assailants, Farmer quickly became convinced

\textsuperscript{41} ibid., letter to Dr. Gamble from R. Barlow, 17 September 1905.
\textsuperscript{42} Farmer, \textit{Three Weeks in Kew}, p.6.
that resistance was useless as he 'saw at a glance that ... he [the coachman] weighed some 15 stone, and his groom was about 12 stone.' 43 In his eccentric publication, Farmer maintains that he was sent to Kew as a result of professional jealousy by some of his colleagues. He also had a sister who died in the Ararat asylum, and a brother who was housed in an asylum. 44 This meant that any eccentric behaviour by him would have been more readily interpreted as a sign of insanity by his peers: a fact of which he, as a medical man would have been painfully aware. Nevertheless, he was able to convince the asylum medical staff of his sanity, who transferred him to a private asylum and after a short time was 'allowed with [his] wife to go to the country or seaside.' He was discharged completely in December 1899.45

For the majority of the patients, their arrival was not surrounded by such melodramatic and secretive activity. Nor were most afforded the discretion that was apparently granted to Farmer who was most anxious that his brief incarceration not become widely known among his fellow practitioners and patients. For some, especially patients from country towns, their journey and arrival at the asylum was a public event reported in the local paper and so became part of local knowledge and gossip. When John Brady from Terang was admitted in 1878 the report of his progress was described in The Camperdown Chronicle The article read:

A man named John Brady lately in the employ of Mr. Boyd, shoemaker, Terang, was committed to the asylum at the last meeting of the Terang Bench as a lunatic, and passed through Camperdown yesterday on his way thither in the charge of Constable Graham.46

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43 ibid.
44 ibid., p.35.
45 PROV, VPRS 7398/P1, Unit 16, p.5.
46 Camperdown Chronicle, 23 August 1878.
Brady's own reaction to his committal was not recorded, but he was never to leave the asylum. Although only 27 at the time of his admission in 1878, by May of 1885 he was dead. He died from 'disease of the lungs and heart'. An account of his arrival at the asylum could have justifiably ended like that described in fiction when Mahoney's wife cries 'with the shutting of the gates fell a horrible death-like silence'.

Day to Day Life.

Patients

Just as the circumstances of arrival differed from patient to patient, so too did the experience of everyday existence. Although the asylum was run by adhering to an observable set of procedures, individuals reacted differently in response to them. The design of the building with its two wings, separated by a large hall, facilitated the administration of the institution along sex-segregated lines. One wing housed female inmates, the other males. Although the basic layout was replicated on both sides of the building, the effective space for females was slightly less than for males. This was because some of the wards were smaller to allow for the laundry and drying ground which were on the female side of the building.

Besides a broad categorisation of the type of insanity from which a patient was suffering, the medical staff used their own observations and the information collected on admission to decide to which particular ward the patient should be sent. Dr. Robertson, the first superintendent at Kew, established guidelines for the placement of inmates which were largely followed for many years. The determining factors, as explained at the Inquiry in 1876, reveal a combination of medical and social reasons why it was felt that particular

47 PROV, VPRS 7398/P1, Unit 6, p.180.
48 Richardson, Richard Mahony, p.807.
inmates should be accommodated in certain sections of the asylum. According to the
report, Dr. Robertson classified his patients as follows:

1. The Receiving ward into which all patients are admitted.
2. Those who are suffering from bodily disease in the hospital.
3. Ward for epileptic patients.
4. For the dangerous patients, where extra warders are required.
5. Two convalescent wards for the convalescent and the more quiet and
   better educated patients.
6. Two yards - one for the noisy and disorderly, and one for the quieter and
   more orderly patients.\textsuperscript{49}

Regardless of the class-based assumptions implicit in some of the classifications, there
was clearly a need for some system which recognised that patients were not simply a
homogeneous group. Just as clearly, some patients were suffering from physical
illnesses for which they needed medical care. Others exhibited extreme forms of anti-
social behaviour from which their fellow-patients needed to be shielded. Unfortunately
for the patients however, although differences between them were recognised, the asylum
was rarely organised with a view to catering to their particular needs. The purpose of the
separation of different ‘types’ of patients was articulated in terms of their apparent self-
control, principally with a view to the smooth running of the establishment.

