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**Ure, Gale Barbara**

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# A HERMENEUTICAL ANALYSIS OF THE IMPACT OF SOCIO-POLITICAL AND LEGISLATIVE DEVELOPMENTS ON SOUTH AFRICAN INSTITUTIONAL MENTAL HEALTHCARE FROM 1904 TO 2004

**Name: Gale Barbara Ure**

**Student Number: 0616991E**

**Submitted in fulfilment of the degree of Doctor of Philosophy (PhD) in Bioethics and Health Law, Steve Biko Centre for Bioethics, University of the Witwatersrand.**

**Johannesburg, 2015**

**Supervisor:**

**Dr Anthony Egan,**

**BA Hons, MA (UCT), MDiv, S.T.L., PhD (Wits)**

## DECLARATION

This research report represents my own original work, produced with supervisory assistance. All the relevant sources of knowledge that I have used during the course of writing this research report have been fully credited and acknowledged. Furthermore, this research report has not been submitted for any academic or examination purpose at any other university.

Name: **Gale Barbara Ure**

Signature:

Date: **20 July 2015**

# DEDICATION

To the tens of thousands of institutionalized men and women who have lost their lives behind the walls of mental health care facilities in the name of power and financial agendas. This is just a small part of their story.

## ACKNOWLEDGMENTS

Kevin Behrens—who managed the chaos. I really, really appreciate the safety net, often used. There will be non-perverse incentive wine when this is done!

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Leslene Pukke and Dean Mewse—friends who read, and read and read… and never shirked… Love you both.

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All of the people who didn't return calls or fobbed off my requests and made me look even harder for the backstory. Now it is real.

Donna—All my love.

# ABSTRACT

The use of diagnosis and treatment of mental illness to manage and manipulate the shape of the social and political world is not a new concept. It has been documented in the USA, the USSR, Indo-China and other countries internationally. There were a number of accusations of rights abuses made against South African (SA) mental health institutional practices by international bodies in the heyday of apartheid in the late 1970s and 1980s. The South African government vehemently denied politically directed rights abuses against patients in long term psychiatric institutions that were used to further the aims of the then apartheid government. International health bodies travelled to the country to investigate the claims made by the Citizens' Commission for Human Rights (this group mainly represented the interests of the Church of Scientology) and the findings that that there were abuses occurring were rejected by the SA Government. In spite of the rejections, legislation was put in place to prevent further incidents of investigation and to protect practitioners who were employed to work in these facilities.

The abuse of human rights was not to be found in general clinical practice of South African facilities or practitioner practice of psychiatry. It was imbedded in the system of sending people, who were guilty of apartheid social offences (for example not carrying pass books, public drunkenness or simply for not speaking English or Afrikaans), to homeland 'retraining' facilities or South African 'rehabilitation' facilities. It was also entrenched in a system of institutional care that was both differently funded and provided across the colour bar. These people were left isolated and neglected in circumstances, which over time degraded their dignity and humanity to the point of institutional stasis. Homeland facilities, while ostensibly not linked to South African practices or government, were paid for by the South African Department of Health to house Black persons who had proved not to have the social skills or the desirable qualities of a suitable worker in the South African system. They were simply returned to their cultural region, away from White areas, where they did not fit in.

South African mental health professionals, who had been concealed behind the justification that they were pawns in the political process and could not change the status quo, were guilty of a greater crime than actively using their profession to commit politically motivated acts of direct abuse against individual patients. Being not only aware of the political issues in psychiatry and being pressurized by their international peers to do something to demonstrate their rejection of the system maintaining the abuse, the majority of practitioners chose the option of distancing themselves from the areas of mental healthcare under scrutiny. This action - considering that many were an intrinsic part of the both the private and public service delivered to government - had no effect whatsoever on changing the status quo. A

number of practitioners continued to attend the patients in these facilities under the auspices of government and some continue in their personal capacity to the present day. Practitioners continued to refer patients to these private facilities from provincial hospitals. They knew what these facilities were because they had publicly rejected them as a professional body, and they knew that these patients would not be given appropriate care because this was the reason they had given for their rejection.

They turned their backs on a situation which they were very aware would leave vulnerable certified patients at the mercy of a system of private mental healthcare, providing paid incarceration and relocation services to the South African government, under the guise of 'rehabilitation'. They effectively omitted these people from their clinical practice scope by rejecting the facilities in which they were held in the name of conscientious objection.

This denialism was part of the deep and pervasive abuse perpetrated by the law and political structures that underpinned all of South African life. The process of sending 'patients' to these facilities lay at the door of psychiatrists and mental health professionals in South African provincial mental health facilities. They continued this practice well into the 1990s.

This research identifies the processes, players and specific historical incidents that drove the promulgation of various acts, social principles and legislation into a place where such abuses could occur. The rise of private for-profit institutions and the human rights abuses that occurred are testament to how professional, personal and profit agendas can sublimate the mores on which ethical clinical care is based. The concepts of beneficence and non-maleficence, as examples, are lost in the business concepts of providing a service for a customer, who perhaps does not see the provision of ethical and quality care as an operational mandate of importance, and the customer being right. The set of interconnecting contexts and circumstances, during this period, opened the door for abuse of the process of care by a series of national agendas and power plays in international politics, the expansion and self-promotion of medical practitioners' own agendas and the accumulation of personal wealth.

Critique of the conditions and practices in South African mental and social institutions continues to the present. As the people who were placed in these facilities begin to die of old age, many having spent 30 years upward of their lives incarcerated for social and political agendas, time is simply running out because they have been forgotten by the very people who should have been there to protect them. They are unwitting detritus on the road of history and are now a complication which both the Department of Health and those same practitioners, now in positions of authority, are loath to acknowledge still exists. The new Mental Health 'Action Plan' - to which the South African Government and the WHO are

signatories - is hailed as the new era of mental health care in the country, yet, these patients are still missing from the numbers of the research and statistics which the government is presently using for service planning going forward.

**Human Research Ethics Committee (Medical)**

Research Office Secretariat: Senate House Room SH 10005, 10th floor. Tel +27 (0)11-717-1252
Medical School Secretariat: Medical School Room 10M07, 10th Floor. Tel +27 (0)11-717-2700
Private Bag 3, Wits 2050, www.wits.ac.za. Fax +27 (0)11-717-1265

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***TO WHOM IT MAY CONCERN:***

**Waiver:** This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

**Investigator: Gale Ure (Student No 616991E).**

**Project title: A Hermeneutical analysis of the impact of socio-political and legislative developments on South African institutional mental healthcare from 1904-2004.**

**Reason:** This study uses information in the public domain. There are no human participants.

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HREC (MEDICAL)
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JOHANNESBURG

Professor Peter Cleaton-Jones

Chair: Human Research Ethics Committee (Medical)

Copy - HREC(Medical) Secretariat: Anisa Keshav, Zanele Ndlovu.

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# INTRODUCTION

> ***The only way to deal with an unfree world is to become so absolutely free that your very existence is an act of rebellion.***
>
> ***Albert Camus*** *(Camus, n.d.)*

*Nontetha Nkwenkwe was born in 1875 in King Williams Town. As a mother with ten children, she is one of the most poignant examples of mental health's malfunction and misuse. Her story is no different to that of thousands in South Africa. Surviving the flu epidemic of 1818, she believed that she had been spared for a higher purpose. She began her work as a seer, and gained popularity for divining. Nontetha began to be viewed as a prophet, and established an independent church, setting herself up as its religious leader. In contrast to her counterparts, who included Enoch Mgijima, she was initially supported by the authorities and allowed to continue unobstructed, as her teachings included abstinence from alcohol, dancing and other ethnic traditions. Her popularity extended into rural Ciskei, East London, Middledrift and King Williams Town. The annihilation of African Israelites which occurred at Bulhoek in 1921 was to change all of this* (Edgar & Sapire, 1999).

*White paranoia had altered the attitude of officials to large gatherings of Black persons. There were reports that Nontetha was beguiling farm workers with her ideas and they were increasingly unwilling to return to work. She fell under suspicion for promoting unity between educated and uneducated Blacks in the Eastern Cape. These opposing groups had been the cause of widespread destabilization in the area, which worked in the States favour. The authorities in the area were not only satisfied with the status quo, but maintained it, as these feuds and conflicts were seen as a method of social control. A further accusation was that she was the cause of Africans not wishing to attend White churches. Her reputation changed to that of being a subversive element, and she was arrested in 1922. Her supporters were furious at her detention and hundreds of them gathered to show their solidarity, ready to oppose the authorities with force if their heroine was charged. As the authorities were very aware of the backlash unrest that could occur if Nontetha made a court appearance, they committed her to Fort Beaufort Mental Hospital. Two years later, in 1924, she was transferred to Weskoppies Hospital in Pretoria* (Edgar & Sapire, 1999).

*In 1926, after there had been no outcome as to what Nontetha's fate would be, her followers walked over 600 miles to see her. In doing that, they broke the pass laws, and were arrested. In 1930, a further delegation of her followers made the trip and was promptly sent back to the Eastern Cape by train. She was respected among her contemporaries, and many women were drawn to her cause. The church that she started continues today. By the 1920s, and certainly before she was admitted to Fort Beaufort, Nontetha was a figure, who not only commanded respect as a seer and herbalist, but who was also a forty year old, fully initiated*

> *woman, the head of a household and an admired member of African society. Her community, family and friends, and even her rivals, would not accept the allegations that she was ubugeza[1], but acknowledged that she was certainly subversive* (SAHistoryOnline, 2011; Edgar & Sapire, 1999).
>
> *The bureaucratic position on Nontetha was diametrically opposite to that of her followers, her community and her family. The official stance was that she was an unstable psychiatric patient, who was a danger to her society and who needed to be isolated and confined* (SAHistoryOnline, 2011; Edgar & Sapire, 1999).
>
> *Although there were numerous protests from both African groups and White officials, all of these were disregarded. Nontetha remained in Weskoppies Hospital for the rest of her life, dying alone and far from home aged 60 in 1935. She had spent 13 years in state psychiatric institutions for having the potential to cause unrest* (SAHistoryOnline, 2011; Edgar & Sapire, 1999).

