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Visibly Hidden in Suva: St Giles

Jacqueline Leckie

Since 1884 Suva has had a mental asylum, first known as the Public Lunatic Asylum or the Suva Asylum: a physical site that has conjured fear and mystery, and been pivotal to the stigma associated with mental illness in Fiji. In 1936 the asylum was renamed the Suva Mental Hospital, because the old name was 'too redolent of Bedlam'.[1] During the early 1960s the name St Giles Psychiatric Hospital came into use, but the term 'asylum' has persisted.[2]

One reason mental asylums were so foreboding is because they were physically separated from the rest of the community. St Giles is located on a steep ridge some distance from the main town in Suva. It was surrounded by high concrete walls – impenetrable barriers that screamed incarceration and separation, like the piercing screams and wailing from inside that people could hear from outside the walls. Similar to many asylums, St Giles has vast grounds to accommodate patients and staff, and to supply food for the asylum. By the time St Giles was established,

1 Margaret Guthrie, *Misi Utu: Dr D. W. Hoodless and the development of medical education in the South Pacific* (Suva: Institute of Pacific Studies, University of the South Pacific with the South Pacific Social Sciences Association, 1979), 34. Guthrie was the daughter of Medical Superintendent David Hoodless. Much of this chapter is based on Jacqueline Leckie, *Colonizing madness: Asylum and community in Fiji* (Honolulu: University of Hawai'i Press, 2020), doi.org/10.1515/9780824881900, where extensive documentation can be found.

2 For example, Sainimili Lewa, 'Madman attacks asylum staff', *Fiji Times,* 18 January 2002, 12; Irene Manueli, 'Asylum can't cure morphine addict', *Fiji Times,* 5 January 2002.

many European asylums had gardens because these were considered therapeutic for mental patients; but in Fiji, digging and planting cassava and *dalo* was often more exhausting than the genteel tending of flower gardens in more temperate climes. St Giles in Suva occupies a site of physical beauty, amid lush tropical vegetation and breath-taking views of Suva Harbour. The vista also takes in Suva Prison – a reminder that the asylum is located above another institution of incarceration. St Giles is also adjacent to Suva's military and Chinese cemeteries and so the locale embraces key sites of separation, fear and danger, as well as between 1945 to around 2004 being near Suva's rubbish dump: 'The dump, the dead, the mad and the bad.'[3] Asylums throughout the world were associated with prisons, metaphorically as well as by proximity. Before the asylum was built, lunatics in Suva were confined in jail. The links between the jail and the asylum continued – eventually connected by a road – and with many patients sentenced to the prison before certification and transfer to the asylum. Suva's public have tended to regard St Giles as a prison rather than as a hospital. In 1992 Alison Cupit, chair of St Giles's Board of Visitors, condemned St Giles's buildings 'as prison camps without the elaborate fencing'.[4] But the asylum has always occupied an ambiguous space between prison and hospital: a place of incarceration, but equally of treatment, care and possible cure. St Giles is also known in Suva as a *vale ni mate* (place of death) or *bakava* (tin shack) – a reference to the fences that replaced the hospital's foreboding concrete walls during the 1960s. *Bakava* also became an adjective meaning a crazy, silly person.[5]

As the chapter's title reflects, St Giles and its inhabitants are 'visibly hidden'. In one sense, the place is easily recognisable, but in another sense, it is well hidden within Suva's history. It would be a huge injustice to portray St Giles's role in Suva as just a place of fear and incarceration. Although this dominant representation threads throughout this chapter, we will explore: firstly how patients at St Giles are a window into the social history of Suva, secondly St Giles as a community in itself, and finally the relationship between St Giles and Suva.

3 Seona Smiles, *Fiji Times,* 2 April 2011.
4 *Friends of St Giles*, newsletter, 1992, St Giles file (STG) 1/3–I. Held at St Giles Hospital.
5 Ronald Gatty, *Fijian–English dictionary: With notes on Fijian culture and natural history* (Suva: Southeast Asia Program, Cornell University, 2010), 11.

Figure 8.1: Walls of St Giles Hospital, 1965.
Source: Courtesy National Archives of Fiji, # G7247.

The Asylum: Suva's Hidden History

The story of Taniela, a villager from Vanua Balavu, encapsulates how the path into the asylum offers insight into a lesser known social history of Suva as well as the asylum and Suva's relationship with other parts of Fiji. In 1895 the *buli* Lomaloma, the iTaukei official in charge of the district, noticed that Taniela 'gave strange wandering answers and looked and wandered about in a dazed fashion'.[6] The *buli* ordered Taniela to Suva for further examination by a European practitioner – not unusual, as Suva was the centre where villagers were sent for specialised medical treatment. On one of the islands where the boat stopped, Taniela killed, boiled and ate a cat, with the skin on it. He briefly moved throughout Suva before incarceration in the prison and the asylum. Things were not quite right with the man and, as planned, Taniela was admitted to the Colonial Hospital. He sneaked away and was reported to the police as 'an insane man' wandering in the bush near Vatuwaqa. After another stint in

6 'Assault committed by Taniela mad Tongan on 7th inst', CSO (Colonial Secretary's Office: Outwards correspondence of Colonial Secretary) 1465/95. All documents, unless stated, are from the National Archives of Fiji.

hospital, Taniela stayed in a Fijian's house near the Government Buildings and said he spent a night 'with a devil in the Indian town'. Taniela then stayed overnight with another Fijian near Cumming Street. The following morning he fatally attacked a Malaitan labourer. Sergeant Ulaiasi pursued Taniela up Waimanu Road, only for the sergeant to be seriously wounded. Police came running from the police station and overpowered Taniela. He was charged with murder and detained for 24 hours in the asylum before spending eight days in jail. He was acquitted of murder on the grounds of insanity and sentenced to confinement in the asylum, where he died on Christmas Day, 1896.