D ward or the ‘receiving ward’, was the first contact every patient had with the asylum as
a way of life. Contrary to the rhetoric which implied that this would be a brief stay while
medical staff assigned them to more ‘suitable’ accommodation, many patients found
themselves confined to this part of the asylum for some time. Here, according to the
Vagabond, they might languish for days or even weeks ‘dosed with purgatives and

\textsuperscript{49} Kew Inquiry VPP 1876 vol.3, p.20.
sedatives while the medical officers are studying their cases.\textsuperscript{50} As the doctors themselves explained in somewhat 'unscientific' terminology in 1886, the newly-admitted patients were kept by themselves for a time 'until their peculiarities [were] understood'.\textsuperscript{51} Although the classification system was designed primarily to effect maximum control of the patient population, the particular ward that an individual inmate was assigned had a real effect on the life they would lead in the institution.

Each 'ward' was really a series of rooms, which consisted of sleeping dormitories, day-rooms and bathrooms. In 1886, a visiting doctor noted that the men's quarters on the east of the main hall consisted of 'somewhat narrow day rooms with single dormitories built along one side, and large dormitories at the end. Off these rooms (were) the bathrooms lavatories etc'.\textsuperscript{52} B ward or the hospital ward was considered the 'worst in the asylum,' by the attendants, with the most 'disagreeable duties'.\textsuperscript{53} From the patient's point of view, conditions in the hospital ward were probably little short of horrific.

Although the hospital ward housed the inmates most in need of expert medical attention, the attendants who worked there, apart from the attendant in charge, were the least experienced in the institution. In addition, they clearly regarded their duties as abhorrent. Located on the ground floor, the hospital section was entirely devoted to patients with physical illnesses, epileptics, and those suffering from paralysis, or whose chronic mental state rendered them all but immobile. In terms of design, it was little different from the other wards, except that the sleeping area was one large room, generally holding some 60 or 70 patients.\textsuperscript{54} Some of the beds were raised just off the floor in order to minimise injury to patients, especially epileptics, who were prone to falling out of bed.

\textsuperscript{50} James, 	extit{Vagabond Papers}, p.22.
\textsuperscript{51} W.Moore, 'Notes of a Visit to the Kew Asylum' \textit{AMJ}, vol.viii, no.3, (March 1886), p.98.
\textsuperscript{52} ibid., p.97.
\textsuperscript{53} James, \textit{Vagabond Papers}, p.82.
\textsuperscript{54} ibid. 
Aside from this, no other concession seems to have been made for these patients who were suffering from serious physical ailments. There is little evidence that greater medical care was afforded them, and, as the institution was always severely understaffed, this was unlikely. Many of the patients spent months, or even years, confined to their beds in this most depressing of all the wards in the institution.

The ward known as B1, was for patients who were not as helpless as those in the hospital ward, but held ‘every other class of patient ... refractory, dirty, chronic, idiotic-every grade of insanity up to apparent convalescence’. 55 The Vagabond described conditions there during his visit. He noted that there were over 90 patients in the ward, and described how appropriate space was determined. There was, he observed, painted over the door, the number of cubic feet the ward contained, so that the superintendent and medical officers ‘could tell at a glance the maximum number of patients to be placed therein, according to the minimum allowance of cubic air for each patient 56. Nevertheless ‘there [was] a great lack of superficial space, not counterbalanced by the extra height’. 57 The overcrowding was so severe that the day-room had been converted to use as an extra dormitory. This meant that during inclement weather the patients had to crowd into the corridor. Seven attendants were assigned to take care of the patients in B1 ward. However, two of them were usually working outside, so only five were regularly in attendance. This made for generally chaotic conditions.

The patients assigned to any of the C wards on the other hand would have found life to be tolerable, if monotonous. These were the inmates who were either convalescing, or were considered ‘more quiet and better educated’. 58 As there were fewer patients than in other sections, the day-rooms, although poorly furnished, were used for their intended purpose:

55 James Vagabond Papers, p.114
56 ibid.
57 ibid.
58 ibid., p.82.
as a space in which the inmates could relax as if in the sitting-room of their home. The Vagabond described a peaceful scene of domesticity and normalcy in this area. There were, he claimed, ‘gathered round the fire, reading or smoking, a number of patients, to all outward appearances, as sane as I was’. 59

his section of the asylum was probably the section to which Dr. Moore, a dermatologist from Melbourne Hospital, was referring when he wrote his ‘Notes of a Visit to the Kew Asylum’ in 1866 for the Australian Medical Journal. The walls of the dormitories, he claimed, were painted ‘in lively colours’ and the ‘beds [were] very comfortable, and...scrupulously clean’. 60 The patients in these wards were also permitted access to the ‘front yard’ and during the days spent much of their time there. This was a smaller area than the yard for the more troublesome patients, but it was considered to be more interesting. This was because these more tractable patients were regarded as having a ‘greater curiosity as to what goes on in the outer world.’ 61 This interest was considered adequately catered to with a view of ‘the city of Melbourne stretching out like a panorama’ and by the inclusion of ‘a round house which had three parrots in a cage.’ 62 The view from the front yard was actually restricted in that it was bounded on two sides by buildings, and in common with the other enclosures ‘rough and bare’. 63 However, the remaining two sides offered unlimited vistas as there was neither fence nor wall, the security being maintained by the existence of a ‘ha-ha,’ or walled ditch that sat below eye level. 64

Rather than wander the yards admiring the views or feeding the parrots, it was preferable however that the more ‘able’ patient of C ward was ‘never permitted to go into the yards

59 Ibid., p.120.
60 Moore, ‘Notes of a Visit’, p.97.
61 James, Vagabond Papers, p.99.
62 Ibid.
63 Moore, ‘Notes of a Visit’, p.98.
64 See Chapter One, ‘Constructing Melbourne’s Grand Asylum’, p.7 for further details of this arrangement.
but [had] some work allotted to him’.\textsuperscript{65} A number of the patients did engage in work
during their days in the asylum. Like other activities, this work was strictly segregated
along gender lines. The women had their own work-room wherein a large number were
engaged in sewing and mending clothing. The other females who worked were mostly
employed in the laundry or the wards and airing courts. Some males also worked in the
wards and airing courts, but on the ‘male’ side of the building. The males also had a
smaller workshop where the chief occupations were shoemaking, tailoring and painting.
However, the majority of the male inmates capable of working were employed outside in
the garden, or elsewhere about the grounds. Dr. Moore was convinced from his
observations in 1886 that the patients found the work both enjoyable and therapeutic. As
he explained in his article:

A great number of women find employment in the laundry, and seem quite
contented and even happy at their work. Others are engaged in sewing, and a great
number, both men and women, are occupied picking oaktum: and it is astonishing
that so many...are wonderfully quiet over their work.\textsuperscript{66}

Similar sentiments were echoed by the Inspector of Asylums, Dr. Dick, in his annual
report for 1889. ‘The inmates of our asylums,’ he announced,’ being largely drawn from
the labouring classes find their most congenial occupations in manual work.’\textsuperscript{67}

The employment of inmates served a twofold purpose. It not only helped with the
running of the establishment, but employment, especially of a physical kind, was
considered to be a valuable component of ‘moral treatment’. Dr. Dick was of no doubt
that ‘in the treatment of insanity it is of the first importance to engage the patients in
healthful employment’.\textsuperscript{68} The monotonous nature of the work does not seem to have

\textsuperscript{65} ibid.
\textsuperscript{66} ibid.
\textsuperscript{67} Annual Report 1889, \textit{VPP} 1890 vol.3. p.15.
\textsuperscript{68} ibid.
been considered, although the Annual Report 1878 found cause to comment that ‘the monotony of their lives has a most depressing effect on many patients’. The medical journals, however, continued to expound the view that ‘the medical attendants recognise the importance of employment as a means of furthering recovery, hence all the work about the institution is done by the patients, with the assistance of the ordinary [i.e. non-medical] attendants’.

**Attendants**

The attendants, who were not medically trained, held the most unenviable position in the asylum staff hierarchy. Sometimes called ‘warders’ (which probably described their function better), they were responsible for the general state of the wards. They were also responsible for the cleanliness and general behaviour of the patients. It was their job to exert the control over the patients necessary to allow the institution to function smoothly. Because of the lack of prestige and the low wages, besides the often unsavoury nature of the work, the type of person who usually filled the positions ranged from those whose lack of qualifications ill fitted them to any other kind of employment to convicted criminals. The Vagabond’s high-minded, if slightly tongue-in-cheek utterance that he ‘had the satisfaction of serving his country’ with his time spent as an attendant was probably a view shared by very few of the genuine attendants. The major qualification for the position was a general degree of fitness combined with a certain amount of strength.