I have used Nontetha's story to highlight a single person's experience of indirect mental health abuse and to set the scene for this research.

The abuse referred to in this research was not that practitioners made use of the practice of the clinical specialty of psychiatry, psychology or social work in the practice of mental health to commit acts of abuse. It stems from the use of the context of mental health that was present at that point of time in South Africa, and the stigma and social rejection this engendered between both social and racial groups. This, combined with a specific view of what is now considered to be pseudoscience, was used by various arms of the South African apartheid government to manage a group of inconvenient[2] people through legislation and discriminatory social structures.

This illustrates how a combination of seemingly unrelated factors and contexts can result in a distinct and apparently random outcome. While these outcomes are deceptively disparate on one level, they are consistent with a broad and often indiscernible network of events on a different plane to those that are apparently causal. It is, for example, not simple to see the connections between the practice and profession of psychiatry and the international growth of a pseudo-religious cult. All of these are involved in the formation and maintenance of the practice of institutional mental health care in South Africa. My goal is to identify the broad

[1] According to the late Reverend William Jeffrey Davis in '*An english-kaffir dictionary: principally of the xosa-kaffir but including also many words of the zulu-kaffir dialect*' in 1903 the term *Ubugeza* was a blanket term for craziness, and covered a number of Western references to mental disturbance, for example: insanity, madness, mania, delirium and derangement. Other uses of the word, such as desperation, rage, fanaticism and rashness, demonstrate that extreme social behaviours also fell under this definition.

[2] These 'inconvenient people' were migrant workers who travelled without passes providing permission for them to be present in certain White areas. At the time, social misdemeanours and civil disobedience could be diagnosed as symptoms of illness or intellectual disability. This is described in greater detail in relevant chapters throughout this thesis.

lattice of seemingly unrelated events and entities outside of the area of institutional psychiatry that had a far more profound effect on the ethical practice of institutional mental health in South Africa than the practice of medicine in the treatment of mental health patients.

By taking a hermeneutic approach, and through the medium of narrative, I will provide an understanding of the events that had an influence on the subject from 1904 to 2004. I will endeavour, as far as possible, to conduct the analysis with documents in the public domain from the time periods covered by the research. The choice of research methodology has been made as the number and diversity of texts, and the recursive nature of the story within the research are such that this method lends itself to understanding the nuances of the various themes which interlink throughout.

To do this, I will pursue the following process through the thesis;

1.1. Firstly, using a number of historic texts from various time lines present in this diachronic study, I will locate the topic under discussion within the epoch of a developing South Africa from the periods of 1904 to 2004. These include, but are not restricted to, legislative analysis and research documents, books and articles on social and scientific history, as well as mental health and health articles in both South African and international journals.

1.2. I will compare these sources to available modern and historic texts to establish the understanding present in the historicity that is depicted in these. These will also be utilized to critique present thinking on the subject matter. Chapters 2 and 3 introduce the foundation thinking around mental illness and the treatment mechanisms which developed over time.

1.3. Some of the language and terminology I will use throughout this thesis would likely be offensive to present day readers, given current notions of political correctness in the use of language. It needs to be understood that these terms were both the social and medical terminology of the time and will aid in understanding the various connotations that build the signifiers of this period. This is intentional use to place the discourse in its own historical context in the periods covered. Chapter 4 covers the concept of labelling, and how this impacted on mental health diagnostic classifications.

1.4. The introduction portion of the thesis places a synopsis of the social, legal, political and ethical problems of the study into the research domain. These include, amongst others, the existence of a great number of institutional mental health patients who died over the period covered by this research. Many were allegedly denied access

to basic healthcare and died due to neglect and withholding of resources. One question could be how this could occur in long stay mental health institutions, run for the Department of Health, by health personnel, without identification of the lack of appropriate care. Another question could be how patients admitted in the 1970s and 1980s remained institutionalized into the 1990s and 2000s, even though their admissions were in line with apartheid thinking and practices and not necessarily because of a scientific, clinically acknowledged diagnosis. These people were incarcerated with no formal psychiatric diagnosis, but rather for overstepping social and political norms of the time. Modern day interpretations of the rationale for these admissions show a number of ethical and human rights violations of the South African Bill of Rights. Some of these rights include those of:

- Equality
- Human Dignity
- Freedom and Security of the Person
- Slavery, Servitude and Forced Labour
- Privacy
- Freedom of Movement and Residence
- Environment
- Property
- Housing
- Health Care, Food Water and Social Security
- Language and Culture
- Cultural, Religious and Linguistic Communities
- Access to Information
- Just Administrative Action
- Access to Courts

1.5. The research question which could reasonably be asked is 'what were the contextual conditions under which these rights abuses could occur?' These are reflected in the title of the thesis. Problematisation of the actions of both the characters and the various social and other elements under observation opens discourse that will retrospectively identify ethical anomalies and the ethical drift which occurred over time.

1.6. I have provided a general history of institutional mental health in South Africa in Annexure A, where I have placed the subject matter in a defined framework of 100 years. Most of the information is from a series of articles published over three years in the SAMJ by M. Minde, who appears to be the only person to write a history of mental health care during the early period covered by this research.

1.7. The use of a hermeneutic methodology as the means to analyse and present the information will be explained briefly in Chapter 1. Schleiermacher, Dilthey and

Webber, Foucault, Kant and other thinkers will be used to both contribute to and to reinforce the stance on historicity taken by this thesis.

1.8. In Chapter 5 I have addressed the impact of legislation on mental health in South Africa. While this research highlights the legislative and political shifts in mental health during a time period, it also demonstrates the effects of this legislation and the national, clinical and social changes that were occurring rapidly in the Republic. Changes in the formal ethical position of the protagonists could also have been a factor in why the care provided was both mediocre and deteriorated over time.

From the notorious psychiatric hospitals and poor houses of the British Isles of the 18th and 19th centuries to the Smith Mitchell mental health institutions of South Africa in the 1970s and 80s and through to the modern day revulsion expressed for the Irish Magdalene Laundries, there is outrage at how human beings can use others less fortunate as a financial means to an end. In the latter case, a congregation of Catholic sisters were paid per capita grants and provided with valuable government laundry contracts for which the girls in their 'care' received no payment and lived in appalling living conditions in the name of protecting mentally and intellectually vulnerable girls (Irish Department of Justice and Equality, 2012; Titley, 2012); in the previous instance mentally ill patients worked on government contracts, also in laundries (hired patients were called 'Wet and Dirties' by staff of these facilities), and shared one bed between 1200 Black patients in South Africa (Deeley, 1975). The common denominator is that these people were vulnerable and diagnosed as ill or intellectually disabled. Both groups found themselves at the mercy of, and were abused by, the very systems which were meant to protect them. They were displaced and placed in institutions by the courts, their parents and other, often politically motivated, authorities under mental health certification laws for treatment and care, sometimes without just cause.

While the apartheid socio-political agendas have fallen away under the new dispensation, the results of the previous era's oversights are hidden behind superficial compliance with service delivery. In 1998 a report on the inadequacy of care being provided to uphold both human rights and dignity of patients in private institutions (where profit remains the primary focus) was produced by the Centre for Health Policy at Wits University (Porteus, et al., 1998). Critique of the conditions and practices in South African mental and social institutions continues with recent articles in the present decade (Mallinson, 2013; Philp, 2006). The Minster of Health, Dr A P Motsoaledi, at the 12 April 2012 National Mental Health Summit in Pretoria said:

> *It is difficult to understand how it came about that health infrastructure degenerated to the state that it is in. Some blame must be placed at the door of history, where Mental Health care was something to be hidden away and not spoken about – and where any old, used and abused building was identified for use as a mental health care facility. In some provinces modern facilities have been built and conditions for the people in psychiatric care has improved very substantially but we still find ourselves with a legacy of many unsuitable facilities, situated in inappropriate places far away from family and community, in which scarce mental health care workers are expected to render a caring, rehabilitative service to users* (Khumalo, 2012)

Institutional mental healthcare has gone through various incarnations throughout the Western world over time. It has emerged at a place in world history where long term chronic care of psychiatric illness has become an anathema to personal freedom and human rights based democracies. Changes in government mandates around the world have shifted mental health practices to primary health care models, with community based services to manage this group in their communities. This effectively means implementing community services and integration of patients back into open society. This research will not explore the success or failure of this process, which is a topic for a future discussion.

Mental health, both past and present, is an area of emotive and reactive (even at times reactionary) writing. There are opinions which are polar opposites, and which range from those of anti-psychiatry schools (Rissmiller & Rissmiller, 2006, pp. 863-866; Laing, 1961; Laing, 1967; Barnes, 1979) to the fiercely contested branches of mental health practitioners defending both their knowledge and expertise as professionals. Because a number of the areas of mental health do encroach on personal freedoms and social rights, there is also the confounding influence of populist political views. These appear in public news media and are often sensationalist. There are no academic texts that capture the following events and interpret them with pragmatism and hopefully, an absence of excessive bias, as I intend to do.

There are four temporal shifts that take place in mental health service provision from 1904 to 2004. They are significant because they move the development of both mental health and associated social and political changes through the late 18$^{th}$ century into the early 19$^{th}$ century and then further, into the 21$^{st}$ century. In the early days of the colonisation of South Africa, there was a disorganised system of mental health care, largely due to the unclear nature of the political borders between provinces. Later, there were very clear differences in services which emerged because of the distribution of the economic centres developing in the Union (Legassick, 1974, pp. 5-35).