Taniela's narrative shows how Suva was a centre for many sick patients from all over Fiji – indeed, from many parts of the Pacific. Colonial authorities did not want Suva to be a dumping ground for sick, let alone mad, people. The colonial secretary advised Sir John Bates Thurston, the governor, that 'Lunatics should not be indiscriminately shipped to Hospital by Native Officers'.[7] According to Dr Bolton Corney, this irregularity could result in a delay in admission to the asylum, which posed a 'possible public danger as they are kept at large'.[8]

Throughout much of Fiji's colonial history, there were few personnel outside Suva who could legally diagnose mentally ill people. Native medical practitioners were not permitted to certify asylum admissions. Taniela's case evidenced considerable ambiguity: despite his strange behaviour, the *buli* had not suspected 'mental disease'. The medical and legal expertise for determining insanity was in Suva. A key reason for establishing the asylum had been to provide a place of observation to determine if someone was really mad.[9] Possibly because Taniela was relatively docile, he was sent to the main hospital for observation. The Colonial Hospital did not like to hold disruptive patients, and if suspected of being mentally ill, they might be sent on to the asylum.

7 CSO 1465/95.

8 CSO 317/96 on PN 112. Unless stated, personal information is from admission papers, usually cited as a patient's first admission number (PN), at St Giles Hospital.

9 This points to the complex problems of diagnosis and definitions of insanity that varied between cultures. Medical diagnoses changed throughout St Giles's history. See Leckie, *Colonizing madness*, 116–51. It would have been very difficult to have someone committed to the asylum who did not suffer from a serious mental disorder and such people were also cared for or confined within their communities. Leckie, *Colonizing madness*, 77–85, discusses the controversial issue of some iTaukei political and religious leaders who were committed to St Giles.

For example, a 19-year-old from the Armed Native Constabulary in Suva, first treated in the Colonial Hospital, was admitted to the asylum in 1901 after he:

> ran away several times from [the colonial] hospital; fought violently attempts to bring him back; struck some of the students taking care of him; threatens to kill them as soon as he gets well … noisy, threatening, restless and violent delirium at night while in hospital ward, terrorising other patients and nurses; says possessed by demons whose business is to slay people.[10]

The need for a separate space to confine and treat disruptive patients was yet another impetus behind the establishment of the Suva asylum.

Despite evidence of Taniela's disordered mind, it was not until he had committed a murder that he was finally sent to the asylum. Very few St Giles patients were dangerous. A notable exception was Qaqa, among the first intake of asylum patients in 1884. He had been declared a 'victim of homicidal mania'.[11] Since 1882 he had been an inmate at Suva Prison because he had viciously assaulted a European woman on Ovalau. Prison authorities considered him dangerously insane – proven when he killed another prisoner, John Murray. Mr Halkett, Fiji's superintendent of prisons, despaired that he could not manage prisoners like Qaqa, who 'should be sent to an asylum as soon as it was built'.[12]

Over the years, many patients, like Taniela, originated from outside Suva. Several were overseas migrants: indentured labourers, travellers and settlers from all over the Pacific and beyond, who, by the time they disembarked in or near Suva, were suffering from severe mental illness. When Dr William MacGregor, Fiji's chief medical officer and colonial secretary, who was pivotal in the establishment of the asylum, remarked that Fiji was 'a great sufferer from the arrival here of insane persons', he could have just been referring to Suva.[13] Sukudaia, an indentured immigrant from India was among the asylum's 1884 intake. She was highly visible in Suva where she wandered the streets with her child.

10 PN 175.
11 PN 6. Colonial Secretary (CS) to Superintendent of Prisons, CSO 888/84.
12 CSO 1178/84, Outwards Correspondence of CS.
13 CSO MP (Minute Paper) 86/84, 21 April 1886.

Once the asylum had opened, she could be hidden from view.[14] By 1915, Acting Magistrate R Greene described Suva as 'reeking' with vagrants.[15] Among the destitutes admitted to the asylum were some Europeans and indigenous Fijians but the majority were *girmitiyas* who could not endure indenture or lacked support after their bonds ended. Some flowed into Suva and were extremely disorientated, such as an Indian 'found in Suva' in 1902 who would not talk but laughed, shouted, cried and behaved indecently. His condition deteriorated when he was confined to a prison cell, and he was briefly transferred to the asylum.[16]

Below St Giles the Indian Depot at Korovou was also known as the Poor House. It was originally established to accommodate new immigrants and those awaiting repatriation to India. Patients admitted to the mental hospital from the depot tended to be in a very weak physical condition, such as a 60-year-old male in 1934, in a 'religious frenzy … helpless and dirty … [who] could not assist himself in any way'.[17] By the 1930s more elderly Indians were admitted to the asylum than before, reflecting both an aging Indo-Fijian demographic and, for some, no family support. For example, a 75-year-old woman was admitted from the Indian Depot in 1941, where she had been abusing others and wandering at night.[18] A Muslim beggar, aged 70, was admitted in 1948 after attempting to hit a Muslim priest over the head with a stone. While in hospital he 'always appeared depressed' and committed suicide in 1950.[19]

Not all patients were destitute or immigrants. St Giles was a microcosm of Suva's changing population: an intersection of ethnicities, occupations and classes. Initially Europeans accounted for around 18.6 per cent of total admissions but after 1900 the proportion of Europeans fell in the asylum – a larger proportion than the 2.7 per cent in Fiji as a whole, but smaller than Suva's European population of around 27 per cent in

14 See Leckie, *Colonizing madness*, 10, 26, 87–88, 112–114; Sudesh Mishra, '"Bending closer to the ground": Girmit as minor history', *Australian Humanities Review* 52 (2012): n.p., australianhumanities review.org/2012/05/01/bending-closer-to-the-ground-girmit-as-minor-history, doi.org/10.22459/AHR.52.2012.02.