On a daily basis, the attendants were the most important component in the implementation of moral management. It was their job to cajole, bully or otherwise coerce the patients into behaving in terms of institutional correctness. Certainly their demeanour and compassion, or lack of it, impacted most directly on the lives of the

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70 ibid.
71 James, *Vagabond Papers*, p.78.
patients, who, for most of their waking [and sleeping] hours, found themselves under the
direct control of at least one attendant.

The female attendants, all of whom were unmarried, and the male attendants who were
single were required to 'live in'. They shared dormitory-style bedrooms with one or two
of their colleagues. Despite a major change in the perception of attendants in that they
received some training from 1887, their actual conditions of employment remained
unsatisfactory. The attendants had been most outspoken about their conditions when an
outbreak of scarlet fever exacerbated existing tensions in 1875. The *Daily Telegraph*
reported that:

No amelioration in the condition of the warders attached to the Kew lunatic asylum
has yet been attempted and great dissatisfaction is manifested by the members of
the staff in consequence. Scarlet fever has broken out and considerable alarm exists
at its presence...The leave of all the warders has been stopped, and the men are
also greatly overworked.  

That little had changed over the years is revealed by the *Argus* in 1922. The article
testified to the continuing lack of provision for these workers, and concluded:

Most of them [attendants] occupy cheerless and depressing rooms contiguous to the
wards and their sleeping hours are disturbed by the restlessness of the patients. ...
No provision is made for their recreation when off duty.  

The attendants’ day began early, half-past six in the summer and seven o’clock in the
winter when they were awakened by the ringing of a bell. Their duties in the morning

72 PROV.VA 475 Chief Secretary’s Department, VPRS 3991/P1 Inwards Registered
Correspondence 2, 1864-84, Lunacy Unit 752, Item 888. article from *Daily Telegraph* 5
March 1875.

73 *Argus*, 16 February 1922, p.2.
commenced with the simple act of opening the dormitories, followed by the more
difficult task of helping the patients to wash and dress. The clothes which had been
discarded the previous night were not taken into the wards but kept in communal shelves
in the corridors, so these had to be collected and some attempt made to distinguish which
clothing belonged to which patient, or at least which particular garments they had worn
the day before.

The more ‘able’ patients were also required to help in the washing and dressing of those
less capable or co-operative, under the supervision of the attendants. So necessary was
this help, the Vagabond noted, that ‘but for such patients the whole work of the asylum
would come to a standstill’.74 Once the patients were washed and dressed, it was the duty
of the attendants to do a rudimentary amount of housework; making beds, dusting,
sweeping floors and so on.

These tasks completed, it was usually near 8 o’clock, which was the time set aside for
breakfast. The patients were then led, dragged or carried to their places for their meal. The
food served at breakfast was basic and monotonous, usually consisting of tea, coffee,
bread and butter. Occasionally, cheese was added, but it was usually reserved for those
patients who worked about the asylum. At lunch-times some meat was usually offered,
accompanied by potatoes, and the evening meal resembled breakfast except that during
the season there was ‘a plentiful supply of salad’.75 Paul Farmer was less charitable about
the condition of the food, claiming that ‘the coffee was a tasteless fluid, resembling the
usual decoction[sic] only in colour and the vegetables were of a very coarse rough
nature’.76

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74 James, *Vagabond Papers*, p.83.
75 ibid., p.109.
According to the Regulations for the Guidance of Attendants, ‘meals must not be hurried over, and the patients must be taught to sit down in an orderly manner, without their hats’. But in spite of these regulations, meal-times were fraught with tension. Some of the patients objected to the manners of their fellow inmates. This problem arose, according to the Vagabond, because of the disparate classes represented. ‘Seated next to a dirty idiot in a canvas frock [a form of restrictive clothing] or a violent Chinaman [sic] who feeds like a wild beast ,’he claimed,’ a convalescent of formerly good breeding can have little relish for his meals’. Notwithstanding the racism and class prejudice implicit in these remarks, it is apparent that meal-times were often characterised by outbreaks of disorderly behaviour. On many occasions, ‘slight disturbances [arose] and fights took place at dinner-time, potatoes forming a handy missile’.

