Kew Asylum – was the most extensive and lengthy investigation into conditions within a single institution ever held.

Ironically, in common with many of his patients, Dr. Robertson suffered from epilepsy for many years. Whether this increased his compassion for his patients is difficult to judge. It is clear, however, that he was fairly conservative and a disciplinarian. He was also one of the growing band of medical practitioners who believed that the superintendent should have ultimate power in the running of his own asylum free from outside interference. One of his oft-voiced complaints was that he did not have the power to hire or dismiss attendants at his institution. He felt it unfair that ‘the subordinates should owe their position to political influences ... and were placed completely beyond the control of the officer who was responsible for the maintenance of discipline.’

In insisting on the need for rigorous discipline in the institution however, Robertson was echoing the conventional wisdom of the medical profession in the management of asylums in general. Another of his major contentions was also an echo of contemporary medical doctrine: that relief from insanity was to be found in hard work. During the Inquiry he told the Board, ‘I regard employment occupation as the chief means of curing insanity of all kinds’. The Board agreed, quoting the respected John Conolly:

> Among the means of relieving patients from the monotony of an asylum and of preserving bodily health and at the same time of improving the condition of the mind and promoting recovery employment of some kind or other ranks the highest.

With a view to conforming to this ideology, Robertson was adamant that he endeavoured to ensure that ‘as many curable patients are employed as possible.’ Although he

107 ibid., p.83.
109 ibid.
110 ibid.
appeared uncompromisingly rigorous in his treatment of staff, Robertson was a hard-
working, conscientious doctor who seemed to have been genuinely concerned with the
well-being of his patients. However, this concern was clearly interpreted through his own
personal ambition to be seen as a successful doctor in terms of his treatment of insanity.
One of the attendants, known as Cody, complained at the inquiry that ‘Superintendent
Robertson is too kind to the patients’, adding that Robertson was inclined to ‘take too
much notice of their complaints’.111

Under Robertson, a formidable regime was put in place. Doctors were required to
examine patients on arrival, and thereafter visit them as often as three times a day,
prescribing drugs or dietary restrictions. They were also expected to check the work of
attendants by ‘dropping in’ unexpectedly on them at any time of the day; a practice that
was much resented by many of them. In addition, the doctors had a large amount of
bureaucratic work, such as completing short summaries of patients’ symptoms and
progress in their case history notes every few months. In addition, they were to be
available to escort official visitors around, as well as helping to produce annual
reports. The rapid growth in the number of inmates made the job of the doctors
increasingly difficult (by 1875 there were over 900 patients in residence) so that the visits
to check the health of patients became little more than a cursory glance into the wards.

Medical staff became even more overworked with the outbreaks of disease or influenza at
the asylum. The first such epidemic, an outbreak of Typhoid Fever in 1875, was
responsible for the deaths of four patients and a great amount of discontent among the
attendants. Reappearances of the disease in 1890, 1891, and a more serious outbreak that
lasted for over a year during 1907-1908 prompted the doctors to renew their requests for
alternative sewerage arrangements to replace ‘the old and dangerous double pan
system’.112

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111 ibid., p.83.
It was the continual inadequacy of these basic amenities that probably proved most frustrating to doctors throughout the years, as they attempted to run the asylum. When ill-health forced Robertson to retire in 1877, his place was taken by Dr. Thomas Dick. When Dick took up the position he immediately complained about the state of the toilets, and reported that the entire building needed repainting. The reluctance of governments to spend more than niggardly amounts on asylums meant that any calls for improvements were either ignored or extremely slow in coming.

Even Dr. McCreery’s seemingly modest request in July 1883, for ‘the sum of 10 pounds to purchase pictures for the wards’ seems to have gone unheeded. McCreery’s concern with the appearance of the institution tended to merge with his notions about order and discipline, including the appearance of the non-medical staff. He was firm in his advocacy of uniforms for the warders, adding that it would be ‘a marked improvement to the general appearance of the institution, and would tend in many ways to advance discipline’. This suggestion had been firmly rejected by Dr. Paley, during his time as Inspector of Asylums some years earlier. In his opinion ‘distinguishing uniforms ... tend to foster in morbid minds the idea of imprisonment for some fancied offence’.

McCreery, a man with a practical, as well as an aesthetic sense, was more successful in improving the quality of food at the institution. In 1883, he persuaded the authorities to allow him as medical superintendent (along with two members of the board of visitors) to have the power to condemn and reject any articles of food that ‘may be of inferior

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113 Best Overend and Lewis, Conservation Analysis, p.131.
114 PROV, VPRS 1226/P1, Supplementary Inwards Registered Correspondence, Unit 17, Item 83/1064, Letter from J.V.McCreery to The Inspector of Asylums, 28 July, 1883.
116 PROV, VPRS 3991/P1, Unit752, Item 72/12248, Letter from E.Paley, Inspector of Asylums, 5 November 1872.
quality'. He was also instrumental in encouraging food production at the asylum. By 1886, he was able to report that the ‘food supply is more satisfactory since I took charge’. He also saw this as a vindication of the granting of more power to superintendents. He felt ‘the somewhat enlarged powers given to superintendents to deal with complaints about food have been beneficial’.

McCreery was also a strong defender of moral management, which he explicitly termed ‘moral restraint’. ‘The groundwork of an asylum,’ he insisted, ‘is to keep the patients under moral restraint of the staff.’ The major change that occurred during McCreery’s time as superintendent was that the attendants began to be transformed into nurses. In 1887, Dr. O’Brien the then deputy medical superintendent, began lectures on nursing to male warders. In 1890 the first qualified female nurses were appointed.

In 1903, with the highly respected William Beattie-Smith now superintendent, the asylum became known as The Hospital for the Insane. The emphasis on ‘cure’ rather than care became even more pronounced. The instructions for the Medical Examinations of Patients in the Hospitals for the Insane amply demonstrate the doctor’s intentions. For newly arrived patients the regulations recommended:

not more than seven days from patient’s reception the Superintendent shall examine him[sic] with a Medical Officer and have record made in the case book. If deemed curable the medical officer shall make at least weekly note in the case book for the first few months... and at least once a month, whilst deemed curable.

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118 Annual Report 1886, VPP 1887, vol.2, p.44.
119 Annual Report 1887, VPP 1888, vol.3, p.44.
120 PROV, VPRS 7397/P1, Unit 14, ‘Instructions for the Medical Examinations of Patients in the Hospitals for the Insane’, handwritten on cover of Case Book.
If, on the other hand, the patient was deemed incurable he or she was then to be treated as a “chronic case”. This meant that he or she was only to be ‘examed once in six months [and] notes must be made in Case Book of any bodily disease that any patient is suffering from’.\textsuperscript{121} There is evidence to suggest that those patients considered to be incurable were often consigned to back rooms in the asylum and all but forgotten. There they received only intermittent examinations until they did contract a ‘bodily disease,’ died of old age, or were eventually discharged as ‘harmless but incurable’.

One patient even wrote indignant of the extreme casualness of her six-monthly medical examination. Susannah Taggart was brought to Kew on 13 June 1898 by the police. At this time, Beattie-Smith was Superintendent, Dr. Mullins was deputy and Dr. Campbell was the third medical officer. According to her case history, Susannah was 62 years old, a widow and suffering from ‘Senile Dementia’. She arrived ‘emaciated in health’, but being ‘quiet, clean and tidy’ was a model patient.\textsuperscript{122} She was discharged in June 1900, and soon after wrote a letter expressing her indignation at having been detained in the asylum. This was not in itself an unusual occurrence, but her main accusation centres around her treatment when she came for her examination:

\begin{quote}
I came over expecting medical examination - a man was in your place that I thought was your secretary, he asked my name in full, that was all he said to me, if that is medical examination anyone can do that ... to my astonishment he said Mrs. Taggart your probation is extended for another six months ... I asked who are you and what is your name. He replied he was Dr. Mullins.\textsuperscript{123}
\end{quote}

There may have been very good reasons why the doctors decided to extend Susannah’s stay in the asylum, but her major worry was that she considered she had not received a

\textsuperscript{121} ibid.
\textsuperscript{122} PROV, VPRS 7397/P1 Unit 12, p.233.
\textsuperscript{123} ibid., Letter from S. Taggart to Dr. Smith (undated) .
proper medical examination. She was not the only patient to complain of offhanded treatment by the doctors. In a rather lengthy letter, the patient Thomas Kyme expressed the doubts he held about the resident doctors' proficiency. Kyme was 'about 50' when he was admitted in 1907. His letter, addressed to the Inspector Dr. Jones, was written three months before he was discharged 'able to look after himself' in April 1909. 124

Doctor Shaw comes through the yards once a day, [he wrote] The Superintendent Dr. Barker comes about once a week or a little oftener [sic], while you come through about once a quarter and when you come you appear as if you were in a hurry to catch a train, now I ask what can any of you know about the inmate. Absolutely nothing [his emphasis].125

Inadvertently, he was probably also testifying to the overworked nature of the doctor's life, but his concern was with the lack of insight and genuine care for the patients this punishing schedule brought about.

Even for patients who were deemed to be 'curable', the actual treatment itself was often intermittent and idiosyncratic. Much of it consisted of simply moving patients from ward to ward within the hospital and keeping them sedated. Other 'treatment' was to simply observe their behaviour and pronounce them cured when their behaviour met certain standards felt by staff to be appropriate. Although the regulations stipulated a monthly appraisal, even a brief glance at the case books of individual patients reveal that this was rarely carried out. Often several months elapsed between comments by doctors or other staff. Nevertheless, many individuals did leave the institution feeling that they had been successfully treated. The many letters in existence that are full of praise for the doctors, written by or on behalf of former patients, testify to this.