15 'Island news', *Auckland Star,* 7 September 1915, 9.

16 PN 186.

17 PN 1041; Colony of Fiji, *Blue book of Fiji, 1934* (Suva: Government Printer, 1934). British colonies had to submit annual *Blue books* of statistical and other information to the colonial office.

18 PN 1312.

19 PN 1530.

1911.[20] After World War I, admissions of Europeans and those who were not Fijians nor Indians dropped to approximately 5 per cent of total admissions. In 1921 Fijians made up 17 per cent and Indo-Fijians 64 per cent of Suva's population,[21] which is relatively similar to the figures among first admissions between 1919 and 1923 of 21 per cent Fijians and 66 per cent Indo-Fijians. Indo-Fijians represented the largest ethnic grouping of patients admitted to St Giles during the colonial period, although briefly from around 1889 to 1904, Fijians formed a higher percentage of admissions. As indigenous Fijian migration to Suva increased during the late colonial and postcolonial years,[22] so too did the number and proportion of indigenous Fijian patients in St Giles. The late colonial decades brought intense social and economic change and mobility for Fijians of all ethnicities, increasing permanent migration to Suva. Many were attracted to paid employment and educational opportunities. Change impinged upon villages and settlements on Suva's periphery and beyond, increasing economic vulnerability, social problems and mental stress. As social and economic changes for indigenous Fijians and Indo-Fijians intensified during the decades after World War II, the capacity of communities to care for those with mental disorders became stretched.

The St Giles Community

A distinct community emerged over several decades at St Giles, but nevertheless it was still part of Suva. A cursory view might suggest that St Giles was a 'total institution':

> a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.[23]

20 Fiji Bureau of Statistics, 'Key Statistics: June 2012', Table 1.2A Census population of Fiji by ethnicity. catalog.ihsn.org/index.php/catalog/3602/download/50136, accessed 5 December 2019. Suva figures from James Sutherland Whitelaw, 'People, land and government in Suva, Fiji' (PhD thesis, The Australian National University, 1966), 51. For a detailed discussion of race and ethnicity in the asylum, see Leckie, *Colonizing madness*.

21 Whitelaw, 'People, land and government', 55.

22 See for example, Chris Griffin and Michael Monsell-Davis, *Fijians in town* (Suva: Institute of Pacific Studies, University of the South Pacific, 1986).

23 Erving Goffman, *Asylums: Essays on the social situation of mental patients and other inmates* (New York: Doubleday Anchor, 1961), 1.

As discussed below, the walls were more porous and St Giles was hidden but still visible to the rest of Suva. That community was forged by location, infrastructure, history, legislation, rules, diet, dress codes and therapies, but above all by the social relationships within. These could be short encounters, such as between doctors and patients, or, more commonly, between those who resided and worked within the asylum compound and might form a relationship over several decades: that is, the patients and their keepers, known as warders, attendants and orderlies.

Insanity created a unique community by throwing together groups usually segregated spatially and socially. Suva was a colonial city segmented by racial segregation within workplaces, schools, social clubs, recreational areas and residential areas.[24] However, unlike many colonies where separate asylums for Europeans and 'natives' were established – where 'native' meant all non-Europeans – the Suva Asylum catered to all ethnicities. Instead, from the early twentieth century until the 1960s racial and gendered boundaries operated internally, with separate wards for European men, European women, native men and native women. In 1906 a female 'side', enclosed within a fence, was established and by 1910 there were European wards.[25] The European Women's Ward had a separate entrance (possibly for privacy) from the asylum's main entrance and was located away from the men's wards, with the native female ward between. During the early twentieth century, however, insufficient beds for 'natives' meant that some were accommodated within the European wards.[26]

Part-Europeans were usually accommodated with Europeans, although family connections or class could determine to which ward they were allocated. A Part-European admitted in 1948 was assigned to the European women's ward. But the next day she was sent to the main women's ward after threatening to hang herself and being 'uncontrollable'. She was allowed to return to the European ward but after another escape attempt she was sent to the 'native cells'.[27] Disruptive Europeans might also be punished by being consigned to the native wards. On 27 March 1951, a European male, who voluntarily sought admission, damaged his bed and room. He then jumped over the asylum's wall and was later apprehended by police on a launch in nearby Walu Bay. He was sent to the native ward until 6 April when he was 'moved to European quarters as he had settled'.[28]

24 Suva was proclaimed a city in 1953.
25 *Fiji Royal Gazette* 1907; CSO MP 9771/09.
26 CSO 14/8621: CSO 3916/15.
27 Case books (CB) of Suva's asylum, 19 May 1948; PN 1537.
28 CB, 6 April 1951; PN 1673.

Figures 8.2 and 8.3: Moala ward, 2018.
Source: Courtesy Jacqueline Leckie.

During the late colonial period the wards were named after some of Fiji's islands and localities. The wards, with differing protocols and routine, were designated for different patient groups. The European women's ward, which closed in about 1962, was Levuka ward. The main women's ward (rebuilt in 1962 where the receiving ward had been) became Moala ward. Male patients were housed in Kadavu ward, or if at 'low risk' of escaping, in Vuda ward. Bua ward was a locked ward for patients under seclusion. The rooms in here were grim concrete cells with bars on the windows. Padded cells were installed from 1910 until World War II, but humidity and patients destroyed these. In 1977 St Elizabeth's Home, formerly for leprosy patients, was absorbed into St Giles, mainly for the care of those with severe intellectual and mental impairment.