More serious than the occasional potato-fight, was when real tragedy interrupted meals. In 1878, a patient identified as J.S. fell down in a fit while eating and died within minutes. The post-mortem revealed that ‘he had suffocated on some food he was eating’. Epileptic patients and certain others were always considered at risk from an untimely death in this manner, so the attendants were required to cut their food very finely, before feeding them, and the only meat they were allowed was mince meat. A second patient , this time a female, identified as E.T., died in October of the same year ‘suddenly at tea-time through choking’. According to the annual report she was ‘always in the habit of feeding herself and it was not considered necessary to put her on a mince diet’. The prevention of accidents of this kind was generally considered the responsibility of the attendants, as the Inquiry in 1876 confirmed:

77 PROV, VA 475 Chief Secretary’s Department, VPRS 3991/P Inwards Registered Correspondence 2, 1864-84, Unit752, Item 74/E2729, ‘Regulations for the Guidance of Attendants in Hospitals for the Insane’.p.5.
78 James, Vagabond Papers, p.110.
79 ibid., p.107.
81 ibid.
The character of particular patients and of all the patients in a ward takes its colour from the character of the attendants placed in it. On their being proper or improper instruments ... it depends whether many patients shall be cured or not cured, whether some shall live or die; whether frightful accidents an increased mortality, incalculable uneasiness and suffering and occasional suicides shall take place or not. 82

Clearly this was a heavy and rather unfair responsibility to put upon the attendants, most of whom had no medical training. The attendants were bound by a set of regulations that emanated from the Department of the Chief Secretary, which was the government department directly responsible for lunatic asylums. These guidelines stated that the attendants ‘will be liable to punishment for drunkenness, falsehood, insubordination, breach of regulations, ill-treatment of patients, absence without or beyond leave, neglect of duty, loss of stock or general inefficiency’. 83

The regulations were frequently broken and there were numerous complaints against the attendants, many of which are detailed in a Complaints Book. The complaints ranged from accusations of cruelty to patients to reports of unpunctuality. These complaints came from patients, doctors and other attendants and were treated accordingly. Complaints from patients were usually considered rather frivolous or ill-advised, whereas complaints from doctors were treated with the utmost seriousness. Doctors had no power to dismiss attendants in their institutions, but could only complain to the Governor-in-Council. The nature of the complaint also had a great bearing on the type of punishment meted out, with the emphasis being placed on disciplinary matters. Disobeying a superintendent, being absent from a ward without leave, and being drunk on duty were the misdemeanours most severely dealt with. Thus, Ellen Enright was dismissed in July 1877 for only one recorded complaint of disobeying orders, yet a series of complaints

82 Argus, 22 December 1876, p.6.
83 PROV, VPRS 3991/P, Unit 752, p.5.
over four years earned Mary Kent only reprimands. Mary’s misdemeanours which occurred from 1875 until 1879 included acting rudely to a patient, neglecting a patient by allowing her out into the yard insufficiently clad, and ‘boxing the ears’ of another patient. Her most severe reprimand was the result of her ‘having visitors in her room’ after a dance night. 84

Attendant Walsh, a male attendant, was one of several dismissed for ‘returning to the asylum under the influence of liquor’. 85 Certainly, some attendants were dealt with harshly for ill-treating patients and outright cruelty was discouraged. However, it seemed that attendants’ tendency to seek respite from the drudgery of their lives by indulging in recreation of a sexual or spirituous nature was considered by the asylum administrators to be the most serious of all offences. As the Vagabond so rightly observed the occasional ‘clout’ or pushing or dragging a patient or even ‘passing one’s arm round a patient’s neck a la garrote’ 86 was ‘part of the system on which Kew [was] built’. 87

The most explicit examples of the attendants losing their tempers and ill-treating patients were detailed in the Inquiry commissioned in 1876. This inquiry – originally set up to investigate the circumstances surrounding the sudden death of a patient Leon Warneck Lewis– became a general inquiry into matters at Kew, especially with regard to the professional behaviour of the attendants. The Inquiry was directed to ‘ascertain if there was any ground for supposing that cruelty or ill-treatment existed in the establishment’. 88

The evidence brought forward at the inquiry overwhelmingly suggested that rough treatment, cruelty to, and humiliation of patients was commonplace. Several attendants

84 PROV, VA 2840 Kew Asylum, VPRS 7544/P1 1873-83, vol.1, ‘Register of Complaints against Staff,’ p.44.
85 ibid.
86 James, Vagabond Papers, p.84.
87 Argus, 22 December 1876, p.6.
were charged with specific instances of cruelty or ‘ill-use’ of patients. The young, tall and solidly-built Mary Carey was categorised as ‘the worst of all’. Elizabeth Scott, a patient, gave details of how she had observed Carey forcibly administer medicine to an unwilling patient by ‘throwing her upon a table, beating her head on the table, until it bled’, and when the patient was ‘partially insensible’ forcing the liquid down her throat.  