From the 1600s to the mid-1700s the most common complaints of the Cape settlers were those of exhaustion, hypervitaminosis[3], alcoholism, and venereal disease. Mental illness was often a consequence of these. The population was too small for the provision of specific facilities for 'lunatics' (this was the then commonly used term for the mentally ill). The colony was situated in a busy port, and with the great number of slaves, as well as the steady influx of sailors with mental illness to the port, there was a general, albeit limited, acceptance of 'lunatics' in and around the general population. The slave lodge, convict station on Robben Island, or the ordinary general hospital were available for housing mentally ill persons. The mentally ill were often the victims of aggression by the less than sympathetic local population, as these conditions were neither understood, nor tolerated. (Minde, 1974a, pp. 1270-1272).

Developments in Western medical care were of benefit to White colonists as well as their slaves, and the surrounding Black community also benefitted from these advances. While there has been a debate on the benefits of Colony interventions and involvement (and to a degree, interference), the actual impact, whether negative or positive, is unclear. (Deacon, 1996; Rich, 1990). One of the criticisms is that, as well as being culturally different from the medicine practiced by indigenous peoples, it was often inadequate in approach. So, while it was ethical of the practitioners to provide treatment and care for the local population, the possible racist undertones negate the value of the interventions to a degree. Mental health care in South Africa was on a par with that practised in the developed world, with a supporting colonial ideology that matched the Eurocentric world view. Understanding of the micro-contexts of the time and environment through which segregation emerges and is maintained will form a large part of this research (Habermas, 1962).

Black indigenous people far outnumbered the Whites at the colony, and differences and disabilities made some people easy targets for aggressive and sadistic acts. This behaviour was acceptable and there were no consequences for the perpetrators. Differences in behaviour and lifestyle choices that are socially acceptable today were rejected on religious grounds. In the Cape, the practice of medicine was embedded in both the ideology and political activities of the time, a composite of social class sensitivities and their attendant practices within colony politick (Deacon, 1996; Ure, 2009).

Medical progress, influenced by the socio-political links with Europe, was to have a significant effect on South African society. One of the criticisms against colony doctors' provision of Western medicine to colonised peoples was that there was a class-driven

[3] The present term is vitamin deficiency.

inequality in both the access to, and levels of, care. There was a differentiation between that provided for Whites that provided for slaves and persons of colour. (Deacon, 2000). This colonial thinking was consistent with that of the developed world, and was not endemic to South Africa (Ure, 2009).

The first shift is the 1916 promulgation of the inaugural National Mental Health Act of the Union. This came in reaction to the rapid economic and human capital growth of the Union, and the resultant influx of people to and from the various provinces. International labourers and speculators were arriving on the shores of the Cape in droves. They brought with them numerous medical and social issues. While, previously, provinces had provided for their own limited population's facilities and mental health needs, increased movement between provinces for employment, visitation, marriage etc., meant that a single approach to State service provision needed to be put into place (Dubow, 2006). Practical issues, such as payment for psychiatric services and medical transport between provinces and internationally, for example, had become problematic and needed legislative resolution (Minde, 1977a, pp. 549-553).

The 1960s brought a radical change to the Western world. This set the stage for the second shift in mental health. The atrocities and wholesale genocide of the Second World War had highlighted how contemptible the deeds of man could be towards his fellow man. It had become clear that a climate of inequality, where one group perceives itself to be more powerful than another, could evolve into any number of abusive situations (Arendt, 2006, pp. 286-294; Goldhagen, 1996, pp. 27-79). From a politically strategic standpoint there was an upwelling of socialist sensitivity and legislative shifts towards more humanist thinking, and mental health—because of its coercive nature—was squarely in the spotlight. The process of deinstitutionalisation had its official beginnings in tandem with the start of the human rights movement in the early 1960s. This was aided by the development of psychiatric medications which were proving to be effective in alleviating a number of psychiatric symptoms. These allowed for violent and aggressive patient behaviours to be contained and for hospital stays to be shortened. Lithium, which was discovered in 1949, and Chlorpromazine (developed in 1955) were two of the first of these (Belcher & Rife, 1989, pp. 611-616). The discharge of these patients into the community became a reality that mental health practitioners eagerly began to explore (Gillis, 2012, pp. 78-82).

Along with these developments were a number of strong social statements being made by both the social media and in public forums around discrimination against marginalised groups. If we take the USA as an example, public discourse around racism and equal rights by default brought discussion of mental illness into the art media. The most well-known of

these are the novels *One Flew Over the Cuckoo's Nest* written by Ken Kesey and *A Clockwork Orange* written by Anthony Burgess, both published in 1962 (Rissmiller & Rissmiller, 2006, pp. 863-866). South Africa did not have any such directed social engagement to drive a human rights motivated change process. Institutional care, and the substandard conditions in these facilities, continued largely unchanged until the 21st century.

The 1970s heralded a new era in mental health care in South Africa—the third shift—a secretive, defensive period where there were accusations, counter accusations, political machinations, and international intrigue around clinical care and institutional practices. These laid the groundwork for the eventual degradation and passive abuse through neglect of patients in both public and provincial mental health facilities. It was not meant to happen. In 1977 the SA Medical Journal/ SA Mediese Tydskrif, published the following:

> *Fortunately, the Government has produced an ingenious solution. The Department of Health retains control of mental hospitals and has taken over control of university departments of psychiatry at teaching hospitals. Professors of psychiatry are now a part of the Department of Health and are only to a small extent responsible to university and provincial authorities. This will have a profound influence on the mental health service. The university department of psychiatry are the most advanced in the country. They either have or will soon have up-to-date wards, day hospital, community services, and children's departments. These facilities, and the spirit animating the staff, are sure to have great influence upon the mental hospitals now directed for clinical purposes by the professors of psychiatry. The hitherto rather somnolent mental hospitals will be awakened. They will in time be staffed mainly by one-time members of university staff with knowledge of the most recent advances: Another result will be the merging of the mental hospital and the university department of psychiatry, where the public is concerned. While this, generally, is a favourable development, tending to abolish the different outlooks on mental and physical disease responsible for much of the stigma attached to the former, there is a real danger that the mental hospital will gradually become a dumping-ground for incurable patients, while curable patients will be treated in the general hospital. This would inevitably bring about a lowering of standards in the mental hospital* (Minde, 1977a, pp. 549-553).

In the above excerpt from the South African Medical Journal in 1977, Minde gave a voice to the relief that mental health practitioners felt at the promise of an increase in provision of resources for the mentally ill. It also held the promise of further legitimising and cementing psychiatry in South Africa. The development of these new facilities and services on the scale mentioned above would never materialise, however. The involvement of the university departments would simply maintain the status quo, both in terms of the curriculum being taught, and their absence from the community reintegration environment that was touted to be opening up with the introduction of new psychiatric medications. The concerns about the

dumping grounds were to materialise in the form of the notorious Smith Mitchell facilities (Minde, 1977a, pp. 549-553).

The late 1970s into the 1980s carried with them impotent posturing from international human rights organizations and mental health bodies that accused the South African government and the South African practice of psychiatry of human rights abuse in mental health institutions. The South African Department of Health stood firm in their insistence that the care provided to mental health patients was of the highest quality. Even when an international World Health Organization (WHO) meeting in Brazzaville was held to discuss the atrocities which were being perpetuated in Africa in terms of basic dignity and rudimentary care, South Africa maintained its adamant stance that its mental health treatment was superior (World Health Organization, 1983). Over the years, the private Smith Mitchell facilities changed name, brand and owners, retaining the business of institutional mental health. They maintained both distance and silence in the face of the accusations which were levelled at the Department for over 30 of these tumultuous years[4].

The 2004 end-date of the research, while ushering in the fourth shift in mental health history, is not the end of the story for the numerous institutionalised patients in South African facilities. It describes yet another legislative milestone in the path that mental health care would take through the history of South Africa. The first democratic elections in 1994 had heralded a new, human rights orientated, service delivery mandate from government. The Mental Health Care Act No 17 of 2002 was soon to follow. South Africa had finally crept closer to the strides made in the USA and UK in terms of rights for all of its citizens. However, there has still been little movement in mental health institutional chronic care in South Africa and the alignment has been slow to filter into chronic mental health facilities. This might be because there are still wide funding gaps between the ideals of the policy and what is being provided by the State to ensure that the legislation is in line with human rights mandates. It is also likely because of a lack of will to change the status quo (Porteus, et al., 1998).

> *If there is one critical finding from this study it is that patients are currently enduring low levels of care in these hospitals. In the spirit of the emerging commitment to human rights, these hospitals need to be put on the centre stage for health sector improvement. The lack of quality performance is consistent with*

[4] There are no records in the public domain of any present day formal responses to accusations of inferior care during the apartheid era. This is most obvious in the Truth and Reconciliation Commission hearing transcripts, where a whole report was done by the Citizens Commission on Human Rights which included accusations against Smith Mitchell and the Departments collusion in abuse. No response or rebuttal was given by the company or the Department of Health, even though the Department had often formally supported both its mental health care practices and its position internationally during apartheid.

> *the contract designs. The contracts were not designed to promote quality or efficiency. The quality specifications which did exist were vague and related only to custodial care objectives. There were no penalties for non-performance. Monitoring mechanisms were non-existent, specified in vague terms or ineffective in practice. The contract price increases annually despite little or no evaluation of performance. The design of the contracts places risk disproportionally on the public sector and the patient population, with little to minimal risk residing with the service provider. The low quality outcomes—minimal achievement of a custodial care objective—flow logically from this design* (Porteus, et al., 1998).

The Centre for Health Policy at the University of the Witwatersrand (Wits) conducted a cost of care comparison with facilities around the country—both private and public—four years after the shift to democracy in 1994. As quoted above with regard to private mental health facilities, where the majority of the chronic institutionalised patients are housed nationally, the findings sustained the mantra which had followed custodial care since the 1800s: that the care was low cost and mediocre. Nothing had changed. Despite all of the political changes, world events and national renaissance, nothing within the walls had shifted in the decades from the 1950s.