The physical infrastructure also framed the hospital's culture; within a closed institution, poor sanitation and overcrowding heightened tensions between the residents. Sanitation throughout the compound was appalling during the first half of the twentieth century. In 1927, there were only one bath and two bucket-closets in each of the native wards, with 46 patients in the male native ward and 31 in the female native ward.[29] In the same year, approximately 45 native attendants and their families lived in the asylum's compound sharing only one bucket-closet and one bath. Sarjudei's death in 1927 from septicaemia, caused by dysentery, precipitated Dr Philip Harper, the acting chief medical

29 'Head attendant (Anderson) Public Lunatic Asylum to Medical Superintendent: Sanitary arrangements at the asylum', CSO 2216/27.

officer, to highlight the dreadful sanitation for both attendants and patients, 'with a consequent high mortality from dysentery, the Samoan attendants have been grossly overcrowded with a consequent high morbidity and mortality from lung diseases'.[30] Harper blamed structural issues and the government's inadequate expenditure on the asylum for its high death rate: 'the Asylum is in fact starved and we work against great difficulties until something goes wrong'.[31] Chief Medical Officer and Medical Superintendent Dr Aubrey Montague denied these assertions, but admitted that he had 'been willing to pinch, perhaps unduly, the expenditure on the asylum' because of other financial demands.[32]

By the 1920s, the average patient population increased to 61 and by the 1930s to 80. In early 1955, 143 patients resided in the hospital, despite only 80 official bed spaces:

> sixty men and women must sleep on the exposed verandas. In the cold weather or when the verandas are wet with rain these patients lie huddled in their blankets on the cold, wet cement.[33]

After a visit in 1951, the chair of the Board of Visitors, EC Woodward, remarked that these crowded and substandard conditions exacerbated 'quarrelling and annoyance' among patients as they sought out the few dry spots.[34] Overcrowding continued to plague St Giles, peaking at around 235 inpatients by the end of 1960 when the official bed capacity was 98.[35]

The asylum community comprised patients and those staff who had to be onsite for nursing, cooking, cleaning, laundry and security. From the beginning, the primary care and custody of patients at St Giles was entrusted to warders who had a huge responsibility. They assessed, managed, cared for and controlled, with minimal resources, patients from diverse cultures who had wide-ranging mental and neurological disorders. Many patients were admitted as malnourished and destitute, with physical injuries or other signs of bodily neglect such as scabies, lice, fleas or tropical ulcers. Several patients had serious illnesses, such as tuberculosis,

30 Harper to CS, 'Issues raised following report of Chief Police Magistrate into death of Sarjudei, 10 August 1927', 19 August 1927, CSO MP 27/3359. See PN 848.
31 Ibid. See PN 848.
32 Montague to CS, 3 January 1928, CSO MP 27/3359.
33 Unpublished annual reports on the mental hospital, 1954, St Giles Hospital.
34 Board of Visitor Reports, 6 March 1951, CSO MP 3359/27, F48/10, part 2.
35 Colony of Fiji, Council Paper (CP) 32/61, *Medical department: Annual report for 1960* (Suva: Government Printer, 1961), 23.

anaemia or tertiary stage syphilis, or contracted life-threatening sickness, especially influenza, in the asylum. A number of female patients suffered from severe mental conditions exacerbated by childbirth or from physical and mental abuse. Regulations governed the asylum but were negotiated between patients and warders. Warders, as much as their charges, forged a community within the asylum. All residents endured substandard conditions, including poor sanitation. In 1947 health authorities condemned the warders' quarters.[36]

Warders also had their own hierarchy, headed by the chief warder, and they were subsumed within medical and administrative hierarchies, having to defer to doctors and the medical superintendent. A permanent medical officer, Dr Isaac Karim, was not appointed at St Giles until 1962. Two years later Dr Duncan Macgregor became the hospital's first psychiatrist and full-time medical superintendent. A psychiatric nurse was only appointed at St Giles in 1970.

St Giles's unique community until the 1960s rested with its Samoan staff, who were also a well-known part of Suva's Samoan community.[37] The growth of a Samoan community at St Giles reflected Suva's diverse cultural heritage from being a centre of trans-Pacific mobility. Fusi, from Samoa via Hawai'i, was one of the first warders appointed at the asylum in 1885.[38] Acting Chief Medical Officer Corney considered that Fusi 'is nearly as competent as a white man'[39] – a sign of the future preferential hiring of Samoans as warders. Racialised stereotypes concerning the abilities of different ethnic groups were entrenched within Suva's colonial networks: 'Samoan warders in many ways do their work very well, better than any other natives could do it, but they are South Sea Islanders and must be treated as such.'[40] Preferential hiring also reflected Suva's racially drawn labour pool, which was constrained by restrictions inhibiting Fijian settlement in town. Samoans and their descendants were landless immigrants in Suva, dependent on paid work. Over the generations at the asylum Samoans acquired a reputation for 'the special aptitude of the people of those islands for the duties of attending to people of

36 Board of Visitors report, 24 January 1947.

37 See Morgan Tuimaleali'ifano, *Samoans in Fiji: Migration, identity and communication* (Suva: Institute of Pacific Studies, Fiji, Tonga, and Western Samoa Extension Centres of the University of the South Pacific, 1990).

38 CSO 1645/85, 8 June 1885.

39 CSO 1047/85, 15 April 1885. Corney, Acting Chief Medical Officer (CMO) to CS.

40 MP 1412/14, 6 February 1914, to CMO.

unsound mind'.[41] Samoans were also positioned to work across the two main 'races' of Fijians and Indians, while Europeans cared for their own kind. Ethnic and kinship networks within Suva were important in hiring Samoan employees. The St Giles community of warders and their families became more ethnically diverse as Fijians were hired after World War II and a Kailoma (ethnically mixed) identity developed at St Giles, through intermarriage between Samoans, Fijians, Europeans, Indo-Fijians and others. Many lived onsite, although some orderlies lived just outside the compound in Valenimanumanu, Suva's oldest indigenous Fijian settlement,[42] or elsewhere in Suva.