An ex-attendant Mrs. Young, also claimed that she had seen Carey ‘drag patients to the ground and stamp on them from her own temper’. 

Although the Board found three of the charges against attendant Carey to be ‘proven’ including one instance where she had clearly ‘roughly treated’ a patient, she was not dismissed. Carey herself seemed bemused at the charges laid against her, stating that she often had to use force with patients, although not in the manner described. She seemed to believe, probably quite rightly, that it was her undoubted strength in being able to restrain patients that was her most valuable asset in her employment. 

One of the most disturbing accusations that came out at the Inquiry was that the attendants often used a ‘bath’ or the threat of a bath as a punishment for objectionable behaviour. A female patient complained that ‘when they gave you a plunge bath it was the same as if you were going to be drowned,’ describing how the attendants would ‘hold your head under water and keep your feet and legs up’, and sometimes going so far as to tie the patient’s legs. 

These incidents were not isolated events. Several patients described how they expected to be punished for misdemeanours and were aware that forcible bathing was a possible means of punishment. Margaret Henderson, who—according to evidence at the Inquiry—was almost drowned by two attendants in this manner, kept crying out during her ordeal that she ‘did not deserve it’. Ann Cook, another victim of this barbarous punishment, conceded that she ‘might have been doing

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89 ibid., p.45.
90 Ibid. p.48.
91 Kew Inquiry VPP 1876, vol.3, p.49.
92 ibid.p.57.
something objectionable before she would be put unto a bath and would look to be punished for it.\textsuperscript{93}

Although the Inquiry went on for several days and many recommendations were made during the course of it, there was implicit agreement that some force was not only acceptable but was often necessary to subdue patients. The Board decided that ‘cruelty’ to patients was really a matter of interpretation. As an addition to its conclusions, the Board, with chilling pragmatism, noted that:

\begin{quote}
early in the Inquiry we ascertained that the term ‘cruelty’ was used by several of the witnesses rather in a general than specific sense. What was denominated cruelty by some was toned down by others to ‘harshness’, ‘roughness,’ ‘a good shaking’ and ‘a slap in the face’.
\end{quote}\textsuperscript{94}

Throughout the Inquiry, most of the evidence about the treatment of the patients at the hands of the attendants was damning. Nevertheless, at least one of the patients who testified was moved to suggest that ‘the attendants were very kind at times’. \textsuperscript{95}

During his three week stay in 1899, Dr. Paul Ward Farmer could only comment favourably on the forbearance and patience of the attendants:

\begin{quote}
the only wonder to me is that they [attendants] keep their tempers, and are as for bearing as they are, for the constant action of the mind of a man who thinks himself wrongly imprisoned- as they do in many cases .must try the tempers of the attendants very much.
\end{quote}\textsuperscript{96}

\begin{flushleft}
\textsuperscript{93} ibid., p.49.  \\
\textsuperscript{94} ibid., p.65.  \\
\textsuperscript{95} 'Minutes of Evidence' Kew Inquiry, VPP, 1876, vol.3, p.49.  \\
\textsuperscript{96} Farmer, Three Weeks in Kew, p.23.
\end{flushleft}
While there may be some equivocation in this statement, some former patients and their families were fulsome in their praise of the staff at the asylum, particularly in later years. The 1890s saw the first trained nurses (male and female) take up positions as attendants, which was undoubtedly of great benefit to the patients. It also meant that the position of attendant was accorded a greater respect. In 1904, one of the patients at the asylum, in writing to her husband of her intention to kill herself, felt the need to mention the kindness of the staff. In a letter that is brief, lucid and despairing she begins, ‘I am going to take my own life’. After begging her husband not to remarry she continues, ‘everyone in the ward is very kind to me especially the nurses. They can’t do any more than they have done for me’.97

The relatives of Elizabeth Wait, who was admitted in 1905, were most anxious to express their gratitude to the administrators at the asylum. Upon her death, 12 months after her discharge, they sent a letter of thanks to Dr. Gamble and the staff at Kew, commenting on the ‘humane sympathy and the unfailing courtesy and assistance ... by the nursing staff’.98 The husband of Jessie Bayne, who spent nine months at Kew during 1906, echoed these sentiments when he wrote to Dr. Gamble upon his wife’s return home:

She [wife Jessie] desires to join with me in thanking you and the nursing staff for

the kind attention which she received while under your care, and never ceases to

champion a noble institution which, I fear is too often vilely slandered.99

It appears that the public perception of the attendants did improve over time, but with very little corresponding improvement in their status or conditions within the institution itself.