In 2004, the South African government mental health departments embarked on a process of pressurized deinstitutionalization of long term institutionalised care patients from hospitals custodial care wards, those operated by private companies and those operated by provincial government. Privately owned custodial care facilities housed between 8000 and 9000 involuntary patients at this time, far higher than those housed in government facilities. The number of custodial care patients in these facilities had numbered as high as 16000 to 18000 people through various periods from the 1950s. The numbers were reduced considerably from 2000 to 2004, although the care and living conditions in these facilities remained of a significantly low standard (Porteus, et al., 1998; Dartnall & Porteus, 1998).

> *… the situation in the mental health field deserves special attention because it epitomizes some essential features of apartheid in health. Although psychiatry is expected to be a medical discipline which deals with the human being as a whole, in no other medical field in South Africa is the contempt for the person, cultivated by racism more concisely portrayed than in psychiatry. The racism which underlines the dehumanizing practices in mental health (as in other fields of health care) is not merely a manifestation of psychological attributes on the part of the medical profession. It is the result of those objective social and economic forces described in some detail…* (World Health Organization, 1983)

The quote above lays the foundational thinking for this thesis. It puts mental health into the hands of apartheid to be used to form social structures which could be legislated and used to manage people for whom the government felt contempt. The early use of mental illness to

manage and manipulate the shape of the social world opened the door for abuse of the process of clinical mental health care by a series of national agendas and power plays in international politics, the expansion and self-promotion of medical practitioners' own agendas and the accumulation of personal wealth (Parry-Jones, 1972, pp. 1-7). Behind the machinations of corporate structures (in the form of private, for profit, mental health care, and questionable business ethics and practices), lay government's parochial manoeuvrings to keep political position in an aggressive, changing and socially awakened world (Deeley, 1975; Taylor & Francis, 2007, pp. 52-58).

# CHAPTER 1: THE HISTORICITY OF ETHICAL DRIFT

In this chapter I will begin by positioning ethics and ethical behaviours within specific time periods and thinking. It may be a mistake to believe that behaviours considered to be those of an ethical professional are cast in stone. I will challenge this thinking by demonstrating why ethics can form a fluid and dynamic concept that not only changes over time, but that cannot simply be interpreted by applying a present day standard to a particular time. It is possible to make moral judgements retrospectively, however, and I will identify some to these instances. I will expand on the theoretical bases for this these, as well as identify some of the confounding issues that arise with any analysis of historic documents.

> ***The very ink with which history is written is merely fluid prejudice.***
>
> ***Mark Twain*** *(Twain, n.d.)*

To understand ethics in institutional mental health, one cannot speak for practitioner's individual inputs in creating a good/ bad, moral/ immoral process. The same goes for identification of individual patient's experience of abuse or ethical care. Institutions function as ethical entities in themselves. The ethical culture of these facilities is both formed and maintained by factors both separate from, and inherent in, the management and power systems of the system and social context in which the facility is required to exist. The power systems which both built and maintained ethical and unethical institutional mental health structures had their own composite characteristics that provided a platform, which can be identified as the catalyst for a pervasive organization of questionable behaviours and structures that practitioners both believed in and maintained as being good and ethical. This could also explain why, in spite of the international findings of inferior and unethical care, as well as complaints of human rights abuse from both formal and informal sources, there was a continuous litany of denials from the South African psychiatric community. According to the State and formal psychiatric bodies, the care was nothing less than superior (Gillis, 2012, pp. 78-82; World Health Organization, 1983; The Centre for Health Policy, 1998).

This incongruent depiction of mental health in South Africa can be linked to the concept of ethical drift, a concept that will form the basis of discussion of behaviours of structures and practitioners through the changes of this period. How ethical behaviours are perceived can certainly change over time, depending on the era and the rules of that specific epoch. What may have been seen as an ethical action at a certain time, because of certain socio-political

or legislative structures in place, may be a human rights disaster once a government is overthrown or there is a power shift, for example South Africa's move to democracy from apartheid. This shift added millions of people, who had been previously disenfranchised and perceived as inferior in terms of legislation, but also in terms of position in society and provision of resources, to a group which had all of the human rights available to the previously advantaged (Seiler, 1975, pp. 447-468; South African Government, 1996). It also added a whole new dimension to mental health care practice.

Purported ethical behaviour and care is reliant on the presiding power of the time for its legitimacy. In South Africa for example, to be seen to provide better care for Whites than Blacks was not regarded as unethical during the apartheid era and prior. In the years prior to the 1950s, it was in line with the scientific and international social thinking, prevalent at the time, that some people were inferior and either did not appreciate or would not benefit from the same care which others would. Segregated care was a western standard in psychiatry and mental hygiene, and South Africa was on a par with international norms (Koren, 1912). At this point the argument arises that, according to a humanist stance, the ethical mores which should be present across all ages should be applicable to any synchronic period in history as being right behaviours, in contrast with those that are wrong. This provides an erroneous and irrational position if real history is used as a barometer, however. While ethics is often seen as being a universally Black and White notion[5], history has demonstrated that ethical behaviours and what can be perceived as ethical or unethical actions are linked to whichever side of history the behaviour finds itself on in hindsight. Psychiatry is a specialty which trails a history of questionable practices that have not only formed the basis of a number of broad state and private business choices, but when linked to political goals, have been the catalyst for dogmatic partisan behaviours to further political ends. As science changed, and the thinking changed, the understanding around what constituted ethical behaviours changed according to the perceived positive or negative means and ends that were used and what they were meant to achieve. Broadly, mental health—whose influence stretched across the fields of legislation, education and socio political structures—was a significant player in the management of apartheid structures. In modern thinking, mental health in being part of the foundation on which apartheid was built, and being part of the system which maintained it, was therefore obviously unethical.

[5] A phrase in itself loaded with assumptions that exponents of black consciousness, like Steve Biko in 'I write what I like', have eloquently deconstructed (Biko, 1978).

Along with the three mental health Acts which formed the basis of the care provided in the Republic, there were three definite representations of mental health practitioners that emerged during various periods of mental health in South Africa. The Acts both framed their behaviours and highlighted their various agendas and ethical positions. They were also responsible for various ethical structures that emerged through the period under discussion.

The reason for using the device[6] of providing a composite of ethical characteristics to exemplify a practitioner/ structure/ system of the time is not to provide a blanket one-size-fits-all mental health care process to describe the input of all players in all of their diversity at all times, but to describe a specific archetype within the fraternity of psychiatrists and mental health practitioners that typifies the public and accepted face of the profession during the period under review. This face is the one that is seen in the tabloids, the voice heard in communication situations, that makes decisions and provides guidance in political situations, and the one who is perceived as the epitome of the profession. This character embodies not only the profession of psychiatry, but the practice of mental health, and speaks for other practitioners practicing in institutional care.

The first character that presents as the face of mental health is the Proud Professional, a visibly strong and autocratic character of the early 1920s, tasked with providing government, not only with guidance, but with proactive leadership in line with internationally acceptable practice. Predominantly White males, these were the attendees and speakers at internationally conferences, editors and peers, both writing and reviewing articles in the medical press and academic journals. These were also the politicians commissioned to attend to the poor White problem, racial issues and management of social problems, for example intellectual disability. This character was highly regarded both in South Africa and abroad. The list of practitioners comprises well known historical names in the Eugenics, obstetric and psychiatric fields, for example Dr J T Dunston, and Dr Hendrik Verwoerd, whose ethical positions in mental health were not questioned at the time (Ure 2009).

[6] A literary device assists a reader to interpret, understand and analyse a text. They are comprised of either one or two elements – these being literary elements or literary techniques. Literary elements are naturally occurring in all texts and include such things as plot, setting, theme, characters, etc. Literary techniques on the other hand are artistic in nature, and may include allegory, hyperbole, etc. Some examples of the elements which have been identified as relevant to this research are the setting i.e. the time and the place during which a story occurs; and the plot, or the sequence of events which occurred to produce the story.

The second character—the Anonymous Conformist—appeared from the promulgation of the 1973 Mental Health Act to the early 1990s. This was the critical period in mental health, where the deterioration of care went unnoticed and was largely defined by government departments and representatives of private enterprise. There was a slippage into outdated and human rights deficient behaviours for which there was neither consequence nor sanction. This character was to become a pariah in the mental health care field. Care was outdated, politically driven and practitioners who wanted to stand up to the patently discriminatory and inferior care were unable to because of the legal ramifications. Many simply settled into the banal day-to-day operation of the institutions, or left the state or the country. Only those at the top of the hierarchy in the Department of Health and private facilities spoke during this period. Everything that was done, and all practices, was passed off by official spokespersons as being at the top of the curve. A number of government officials held positions within private, for profit, providers of mental health facilities and services, and received some form of remuneration or payment in kind and/ or retired to take positions within the company. Others held shares in the same (Deeley, 1975; Jones, 2003). The ethical aspects of care during this period were mostly absent, especially for Black patients.

The third character is the Apologist. From 1994 the content of mental health communications was reduced from fiery defence to that of the Directorate of South African Mental Health apologizing to the American Psychiatric Association (APA) for their lack of action in response to the report from the late 1970s. This report had highlighted the unnecessary deaths, human rights abuse and inadequate care of mental patients in Smith Mitchell institutions (Pinderhughes, et al., 1978). No formal action to end the type of institutional care that had been provided by Smith Mitchell was instituted. The Mental Health Act of 2004 retained the previous Act's inherent flaw of neglecting to impose penalties or consequences on mental health practitioners for any form of unethical care outside of that reported in terms of other legislation, for example theft or assault , which fell under the Criminal Offences Act. No formal governmental efforts were made to ensure that patients, potentially wrongfully admitted through the previous 3 decades, were released. The situation of contracts running from year to year, without review, remained in place and large portions of the contents of the reports of all of the international organizations, cost and quality of care report (Porteus, et al., 1998), remained the status quo. This character can be considered inherently unethical by virtue of omission and failure to address, firmly and effectively, any of the human rights issues which were not only identified but were the subject of an international apology. A number of these same structures remained in place beyond the period in which they had become public knowledge and into the 2004 implementation of the new Act.