The institutional stamp was pervasive for both patients and staff, where distinct routines, including the language of the asylum (and later psychiatry), emerged. Culture could be framed by legislation covering clothing and diet.[43] The rules varied according to gender and ethnicity. In 1914, Europeans were provided with considerably more clothing than natives, with separate clothing for day and night wear as well as shoes, socks or stockings. Native women patients were allocated cloth to make jackets and *sulus*, but it is unclear what clothing Indian women were expected to wear in the asylum. Native men were supposed to be issued with *sulus* and jumpers, while in 1914 the Board of Visitors found that Indian men were often provided only with a loincloth, which was 'totally insufficient'.[44] Separate diets were also stipulated for Europeans, Fijians and Polynesians, and Indians. These diets differed with respect to quantity and content. European diets consisted of more variety, meat and dairy products than the other diets. In December 1887 diets were formalised according to two classes, which equated to differential fees levied on patients that usually corresponded to racial categories. In practice these diets varied depending on the availability and cost of food and supplies in Suva, the number of patients and the superintendent's prerogative to approve special diets.

Patients and staff shared highly regimented daily routines that were inevitably disrupted by the unpredictability of mental illness, struggles between patients and between patients and staff, as well as environmental

41 Colony of Fiji, CP 40/38, *Medical department: Annual report for 1938* (Suva: Government Printer, 1940), 7.

42 IK Vuetibau, 'Squatting and the California Highway settlement, Suva', in *In Search of a Home,* ed. Leonard Mason and Patricia Hereniko (Suva: Institute of Pacific Studies, University of the South Pacific, 1987), 149.

43 See Leckie *Colonizing madness*, especially 91–93.

44 CSO MP 8621/14, Board of Visitors report, 1914.

vagaries such as tropical cyclones, landslides and even an earthquake in 1953 that destroyed several walls and much of the dispensary.[45] Patients and their keepers closely scrutinised one another, engaged in a dance of control and submission, or patients feigned acquiescence. Just as warders could read the signs of a patient's impending 'episode', so too could patients detect when they could challenge the rules and even escape. In 1914, when two warders fell asleep at 10 am in the male yard, 'a lunatic took the key from above their heads and walked out'.[46] Orderlies were playing cards with patients in 1966 when one was able to walk past unnoticed and escape, much to the patient's amusement.[47] Negligence by staff inverted the usual institutional hierarchies; patients disciplined staff by occasionally reporting staff breaches of security and care. During the 1960s, a patient, Temesi, wrote a letter to Head Attendant Charlie Sachs at 3:30 am, reporting that a warder 'paid no attention to his duty' and 'sleeps when he should be on guard'. This breach enabled Temesi and another patient to escape. In his letter, Temesi wrote, 'Dr—you shouldn't employ this hopeless man', and threatened to contact political and chiefly leader Ratu Kamisese Mara if his complaints were not considered. An Indo-Fijian patient also reported that a warder was asleep while on night duty and the warder was dismissed.[48]

Violence has been part of the St Giles community – embedded within institutional informal rules and a hierarchy that has often, but certainly not always, turned a blind eye to the struggles between patients and staff and between patients. Ideally, and according to asylum regulations, patients were not meant to be controlled through physical force, but staff did resort to physical coercion, including spatial and solitary confinement, to quell patients. The introduction after World War II of long-term drug therapy was supposed to alleviate violence. The true extent of violence and abuse has notoriously been kept within the confines of closed institutions. In Suva, this blanket was briefly lifted when allegations of a culture of violence were headlined in 1970 in the *Pacific Review*: 'Are Mental Patients At Suva Subjected To Cruelty? A CORRESPONDENT SAYS "YES".'[49]

45 CB, 15 September 1953.
46 CSO MP 7315/14.
47 MS (Medical Superintendent) to DMS (Director, Medical Services), 30 November 1966, 'MS. 56.2 Incidents' file at St Giles.
48 Confidential files, MS; PN 2471; PN 2783. Temesi is a pseudonym.
49 'Are mental patients at Suva subjected to cruelty?', *Pacific Review,* 29 August 1970; PN 2633.

The letter writer, signed as 'A sick patient' of Suva, claimed that St Giles is 'run like a 12th century Roman slavery camp' and 'virtually run like a prison':

> The inmates are treated very harshly, cruelty and savagery is rampant everywhere … A common source of fun for SOME ORDERLIES is 'Charlie' and 'Safique'. These two unfortunate patients have been inmates of this institution for some time. These poor unfortunate beings are treated like punching bags. One orderly takes pleasure in punching Charlie everytime he passes him. Poor Charlie simply steps aside trembling. If someone else speaks for Charlie, the orderly tells him to 'shut up' and mind his own business. It is no use complaining to the visiting doctor or anyone else. They simply ignore us and accept the words of the Orderly … Some orderlies excite other patients to violence and when the patients start fighting among themselves, the orderlies appear to derive sadistic pleasure out of it and simply stand and watch and actually kick some of the patients and provoke them to fight.