124 PROV, VPRS 7398/P1 Unit 20, pp.27-28.
125 ibid., Letter from T. B. Kyme to Dr. Jones, 22 January 1909.
During Dr. Gamble’s time at Kew, there was constant correspondence in and out of the asylum. Both as superintendent and deputy, he appeared to encourage close relationships between patients, their families and staff at the hospital. He wrote many letters asking for information about the pre-institutional life of patients, and inquired after them when they had left the asylum. In turn he received many replies furnishing him with the requested information, reporting on the progress of ex-patients and thanking him for the care and attention they or their relatives had received.

Typical was a short note from the husband of Sophia Dunlop. Sophia came to Kew in 1905 and remained there for about 16 months. Her husband, David Dunlop wrote back promptly when he received an inquiry from Kew. ‘Received your letter yesterday, and am very glad to be able to inform you that Mrs. Dunlop is getting stronger every day’, was his succinct but grateful reply.\(^{126}\) Other letters were far less complimentary, often accusing doctors of any number of offences, either real or imagined. Perhaps the most pertinent was a comment from Emma Grover. In reply to a query from her son as to her health ‘in mind and body’, Mrs. Grover replied that she had no complaint except that she was ‘rather neglected you know, not enough attention paid me’.\(^{127}\)

Order and Chaos

Discordant Behaviour

Although the foremost aim of the staff was to maintain a regulated institutional order, given such a volatile situation it was an almost impossible task. Both doctor’s and attendant’s efforts were often thwarted by their own ineptitude, the lack of proper facilities, or the waywardness of inmates. The small number of staff, both trained and

\(^{126}\) PROV, VPRS 7397/P1, Unit 15, pp.219-20, Letter from D. Dunlop to Dr. Gamble 31 December, 1905.

untrained, relative to patient numbers also contributed greatly to the loss of order. Noise was always a problem at the asylum. The Vagabond describes how in the yard for the ‘worst’ patients there was ‘a mingled discord of singing, swearing and howling’. 128 Probably the worst aspect of this problem however, occurred at night. Although there was a rule about lights out at ten o’clock, many of the patients did not fall asleep readily. Some of the patients, especially new-comers, were observed to have been ‘noisy at night.’ Some were especially disruptive in this regard. Mary Humphries, was admitted in March 1875 and diagnosed as a melancholiac. She caused some consternation and no doubt a little amusement among the staff when she appeared to be be suffering from a delusion that she was a cow. She gathered her clothes behind her ‘to resemble a tail’, and also ‘lows like a cow all day and all night’. 129 Mary was prescribed brandy and Chloral Hydrate, a hypnotic, which helped her to ‘sleep a little’.

Other patients, especially those deeply depressed, like Edward Holder who spent six months at Kew in 1902, simply slept badly and ‘wept for long periods’. 130 Although sedatives were routinely given to prevent it as much as possible, the cries and moans of patients in physical pain or suffering the torments of their fevered imaginations would often fill the wards, preventing the calmer patients from going to sleep. The overcrowding of wards and the fact that in some cases patients were forced to sleep in corridors was certain to have exacerbated the problem.

**Employment and Recreation**

Life at the asylum during the day-time, particularly in the areas that were reserved for more co-operative inmates, assumed a monotonous, ordered regularity: a series of uneventful days that drifted into weeks, months or even years for some. Patients walked

128 James, *Vagabond Papers*, p.93.
129 PROV, VPRS 7397/P1, Unit 3, p.21.
130 PROV, VPRS 7398/P1, Unit 16, p.398.
sat, read, or worked about the asylum, being awakened, fed and let inside or outside at
prescribed times. The Vagabond described a cozy domestic scene, wherein patients 'play
at draughts or cards, seated under the roundhouse, others read newspapers of various
dates [never current]. Some walk around the paths, or collect in little groups, conversing
together'. 131 If asylum life was never quite as convivial as this image suggests, it was
certainly true that many days were consumed by activity that eschewed normality. As
testament to this in 1877, largely through the efforts of patients, 17 acres of the grounds
were prepared and brought under cultivation.132 The asylum was eventually able to
produce much of its own food supply. Efforts in this direction were always hampered by
an inadequate water supply, the theft of various foodstuffs by staff-members and the
tardiness of authorities in supplying needed buildings and equipment.

In 1886, after much persuasion from Superintendent McCrery, the grounds underwent
a major beautification treatment. The 'labour yards were trenched and planted with shrubs
and a large extent of the surrounding ground also was planted with shrubs and trees'.
This occurred, according to McCrery, in addition to the 'usual farm and garden
work.'133 The work of the female patients in the laundry and the sewing-room also
contributed in no small way to the smooth running of the asylum, as they were able to
supply and launder much of the institutional clothing.

When patients were not working there were recreational activities available. These
included a library which contained 'a fair supply of books and cards, chess, draughts and
dominoes'.134 There was also a billiards -room. For those who wished for more
energetic pastimes it was recorded that:

131 James, Vagabond Papers, p.100.
133 Annual Report 1886, VPP 1887, vol.2, p.44.
male patients play cricket on Wednesday, and on Saturdays numbers of both sexes
attend to witness the regular weekly match of the outside clubs...small parties of
female patients are taken for drives in the asylum waggonette into the city and to
the beach.\(^\text{135}\)

Paul Farmer recalled that during his stay, ‘in the afternoons we used to play tennis on a
very nice court’.\(^\text{136}\) If this is evocative of some sort of eccentric Arcadia, it is apparent
that the reality of the situation fell far short of the rhetoric surrounding it. At the Kew
Inquiry, the failure of the efforts to satisfactorily entertain the patients was repeatedly
referred to. It appears that in spite of the facilities supplied, many of the patients spent
their days wearily walking the yards or confined to their wards.\(^\text{137}\) There was a limited
supply of sporting equipment and the billiard-room in particular seemed only to be used
by the attendants.\(^\text{138}\) In 1880, the acting Inspector of asylums repeated the allegation that
‘the amusements provided for the patients were really usurped by the officers’.\(^\text{139}\)

The overcrowding of the institution also meant that during inclement weather the
corridors were the only places for patients to spend their day. Dr. Dick admitted in 1878,
that, boredom due to ‘the monotony of their lives had a most depressing effect on
patients.’\(^\text{140}\) The Vagabond reserved his harshest criticism for the fortnightly balls, which
were the only occasions when the two sexes intermingled. The spectre of the ‘Lunatic’s
Ball’ is a device much used in fiction and art as an indication of a breakdown in society.
The Vagabond’s description of the ball at Kew, with discordant music and awkward
dancing, probably owes more to this tradition than any observed reality. Nevertheless, the
bizarre nature of such an event cannot be overlooked. Farmer on the other hand, found

\(^{136}\) Farmer, Three Weeks in Kew, p.10.
\(^{137}\) James, Vagabond Papers, p.133.
\(^{138}\) ibid., p.132.
that the ball he attended in 1899, ‘was very nicely conducted ... and was most enjoyable’.

He also expressed the view that the ‘evening concerts’ in his ward and in which he was sometimes a participant, revealed the men to be ‘better-conducted’ than many others he had known.

The position of the recreational amenities was an interesting one. Although they were intended to enhance the life of the inmates they also, by their very nature, reinforced the notion of an institutionalised life. Irrespective of their suitability, or the quality of the materials used, they were all constructed both within the asylum and under the rules of institutional living. This meant that they were part of the process of changing the individual into a ‘suitable’ inmate. The controlled ‘inside’ recreational activities served to further distance the inmates from the usual social complexities that made up their world. As Goffman explains it:

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\text{a basic social arrangement in modern society is that the individual tends to sleep, play and work in different places, with different co-participants, under different authorities, and without an overall rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life'.}
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The inmates of Kew already slept and were encouraged to work within the confines of the asylum. By their inclusion of all entertainment and recreational outlets within the procedures of the institution, the administrators broke the last real contact the inmates had with the social structures by which they were able to make sense of their world. Patients had forfeited the power even to make decisions about their own hours of relaxation. Even if the comfort and entertainments provided were exemplary (and they were far from that),

\[142\] bid., p.10.
\[143\] Goffman, *Asylums*, p.5.
their implementation served to remind inmates that their own choices were being appropriated, or at least severely curtailed. The dislocation thus suffered by the inmates was that of losing not only control of their lives, but that of being denied access to the underlying social structures that had previously defined them. This separation results in what Goffman describes as ‘role disposssession’.144

Again according to Goffman, this negation of self was imposed upon inmates gradually until they presented as fit subjects to be transformed into an ‘inmate population’. Many of the patients at Kew did not however unknowingly surrender their autonomy, but were all too aware that decisions were being made that would have a direct bearing on them, but were out of their control. Paul Farmer expressed it best when he wrote simply, but appropriately, of experiencing ‘the discomfort of not knowing what was being done’.145 Even if they were unable to articulate it, many of the patients must have experienced similar emotions. Left floundering without their customary support system, some of the patients experienced a deep and abiding frustration. Many of these patients had real psychiatric problems of varying degrees of severity, and this dismantling of their understood world without doubt exacerbated their condition. Many seemed to have been unable to distinguish between the terrors of their imagination and the very real horrors involved in institutional life, and reacted with unhelpful, but predictable violence.

Accidents, Attacks and Escapes

The situation generated incidents which upset the already fragile institutional order. Accidents, or deliberate acts of damage were not uncommon. In 1876, ‘a man had driven his hand through one of the plate glass windows’.146 In January of the same year, one of the other patients had escaped from a ward, and broken ‘a form and some panes

144 ibid., p.14.
145 Farmer, Three Weeks in Kew, p.10.
146 James, Vagabond Papers, p.89.
of glass’ before being returned. More frequent, and more serious than damage to property were the injuries patients inflicted upon themselves.