These three ethical positions reveal the character of mental health over time and are almost barometers of whether the care remained ethical. In a historic environment, the care was viewed as ethical. However, it was actively unethical in a blatantly racist and abusive political environment during apartheid. Mental health care remained unethical by abdicating transformation by simply retreating from the status quo, leaving patients in the private institutions still in neglected and impoverished conditions, while transforming state facilities and holding those up as examples of effective transformation. It can be seen that the second unethical phase of South African Mental Health history informs the unethical position of the third. In the second period, the state admitted patients into facilities with politically motivated and social diagnoses rather than clinical ones. They were then sent to long term rehabilitation facilities. The third phase, understanding that the second phase had acted unethically, distanced themselves from the unethical practices by turning their backs on patients' need for intervention. Patients became secondary to profit making and the state maintained the status quo for convenience. It begs the question as to why the state felt that relying on the private contractor to act ethically was sufficient. Some of these patients had been in these facilities for over 40 years, the clinical reasons for their admissions long changed by advances in both the social and mental health arena.

## MORALITY IN HISTORY: UNDERSTANDING ETHICAL DRIFT

The study of ethics and moral behaviours over time has its own philosophical grey areas and interpretational blind spots. While the concepts of right and wrong would appear to be clear cut across temporal lines, it can be seen that good men, with the best intentions, functioned naively within exclusionary margins at times in history, when that was regarded as the ethical way of behaving. It behoves us to look at segregation practices as being part of the human condition over time—whether right or wrong in hindsight—and as part of a notion of ethics which can be accused of slippage in the name of the greater good.

To interpret how South African mental health chronic institutional systems developed racially discriminatory practices, the relationship between the events of the era and the reported behaviours needs to be interrogated. These practices were considered and defended by their practitioners as being ethical in terms of both patient care and by virtue of the elevated role of the clinician as social protector. The starting point needs to be an understanding of how ethical systems fail when they are perceived as a distinctive form of knowledge rather than having ethics play the part of an essential partner in a comprehensive vision of all human knowledge. What this means is that ethics cannot be separated from the overall formal, human schema ‘‘in which the parts presuppose the whole and the whole expresses

the parts''. This is done through a process of dialectics[7]. This discussion is tension based. The process identifies conflicts, in this case, how the concept of mental health care became that of a political and social tool for segregation and neglect, and will identify inter-relational connections and continuities that remained in position up to 2004, largely because of the misinterpretation of history (Wallhausser, 1989, pp. 25-39).

## WHEN THE ACT OF AUTHORING MISSES THE POINT

There are definite conflicts and snags in developing a discourse around a number of different sources of information, not all of which travel the same informational trajectory. As will be seen in this thesis, the failure to appropriately link concepts has the effect of providing a history that can effectively hide or dodge important information. This can, and has often in the past, diverted attention from the real issues of abuse in mental health, and in so doing, prolonged and rationalized unethical care in mental health institutions.

The author of history may interpret the information and its links without substantive knowledge about the topic and fly way off beam in the interpretation, effectively creating a history that has limited bearing on the facts of the time. This history also has the effect on scholarship of diverting readers to ideas that are not valid.

Two philosophers, Wilhelm Dilthey and Max Weber, both identified the problem of the position of the author in the interpretation process, and raised questions about the skewing of presentation of historic information to fit an author's particular historic position. Both Dilthey and Weber's areas of interest were the historicity of human existence, coupled with the historical character of knowledge itself. At the height of their contribution to knowledge and science, history was being touted as an exact science, along with the natural sciences. By using various other areas of study, for example, archaeology, ethnology, philology, bibliography and politics, new vistas had been opened to increase the scope of historical knowledge. By the late nineteen century, historic material had become specialised and its accuracy was considered to be precise. Building on this history was of great importance (Bergstraesser, 1947, pp. 92-110).

Absolute belief in the accuracy of interpretations of the vast amount of source material to hand was fading. Historical development, or more meaningfully, our capacity to understand historical causation in a more concrete manner, became an important area of study for both Weber and Dilthey. They began with the concept that, if we think about aspects of human

[7] Dialectics is a form of argument that is used to resolve disagreement and differences of opinion. It is a way of establishing the truth when there are differing views on a matter. The dialectic process is used to tease out the legitimacy or validity of the opposing opinions and ideas.

society, be they religion, law, philosophy, art or economics, and they are all dictated by an evolutionary concept of history, then all judgments tend to become relative. Based on this relativity, historicity becomes mistrusted as part of a moral crisis. Using only empirical analysis, and attempting to avoid all metaphysical conjecture, they investigated how, if human judgments and values are historically relative, in principle, and rather than being satisfied with ambiguous generalizations, we should at least be investigating the ways in which, and the phenomena to which they are relative (Linge, 1973, pp. 536-553; Holborn, 1950, pp. 93-118).

An example is given below in the form of a present history of the business of institutional mental health in South Africa. The abstract on Amazon states that

> *In the late 1970s, South African mental institutions were plagued with scandals about human rights abuse, and psychiatric practitioners were accused of being agents of the apartheid state. Between 1939 and 1994, some psychiatric practitioners supported the mandate of the racist and heteropatriarchal government and most mental patients were treated abysmally. However, unlike studies worldwide that show that women, homosexuals and minorities were institutionalized in far higher numbers than heterosexual men, Psychiatry, Mental Institutions and the Mad in Apartheid South Africa reveals how in South Africa, per capita, White heterosexual males made up the majority of patients in state institutions. The book therefore challenges the monolithic and omnipotent view of the apartheid government and its mental health policy.*
> *While not contesting the belief that human rights abuses occurred within South Africa's mental health system, Tiffany Fawn Jones argues that the disparity among practitioners and the fluidity of their beliefs, along with the disjointed mental health infrastructure, diffused state control. More importantly, the book shows how patients were also, to a limited extent, able to challenge the constraints of their institutionalization. This volume places the discussions of South Africa's mental institutions in an international context, highlighting the role that international organizations, such as the Church of Scientology, and political events such as the gay rights movement and the Cold War also played in shaping mental health policy in South Africa* (Jones, 2012).

Written by TF Jones, it appears to rely heavily on limited sources (those relating to Whites-only facilities and military records) and takes these same out of context (that of general mental health care in South Africa) to make sweeping and incorrect statements[8]. The

[8] The statement refuting that institutionalized patients were predominantly black and were in fact heterosexual White males is ludicrous in light of the South African demographic as well as the specific bed numbers allocated paid for and allocated to black patients in all of both state and private health facilities. It does appear that the book has taken military hospitalisation records for White males (there were very few black males in the military) as the number of patients housed permanently in mental health facilities. This is incorrect purely in terms of demographics. There is a marked difference between the hospitalisation for two months of a White soldier with stress in a better funded and staffed facility, for example, and being sent to a rehab facility in the homelands for 'retraining' for

weighting towards Whites only care, and their ability to control their own mental health care processes certainly points to specific facilities and structures and is not indicative of the reality present in the practice of psychiatry during that time (T. F. Jones 2012). This construction of history diverts attention from the actual human rights issue—that unethical practices occurred until well after 1994, that Black patients were not only the majority of the victims of these practices, and that a number remained incarcerated for well over the 27 years which Nelson Mandela spent in prison—with outdated diagnoses and for inappropriate social offences.

There is a tendency on the part of authors when dealing with any historical interpretation, to make judgments on heuristic[9] grounds, because the material on which the interpretation is based is available may be limited, and apparently credible in its own right, often based on the authority of the person who wrote it.

Jones' (2012) history of the business of mental illness in South Africa can be used to demonstrate the difference between using historical documentation and hermeneutic interpretation, versus utilizing present day interpretation and documentation. These bring pre-existing interpretations as a confounding element in the interpretation process (Jones, 2012). This research, while certainly not hiding behind the guise of absolute knowledge presenting an absolute truth, has attempted to link actual and available history of the time to the development of legislation and the effect of this on the ethical management of psychiatric patients.

The necessity of categorizing and combining parts of ethics as a coherent discipline and its limitations as a distinctive and separate form of knowledge history with which to understand the whole, was identified by Friedrich Schleiermacher, a historic philosopher who formulated this particular theory in the 1860s (Wallhausser, 1989, pp. 25-39). Dilthey built on Schleiermacher's introduction to historical thinking with the belief that all human creations can be understood by humans. Cultural differences overlay a basic general understanding

years, for failure to carry a passbook. There seems to be a general confusion around what constitutes a placement via the legislative framework (which is a rights limiting process - used predominantly with black certified and institutionalized patients) versus that of a voluntary admission for treatment by a White male. This is also a vital difference in terms of interpretation of governmental culpability in ordinary citizens' abuse in the mental health care system. If anything, it highlights the absolute discrimination and abuse in the care provided to black patients, generally.

[9] Heuristic thinking simply means short cutting to what we think we know about a subject, based on our limited knowledge on hand, without investigating as far as possible before making a judgment. Use of these cognitive shortcuts makes it difficult to see alternative scenarios. In the case of mental health history various agendas of creators of various histories of this topic have relied on specifically selected areas in order to give credence to, for example, propaganda material which they have developed as in the case of the Church of Scientology; or histories which they may have written using too few or limited available resources, as in the case of T F Jones' book on the business of madness in South Africa.

within specific communities. This meant that any interpretation of the human sciences should be approached in a very different way from the natural sciences, with the basic premise that natural science composes a hypothesis, and then tests it. In the humanities or social sciences, a subject interprets another subject and reconstructs the meanings, with the emphasis focused on understanding and description rather than on application of general laws, prescription and explanation. Dilthey believed that the application of natural scientific methods to the study of cultures impoverished our knowledge of the subject. He also believed that positivism failed to grasp the importance and uniqueness of cultural sciences and the fact that knowledge in these areas derives from interpretation, intuition and empathetic understanding (Holborn, 1950, pp. 93-118; Goebel, 1926, pp. 145-156). It is interesting to note that HF Verwoerd, whose academic roots were deeply imbedded in Mill's positivism, would have appreciated this position, because both David Hume and John Stuart Mill were both technically forerunners of Dilthey's thinking (Goebel, 1926, pp. 145-156).