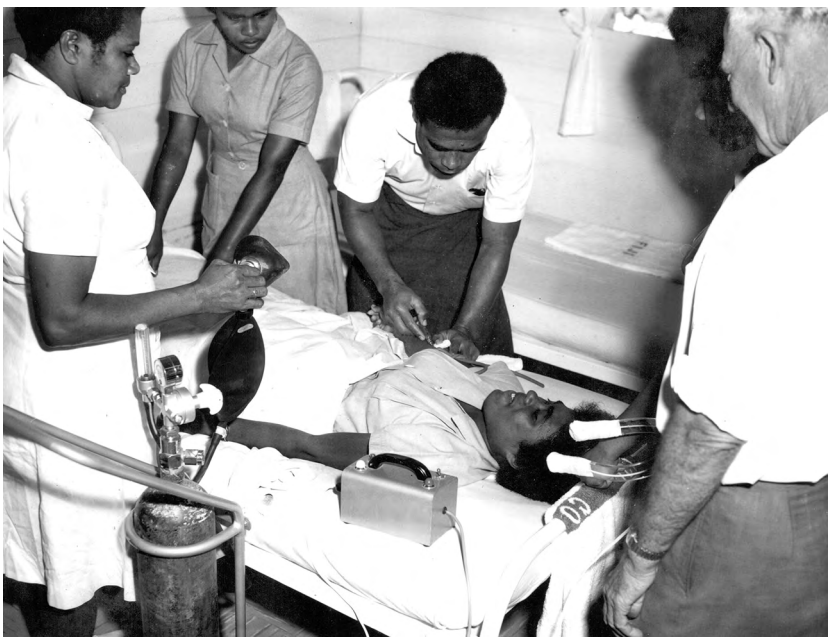

Figure 8.4: Mock ECT, St Giles Hospital, 1965 with Dr M Vuki, deputy head orderly, Asena Ranadi and head orderly, Charlie Sachs.

Source: Courtesy National Archives of Fiji, #G7245.

Routines changed for the St Giles community after World War II, when new drug regimens of antipsychotic and sedative medication and shock therapies of cardiazol, modified insulin coma, but mostly electro-convulsive therapy (ECT), were introduced.[50] A calmer atmosphere enabled patients to be provided with some amenities previously limited to the European ward: curtains, mats, pictures, chairs, dining tables and cutlery.

A large part of the daily routine at St Giles during the colonial era centred on work and occupational therapy. Work has long been regarded as therapeutic and essential in the restoration of moral, mental and physical normalcy for mental patients.[51] In 1887 the asylum's Board of Visitors observed that some patients were 'permitted to amuse themselves in gardening close to the Asylum grounds, under the supervision of a warder'.[52] Work was not simply for pleasure, but patients' labour and food production was necessary to supplement the asylum's meagre budget. The chief warder was denied prison labour in 1888 because 'the work must be done, as opportunity occurs, by the patients who may be physically fit'.[53] Patients produced crops such as *dalo*, cassava, yams, bananas and pawpaw.[54] They maintained the asylum lawns and gardens and at times did heavier labouring.[55] The asylum even had dairy cows in 1915. Many patients enjoyed participating in familiar routines, such as planting, weeding and harvesting crops.

Patients who were able were expected to clean the wards and some patients were selected to clean the staff quarters.[56] Before World War II, a few patients served as messengers for staff. Regulations in 1914 stipulated that the European female attendant was to 'endeavour to find occupation[s] for all the patients, such as reading, gardening, sewing clothes, washing, scrubbing and other suitable occupation[s]'.[57] At various times patients worked in painting, carpentry, the asylum's laundry, a canteen, book-bindery and even making envelopes for government. Suva's weather was often a dampener on outdoor activities and confined patients indoors or

50 Leckie, *Colonizing madness*, 174–78.
51 See Waltraud Ernst, *Work, psychiatry and society, c. 1750–2015* (Manchester: Manchester University Press, 2016), doi.org/10.7228/manchester/9780719097690.001.0001.
52 Board of Visitors report, *Annual report*, 16 December 1887, CSO 3847/87.
53 Corney, Acting MS to Chief Warder, 14 January 1888, St Giles Hospital.
54 For example, Montague to DMS, Annual Report, 1932, F48/4/5.
55 Commented on in several annual reports, for example, *Board of Visitors annual report, 1897*, CSO 96/98; *Annual report for 1938*, F48/4/5.
56 Dorothy Sachs, personal communication, 17 January 2002.
57 CP 8621/14.

on verandahs, where they were often bored and in cramped conditions. Only some patients were considered suitable to participate in occupational therapy: art, sewing and craft work such as making doormats and quilts and weaving mats, fans and baskets.

Patients did object to working and in 1924 one wrote a clearly exaggerated letter to the 'Protector of the poor', alleging that the asylum operated with forced labour – 'we are treated as prisoners' – with male patients working between seven and nine hours a day, carrying firewood and stones. He claimed that patients were beaten and held, suffering 'blows on our stomachs', and that patients were almost starved.[58]

Hidden and Visible: St Giles and Suva

The power of all-encompassing and enclosed institutions and the fear of mental institutions has partly been because of the secrecy over their internal functioning. St Giles has moreover unfortunately been not only a hospital for care and treatment but also used as a 'dumping ground' for a small number of people suffering from mental illness. Yet St Giles was never an institution totally cut off from the rest of Suva. Government authorities tried to manage public perceptions. The letter written by a patient to the *Pacific Review* could not have been published at a more sensitive time, with Fiji's looming Independence. The newspaper's editor, Ratu Mosese Varesekele, although a watchdog of the civil service,[59] was circumspect in his response: 'It is well known that the St Giles Mental Hospital in Suva is a humane institution with warm and understanding staff.' Doctors privately regarded the letter writer as 'a delusional' patient who had made allegations that were 'quite untrue' and his 'absurd allegations are lies and fabrications'.[60] Publicly, the acting director of medical services, DW Beckett, denied the 'cruel charge', defended St Giles staff and suggested that such allegations could deter mentally ill people from seeking treatment. He explained that the letter was symptomatic of mental disease where there can be a desire to make complaints and cause trouble out of sheer maliciousness.[61]

58 PN 693; PN 737; CSO 24/1059.

59 See Brij V Lal, *A vision for change: A. D. Patel and the politics of Fiji* (Canberra: Australian National University Press, 2011), 121–24, doi.org/10.22459/VC.11.2011.