Most annual reports record at least one death at the asylum due to accident or suicide. There were also many attempted suicides. Patients suspected of harbouring ‘suicidal tendencies’ were subject to special regulations. They were required ‘to sleep in E observation dormitory, not to have a knife at dinner, to be searched carefully every night and to be kept under strict supervision.’ In spite of these precautions however, some patients whom staff had never contemplated as potential suicides, or those on whom they had relaxed their vigilance, made determined efforts to take their own lives. Such a case was that of Sophia Law. Admitted late in 1889, she was allowed to go home ‘on trial’ in February of the following year. During that time, the medical officer received a letter from the police at Brunswick giving details of Sophia’s attempt to drown herself. ‘I have the honour to report for your information, that the woman Law, a patient ... from the Kew Lunatic Asylum attempted to commit suicide by drowning’, wrote the sergeant. ‘Yesterday at about 7pm she was found in Merri Creek near Albion, at Brunswick.’ Fortunately for Sophia she was ‘dragged out of the water by two men who happened to be passing’, as the ‘water at the place was not deep’. He added somewhat censoriously that the patient was unfit to be at large ‘as she [was] of suicidal tendencies’. Sophia was returned to Kew, eventually to be discharged in February 1892.

Not so lucky was Amelia Pearson, who was also home on probation in May 1912. A housewife from Heyfield in Gippsland, the 48 year old woman was admitted in October 1911. Although her photograph shows a healthy looking woman, neatly groomed and

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147 PROV, VPRS 7544/P1, Unit 1, p.14.
148 PROV, VPRS 7397/P1, Unit 14, Memo from Medical Superintendent 28 June 1904.
149 PROV, VPRS 7397/P1, Unit 9, p.253, Letter From J.Brown, Sergeant Of Police Brunswick Station, Melbourne Police District to The Medical Office Kew Asylum, 10 February (no year given).
150 ibid.
apparently cheerful, her case notes describe her as 'depressed, apprehensive and inclined to be violent' with an 'unreasonable dislike for her husband and children'. 151 A letter from her husband reveals how he left her alone in her room one night 'contrary to my usual habit' for over half an hour. Upon discovering her room empty when he did return he then 'rushed to the river ... and found her body there quite dead'. 152

The occasional suicide barely seemed to disrupt the routine of asylum life however. It was duly noted in the patient's case notes and recorded for the annual report, then apparently forgotten. Viewed with more concern were the small number of patients who escaped each year. Most of them were swiftly apprehended and returned. In 1889, the annual report noted that a record 12 such attempts were made. All 12 were 'retaken'. 153

Although they were almost always male patients who absconded, a case that attracted particular interest was that of a woman, Mary Henry. Mary was admitted in December 1901. She was brought by her mother and diagnosed as melancholic. 154 Her time at the asylum did nothing to relieve her of her depression, but it made her contemptuous of the medical staff. Deeply distressed, she wrote to her mother in February the following year. 'I have tried these doctors to do something for me and they never gave me no satisfaction [sic]' 155 she wrote. On the previous day some of the inmates, including Mary, had been on the annual picnic. During the afternoon, as she explained in her letter, she 'disguised myself and made my escape'. Mary made her way back to her the street where she had lived with her mother prior to her admittance to Kew, but kept out of sight. She was reluctant to admit her presence, for fear that her detection would immediately lead to her

151 PROV, VPRS 7397/P1, Unit 20, p.88.
152 ibid., Letter from J.H. Pearson to Medical Superintendent, Kew, 24 May 1912.
154 Melancholia was the term which would be most closely understood as 'Depression' today. It was often, although not exclusively used as a diagnosis for women. For a more comprehensive explanation of Melancholia see Chapter Six 'A Gendered Malady' in the section on types of madness under sub-heading 'Depression and Melancholia' and Melancholia in the Twentieth Century'.
155 PROV, VPRS 7397/P1, Unit 13, p.690.
being returned to the asylum. Her letter continued, 'I'm afraid to come home for those cursed wretches will bring me back. I'm wandering about the streets of Melbourne without a friend.' Mary was discovered the following night concealed under the house next door to her mother's home. Because of her extreme reluctance to return to the asylum, and her mother's intervention on her behalf begging 'to be allowed to keep her daughter who was very averse to returning', the doctors agreed to allow her out on trial. She was discharged shortly after.

In spite of the insistence by the administrators that asylums had by the early twentieth century, become much more congenial and more hospital-like rather than prison-like, some patients still felt the need to escape. Occasionally, this had tragic consequences. In 1914, 14 males and two females escaped. By the end of the year 'four of the men [were] still at large, while one had drowned in the Yarra'.

Due to the volatility of the population, on even the quietest day in the asylum there always existed the possibility that violence could erupt at any moment. As noted earlier, mealtimes were especially tense, but they were not the only times disruptions occurred. The very presence of patients such as Samuel Alardice, no doubt caused great concern to the medical staff. Alardice had been convicted for murder before his admission in 1889. He was, according to his case history, 'a big man, dangerous, homicidal' but 'quiet if undisturbed'. Doctor Mullins was understandably nervous of him, being afraid he was going to 'have an attack of furor [sic] during my examination of him.' Although no attack by Alardice is recorded, some of the other patients were habitually violent towards fellow patients or attendants.

156 ibid.
157 ibid.
159 PROV,VPRS 7398/P1, Unit 11, p.84.
160 ibid.
For almost a year in 1891, Arthur Casey continually harassed his fellow inmates, terrifying them with his threats and noisy demeanour until he was transferred to the isolation ward.\textsuperscript{161} Unexpected attacks were also common. In August 1899, the previously quiet James Geary from Wild Duck Creek, a man of 'temperate habits' who 'spoke very little', suddenly 'attacked and struck an attendant'.\textsuperscript{162} During a week in September 1907, Michael Doyle knocked down one attendant and tried to throttle another.\textsuperscript{163} Frederick Salmon, who was in the asylum at the same time, struck both an attendant and a fellow patient whom he was reputed to 'have a set against'.\textsuperscript{164}

Although the majority of attacks involved male inmates there were occasions when the behaviour of female patients was a cause for alarm among the medical staff. That these 'attacks' were sometimes of an amorous nature seemed to heighten rather than lessen the doctors' concern. During his time as an attendant, the Vagabond was moved to sympathise with the medical officers who were often the object of a patient's desire. 'Some of the patients, with erotic tendencies, will seize upon and kiss the doctors', he noted, particularly Dr. Robertson who was 'much run after by ladies'.\textsuperscript{165} Although this was greeted with 'great amusement by the female attendants', this type of incident came to be regarded with the utmost seriousness by the doctors. In the years after 1900, any hint of sexual behaviour exhibited by patients, especially female patients, was interpreted as proof of a further disintegration of their mental capacity.

In 1907, Fanny Barlow caused staff to reconsider the advisability of releasing her from her restraints. She was prone to stripping herself completely naked on occasions when left unattended in her room. She also developed the habit of referring to one of the medical officers as 'darling Jack,' a term that seemed to cause some alarm rather than

\textsuperscript{161} PROV, VPRS 7398/P1, Unit 12, p.106.
\textsuperscript{162} PROV, VPRS 7398/P1, Unit 15, p.480.
\textsuperscript{163} PROV, VPRS 7398/P1, Unit 20, pp.51-52.
\textsuperscript{164} ibid., p.129.
\textsuperscript{165} James,\textit{Vagabond Papers}, p.156.
being treated as a harmless affectation. Fanny, it had previously been noted, without further explanation, was possessed of 'filthy sexual habits'.

Control and Restraint

Whether motivated by desire, fear, hatred, or frustration, many incidents of a violent nature did occur within the walls of the asylum. Many of them occurred because of the volatile nature of the inmate population. However, unsettling as these incidents no doubt were, the greatest tension was generated by the actions of the staff. Earlier I discussed the acts of violence for which attendants were liable to be reprimanded: the type of incidents which were discussed at length during the 1876 Inquiry, or which appeared in the Complaints Book. Reprehensible as these acts were, they were not the major form of violence practised within the asylum. The real role of the Inquiry and the book of complaints against attendants was not to eliminate violence in the asylum. It was to distinguish between the violence 'necessary' for the smooth running of the institution and any gratuitous violence inflicted by the staff. As Dr. Dick commented in 1877, 'it is very difficult to decide where justifiable force ends and wilful cruelty begins'. Indeed, as the Vagabond so aptly remarked, 'the Inquiry showed that tenderness is not the rule.'

The regime of moral management was founded on principles of non-violence. Although notions of humane treatment were aspired to, in reality, the asylum system operated almost exclusively in terms of institutionalised violence. At Kew, the size of the institution, the nature of the population, coupled with the obsessive concern with regulation and control meant that order could not be maintained by any means other than external restraint imposed by the staff. The Report of the 1876 inquiry found that 'Among

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166 PROV, VPRS 7397/P1, Unit 15, p.20. 'Filthy sexual habits' was an expression sometimes used about patient's behaviour in case notes. It often meant that they masturbated. It could also mean that they indulged in inappropriate public behaviour such as undressing in front of other patients, persistently singing lewd songs or using lewd expressions.