Hermeneutics is not qualitative research because, simply, it is not about personal experience and has no personal emotive content present in the interpretation process. It cannot be measured, controlled and commented on from standardised findings that can be generalised, but rather, the interpretation medium provides a foundation for homogenized understanding. Whereas empirical data can be presented and explained by numeric methods, hermeneutic interpretation requires a rational basis for interpretation and understanding of source material, almost like having a map to provide terrain information. This is necessary because the phenomenon under investigation may be categorized by high levels of ambiguity, for example, when we compare the polemical content of inputs from the Church of Scientology (Kotze, 1972) against institutional tariff payment schedules for different racial groups (Department of Health, 1978). While they are seemingly very different, the cumulative substance of the two documents not only refers to, but substantiates a third and powerful macro statement, namely, that abuse of patients did occur in a number of seemingly unrelated ways. In hermeneutic interpretation, there is a need to expand on an explanation of phenomena in a holistic, rather than in a multivariate fashion. The interpretive paradigm also acts as a guide for the physical collation and inclusion of the various information sources that will form part of the research process. This means that the act of collation of sources and inclusion as part of the process of interpretation—whether to make or understand a point of discussion—are also part of the interpretative paradigm (Patterson & Williams, 2002, pp. 5-11).

This type of research must however, as with all scientific research, adhere to a specific system of principles. The paradigm has been chosen for this research to provide a

structured interpretive narrative across a timeline that spans over 100 years[10]. Terminology was very different and social structures were not as they are today. To interpret behaviours and systems, firstly, further in-depth knowledge of the social environment must be incorporated to provide a broad basis for interpretation. This is the storied element that places the various elements in their relative positions. An interpretational research approach requires normative philosophical commitment. The term is utilised from a sociological perspective – and encompasses rules and standards for scientific behaviour—which, in this instance, refers to those paradigms used in a specific time period, with regard to a specific way of practising science during that period. It describes a specific set of philosophical allegiances or 'buy-in' that occurs in the practice of science at any given point in time. This can be misinterpreted as a universal characteristic of science, but on closer inspection, within a scientific approach, a number of normative methodologies legitimately coexist. This highlights the variations within the interpretation of scientific endeavour, rather than attempting to pull understanding around 'universal' characteristics (Patterson & Williams, 2002, pp. 5-11).

One of the noteworthy consequences of examining the historicity of a set of events, which make up a context that causes or drives the evolution of social norms and thinking, is that the interpretation then includes a further interpretational element. This is in addition to the events or information, which was captured in the texts that had been sourced. The interpreter's own values and understanding adds nuances to the interpretation that then provide the basis for its placement in context. This effectively renders the objectivity of the observer moot. David Linge (1973) and Bergstraesser (1947) have both investigated this phenomenon, alternatively contrasting and comparing Gadamer and Max Weber's thinking with Wilhelm Dilthey's, in an attempt to integrate the concepts of making history and studying it. To quote Dilthey, ''the one who studies history is the one who makes it'' (Linge, 1973, pp. 536-553; Bergstraesser, 1947, pp. 92-110). This means that in order to provide a platform ideal of objectivity, a synthesis between the historicity of the knower, combined with historical scholarship and the interpretation of the knower, must be reconciled to provide a logical basis for interpretation. Logic then takes primacy over less-than-perfect objectivity.

An excellent example of this would be the use of present day Citizens Commission on Human Rights (CCHR) documentation to investigate the idiosyncrasies and developments of past mental health thinking under the umbrella of apartheid human rights abuse and racist practices. The CCHR, which is the secular arm of the Church of Scientology (CCHR, 2000)

[10] The choice of 100 years is aesthetic, and is not meant to provide a rigid start and end point, as it would in quantitative research. There are overlaps in both contexts and knowledge which covered this period.

has however, also been involved in rewriting this portion of history to suit the organization's present agenda. This was possibly done to provide credence to the organization's attempts to enhance their position and to grow their church in South Africa and abroad. This was by currying favour with the apartheid government of the time, and came in the form of supporting both the racial and segregationist polices of HF Verwoerd (Kotze, 1972).

The CCHR's version of the events of the 1970s have formed the basis of present day Scientology cult hype to both corroborate and reinforce their anti—psychiatry stance. It serves to link the concepts of apartheid and psychiatry (CCHR, 2000). The attempt to politicize the cult's apparent anti-psychiatry cause only served to derail an investigation, which could have been of value to institutionalised patients. It did the opposite, rather reinforcing international moves to reject and contain the aggressive actions of the followers of L Ron Hubbard (Corydon, Jnr, & Ambry, 1995; Foster, 1971; Kotze, 1972).

If historians are tempted to use this propaganda documentation uncritically, they are provided with distorted insight into events, with an attendant flagrant inaccuracy in interpretation. The elevation of the CCHR to a heroic protagonist of the events of the past is an awkward blunder. This is clearly illustrated in the book published by Jones on the business of mental health care during the apartheid era. Using CCHR documentation to place the political abuse link in her history inadvertently aids and bolsters the propaganda motive of that organization (Jones, 2012). As Dilthey and Weber have indicated—history is made by the writer (Goebel, 1926, pp. 145-156). In this case, history has been written which aggrandizes the one organization which behaved as badly as the other protagonists of the piece. All of this constitutes additional credibility for Scientology, acquired without merit or effort, and the rest of the document is called into question because of it.

Using the above as foundational thinking for the interpretation of the available texts, I will proceed to demonstrate the historical trajectory of mental health care legislation through the period of 1904 to 2004. The historic account and confluence of influences will be presented in narrative format. Even with the intention of structured analysis, the developments which combined to create a formalised institutional mental health system make a very readable chronicle. The sources of information are varied from academic texts and journals to minutes of meetings, reports, personal accounts, staff records, conference papers and opening statements, sourced from both national and international sources. In addition, a number of out of print and archival historical documents have been traced for collateral.

The international transition to human rights orientated mental health, new medications and the much touted process of deinstitutionalisation will be discussed with reference to the deviation in clinical service delivery that South African mental health pursued. This was in

reaction to national politicking, paranoia and the subsequent legal changes that were implemented to enforce this reaction. This period in South African psychiatric history can be identified as the period where mental health slipped behind that of the rest of the world, and where outdated thinking and deviant teaching practices became the norm. Sanctions, with specific reference to educational sanctions, and the negative impact which this had on medical practice will be discussed, as being partially responsible for the cause of mediocre treatment in the field of mental health (Davies, 1996, pp. 319-332).

The practice of mental health has not always been as it is now. In 2014 we can see that over time mental health has developed its own terminologies, its own institutional structures, bodies of work, teaching structures and its own credibility as a scientific specialty. Developments in pharmacology and treatment methods have taken this practice into the 21st century with credibility. But in 1904, mental hygiene was the pseudoscience of antisocial behaviours, moral judgments and religious fervour (Black, 2003, pp. 159-160; Deacon, 1996; Rosen, 2004, p. 73).

Because of these imbedded links in social and community life, psychiatry does not conform to the traditional grand narrative of medicine. Medicine provides a linear progression of discomfort, diagnosis, treatment and wellness as its scientific trajectory. It is a concrete picture with a clear beginning and an end. Both medical practitioners and the public at large understand the process of medicine on this basis. The contract of medical care is, therefore understood by the majority of persons as having an outcome. Psychiatry however, is different in a number of ways which necessitate deviance from this paradigm. There is no clear wellness trajectory. The process of illness to wellness is recursive rather than linear. There is no clear timeframe of care. Patients were, and can often be, hospitalised for extended periods. There is often debate around the aetiology of the disorders, and good prognoses are often inextricably linked to environmental factors. Unlike other clinical specialties, psychiatry also has an antithetical movement, dedicated to undermining its basic practice mechanisms with the general public, in the form of the anti-psychiatry movement (Rissmiller & Rissmiller, 2006, pp. 863-866).

Minde had the following to say in the only comprehensive publication dealing with the general history of mental health in South Africa to date. Little did he know he was predicting how the world of mental health was to look in the 21st century in his worst case scenarios (Minde, 1977a, pp. 549-553).

> *The study of history is both fascinating and instructive. Our investigation has only covered a period of little over 300 years, which, relatively speaking, is but a drop in the ocean of time, yet, so quickly do customs, manners, and ideas change,*

> *that some of the events recorded appear almost incredible to us. This is especially the case for the period under consideration because the tempo of life has quickened so tremendously and because science has radically revolutionized life in the 20th century. But, while ideas and viewpoints change, man changes but little, and his basic nature, his psychological make-up, the ills his flesh and mind are heir to, change very little. The study of history helps us to meet and overcome present and future problems by utilizing the lessons of the past. How much light does a study of the past throw on existing mental health problems, and how much may it help in framing policies for the future?*

Because the basis of this report is retrospective, and a number of the resources that have been sourced include historic documents, which date as far back as the 1700s and 1800s for context, there are certainly pieces missing that will need to be reconstructed by both intuition and interpretation. The philosophy and hermeneutic process will blend both past and modern philosophy and thinking from both national and international sources. The examples given in this report and the interpretations are by no means exhaustive. They are meant to put into perspective how the various themes of social life, economics and practice in the medical field coalesced to create a context that could cause so much harm and degradation to so many unwitting and equally innocent persons in the name of both social science and mental health practice.

Actual numbers of how many people were incarcerated without diagnoses are unknown, both due to the hurried intervention of the health services to place people in the community after 1994 in a scattershot approach to fixing a long standing human rights abuse issue; and also because of the apparent lack of accountability and record keeping which has been prevalent throughout mental health history. Filing and documentation were either not done or completed in such a way that the information is of no real value (Porteus, et al., 1998).

This thesis will not offer critique of specific mental health processes which were put into place and there will be no value judgments made of the various clinical practices which developed over time. The research will seek to demonstrate, through an interpretational process, how—at a high level—institutional discourse develops over time and the effects, both negative and positive, that this discourse may have had on ethical care over time. It will reflect on the influences that come into play and the resultant outcomes for the broader group of South African patients.