97 PROV, VPRS 7397/P1 Unit 14, p.566, Letter from M. McCann to ‘My dear husband’, 9 September 1904.
98 PROV, VPRS 7397/P1, Unit 15, p.124, Letter from E. Wait and A. Bernham.
The Doctors

Within the hierarchy of the institution, the medical personnel clearly held the highest positions. Within the asylum walls it was the medical staff who enjoyed the most freedom, and who could exert virtually unchallenged control over both patients and attendants while they remained in their charge. Unlike the other residents, they were also able to leave the asylum for extensive trips interstate or overseas, or simply to drive across town whenever they felt inclined.

However this was a dubious distinction. In terms of the wider category of general medicine, to be a lunacy doctor was regarded as belonging to the lowest stratum of the profession well into the twentieth century. The Vagabond expressed this perception in his writing. 'Positions in our asylums are accepted by young medical men not because they feel any special vocation to administer to the insane', he claimed, but 'because they can get nothing better.'100 This was a view which the doctors themselves were most anxious to dispel. During 1883, in an attempt to emphasise the professional respectability of all lunacy doctors, Dr. Hacon, resident superintendent at the Christchurch Hospital for the Insane, stated 'it is quite as necessary for a lunacy doctor to know his work as for a general practitioner to do so'. Nevertheless, he was forced to concede that it was still widely held among their fellow doctors that 'to be a lunacy doctor ... is to be cut off from the profession'.101

Kew Asylum employed three medical men: the superintendent, a deputy superintendent and another medical officer. They were all trained doctors, but did not have any specific training in the area of mental health. These medical personnel, in spite of their relative freedom, were also expected to conform to a set of regulations, the basis of which

100 James, Vagabond Papers, p.154.
101 Editorial, "Lunacy Practice" AMG 1883, vol.iii, p.29.
necessitated that they ‘live in’. The most specific requirement of them was that they ‘be on duty by day and by night’.\textsuperscript{102} On a day to day basis, the medical superintendents were required to ‘visit the wards and the sick as often as is compatible with the due performance of their other duties...be held directly responsible for the proper medical and moral treatment of all patients under their care’.\textsuperscript{103}

As if these duties were not onerous enough, they were expected to manage the financial matters for the institution, by ‘exercising due control over the expenditure and general economy of the asylum’.\textsuperscript{104}

Probably due to this overwhelming workload, the length of service of each superintendent at Kew tended to be short. There were seven doctors who filled the position from the opening of the asylum in 1872 until 1915. The first superintendent at Kew was Dr. Alexander Robertson.\textsuperscript{105} An ambitious man, Robertson came to Victoria shortly after obtaining his degree in Edinburgh. He was appointed superintendent at Ararat asylum when it opened, and as soon as Kew was opened he was ‘brought down from Ararat and placed in charge of the establishment.[Kew]’\textsuperscript{106} He held the superintendency for five years, until ill-health forced him into early retirement in 1877. He died only a year later. It was widely believed among his peers that the demands of his position at both asylums contributed to his illness and premature death. While at Kew, he was to suffer the strain of two enquiries: the first –The Inquiry into Matters affecting the

\textsuperscript{102} PROV, VA 475 Chief Secretary’s Department, VPRS 3991/P1,Inwards Registered Correspondence 2 1864-84, Unit 752, item 74/E 2729, ‘Regulations for the Guidance of Medical Officers in Hospitals for the Insane’.

\textsuperscript{103} ibid., Regulation 1, p.3.

\textsuperscript{104} ibid.

\textsuperscript{105} At the same time as Robertson was appointed in October 1872, Dr. Watkins was brought down from Beechworth as Deputy Superintendent. Six weeks later, McCreery of Ararat was also transferred to Kew. The first Steward to be appointed to the asylum was Robert Wardlaw, who died within a year of its opening. He was succeeded by William Davis. [Source:Brothers, \textit{Early Victorian Psychiatry}, p.97.]

\textsuperscript{106} ‘Obituary Notice from the Argus’ reprinted in \textit{AMJ} vol.xxiii. 1878, p.82.
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