168 James, Vagabond Papers, p.156.
the means of restriction or coercion used at Kew are the camisole, the gloves, bathing as a
punishment, threats, sheeting- i.e. confining the head, body or limbs in a sheet-padded
cells and seclusion'. 169

These methods of 'restriction or coercion' were sometimes referred to collectively as
means of 'mechanical restraint'. Although bathing as punishment, threats, and 'sheeting'
were discouraged by the medical staff, the other forms of control were not only endorsed
by the doctors, but carried out under their instructions. As the report went on to add 'we
have it in evidence that the camisole, the gloves and seclusion [solitary confinement] are
only resorted to in extreme cases, and by order of the medical superintendent or the
resident medical officer'. 170

These appliances were described thus:

The camisole is a modification of the old strait waistcoat ... a loose canvas bag
with arms sewn into pockets at the side and fastened at the back ... the gloves
[were] unlike any other hand coverings. They are formed of two stiff flat pieces of
leather, cut in the shape of a paddle, and sewn together. The hand being in this, it
is secured by a locked strap at the wrist'. 171

Boots and caps that could be locked were often used in conjunction with the gloves. A
tendency to disrobe was likely to incur the use of these restraints. As the Vagabond
noted, 'those who have a mania for undressing themselves have gloves placed on their
hands, and caps and boots locked on'. 172 In common with many members of the medical
profession, he felt that these restraints, while they appeared hideous were 'absolutely
necessary'. 173

170 ibid.
171 James, Vagabond Papers, p.89.
172 ibid., p.94.
173 ibid., p.95.
In the 1877 Annual Report, Edmund Paley, Inspector of Asylums, began to keep a record of the number of patients who were subject to restraint or seclusion. This was a year during which all the administrators would have been especially sensitive about allegations of cruelty in the light of the findings of the Inquiry the previous year. Paley was certainly uncomfortable about the use of mechanical restraint. He was gratified when he visited Kew in 1877 to find only 'two men and one woman restrained by camisoles, and no-one in seclusion'. Even so, he noted that he had 'advised the superintendent to make persistent efforts against restraint becoming habitual'. Dr. Dick, the superintendent, did not appear to have heeded this caution as the annual report for the year revealed there to have been 98 patients who were gloved, 58 who were restrained by camisole, and 95 who were placed in seclusion for several days.

The following year, however, the use of these measures had lessened slightly, as the report noted that there were '86 patients confined by gloves, by camisole 36 and 73 were placed in seclusion'. Dick's ambivalence about the use of mechanical restraint was demonstrated in 1886 when he was the Inspector of Asylums. Although he professed to be pleased at the 'appreciable reduction in the records of seclusion and restraint', he was convinced that the 'entire disuse of such treatment under existing conditions is not practicable, and it is even doubted if this could under any circumstances be effected with advantage'.

By 1904, however, Dr. McCreery was pleased to report that 'asylums have been worked practically on the non-restraint system'. In 1905, it was used on 'only two occasions, once for surgical purposes, and in the second case during a paroxym [sic] of determined suicide frenzy'. While it is apparent that the use of mechanical restraint slowly went

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out of favour, it is also evident that it was a long time disappearing from Victorian asylums, with staff at Kew being the most reluctant to abolish it. The discrepancy between rhetoric and practice in Victoria is further emphasised by comparison with Colney Hatch. This English asylum, upon which Kew was supposedly based, was dedicated to the system of non-restraint with the laying of its foundation stone in 1849.

Despite the fact that the annual reports continued to promote the notion of the disappearance of mechanical restraint, individual case notes often indicated otherwise. The asylum’s report for 1907 insisted that the only restraint was ‘in the form of one glove or muff…solely for surgical purposes’ and that for any other purpose ‘it may be said to be practically abolished’.179 One documented example in 1907, however, where mechanical restraint was used for non-surgical purposes was the case of Michael Doyle. According to his personal report, although he was lame from a recent fracture of his ankle, Doyle’s attempts to attack attendants, and also to undress himself earned him long periods under restraint.180

Mechanical restraint as a contentious issue for so long was apparently peculiar to Victoria. As the 1908 Australian Medical Congress found, there was ‘special provision in the Victorian Lunacy Act restricting the use of mechanical restraint. In none of the other states [was] it thought necessary’. However, it was the view of the writer that there was ‘little fear of its undue use, whether it was prohibited by enactment or not’.181 Whether the patients were as confident about the matter is not recorded. In 1914, Inspector Jones admitted that ‘12 years ago mechanical restraint was applied for 100s of hours per month, but claimed that for all of 1914 it had ‘not been found necessary to resort to either

180 PROV, VPRS 7398/P1, Unit 20, p.51-2.
[restraint or seclusion]. He did not add however, that more and different drugs were being used which had the same effect of rendering the patients more manageable.

**Plumbing and Privacy**

In addition to the direct processes of control used within the asylum, there were matters of a more practicable nature that caused chaotic conditions. One of the major problems was a persistently inadequate water supply. This resulted in unsatisfactory bathing and sanitary conditions throughout the entire life of the institution. At the 1876 Inquiry, evidence was given by an engineer and a plumber about the problems associated with obtaining a fresh, abundant supply of water. James Robertson, a plumber who had ‘worked about the place for two years’, noted that the asylum required 30,000 gallons of water per year to provide adequately for the needs of the people who were resident there. Water from the Yan Yean Reservoir was ‘laid on, but intermittent in supply’, Robertson testified. ‘The river is too distant to be resorted to and the total tank capacity in the roof of the main building...does not afford water enough to supplement the Yan Yean.’ This meant that the water supply was perpetually inadequate and on occasions, especially during summer, the asylum ran out of water altogether. Sewering of the asylum commenced in 1914, but even after that date, facilities remained antiquated and inadequate.

According to the Inquiry, although the regulations stated that: not more than three patients are to be bathed in the same water, and where practicable not more than

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183 Kew Inquiry, p.69.
185 A reporter noted in the *National Times* 14-20 September 1984, p.24 ‘In the aggressive males ward there is one bath for 35 men’.
The Vagabond maintained that while he was there, instead of two or three patients being made to share the same bath-water, he estimated, ‘12 to be nearer the mark’. Besides the lack of water, he also considered the bathrooms themselves to be ‘totally inadequate ... without a sufficient supply of towels’. The testimony of the former attendant Miss McKee at the Inquiry echoed these views. She claimed that ‘it was the custom rather than the exception to bathe ten to fifteen patients in the same water; and for patients to dry themselves on their dirty linen’.

Besides the obvious implications of the lack of hygiene entailed in these procedures, the methods emphasised the fact that the inmates had forfeited their right to basic privacy. That they were forced to expose their bodies to the scrutiny of attendants and fellow-inmates constituted a further stage in the rituals of ‘mortification’ as outlined by Goffman. It was no doubt the certainty of humiliation, as well as the possibility of physical abuse, that caused the Vagabond to observe that for many of the patients the weekly bath was a ‘dreaded ordeal’. With astounding insensitivity, he concluded that it was ‘that dislike for water so strong in our race’, that prompted such dread that ‘a man would cry whimpering like a child, “don’t take my things off” and it was necessary to force them to undress’.

This allowed for the more intrusive procedure of attendants examining patients for bruising or other marks on their bodies, again in full view of fellow-inmates and staff. As Goffman has stated, in total institutions ‘such physical indignities abound.’ Although,

187 James, Vagabond Papers, p.119.
189 James, Vagabond Papers, p.119.
190 Goffman, Asylums, p.22.
as a result of the Inquiry, the ‘bathing facilities were to be improved’, the persistence of other situations which undermined the patients’ rights to privacy continued. This included the absence of doors on toilet-cubicles, which in some cases were directly opposite the baths in the same room. Many patients also had to submit regularly to the most intimate of physical examinations, especially in the case of women whose menstrual cycles were documented in great detail. Even death provided no respite from the prying gaze of the medical profession. It was the proud boast of asylum doctors that the body of every patient who died at Kew was subject to a post-mortem in order to further advance the ‘scientific study’ of insanity.

From the moment of arrival, when personal details were obtained and noted and personal possessions were confiscated, the patient embarked on a course that allowed him or her to be ‘shaped or coded into an object that can be fed into the administrative machinery of the establishment’. Before this could happen the individual had to forfeit self-identification. This was attempted through two major processes. The first absorbed the patient into the asylum so that the institution substituted the whole of their previously understood world as the place where they worked, played and slept. The sense of isolation from the outside world was further accentuated by the censorship of mail and by the prohibition of current, local newspapers on the grounds that they may have caused inmates distress. The second process involved a mortification of the self. The body of the individual became an object to be observed, studied, categorised and labelled. Not everybody succumbed so readily as this implies. Many did not succumb at all, despite the apparent power imbalance. For, in the words of Michel Foucault, ‘where there is power, there is resistance’. The inmates at Kew demonstrated their resistance in numerous ways, consistently challenging, negotiating, and at times appropriating a system that was in itself seriously flawed.

191 Goffman, Asylums, p.16.
CHAPTER 3

Breaching The Walls.

On the one hand, there is a danger of committing a sane man to an asylum ... and on the other, there is the chance that, if the person suffering from partially developed insanity is not promptly taken care of, serious mischief may ensue.

Ephraim Zox 1884

Will you please let the bearer bring my wife home with her on probation as I saw her on Sunday and I think she is much better. Also bring her bedding.