The development of mental health legislation is one such whole. It exists as an entity in itself, and yet it is not exempt from the umbrella influence of a multitude of levels of societal functioning. These may appear to be isolated units of function, but within these levels of discourse lie individual power agendas, self-protection strategies, profit motives, altruistic and economic needs.

The above thinking is not new, but is based predominantly on the work of Weber and Dilthey (Bergstraesser, 1947, pp. 92-110) both of whom understood that man's existence cannot be separated from his history, without loss of many foundational and interpretational elements. Dilthey's study of history was focused towards a universal interpretation of man's relationship with his freedom. Weber on the other hand, whose position has import for this study of mental health, focused on analysis of the social requirements inherent in the trajectory of life in which every man is inherently involved.

Hermeneutic interpretation can be seen as being a similar process that utilizes normative philosophical principles to interpret itself, as were the principles which underpinned the practice of science in the period being researched. The work done in the philosophy of science to date has embraced a system of interpretation and exposure of the normative philosophical commitments that scientists buy into and invest in intellectually when it comes to developing a personal philosophical paradigm. This study of differing research traditions was defined by Thomas Kuhn, who coined the term 'macrostructure' to describe the unit of analysis that is being studied (Patterson & Williams, 2002, pp. 5-11).

The macrostructure is a far broader concept than that of scientific methodology. It is accepted (and this may be either implicit or explicit) that these normative philosophical commitments are present in traditional research without necessarily having empirical support. They guide the practice of science, for example, providing definition and explanation for that which is knowable, describing the application of methodology, and informing decision making around the criteria to be used in peer review processes. All of these need to be understood by the scholars who conduct their research in a particular scientific tradition (Patterson & Williams, 2002, pp. 11-30)

While the subject matter of this thesis is pertinent to understanding the past advancement of mental health, it is equally important to understand our motivations going forward. This is not a traditional research report by any means, because the material is not a linear, single dimensional entity. It also has no structured control (but does have corresponding events and historic process that occurred at the same time on an international level). Correlation of information therefore, has to done on an interpretational and (macro structural) level (Patterson & Williams, 2002, pp. 11-30). It also changes in interpretational structure as present philosophical influences find their place in the process.

The need for a research methodology that would allow for the investigation into the influence of diverse social context does not lend itself to any one phenomenological standpoint. The choice to use a hermeneutic approach provides a scientific basis for discussion of macro situational elements while excluding more flimsy elements. The position is simply this: if we

intend to position our thinking of any matters which relate to human society, be they art, law, philosophy, religion or economics within an evolutionary notion of history, judgments become relative. History can then be suspected of being representative of moral deterioration. To avoid this pitfall, structural investigation of intellectual and social history is employed over that of metaphysical speculation. Understanding that judgments and values are historically relative in principle, there needs to be an understanding of the manner in which, and the phenomena to which, they are relative. Because the historicity of human survival remains the primary driver of human knowledge, thinking and conduct, this prevents interpretations being made using both objective personal perspective and relative time. In other words: in hindsight all judgments should have been better and more ethical.

Loss of inculcated knowledge from the events of history has its own negative outcomes in the form of loss of warning systems and lessons learned from prior behaviors and experiences. Mental health is an area where these lessons should continually inform us going forward. There are issues with this thinking, however. Retrospective analysis of human life and experience needs to be done without injection of present moral value judgments, which are inappropriate from the perspective that present circumstances again have a different historical basis which is brought to the interpretation. This relativity requires that the development of mental health legislation, as undertaken by this study, will attempt to utilize the contexts of the different times for initial placement, and then interpret the present with the building blocks that have been formulated.

There is a tension in the relationship between that of historical understanding and the historicity of human existence in that they are often perceived to be mutually exclusive. Man is a creature of history, so all writing and interpretation will be subjective, including mine and the resources I use (Bergstraesser, 1947; Linge, 1973). This leaves us with the result that all historic knowledge is relative, and that this by definition, makes objective knowledge impossible. My task will be to use the texts in their subjectivity to extract as objective a picture as far as this is possible. As an author I am only human, after all. The process of authoring a research work that is based on hermeneutic analysis implies answerability: that there is on some level a commitment to rightness in conveying the information in such a way that it remains, as far as possible, both true to itself and contributes in value to a body of knowledge of a subject. It also needs to contribute to an ongoing dialogue. Bakhtin, in Vitanova (2010) criticized formal theories of ethics because they failed to address the issue of real human actions performed in the real world by real people (Vitanova, 2010)

Bakhtin's dialogism, for example, provides us the ability to communicate this type of historic analysis within a 'situated ethics' which provides an alternative to an enforced moral

absolutism of a modern ethical interpretation (Vitanova, 2010). Situated ethics allows for the possibility of dialogue around historic specificity without having to necessarily make absolute moral judgments which, as we will see in this case, do not apply uniformly across time. It allows me to place my analysis of the various texts used within a unique social context and to not necessarily exclude factors which, while they may have no concrete link to the outcome of the research, may expand the dialogue to an understanding of a unique human experience of the period, and to use this dialogue to potentially understand present ethical issues.

# CHAPTER 2: EUGENICS

Chapter 2 will be used to show how the scientific and social knowledge of the time had a profound effect on both national and international thinking around mental illness. It will also show the effect that this thinking had on the social, political and legal spheres. I will show how, in a world where new theories and methods of analysis were flourishing in a growing academic environment, South African mental health specialists were among the leaders in modern thinking and implementation of modern practices.

Eugenics as a specific branch of science was not simply embraced in South Africa on its own merit. As collateral science it provided a formidable foundation of thinking for a number of clinical and allied specialties, which included those of obstetrics and gynaecology, psychiatry, social work, psychology, law, economic thinking and state planning. A number of eugenic principles were used to formulate and underpin legislation in South Africa, both in terms of mental health legislation and those around social and economic policy (Benatar, 1989, pp. 111-117)

> ***All great movements are popular movements. They are the volcanic eruptions of human passions and emotions, stirred into activity by the ruthless Goddess of Distress or by the torch of the spoken word cast into the midst of the people.***
>
> ***Adolf Hitler*** *(Hitler, n.d.)*

There has been a great deal of discussion around the effect of Nazi ideology on mental health practices in South Africa (Truth & Reconcilliation Commission, 1997). While there were some similarities, the driving mental health practices, policies and laws which have been erroneously linked to those of Nazi Germany were far closer to similar practices of the USA and other parts of Europe. While there were certainly persons in South Africa who felt strongly that the Nazi hands-on approach at eradicating the threat to the ruling discourse was a worthwhile enterprise (Hilberg, 1961, pp. 355-375; Adams, 1990, pp. 8-50), the majority of South Africans—whether they were in government and high level decision makers, or medical personnel in the mental health field—felt that the United States process of passive attempts to reduce the scourge of ‘bad blood’ was appropriate to the South African context (Dowbiggin, 1997, pp. 191-232). This may have been due to the interpretation of racism and ‘otherness’ as identified by Hilberg, combined with a healthy dosage of Calvinist thinking of the White man as Good Shepherd to the

Blacks' 'errant and childlike' nature, which required firm guidance rather than total eradication (Dubow, 1992, pp. 209-237; Kaufman, 1997, pp. 1-53; Naicker, Undated, pp. 1-7).

## EUGENICS AS A CONCEPT

Eugenics is an immense body of knowledge in its own right, so only the basic tenets of the thinking that apply to this research will be addressed. As far as possible, only South African examples will be referred to. That said, it is not possible to isolate South African mental health thinking from that of the international mainstream, as these correlate on a number of levels. As a philosophy and science in its own right, and with a limited following predominantly by anthropologists in South Africa, eugenics followed a different trajectory in the practice of medicine.

The most important foundational eugenic thinking, and the view which had the most influence on South African thought, was that differences in breeding stock were responsible for certain traits being passed down over generations. This meant, and research at the time certainly seemed to bear this out, that families carried mental illness and intellectual disability from one generation to the next. Racial characteristics were also perceived to be indicators of deviance and deficits in necessary traits and intellectual mores. Cultural characteristics, whether positive or negative, were perceived to be linked to physiognomies. Physical attributes did not change, and therefore, social behaviour patterns were also considered immutable (Hilberg, 1961, p. 13).

The importance of preserving 'good blood' and eradicating 'bad blood' was understood to be crucial. In this way the community could be protected from 'contamination'. While Thomas Galton proposed a natural progression of traits dying out through a natural selection process (which was termed positive eugenics) the Germans, USA and Scandinavia actively put various mechanisms in place to eradicate these traits by means of sterilization, genocide and segregation (Deacon, 1996, pp. 287-308) of those persons perceived to be socially deviant. Because mental illness was perceived to be particularly resistant to any type of clinical intervention, gene cleansing was understood as being a viable alternative to ending the spread of disorder, more specifically elimination of the 'rotten matter of the social body' (Lopez-Munoz, et al., 2007, pp. 791-806). Active euthanasia of certain subjects was written into law on the back of psychiatric political lobbying in Germany in 1933 (Adams, 1990, pp. 8-50).

Negative eugenics focused on the active improvement of health and functioning of the general community by ensuring that the reproduction of purportedly less healthy and capable members was prevented under national legislation. Controlling 'dysgenic' effects or supposedly bad elements and the elimination of genetic disease, disorder, disability and all other assumed defective fundamentals were to be actively reduced by state, social and clinical intervention. This meant imposing a number of restrictions on rights, for example those of reproduction, including the right to be sterilized or not (Editorial, 2000; Holmes, 1921; Kaufman, 1997; Klausen, 1997, pp. 27-50).

Positive eugenics was the process whereby the best traits and capabilities of a society were increased by active encouragement to increase reproduction in those with desired traits. This meant keeping a strict control over the traditional reproductive practices of the community. This was done by enforcing sterilization practices of those considered to be deficient, and by removing those members of the community considered inappropriate to ensure that they were not part of the reproductive environment. There were planned pregnancy and sterilization programmes, as well as programmes focused on the institutionalization of persons considered less able. These were already well established by the advent of apartheid (Bidwell, Undated, pp. 175-177; Nash & Navias, 1992, pp. 437-440; Chubb, 1932, pp. 649-652).

