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Insanity and Immigration Control in New Zealand and Australia, 1860–1930

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People down on their luck fleeing to the colonies on the first available ship is a mainstay of 19th century fiction. It was a convenient way for an author to either get rid of an unnecessary character, or to bring a surprise new person into the narrative mix with dramatic effect. The reality of migration to the colonies was not that dissimilar, although the return of unwanted migrants to their country of origin might have been rather more unexpected and unwelcome.

So what of those who didn't make it as successful immigrants—and why didn't they make it? Both the Australian colonies and New Zealand were desperate for immigrants, but at the same time had learned from experience that the people they really wanted—diligent, self-supporting, healthy, white, Christian—were not always the first to choose to migrate from what were often perfectly comfortable conditions at home in Britain. In fact, it seemed at times as if the Australian colonies' prison origins had made it possible to send pretty much anyone there who you never wanted to see again.

In response to this, both colonial Australia and New Zealand evolved messy, porous, *ad hoc* border control systems that tried to filter out people who were likely to become a public nuisance or a burden on public funds. This included those who were deemed to be mentally unstable or downright mad. But in an era when psychiatry didn't exist, and ideas of madness had barely evolved beyond Pinel's reforms of the eighteenth century, the perpetual question remained: how can you tell, just by looking, if a person is going to go mad or not?

Jennifer Kain has taken on the task of untangling the maze of contradictory regulations, by-laws, border control policies, and case histories of lost souls who tried and failed to migrate to Australia and New Zealand in the colonial period. She identifies the paradox at the heart of Antipodean immigration in this period: the idea of Australia and New Zealand as better Britains with healthier climates, juxtaposed against the reality of an often unforgiving climate, very limited public funds, and very few of the comforts of British civilisation outside the tiny cities.

What is a lunatic migrant? Is it a person who was insane before they migrated? Or is it someone who went to pieces on board ship, or two years after their migration while struggling on a tiny farm in an unrelenting

climate? Today we can admit we know little about the etiology of mental disorders and their prognoses, and we can demonstrate with evidence that migration is a risk factor for developing disabling mental disorders like schizophrenia. In the 19th century, the same ignorance existed, but was augmented and rationalised with crude evolutionary theories of heredity, bad blood, and evil habits.

Kain's study consists of two parts, one on New Zealand and the other on Australia, each with three chapters. The New Zealand content begins with the Imbecile Passengers Act of 1873 and works through to the 1899 Immigration Restriction Act and beyond. The Australian chapters are no less comprehensive, especially Kain's highlighting of the role of Dr William Penn Norris in trying to match diagnosis with bureaucratic policy in his 'Notes and Instructions for the Guidance of Medical Referees', an attempt to help solve the inevitable subjective decision-making about prospective migrants' health and wellbeing. Norris at least, ahead of his time, recognised that travel and migration itself was stressful enough to cause strange behaviour in otherwise apparently mentally healthy people.

And here is the rub: 19th century doctors diagnosed insanity by examining the person and then asking those around the person in question what their opinion was. A doctor who had experience in a lunatic asylum might learn on the job about the finer points of different behaviours in the asylum setting, but this was as far as it went. There were no international or even national standard guidelines or diagnostic criteria for mental disorders until 1952. There was no formal training in psychiatry for medical practitioners until the development of the Diploma in Psychological Medicine by the Royal College of Physicians in 1911.(1) Until some standards were in place, the diagnosis of mental disorders consisted of subjective evaluation and emotive conjugation—or, as *Yes Minister* puts it, "I am an individual thinker, you are an eccentric, he is round the twist."

Kain points out several times that health officials and customs officers were not trained as psychiatric gatekeepers, but in that era, they were no more untrained than practically anyone else. Once a person was diagnosed as insane by a doctor and admitted to a local asylum, it became far easier to repatriate or deport them. However, Kain has moved away from the institutional asylum records—even though these are now becoming more available as they move out of 100-year restriction in some jurisdictions—and has struck out bravely instead into the tangled mess of border control legislation and documentation in colonial Australia and New Zealand. She has a rich mine of records to work with, even though those that survive can be inconsistent and sometimes fragmentary. What they do show, however, is the ever-shifting interface between the lay observer and the potentially insane immigrant.

The problem was that it was in almost everyone's interest not to detect lunacy in a prospective immigrant—including ship's captains, immigration officials in Britain, friends and relatives seeking family reunion via government-sponsored migration. The only people in whose interest it was to detect madness were the border control staff, but it was just as unfair to thrust the burden of responsibility for diagnosis back on to the equally untrained ship's captains and those running ship's companies. Just as easily, doctors with something to hide, or spiteful relatives, could embellish reports of a prospective patient's insanity or otherwise.

A real strength of the study are the vignettes of those who were on the receiving end of experimental legislation and test cases—Elizabeth Wilson, sent home to Scotland for her filthy habits; Miss Chapman, the depressed woman trapped aboard the *Wave Queen* in Auckland harbour in 1874 while attempts were made to use the Imbecile Passengers Act to prevent her disembarking; and the group of intrepid Frenchmen ballet dancers who passed themselves off as skilled artisans in order to get a sponsored passage to New Zealand. 'Harry' was subject to fits but managed an impressive amount of criss-crossing the globe as he was shipped from place to place, while a nameless male immigrant headed for Melbourne was found wandering on the ship's deck in his pyjamas, quoting apocalyptic biblical texts. Miss E.W. was deemed a lunatic and denied entry to Australia because she argued with the ship's doctor about her Christian Science beliefs—only to be examined again on arrival and given leave to disembark (but apparently no apology).