Frederick Archer 1904

When Ephraim Zox announced in 1884 that ‘the maxim adopted in our asylums is, “Easy in and very hard to get out”’, he merely expressed what was a commonly held contemporary perception of asylums throughout the colony. The high walls, elevated position and general forbidding appearance of asylums, Kew in particular, made them appear not only impregnable from the outside but generated the feeling that once inside, people could disappear forever into their gloomy corridors and labyrinthian rooms. While not a medical

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2 PROV, VPRS 7397/P1, Unit 14. p.664. Letter from F. Archer, addressed Dear Doctor (undated).
practitioner, Zox, was a well-known spokesman on philanthropic matters. He was also Chairman of the *Royal Commission on Asylums for the Insane* in 1884.4

The Commission was convened in 1884 and continued for almost two years. While Zox’s remark was intended to be somewhat facetious, it ironically contained an element of truth. It equated asylum inmates with welfare dependents generally, in that they remained trapped within a system that offered them little or no relief from their poverty or illness, but rather sustained their dependency. Yet, the notion that once the inmates entered the asylum they were irrevocably cut off from the wider society was largely a myth. In practice, the asylum never operated as a ‘total institution’ in that it replaced the outside society for the inmate but remained very much a part of it. In some sense, the constant reminders, and inmate’s knowledge of the ‘outside’ society made the asylum even more effective in the maintenance of institutional order.

Goffman describes the asylum as a discursive construct, maintaining that ‘the meaning of it [the asylum] was articulated through a particular kind of tension between the home world and the institutional world’ which operated as a ‘strategic leverage in the management of men’ [sic].5 Discourse has real effects however, and the creation and maintenance of the place of the asylum within imagination impinged upon the lives of many people. This chapter sets out to contextualise the relationships involved, by examining the various mechanisms through which the asylum and the wider society maintained and sustained mutually dependent contact. What developed was a complex, and continually negotiated relationship between the asylum, the law, and the families of inmates. In most cases this relationship did not cease with committal. Most contact between the asylum and outside, whether entering or leaving, was orchestrated through certain specific management

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4 For further information on Zox see Chapter One, ‘Building the Asylum’, p.27.
The methods by which a person could be committed to an asylum in Victoria involved a combination of medical and legal procedures. Lunacy was a chargeable offence, that if 'proven' carried a sentence of committal to a lunatic asylum. The Lunacy Statute of Victoria of 1867 provided 'two modes of committing lunatics to asylums'. They were designated as 1. Magisterial or public committal and 2. Medical or private committal. Both forms of committal were aimed at ascertaining whether the person so charged was in fact 'a lunatic and a proper person to be taken charge of, and detained'. Both magisterial and medical committal required the intervention of members of the medical profession. In 'magisterial committal' the person was apprehended and charged with being a 'dangerous lunatic' a 'lunatic wandering at large' or a 'lunatic not wandering at large, but not under proper care and control, or cruelly treated by relatives or guardians'. These people were generally arrested by the police for unruly or drunken behaviour, or charged with a more serious criminal offence. If they were deemed to be 'mad' rather than 'bad' they were then charged with being a lunatic. Alternately, a person who was already in custody in a gaol or similar institution, and who appeared to 'become mad', could be transferred to an asylum.

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8 ibid.
A person 'discovered and apprehended under circumstances that denote a derangement of the mind, and [their emphasis] a purpose of committing suicide or some crime' could be charged with being a 'dangerous lunatic'. In order to begin committal proceedings two or more justices of the peace or a police magistrate were then required to 'call to their assistance a medical man whose duty it will be to examine the supposed lunatic.' The medical man was not required to furnish a certificate, and the final responsibility for the committal rested with the justices. If they should 'be satisfied that the person is insane or a dangerous lunatic' would 'cause the said person to be conveyed to, and placed in such asylum or hospital or licensed house [private asylum] as they direct'. In the case of the person being categorised as a 'lunatic wandering at large' or one 'not under proper care and control', two medical men were required to examine him or her, and make a report stating that they had:

personally examined YZ, and the said YZ is a lunatic, and a proper person to be taken charge of and detained under care and treatment. "Detained under care and treatment" is in this colony synonymous with being sent into a public or private asylum.

The responsibility of doctors and justices was divided for these types of committal, both sharing the instigation and operation of the procedure.

In 'medical committal', doctors were involved in both the initiation and the carrying out of the committal. For this type of committal the Lunacy Statute required three documents – an order and two medical certificates. The order was a:

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9 ibid.
10 Lunacy Act 1867, Victorian Statutes, no.309, 30-31 1867, Supplement to the Victorian Gazette 10 September 1867, p.35.
request by some relative or friend of the patient to the superintendent of an asylum to admit into it a lunatic, YZ. It is usually signed by the nearest relative; but anyone who can show cause to interfere in the patient’s affairs may sign it. 12

Both the medical men were required to furnish certificates and it was on this basis that the person was committed or not. Whichever form of procedure was adopted it remained apparent, as Stephen Garton has noted in his portrayal of insanity in NSW, that it 'was not insanity itself that instigated committal procedures, but the view of police, magistrates, doctors or relatives that other forms of control were not available'. 13 The situation in Victoria appeared to have also operated within the same framework. Once a person was committed, he or she was legally considered to be a ‘lunatic’. It was not the view of any one of these people or groups individually however, that resulted in a committal; rather committal was ultimately the result of their combined opinion and efforts. Under the lunacy laws, the first diagnosis of insanity was generally made by the arresting police, or by friends or relatives of the potential inmate. The doctors were then required to play their role. From this enforced cooperation, emerged an increasingly complex relationship between members of these groups. It was never an easy alliance, however. The doctors were clearly uncomfortable with the part played by non-medical people in the incarceration of inmates. Nevertheless, they were forced to acknowledge that they had to rely on the police, relatives or friends of inmates to bring them to their notice in the first place.

12 ibid., p.16.
The Role of the Police

When the Kew asylum first opened, the most common method of committal was via the police. Under the 1867 Lunacy Statute, police had certain specific obligations with regard to 'lunatics'. According to the Act, 'every constable who shall have knowledge that any person wandering at large is deemed to be a lunatic ... shall take or cause such person to be apprehended and taken before a justice'.

Furthermore, they were also required to report to a justice any 'lunatic not wandering at large, but not under proper care and control, or cruelly treated or neglected'. In 1875, out of the 659 people admitted to Kew, 407 had been brought by the police. Of the remainder 123 were brought by friends or relatives, and the rest came from gaols, benevolent asylums or other public institutions. By 1886 the ratio had only altered marginally, when 362 of the total 669 had been apprehended and escorted to the asylum by police, while 164 came with relatives or friends.

As doctors sought more overtly to create a specialised area of expertise for themselves within the meanings assigned to insanity they attempted to further the marginalise of the role of the police. In 1874, Dr. Smith noted in the Australian Medical Journal that it was 'unfortunate that the giving of the cause of insanity should in this form of committal be left to friends, and in the other to the guess of an intelligent (!) [their exclamation] policeman'. The most scathing attack on police involvement came from an editorial in the Australian Medical Gazette in December 1886. It lamented that the police had anything at all to do with patients, fearing that their inexperience was likely to have aggravated the patient’s condition, even en

14 'Lunacy Act 1867', Vic, no.309.
15 ibid.
17 Smith, ‘Hints on Lunacy Certificates,’ p.17.
route to the asylum. The article suggested, 'If inquiry were made into the condition of lunatics before their removal from home, and on their arrival at the asylum, it would in many cases disclose differences indicating evil results from injurious management during their transmission'.

This claim was then used to point to the temporal nature of the role of the police, which should cease entirely at the asylum gates, as according to the editorial: ‘We may doubt the competence of police, who have much to do with the transmission of lunatics, to act as their custodians.’ On the other hand, doctors were well aware that the police could sometimes be a useful ally not only in the ‘transmission of lunatics’, but in their initial identification.

The situation is illustrated by the case of Francis Kennedy. In 1890, the sergeant of Elmore Police Station sent a letter to the asylum regarding Kennedy, a farm labourer from Namarooka, who was under investigation for arson. Kennedy had asked for work several times at a station near his home. Each time he had been refused. Finally, he was ordered off the property as ‘he had become a nuisance.’ Four days later, a haystack on the station was mysteriously burnt and Kennedy immediately fell under suspicion. The police were called and the sergeant prepared a report, which read in part:

I found tracks going to and from the stack. They were made by some person wearing large boots nailed. The tracks were followed home to the patient’s residence, where his mother was interviewed by the police.

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19 ibid.
20 PROV, VPRS 7398/P1, p.340, Letter from Sergeant R.Salts re Francis Kennedy.
21 ibid.
During the interview, Francis’s mother suggested that her son was insane. She also added ‘that she was quite sure that he had burnt the stack’. Francis’s guilt and consequently, his insanity were confirmed when his boots were brought to the scene and ‘tracks [were] made with them beside the original ones, and agree in all respects’. 22 Francis was subsequently taken to Kew where he was admitted as an ‘imbecile’. He remained there for 16 years.

The 1903 Lunacy Act heralded a major change in the official discursive construction of the asylum. In it asylums were re-named Hospitals for the Insane and were ‘here after [to be] referred to as such’. 23 This signalled not only a major theoretical shift in the notion of insanity, but also a victory for the doctors in their struggle to make treatment of the insane an increasingly medical procedure. An official shift in the categorisation of the insane from the criminal to the sick also suggested that there should have been a lessening of police involvement. The role of the police did not disappear however. With their position as the unquestioned experts on insanity now firmly established, the doctors were happy to seek the cooperation of the police, within the limits they prescribed.

Along with their desire to re-construct asylums as places of cure rather than detention, doctors had concluded that one of the means of establishing insanity more firmly within their orbit of specialisation was by creating a body of information on the subject. One of the devices they employed was to increase the amount of data recorded about individual patients. In this, the police played a valuable part. Doctors were aware that the police with their local knowledge could not only assist in identifying lunatics but could often act as a source of information on inmate’s pre-institutional lives. Thus, co-operation between doctors and police continued, with doctors often requesting information directly from local police.