60 Confidential file seen by author.

61 Letter to the editor, *Pacific Review,* 18 September 1970, 16.

Such media attention to patient conditions at St Giles was unusual before the twenty-first century. Information about the hospital was more likely to be based on rumour or, at best, when a family member or neighbour was taken there. A few Suva residents worked at the hospital either permanently or were brought in, such as Public Works Department workers. Prisoners sometimes worked at the asylum, but, as during St Giles's earlier years, patients were expected to provide much of the labour.[62]

Suva's main hospital was another conduit between the asylum and Suva. The asylum had started in 1884 as an annex to the hospital before asylum patients were moved to new buildings at the present-day site. The asylum's medical superintendent and nurse visited from the Colonial Hospital every few days. Patients could be temporarily transferred to the main hospital for medical treatment that was unavailable at St Giles. People with acute mental episodes, including those who attempted suicide or who had chronic conditions such as alcoholism, might be treated at the main hospital before admission to St Giles. In 1968 medical and nursing students began to be posted at St Giles for short periods.

Medical authorities tried to manage the visibility of asylum patients. Patient confidentiality and patient safety from public ridicule were key considerations, but minimising embarrassing or adverse publicity about St Giles was important. When concern was raised in the Legislative Council in 1929 over patients frequently carrying supplies and wood from the town and prison to the asylum, the official line was:

> that there is nothing degrading or menial in the performance of useful labour in public, by persons who while mentally unsound are capable of performing the service without hardship and whose bodily health in some cases is materially benefited thereby.[63]

The 'aesthetic aspect' of patients working in public was raised by Dr MacPherson, the director of medical services, when he suggested in 1941 that the mental hospital could be developed like a farm colony, where the 'more fit inmates' could undertake market gardening and milk production to supply government departments. MacPherson pointed out that a 'number of patients tend to divest themselves of clothing, etc., and accordingly public scandal may be provoked'.[64]

62 Prisoner Labour, 28 February 1885, Memorandum from Corney, Acting CMO, CSO 598/85.
63 Question asked in Legislative Council, 30 October 1929, CSO 5191/29.
64 DMS to CS, 2 June 1941, F48/10 part 1.

MacPherson was also concerned that working in the community might offer patients opportunities for escape, a fear held by many within the Suva public who considered all asylum patients as violent. Mental patients were not allowed to leave asylum premises without legal authority or unless accompanied by hospital staff. Some escapees were quite determined, bending wires or removing iron bars, as a patient did in 1946. He then scaled the concrete walls and got as far as Navua where warders caught him.[65] Pita Turaganivalu, diagnosed as a religious maniac and also arrested for seditious activities on Vanua Levu, escaped during the night of 6 June 1913. Like many escapees he fled towards the prison, where he managed to steal a boat. Pita tried to sail to Beqa before he was rescued and captured.[66] Other fleeing patients headed towards nearby Valenimanumanu, up the hill towards Samabula or Tamavua, or down to Tamavua-i-wai settlement, Walu Bay or central Suva. These were mostly uneventful escapes and captures. Patients might take the opportunity to walk past a sleeping attendant. A patient in 1992 calmly waited at St Giles's gates because he had been granted home leave. No one came to collect him, so he proceeded to his home in Nasinu and yet he became an 'escapee'.[67] As earlier noted, a patient here named Temesi who escaped was found by Head Attendant Sachs in town enjoying a cigarette with a watchman before he was returned to St Giles. By the 1990s some patients quietly sauntered out to purchase cigarettes and sweets in Samabula and returned of their own volition. If caught, they were recorded as escapees and could be punished through confinement to Bua ward, 'behaviour modification' and sometimes ECT.

St Giles had non-medical visitors from Suva and further afield. Most of these were carefully staged formal visits, such as the governor's visit in 1946. He was 'impressed by the cleanliness and generally cheerful atmosphere: almost unique, I imagine, in an institution of its kind. It reflects great credit on the Head Attendant and his staff'.[68] The Board of Visitors, appointed by Fiji's Legislative Council and the colonial secretary, was the legal linchpin between St Giles and the community outside. It comprised the attorney-general, the chief medical officer and three governor's appointees who were usually prominent Suva citizens. The board was expected to visit the hospital at least once every three months to

65 CB, 2 December 1946; Board of Visitors report, 24 January 1946.
66 'Reward for the capture of Pita', 20 June 1913, CSO MP 5279/13.
67 File, 'escapes', 15 February 1992–October 1996, St Giles Hospital.
68 CP 1/48 *Annual report 1946*.

report on patients, staffing, management and conditions. Other visitors from Suva were from philanthropic, charitable and religious organisations, who, along with some businesspeople, might donate items to the hospital. Some groups gifted food treats to patients, such as the Indian Ladies Association in 1934 or villagers from Vatoa island who visited St Giles in 1996.[69] In 1977, Grace Deoki, chair of the Board of Visitors, initiated the hospital's first open day. This provided a chance for the curious public to see behind the walls and to purchase items made by patients and plants and produce from the gardens. Proceeds went into a Patients' Comfort Fund, which along with donations collected by the Board of Visitors paid for patients' necessities not provided by families (e.g. soap), recreation equipment, excursions, social evenings (Indian nights, Fijian nights, South Pacific nights), dances, celebrations and feasts such as for Diwali, Christmas and New Year. From the 1970s, selected patients were taken on excursions into town and into the surrounding areas to see movies, attend the Hibiscus Festival, the Diwali lights of Suva, or enjoy bus rides and picnics to, for example, Suva Point, Sawani waterfalls, Deuba beach, Mosquito Island and Orchid Island. Such activities ceased with the 1987 coups. During the 1990s, the open days at St Giles became part of a newly introduced Mental Awareness Week.

The most crucial outside contact for patients was when their families and friends visited them during designated visiting hours. Sadly, many patients never had visitors. Visitors informed others about conditions within St Giles. On 28 February 1940, a visitor complained to politician Vishnu Deo that his son had been hit by a warder. In 1944 another visitor complained that a Samoan warder had 'roughly handled' an elderly male European patient: objections as much about transgressions of race and status.[70] St Giles has also had irregular or unwelcome visitors, some who harassed patients, stole crops or found the compound a convenient space in which to drink alcohol and *yaqona*.[71] St Giles's walls and security have been to keep the public out as much as keep patients in.