Kain opens Chapter 2 with the case history of Charles Flinders Hursthouse—born in 1817 in England and a migrant to New Zealand, whose love of the colony led him to expound in print at length on its virtues. Hursthouse was still lucid in 1857 at the age of 40, but insane by 1875 and dead by 1876 at the age of 59. Kain uses him as an example of how some migrants were not earmarked for deportation in the mid-19th century, but there may be an alternative explanation. I like to avoid retrospective diagnosis, but the simple fact of old age is easily determined: Hursthouse was, comparatively speaking, an old man when he developed his mental disorder, and 'senile dementia' was recognised as a relatively normal consequence of old age. Old age in the 1870s began at the age of around 40, as life expectancy for a British-born male in 1817 was not much over that. Hursthouse's short time in institutional care would also seem to support this theory, so it was unlikely that he would have been deported even under much later and more punitive migrant legislation. The whole conversation about the care of the migrant with dementias of old age in the colonies is a different one: one in which those who have worked long and hard in the colony, even though not native-born, were generally seen as entitled to care.

Another strength of Kain's book is its ability to bring out paradoxes and contradictions in colonial immigration policy and practice. Kain refers frequently to the concept of a 'world without welfare', but shows at the same time that the colonies actually had quite extensive welfare provisions from their foundation. These were ways of providing welfare that partly originated in the private and philanthropic voluntary sector. Kain acknowledges the protective aspects of Britain's Poor Act by default, as the colonies did not share this legislation and so had to evolve their own mixed approach of charities, churches, and philanthropists.

Providing welfare was costly and still is: Australia's social security and welfare bill currently takes up around 35% of its total budget, and the public health system adds around 10% more. This is the fundamental tension in most modern Western liberal societies—how do you balance welfare against aspiration and sustainability? How do you provide a safety net while not disincentivising the taxpaying population? These are overwhelmingly modern concerns in Australasia and elsewhere, which makes Kain's book a highly relevant study. Another element which makes it tragically relevant is the current high rate of mental disorders in asylum seeker and refugee populations in Australasia. Kain is also able to bring to light the paradox of compassionate repatriation: that not all deportation is necessarily punitive, or not desired by the migrant whose health is failing.

Kain reminds readers of the porous nature of the borders of Australia and New Zealand, then and now: enormous stretches of coastline, limited populations, and for most of the 19th century out of sight of Britain, and therefore out of mind. The shadowy ground between merely 'eccentric' and 'mad enough to be deported' was thickly lined with ideas about what made a desirable immigrant, and the perennial problem of sifting out desirable British migrants from non-British undesirables. Life was poor, nasty, brutish, and short; the briefness of life and the reality of colonial financial impoverishment drove much of the apparent harshness of 19th century border control. The detection of fatal infectious diseases in migrant passengers was prioritised far above the detection of the occasional case of lunacy. The poverty of the colonies in question was also very real: most Antipodean colonies struggled until gold was discovered in 1851 in the eastern colonies of Australia.

My criticisms are very few. The chief criticism is that, while eugenic ideas are mentioned frequently, it is one of the hardest things to prove explicitly in policy formation and then in actual case studies. This was the best piece of advice I was given by Professor Paul Turnbull (now at the University of Tasmania) when he critiqued my 2011 work in the same area as Kain: I had assumed that deportation of lunatic migrants was for eugenic purposes, but Paul challenged me to prove it with the documents, and I couldn't. Similarly, I am not sure that the eugenic aspect is clearly proven in practice in this study.

Race-based thinking is evident in the White Australia policy and the idea that the country should attract 'good' immigrants—this is eugenics in its broadest sense—but that lunatics were screened out specifically to

stop them breeding is almost impossible to prove. Kain can point out one doctor, Dr A. Wallace Weihen, making anti-breeding statements about lunatic migrants at the 1911 Australasian Medical Congress, but this is a long way from these ideas becoming integrated into mainstream policy and driving decision-making. Kain herself notes the limited effect of eugenic thinking, and usually adds a question mark to headings on eugenic issues, which I think is wise.

I think also Kain's argument might have been strengthened with some figures about the actual poverty of the colonies in question. Showing some total colonial revenues, and the costs of keeping a person in a lunatic asylum, can bring home the basic financial facts of life very clearly to a reader. While Kain pays some attention to intercolonial migration between Australia and New Zealand, the growth of railway travel across the Australian continent opened another avenue for internal migration between colonies, and later states, which is not explored here. Finally, the impact of these policies on migrant help-seeking could perhaps have been given some consideration: anecdotally, with the lifting of deportation bans after the Second World War, the number of Australian migrants seeking psychiatric help soared, so it is possible that the policies themselves created a climate of fear and failure to seek professional help when it was most needed.

Very minor points: 'fit the stereotype' should be 'fitted the stereotype' (p.26), 'Stephens account' should read 'Stephens' account' (p 46) and 'messy system or border control' should probably read 'messy system of border control (p 196). And it was not I who came up with the expression 'a clean up' with reference to deporting insane migrants—I am quoting a 1933 Commonwealth Home Affairs officer (p 177). These minor points aside, this is a good and accessible history of Australasian colonial border control generally, as well as a major contribution to our understanding of the history of psychiatry and mental health in the Anglosphere.

Notes

1. 'Diploma in Psychological Medicine', *Journal of Mental Science*, 57: 239 (1911), 756. DOI: https://doi.org/10.1192/bjp.57.239.756 [2] Back to (1)

Links
[1] https://reviews.history.ac.uk/item/314258 [2] https://doi.org/10.1192/bjp.57.239.756