22 ibid.
Sometimes this information proved worrying, as in the case of Samuel Alardice. Alardice was originally transferred from Yarra Bend in 1889. His accompanying papers suggested that he had a criminal record. This prompted Dr. Mullens, as superintendent at Kew in 1903, to write a letter to the police station at Alardice’s native Maffra. Constable Drummond furnished the information that Alardice had ‘struck one George Thompson several times about the head inflicting terrible injuries from the effect of which Thompson died shortly afterward’.24 It was apparently the receipt of this information that caused Mullens to be extremely nervous of Alardice. After this time, the observations made about him became more concerned with his potential violence, although it was noted early on that he had ‘an uncertain temper’. 25

Mullens also overtly enlisted the aid of the police, even to the extent of using them as a veiled threat to a patient. Elizabeth Anne Whitehouse was due to be re-committed in September 1903 after three weeks on probation. Mullen’s letter describing the details of her proposed return warned that ‘should Mrs. Whitehouse be too obstreperous the police will as I told her insist on being shown this memo [sic]’.26

The name change from asylum to hospital appears to have been largely rhetorical, with very little difference in the way patients were treated within the institutions. Yet, the rhetoric seemed to have effects beyond the walls. Although ‘wrongful incarceration’ continued to be a concern, the Hospitals for the Insane achieved a guarded legitimacy and acceptance by much of the wider society by the turn of the century. One result of this was that the number of patients being brought directly by relatives and friends began to outstrip the number

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24 PROV, VPRS 7398/P1, Unit 11, p.8, Letter to Dr. Mullens from Constable M. Drummond Superintendent of Police, Maffra, 19 December 1903.

25 ibid., Memo re S. Alardice, 22 September 1891.

26 PROV, VPRS 7397/P1, Unit 14, p.352, Memo re E. Whitehouse.
brought by the police. In 1901, for example, relatives and friends brought 197 patients to the asylum while the police brought only 105. In addition, many families were often involved in the committal process, although it was the police who, according to the records, brought the patients to the asylum. This can be seen in cases like that of the aforementioned Francis Kennedy. Although he was brought to the asylum by the police it was his mother who first suggested that he was insane, and prompted the police to act upon it.

**Doctors and Families and the Committal Process**

The relationship between doctors and families of inmates was even more complex than that between the asylum and the police. This complexity arose because of their sometimes conflicting agendas. Although the desires of both the asylum and the families converged on some points, in other respects their needs were diametrically opposed. On the one hand, families looked to the asylum to help them cope with unmanageable members. At the same time, the asylum needed the families to help supply them with inmates in order to justify its existence. On the other hand, asylum doctors did not want to be burdened with inmates whom they felt were ‘dumped’ on them by uncaring relatives. In 1874, Dr. Paley complained:

> This getting rid of aged, demented, or helpless relatives ... on the most slender of pretexts, and the foisting them upon asylums ... is at once one of our most contemptible traits, as it is one of the worst omens in the community.27

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Two years later, Dr. Robertson also rebuked families, claiming that there was 'too ready a disposition on the part of relatives to saddle the State with the care and maintenance of the "harmless insane".' 28

Doctors wished particularly to discourage families from bringing any patients whose condition was of a long term nature because they believed these would be the most difficult to cure. As outlined in an article in the *Australian Medical Journal* in 1873, there were 'cases where the law allowed removal to an asylum but ... it should not be done'. Into this category came 'all chronic cases, by which may be understood all in which the disease has existed for two years [because] chance of cure in such cases is very remote'.29

The doctors were also keen to stress that friends or families were no more experts in the management of patients than were the police. The article in the *Australian Medical Journal* in 1874 linked the police and the friends of inmates in that both could only 'guess' at the insanity of the patients and its causes.30 The implication was that only they, as doctors, could 'know'. But although doctors seemed to become more confident with the role of the police, they were less certain about the role of the families and friends of the patients. The families themselves seemed to have a clearer idea of what function they wished the asylum to perform. Most often, they only used it as a place of last resort. In spite of doctors' warnings that any delay could lessen the likelihood of cure, family members were reluctant to admit mentally unstable relatives until they felt they really could not cope.

An example of how a family managed for as long as it could is the example of Benjamin Errey. Sixty-one year old Errey was brought before the Camperdown Court in April 1879

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28 Kew Inquiry, p.60.
29 P. Smith, 'Hints on the Giving of Lunacy Certificates', *AMJ*, vol.xviii, (December, 1873), p.360.
and charged with lunacy. The *Camperdown Chronicle* observed that it had been known 'for some time past' that he had been suffering from unsoundness of mind 'in a greater or lesser degree'. As however, 'no serious consequences were apprehended from this by his relatives,' action had not been taken sooner. It was only when he became uncontrollable that Errey's wife sought help. On the Saturday before his committal, Errey, the *Chronicle* declared, had become so violent 'as to necessitate the use of a straitjacket. While this was being put on, the struggles of the unfortunate man were something fearful and the assistance of no fewer than five men were called into requisition'. Two doctors testified that Errey was suffering from 'acute general mania' and he was duly committed. Although Mrs. Errey was present when her husband came before the Bench, her evidence was considered unnecessary.

The role of families was always contentious. They were accused of 'neglect' if they did not keep their insane relative under 'proper care and control'. They were encouraged to seek early asylum committal for affected members who could be cured and to maintain contact with them once they became inmates. Alternatively, families were blamed for 'unsuitable committals' and often simultaneously held to blame for the patient's condition. As the *Australasian Medical Gazette* in 1886 commented:

> many of the cases ... show as one of their symptoms a marked antipathy to particular persons, the odium existing between those standing to one another in the closest degree of intimacy, as husband and wife. ... removal from home is so essential in many cases.\(^{33}\)

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\(^{31}\) *Camperdown Chronicle*, 29 April 1879.  
\(^{32}\) ibid.  
\(^{33}\) Editorial, 'Care and Treatment,' p.74.
In any case, even if the family were blameless as to the condition of the patient if they were to ‘undertake his [sic] removal [to the asylum] their attentions are quite as likely to aggravate his condition’.  

The complexity of relationships between the asylum and the families of inmates was exacerbated by the notion of the Family as the bearer of an ideology which represented it as the basic unit of cohesion and social order. Doctors tended to make decisions based on assumptions coloured by their own perceptions of what families should be like, rather than how they often were. The ‘norm’ that they measured against was the ideal, stable, middle class family. The disadvantage of a dubious family history is illustrated by the example of William O’Farrell. O’Farrell was arrested in Sale as a lunatic on 14 October 1882. His case appeared in the local paper. Although the specific action which prompted his arrest is not recorded, the article noted that William was the son of P.A.C. O’Farrell ‘who shot at Archbishop Gould’, and concluded that ‘insanity, it would appear is hereditary in the O’Farrell family’.  

It is quite possible that O’Farrell had underlying psychiatric problems that are not made apparent in his case history. There is no doubt, however, that O’Farrell was committed because his ‘eccentric habits’ coupled with perceptions of the state of mind of his father had convinced doctors of his incipient insanity.

On the other hand, the respectability of a family could effectively delay, or even halt committal. Such was the case of Annie Rastrick. Annie, a resident of Mortlake, had recently been admitted to the local hospital. After ‘evincing symptoms of insanity with delusions’ she was brought before the magistrates of the Geelong Police Court on 23 October 1888 on a

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34 ibid., p.76.
35 Camperdown Chronicle, 14 October 1882.
36 PROV, VPRS 7398/P1 Unit 8, p.84.
charge of lunacy. The doctor acting on her behalf, Dr. Smith, 'addressing himself to the Bench said he thought that some enquiry should be made respecting the circumstances of the woman’s [Annie’s] relatives [as] he had been informed that she was the wife of a chemist.

The magistrates decided to remand the case for a week, pending inquiries and Annie was returned to the local hospital. While it is not clear whether Annie was ever admitted to an asylum, there is no doubt that the perceived ‘respectability’ of her husband’s profession was regarded as a mitigating circumstance in any definition of insanity being accorded her.

The increasing medicalisation of insanity drew the doctors and families into even closer contact, as fewer cases came to them ‘filtered’ through the processes of the law. The rhetoric surrounding the asylum and articulated by the doctors reflected this changing position. The complexity and confusion of the relationship between doctors and families is partly encapsulated in an article in 1897 by the well known alienist, Dr. William Beattie-Smith. The article purported to explain the certification process, but ultimately became simply an appeal to doctors to avoid omissions and spelling mistakes when filling out admission forms. Beattie-Smith began by acknowledging that ‘insanity is a vague term’. Nevertheless, he believed that a comprehensive and meticulous collection of all the ‘facts’ that could be assembled about patients was one way of ascertaining the truth about their state of mind.

The ‘only way of certifying in private cases [medical committal] is to make oneself possessed of all the facts from various outside sources’, he advised. The asylum physician should, he suggested, obtain a ‘resume of the case, and as far as permissible, the family history’. He also made it clear that it was ‘a duty incumbent upon relatives to personally visit,
explain to, and be questioned by the asylum physician’.\(^{39}\) In instances of police arrest, he insisted that ‘every attention should be paid to full enquiry concerning the patient’s antecedents’.\(^{40}\) He also however, cautioned against simply accepting the word of a family member, urging ‘the necessity of having facts observed by yourself’. Further to this, he suggested that if this was not possible then the doctor could ‘bring them in as “facts indicating insanity communicated to you” and thus make use of them to support you’, being careful that it was ‘definitely stated by whom communicated’.\(^{41}\) Regardless of these qualifications, an exhortation to amass all ‘family history’ seemed to suggest a change in perception from the consideration that the evidence of Benjamin Errey’s wife was ‘unnecessary’.