69 18/12/34 Board of Visitors Report; *Fiji Times,* 14 October 1996.

70 Visitor to CS, 15 February 1944, DMS F48/353.

71 For example, GR Anderson, the head attendant, reported thieving in the asylum's plantations. CSO MP 16/2206.

Figure 8.5: Open day, St Giles, 1981.

From left: Mrs Grace Deoki (chair, St Giles Board of Visitors), Matron Qamrul Nisha Mohammed, Governor-General Ratu Sir George Cakobau and Medical Superintendent Dr Balram Iyer examine a raffia tray made by a patient.

Source: Courtesy National Archives of Fiji, # MB5655.

The first psychiatrist and full-time medical superintendent, Duncan Macgregor, took a decisive step towards breaking down the barriers between patients and outsiders when, in 1966, he ordered the demolition of most of the concrete walls that encircled St Giles.[72] Macgregor hoped that removing the impenetrable walls would offer patients a sense of freedom and that greater visibility might reduce the stigma associated with the place and the patients. His successor, Dr David Sell, reiterated that: 'The mental hospital has stood for too long in isolation with its inhabitants out of sight, out of mind and socially stigmatized.'[73] Those stone walls left standing after 1966 were given new visibility in 2010, when they were painted with vibrant murals by artist John Mausio, staff, patients and members of the Youth Champs for Mental Health.

72 Colony of Fiji, CP 12/68, *Medical department: Annual report for 1966* (Suva: Government Press, 1968), 9.

73 Colony of Fiji, CP 39/69, *Medical department: Annual report for 1968* (Suva: Government Press, 1969), 10.

A potent change in the relationship between St Giles and Suva since the 1960s was the introduction of outpatient mental health services and community care for former patients. For many years such inroads into the community had a very slow uptake, impeded by inadequate aftercare and resources and the persistence of stigma and misunderstanding surrounding mental illness. Community psychiatric nursing for the Suva area began in 1993. The goals were impressive – to provide community psychiatric care, support affected families, decrease hospital admission and readmission rates, prevent new admissions, educate the public and health professionals, raise the profile of mental health and promote community mental health – but hampered through minimal resources and the city's social and economic problems.[74] In 1997 the St Giles Day Care Centre for the rehabilitation of discharged patients was established to encourage their integration into and employment in the community.[75] In contrast to the colonial years, when many patients spent most of their lives hidden from the community,[76] many former patients are more likely to still live within the community, care for their children and engage in productive work. A radical overhaul of mental health legislation in 2010 – the Fiji Mental Health Decree – widened the definition of mental health and treatment away from the restrictive legislation dating from 1884, to liberalise patient treatment and review, the prevention of mental disorders, mental health awareness and the development of rehabilitative and community psychiatric services.[77] Stress Management Wards were established within general hospitals in Suva, Labasa and Lautoka. The new discourse of stress aimed to destigmatise the association of mental health with madness and to treat mental disorders such as depression, anxiety and substance abuse.

74 Abel Smith, 'Community psychiatric nursing: The Fiji experience', Presentation to Community Health Workshop, 15–19 April 1996, St Giles Hospital.

75 Kevin Gounder and Luciana Brugnoli, 'Mental health education', *Mental Health Nursing Newsletter* (February–March 1998). STG 2/3/9.

76 Before 1961 only 35 to 65 per cent of patients were discharged within two years. Duncan Macgregor, 'Notes of a meeting between three South Pacific psychiatrists', in South Pacific Commission, *Mental health in the South Pacific: Report of a meeting of experts held at Suva (Fiji) from 19 to 22 May, and at Noumea (New Caledonia) from 23 to 27 May 1967,* Technical Paper no. 154 (Nouméa: South Pacific Commission, 1967), 2.

77 Mental Health Decree 2010 (54/2010), *Republic of Fiji Islands Government Gazette* 11, no. 119 (2010).

In 2018 Rosy Akbar, minister for health and medical services, announced that St Giles Hospital would be relocated to the former Ba Mission Hospital site.[78] Talk of resiting St Giles has surfaced over the years, beginning as early as 1955, when Vishnu Deo suggested that the buildings be used to house the poor and destitutes from Samabula. Government told Deo that there were competing claims on the site.[79] Many years later I heard that developers wanted to build a luxury hotel on this prime site but possible landslips have been one deterrent to these plans.

By 2016 there were only between 60 to 80 patients in St Giles; no indication of the 4,401 outpatients seen at St Giles in 2015 or the 405 patients admitted that year,[80] or the services and training that the hospital provides to Suva, Fiji and the Pacific. Mental health provisions in Suva are now far more community-based than during the colonial years but there remains a serious lack of supported accommodation for former St Giles patients in Suva.[81] St Giles is still a site of fear and mystery for many within Suva, and as long as this persists, the stigma associated with mental health will remain. Meanwhile an increasing number of people in Suva face mental health issues – even if most will never warrant admission to St Giles. Others who are homeless or begging on the streets are visible, but their plight and mental health needs are hidden. This chapter has provided a synopsis of St Giles's history in an attempt to shed light on these dark corners of Suva's history.

78 Luke Nacei, 'Health minister reveals plans to relocate St Giles Hospital to Ba', *Fiji Times*, 15 October 2018.

79 'Mental hospital. Complaints regarding treatment of patients raised in Legislative Council', 5 December 1955, F 48/524.

80 Gary Batt, 'St Giles hospital Fiji: A step back in time', *Australian College of Mental Health Nurses* (Winter 2017): 12–13.

81 Ana Ravulo, 'Finding homes for patients is a challenge: Dr Koroivuki', *FBC News*, 8 October 2018, www.fbcnews.com.fj/news/finding-homes-for-patients-is-a-challenge-dr-koroivuki/.

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