With the guarded acceptance of Hospitals for the Insane as places where their relatives might be successfully treated, families became less reticent about divulging personal details to doctors. When Lucy Wilson was admitted to Kew in 1906, one of the medical staff wrote to her brother asking for details about her life. Chas. Wilson answered with a jumbled account of childhood incidents and his own observations on the possible reasons for Lucy’s illness. She had been, he informed the doctor:

always very backward and simple could never be taught anything when about ten years of age she fell from a table onto a mangle and cut her head she always complained of pains in the head she never appeared nervous at any time at the age of fourteen she worked in a boot factory and often got wet going to and from business after a while we noticed her getting drawn on one side and she could never straighten herself. ... twelve months ago she was treated for Rheumaticsnever lost her voice at any time no


\(^{40}\) ibid.

\(^{41}\) ibid.
difficulty in swallowing ... during the last six months she has not complained of any pain but got very shaky in the legs and body and very strange in her manner (sic). 42

Wilson’s letter painfully evokes a life of hardship and deprivation on behalf of his sister. Despite its lack of punctuation, this response was clearly informed by Wilson’s understanding that there was probably an organic or environmental reason for Lucy’s diagnosed madness. He was also mindful of the possibility of inherited disability and stressed the general health of the rest of the family. He did however, guardedly admit that their mother had a ‘weak and nervous disposition’.43 Lucy was 27 at the time of her admission, but was listed as having ‘organic dementia’, a diagnosis usually applied to much older patients.

In the same year that Lucy Wilson was admitted, Julia Clancy came to Kew. A request from the medical staff for details of her pre-institutional life elicited a quite different response. ‘Re account of my daughter for the last twelve months’ her mother headed a letter that was primarily concerned with her daughter’s emotional state. Julia had been, according to Mrs. Clancy:

keeping company with a young man and some time ago he contracted a disease which may last all his life, when she first heard of this illness she became greatly distressed and since then did not care for company ... In the last letter she had from him she told me that he told her not to waste time over him.44

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42 PROV, VPRS 7397/P1 Unit 15, pp.337-38, Letter addressed only 'Dear Sir, In answer to your letter'. from C. Wilson re L.Wilson (undated).
43 ibid.
44 PROV, VPRS 7397/P1, Unit 15, p.350, Letter from Mrs. W. Clancy re J. Clancy, 13 April1906.
Julia and her family lived in a remote part of the state, and her mother also surmised that this was a factor in her daughter’s illness. ‘It is a very quiet place where she lives’, she continued, ‘and a long way from any town. She often said she would like to live in a more livelier [sic] place, and often complained about the quietness.’ She mentioned, almost as an afterthought, that ‘her aunt has been in the Sydney asylum for some time through trouble’, but hastened to add that she was ‘the only insane relative’. The 30 old Julia was brought to the asylum by her brothers. She was admitted and diagnosed with ‘acute melancholia’. What these letters reveal is not only the reliance doctors placed on the testimony of families, but also the sophisticated understanding the family members seemed to have of what was required of them by way of reply. They did not appear reluctant to answer any requests for information, and also seemed assured that any information they volunteered would be valuable. ‘Let me know’, Julia’s mother suggested at the close of her letter, ‘if you want any further explanations’.

Aside from those patients brought by the police, or the growing number brought directly by families, there was another group of patients who came to Kew. They were transferred from other organisations which could also be defined as ‘total institutions’.

**Alternative Means of Committal**

Although Erving Goffman’s work on ‘total institutions’ originally included a number of diverse organisations such as monasteries, schools and concentration camps, reviewers of his theory have tended to restrict the term to the state institutions like asylums, prisons, and work houses. It is this interpretation that I have adopted. Although Australia did not have any work houses as such, for my purposes benevolent homes served a comparable function.

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45 ibid.
46 ibid.
There were also homes for women felt to be in ‘need of protection’ which could be understood in the same terms. All of these institutions had what Michael Ignatieff has labelled ‘analogous functions — incarceration, deterrence and rehabilitation’. This was the result of an ideological construction that was driven by an imperative that equated both insanity and welfare dependency generally with lack of respectability. In other words, these institutions were built on an assumption that their inmates were drawn from the same source— that is the ‘unrespectable poor’— a facet of institutional life underlined by Ephraim Zox’s appointment as both the honourable member for Organised Charity and the chairman of the Royal Commission into asylums. Whatever the other implications of such an assumption, there undoubtedly were a number of individuals who became caught in a spiral of welfare and dependency, and spent years of their lives alternating between these institutions. Nowhere is this more clearly illustrated than in the small but significant number of inmates, who, it is recorded as a matter of no surprise, came from the prisons, benevolent homes and other similar institutions, to Kew each year.

Alice Hoare was one of the women defined as being in ‘need of protection’. Alice had been apprehended ‘in the street one eve singing, and surrounded by a lot of larrikins.’ She was taken to the Armadale Rescue Home where she was kept for six months. After this time, Mrs. Pittman the superintendent of the home wrote to the asylum requesting that they admit her. She argued that although Alice ‘seemed to be quite harmless till [sic] the last three weeks we cannot keep her here any longer. She destroys her clothes and does most unnatural things.’ Alice was a domestic servant and appeared to have lost contact with her family. An attempt by the staff of the rescue home to contact a sister in Auburn had been to no avail.

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48 Kennedy, Charity Warfare, p.125.
49 PROV, VPRS 7397/P1, Unit 11, p.422.
Although only 30 at the time of her admission in July 1895, Alice was not to survive another year. She died the following April, after suffering a ‘severe succession of epileptic fits’.\(^{51}\)

With the exception of women like Alice, whose physical deterioration was as rapid as her descent from respectability, many of the mostly female patients who came from institutions other than gaols, were elderly. As a consequence, they had a high mortality rate. This appeared to be because after a lifetime of welfare dependency the asylum was the last institution where they would be accepted, albeit often grudgingly. Beattie-Smith expressed his concern that these people came to the asylum at all as they were often frail and not well disposed to travel. ‘I am distinctly of the opinion’ he wrote, ‘that sufficient time is not spent over these cases, and in many instances the very infirm from Benevolent Asylums are cruelly treated in having to travel at all’.\(^{52}\)

Although he couched his objection in terms that implied his concern for their well-being, it is likely that Beattie-Smith shared the general reluctance of his profession to admit those patients who were ‘beyond cure’ to asylums. Perversely, it seemed to the doctors, other institutions were anxious to transfer their most troublesome patients to asylums. When 50 year old Ann Eliza Kynne came to Kew from the Freemason’s Charitable Institution in May 1908 she was diagnosed as having mania, supposedly caused by the ‘hot weather’. Although her mania was said to have been ‘recent’, the staff at the charitable institution were not keen to have her return later in the year. The secretary wrote to the superintendent at the asylum asking him to keep her there until they were sure ‘all danger is past’, in deference to their other patients. The ‘other inmates, (being of a good old age) were worried with the thought of her coming back’, he wrote, ‘and respectfully request you to keep her in your charge until

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\(^{51}\) ibid.

you consider that all danger is past'.\textsuperscript{53} Like the families of patients the staff of other institutions wanted to use the asylum as a place of last resort, a role in which the asylum doctors were most anxious it not be cast.

\textbf{Receiving Houses}

The details surrounding committal procedures seem to have been designed to be almost impenetrable. Perhaps doctors felt that this would lessen the possibility of people being wrongly incarcerated. There still existed however, the opposing notion that ‘mischief’ would surely ensue if lunatics who ought to have been under control were not apprehended. The relationship between the asylum and the inmates’ families was always fraught with the tension created by this situation. Dr. Robertson opined in 1876, it ‘is not infrequently found that unsuitable cases are sent to asylums ... under orders from friends or relatives’.\textsuperscript{54} The solution suggested at the time was that instead of patients going directly to the asylum there should be a ‘place of primary reception.’ \textsuperscript{55}

The notion of providing places of ‘primary reception’ (or ‘Receiving Houses’ as they came to be known) gained currency gradually after the Kew Inquiry. It was not until the Zox Commission, however, that specific provisions were suggested with regard to them. At this time, the Commission recommended the establishment of Receiving Houses and that ‘certificates signed by medical men shall only assert that the subject should be placed under observation in a Receiving House for one week [and] if necessary the case be reviewed on a

\textsuperscript{53} PROV, VPRS 7397/P1, Unit 17, p.245, Letter to Superintendent, Kew Asylum from G.W. Mitchell, Secretary to the Freemason’s Charitable Institution of Victoria, 28 September 1908.

\textsuperscript{54} Kew Inquiry, p.61.

\textsuperscript{55} ibid.
weekly basis’. 56 The actual process then of sending ‘a man or woman as a lunatic to an asylum should rest with medical authorities at the Receiving House’. 57

In 1888, an amendment to the Lunacy Statute allowed for the creation of ‘receiving houses which could be erected at any asylum’. 58 Alternatively, ‘any portion of an asylum could become a receiving house.’ The Statute then provided that most patients except the criminally insane should go into ‘a receiving house instead of the asylum ... for a period not exceeding 28 days subject to earlier discharge or transfer to an asylum’. 59 The perceived benefits to the patients of being sent to a receiving house before transfer to the asylum are difficult to fathom: patients had, after all, always gone into a type of receiving ward while they were being assessed. The legislation was important however, because it marked the beginning of the ‘specialisation’ of ‘asylum doctors’. It also relieved general practitioners from some of the responsibility of committal. To send a person to a ‘receiving house’ did not carry the same burden of responsibility as signing a certificate to send them directly to an asylum. According to the Zox Commission:

> in all cases of uncertainty the medical man is bound, from prudential motives, to refrain from signing a certificate that may commit a man to an asylum whom the courts regard as sane, and who will seek to recover damages for false imprisonment ... medical men should give their opinion only as experts. 60.

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57 ibid., p.284.
58 Lunacy Amendment Act 1888, Victorian Statutes no.986.
59 ibid.
The receiving house from which Kew acquired most of its patients was the one built at Royal Park, which opened on 26 September 1907. The figures on how people came to the asylum become blurred at this point. Patients were listed as coming from the receiving house, without an explanation as to who initiated the procedure. Another effect of implementing a system of receiving houses may have been an increase in patients. Local doctors could ‘recommend’ that a patient spend time at a receiving house, without having to carry the legal burden of actual committal to the asylum.

The ‘Reforms’ of 1903 and Committal Procedures

The so-called ‘reform’ in the asylum system began officially with the Statute of 1903. The re-naming of asylums as Hospitals for the Insane was the major change. This seemed to consolidate earlier initiatives like the introduction of systematic training for attendants and the creation of receiving houses. Asylums had also gained more credence with society as places of cure rather than detention. In 1913, there were 858 admissions to all Victorian asylums. This was the highest admission rate ever.

The growing confidence of society in general that doctors could offer cures for insanity is suggested by the pragmatism of a letter from the husband of a patient admitted in 1898. The patient, Sarah Sutherland, was diagnosed as having acute mania as a result of an attack of measles. Her husband wrote that he would be on a Snagging Boat on the Tambo River for some time. In the meantime, he requested that the asylum doctor provide a cousin with any information about his wife. Although Sarah had been so disturbed that she had been tied to her bed for three weeks, he suggested the doctors ‘would greatly oblige me if you would allow him (Mr. Pugh) [cousin] to see her when you think fit,’ confidently adding, ‘when she

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is right they will take her to their place." In other instances, families simply sought to obtain some relief from the physical and emotional burden of caring for a family member who appeared mentally unstable. To do this they were more inclined to seek the assistance of the local doctor than the police.

By the early twentieth century, it appeared that within the medical profession itself asylum doctors were becoming more 'respectable' and more acceptable to their peers. William Beattie-Smith even served as President of the Ballarat Branch of the British Medical Association (BMA) while he was superintendent of the Kew Asylum. Increasingly, a family doctor and an asylum doctor were more likely to consult about the condition of their mutual patient. At the same time, these local doctors were being urged to furnish details about the patient's family background in the interests of establishing a case history. They were presumed more familiar with any potential hereditary conditions or any possible environmental 'causes' of their patient's condition. As Beattie-Smith observed in 1903:

> The knowledge of hereditary which the family doctor becomes possessed of is highly important in this connection, for the practitioner must surely in his own interest, recognise this duty to those consulting him, and so study histories past and present. 63

Although there was much discussion about possible hereditary problems, in practice the asylum doctors' actions were largely dictated by the current familial situation of patients. Mary Watson's situation is a clear example of this. When Mary came to Kew in 1904, her local doctor wrote to the asylum superintendent with details about her case. She had been, he noted, 'suffering from acute cystitis' when he first saw her in July of that year. She appeared to be greatly improved the second time he saw her. With hindsight, however, he recalled:

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62 PROV, VPRS 7397/P1, Unit 12, p.275, Letter to Dr. Steele, 10 September 1898.
I noticed her shivering at the time but it was not a rigor (sic) and as she had driven to see me I naturally put it down to the cold weather. I saw her again on July 14th when I found her suffering from pneumonia ... She was at times delirious but apparently was doing very nicely when she passed some very foetid urine with some tenderness over the right kidney region. ... Soon after that she went into the maniacal condition which you found. 64

Although Mary’s doctor appeared to be implying that her mental condition derived from an organic cause, the reason he suggested she be admitted to the asylum was because of her family’s inability to care for her. He admitted that she was ‘to my mind somewhat improved of late’ but insisted that it was ‘impossible for the people[her family] to look after her any longer. They are struggling dairy people and by no means in a good position financially.’ 65

Clearly, Dr. McLean took account of Beattie-Smith’s exhortation to observe the ‘present history’ or situation of the family even if the family members themselves did not supply him with any specific details.

The notion that once a family member had been designated as ‘deviant’ in some way then the family itself was to be subject to scrutiny was one that had been gradually gaining acceptance in colonial Victoria. As an ideological site, the Family was the bearer of notions about the ‘perfectibility’ of society. The family unit was perceived as the cornerstone of social stability and the basic unit of order. If the family could be rendered perfect then society could be also. If however, the family unit contained members that deviated from the ‘norm’ – and clearly those who were designated as insane did – then the entire family became seen as ‘dysfunctional’. Furthermore, once a family had a dysfunctional member they were obliged

64 PROV, VPRS 7397/P1, Unit 14, p.650, Letter from J.McLean to The Medical Superintendent Kew Asylum, 10 August, 1904.
65 ibid.
to offer up any details about their collective lives. The object then of the newly emerging ‘professionals’ was to intervene in these ‘deviant’ families in order to assist in their ‘normalisation’. That the medical profession saw themselves as leaders in this practice was clearly outlined by Beattie-Smith in 1897. He remarked that it was a ‘duty incumbent upon relatives to visit, explain to, and be questioned by the asylum physician’. He even referred to the process as a ‘plan of interrogation’.\footnote{Beattie Smith, ‘Certifying', p.578.}

Jacques Donzelot refers to this intervention in family life, describing it as the ‘psy’ or ‘tutelary complex’ in his work on French families. In The Policing of Families,\footnote{J. Donzelot, The Policing of Families, Pantheon Books, New York, 1979.} Donzelot outlines how the construction of ‘the social’ or what we might call ‘modern society’ brought into being new constructions of the family. One manifestation of this new structure was an altered medical-political relationship between families and the state. According to Donzelot:

\begin{quote}
The transformation of the psychiatrist’s position, the broadening of his social vocation, resulted first from an internal critique of psychiatry ... The theories of the first alienists operated on a basis of a symptomology. The diagnosis of madness was determined by the description of its manifestations ... Intelligibility resided, therefore in exterior signs.\footnote{ibid., pp.127-28.}
\end{quote}

In other words, the manner in which diagnosis was arrived at was by an attempt at understanding how the patient interacted with his or her environment. Around the end of the nineteenth century however, a diagnosis of madness was decided by a method that involved a psychological style of reasoning, in which individuals were determined as being a particular
type. This was based upon certain psychic traits they were assumed to possess. As Donzelot continues:

\[\text{the intelligibility was no longer to be found in the explicit sign, but had to be perceived in what lay underneath this sign, the latter being nothing more than an apparent stage in an ongoing process of development which was predictable by anyone capable of interpreting it.}^{69}\]

This shift from an ‘observation’ to an ‘interpretation’ signified a further move in the definition of insanity that removed it from the responsibility of upholders of the law into the realms of medical science. Those ‘capable of interpreting it’ were by definition the doctors. This is reflected in the change in questions on admission papers and the advent of an accompanying photograph, which occurred at the time. The notion that it was possible to observe degeneracy in a person’s face was consistent with this style of psychological reasoning, whether through a photograph or by direct observation. Thus doctors found during their annual assessment in 1906 of long-term resident of Kew, John Eyre, that he was not only delusional but had ‘the appearance of a masturbator [and] has a flabby handshake’.\(^70\) Again according to Donzelot:

\[\text{mental illness was no longer a spectacular exception ... but a phenomena that was always latent, necessitating early detection and a prophylactic intervention embracing all the causes in the social body which favoured the mechanisms of degenerescence; to wit, miserable living conditions and the intoxications, such as alcohol, to which the poor population were exposed.}^{71}\]

\(^{69}\) ibid.

\(^{70}\) PROV, VPRS 7398/P1, Unit 1, p.47.

\(^{71}\) Donzelot, Policing, p.128.
The debate around insanity then became one of the recognition and management of potentially ‘problem individuals’. These individuals or ‘types’ were, according to contemporary common sense notions, to be found among the poor of society. They were, however not merely ‘the poor’ but a particular section of the poor, that section who had succumbed to the ‘intoxications of their miserable living conditions’.

These were those who could be described in the manner used by her doctor to describe Kate Black, who came to Kew in May 1912. He reported that her ‘general aspect and demeanour always gave one the impression of an alcoholic or drug taker’. 72 These were the unrespectable poor, who could be identified through and by their family history and whose position as deviant was confirmed by an interpretation of their appearance and demeanour. Ironically, it would seem, it was to their families that the asylum doctors looked for assistance in identifying and bringing to their notice their problem members. That they often did so suggests not only the desperation of some families to obtain a measure of relief from having to care continuously for difficult and/or unproductive relatives, but also their determination to assist in finding a cure for their often very real problems. It does not appear to have been the case, however, as Dr. Robertson complained at the 1876 Inquiry, that there had been ‘too ready a disposition on the part of relatives’ to saddle the State with the care and the maintenance of the harmless insane’. 73 Rather, it would appear that families used the asylum discriminately, usually at a point when the behaviour of their relatives became such that they were desperate for some respite. This division of responsibility between the families and the asylum had profound effects however. The manner in which insanity was understood within the medical framework automatically assigned power to the doctors, as only they were the experts who knew how to handle patients.

72 PROV, VPRS 7397/P1, Unit 20, p.189, Letter to Superintendent, Kew, re K. Black (undated).
73 Kew Inquiry, VPP 1876, vol.3, p.60.
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