There was no clear differentiating line between the two, although some of eugenics' followers made moral distinctions between the two aspects of the same goal. Obviously, what were considered to be the more serious abuses were those carried out as negative eugenics. The shift from being benevolent and acting in the name of disease prevention became the eradication of people who were perceived to be carriers of the disease. This position was stretched to incorporate social problems, which were thought to have economic repercussions, for example, idleness, joblessness and 'feeblemindedness'. This thinking, at the time of the rise of social movements around the world, led to calls for state intervention and the additional need for expansion of community services. It also became important to develop legislation to handle these challenges appropriately. These interventions appeared to be successful in managing a number of social afflictions. There needed to be a way of controlling the 'bad blood' to prevent its contaminating the good. This could be done in one of either two ways: by changing the environment or controlling reproduction (Klausen, 1997, pp. 27-50; Dowbiggin, 1997).

## THE GERMAN VS THE AMERICAN MODEL

While there were some similarities in eugenic thinking, they were those of the Western and developed world and not a specifically South African phenomenon. While many parallels have been drawn between South African apartheid practices and those of the German Reich during the Second World War, there are few similarities between the two after the late 1930s and certainly into 1940 to 1945. What bears the drawing of a parallel is the progressive implementation of legislation, with seemingly clinical and social overtones initially, but which steadily began to incorporate the doctrines and needs of the ruling party to remain in a position of power (Adams, 1990, pp. 8-50).

Eugenics is the study of transfer of 'bad blood plasma', which purportedly resulted in both personal disability and personality traits that were less than desirable, but also which maintained socially unacceptable environments and structures. The thinking was that once this 'bad blood' had been passed to a member of the person's family, the children were predisposed to the same disorders and behaviours. Charles Darwin had opened scientific discourse around traits and transfer of weakness of both the body and the mind (Darwin, 1859).

The Eugenics Record Office in the United States made it possible to carry out studies of notorious family names to follow less-than-desirable behavioural characteristics and outcomes of these behaviours. These included, for example, the Jukes and the Kallikaks, who have over time become the foundational archetypes underlying eugenic thinking. Other families, which included the Tribe of Ishmael in Indiana, were linked to crime and social decay as were the Zero family of Switzerland (Black, 2003; Dowbiggin, 1997). Links were made between social issues and class disorders, for example, criminality being found in successive generations of certain families. Pauperism, alcoholism, prostitution, syphilis and mental defects were commonplace. It was estimated, at the time, that at least a quarter of every inmate population of the prisons and penitentiaries in the US was 'feebleminded'. (Holmes, 1921, p. 88)

The perceptions of race differences that were present in the early 1900s were principally class based, and South Africa was no different in this regard. Doctors were a significant force in both the process of nation building and the changes in social relations which were taking place in the new addition to the world economic stage, the Union of South Africa. There was swift transformation from a primitive colonial outpost to an industrialized country with a burgeoning mineral industry and international economic interest (Dubow, 1992, pp. 209-237; Van Onselen, 2001, pp. 309-389).

This brought with it fundamental social changes in the pre-existing cultural systems. From the mid-1920s the race preservation discussions in the union were predominantly those dealing with conflict between the two main White groups (Dubow, 1992; Klausen, 1997). As can be seen, the discourse that comprises the discussion of race and eugenics must expand to include the social attitudes of the then political landscape as well. Because of this, the eugenics discourse in South Africa was not restricted to that of the mentally ill and disabled, but also reflected South African political discourse between men and women, poor and privileged and Blacks and Whites. There was also an observable animosity between English speaking and Afrikaans speaking White people (Klausen, 1997, pp. 27-50).

By the mid-1920s the Depression had affected a large number of people in the USA, and a similar situation began to play itself out in South Africa. Rural poverty escalated rapidly after WWI, which led a large number of mostly unskilled, young, Afrikaner men and women into the urban labour environment. This, in turn, led to increased urban poverty. A far greater issue for the state, however, was not the growth of White slums of impoverished Whites, but rather the multiracial slums, which were rapidly increasing in size. Fears had shifted to the rising possibilities for miscegenation and intermarriage. Whites were reduced to the level of the Black underclass, and were competing for the same jobs: a competition which Whites often lost because Black labour was prepared to work for a far lesser wage (Van Onselen, 2001, pp. 1-47; Dubow, 1992, pp. 209-237).

The fear that 'inferior' Whites were going to be the ultimate downfall of the White race as a whole became the growing focus of social and medical thinking. By the late 1920s, there had been a definite shift in political thinking around class. Racial elements began to feature more, and eugenics came to form the foundational mechanism for maintaining White domination over the African majority. This was based on supposedly inferior genes over superior ones. The terms describing class and White ethnic disparities made the shift to ones denoting colour differences instead (Klausen, 1997, pp. 27-50).

This thinking was also not specific to the medical establishment of the South African Union. Doctors around the colonial world and Europe had long since had a role to play in not only the health of their patients, but a role to play in the prevention of health issues and the betterment of the social condition. An excerpt from the 1922 American Psychiatric Association (APA conference) conference in Quebec puts this thinking into context. The opening address by the Hon. L. A. Taschereau, Prime Minister of the Province of Quebec, puts governmental thinking around the roles and relationships between government and the mental health practitioner into perspective, as well as the potential social implications, which

had been growing around this position. Referring to this new eugenic thinking in psychiatry, he continues[11]

> *They are more interesting to the general public, these questions, and can be more easily understood by those who are not students of your specialty. We quite realize your superiority over us in this branch and readily acknowledge that there is a particular interest attached to the debates on such questions so closely connected with public life. The treatment and segregation of mental defectives, the problems of mental hygiene, are all matters which are bound to appeal to any one gifted with the least public spirit. Such advances have been made in the latter part of the nineteenth century and since the beginning of the twentieth that we are now facing for the future. We feel sure that the alarming problem of the proper care of mental defectives is being solved every day in the most satisfactory way. The interest of the public has been aroused and very few of our leaders at present would fail to consider as one of the most important questions the subject of the betterment and of all means of cure for such patients, or be unwilling to grant any help required in modern treatment. This present state of things, the interest public men have been led to take in matters of science, has been vastly extended by the successful work of the different scientific meetings held all over the world. The investigation of appropriate cases, made in such a way as to put them within intellectual reach of an informed public (though not absolutely prepared scientifically), has been, I consider, the basis of the impulse given to present-day science, and the pioneers in this were undoubtedly the members of those congresses.* (American Psychiatric Association, 1922)

Membership of international bodies and associations, and attendance at conferences was routine for South African doctors prior to the implementation of sanctions on South Africa in the 1980s (Jewkes, 1984). The removal of these interactions with peers and exposure to new thinking and developments on the international front was to have a profoundly negative effect on apartheid mental health knowledge, and directly on patient care (World Health Organization, 1983). This change occurred during the years when academic sanctions were applied to South African universities, a move which would severely impoverish medicine, and psychiatry as a specialty (SAMJ, 1987).

## J T DUNSTON

In an effort to grow the specialty of mental hygiene on the world's clinical stage, South African doctors joined a number of eminent specialists from the field of mental health medicine and the social sciences from the 1900s to the years following the second world war. One of the foremost figures, Dr J T Dunston, was an English medical doctor who went on to become one of South Africa's most formidable influences of the mental hygiene movement. He had gained his experience over a number of years by working in British

[11] The language is correct, despite it's being offensive.

mental hospitals. Dunston was married to the great granddaughter of the (1827) Superintendent of Robben Island Lunatic Asylum Dr FLC Biccard (Minde, 1974b, pp. 1629-1632). He assumed a position as the assistant medical officer at the Pretoria Lunatic Asylum in 1905. An ambitious and authoritative figure, he applied for the position of medical officer to the New Central Prison in Pretoria. In 1908 he assumed the position of Medical Superintendent of the Pretoria Lunatic Asylum. By 1914 he was the inspector of asylums in the Cape Province, during which time he also held the role of acting Superintendent of Valkenburg Asylum (Ure, 2009).

Dunston played a significant role in the development of the Union's first Mental Health Act specifically focused on treatment of the mentally ill. He had an illustrious career, which included being made Commissioner of Mental Disorder and Defective Persons for the Union in 1916. In 1924 the title changed to the Commissioner of Mental Hygiene to reflect international mental health developments (Minde, 1975a, pp. 405-409).

Dunston was to exert perhaps more influence over how scientific and medical thinking shaped both the social and mental hygiene structures in South Africa than H F Verwoerd. Although Dunston had formally retired in 1931, he was reassigned to the position of Commissioner of Mental Hygiene, a post which he held until 1951. By the time he officially retired, statutory admissions had trebled in number, services had increased, and more facilities had been brought online. There were two new psychiatric hospitals and the intellectually disabled had been provided with extra institutional care (Minde, 1975a, pp. 405-409).

He was the driving force behind the development of the South African Mental Hygiene movement, a distinguished psychiatrist, both here and abroad, as well as being a member of the American Psychiatric Association. His opinion in his fields of expertise was valued and carried considerable weight with both his peers and the South African government. In an article published in 1923, J. T. Dunston, the then South African Commissioner of Mental Disorders, showed however, in spite of his being a man of science, how social observations could affect scientific opinion. Mental test results and findings from Porteus, Maze, and Healy et al, reinforced Dunston's thinking that Blacks, compared to the average White, showed a lower level of intelligence. He also wrote that they could not learn from experience, and were unable to take the initiative or anticipate outcomes. Based on their lack of knowledge of their ages according to the developed world's calendar, he drew the conclusion that they had a problem with temporal constructs. His position on their meritocracy was reinforced by his opinion that they had no mechanical skill and had no

written language and both their art and dance were unsophisticated. He drew the conclusion that their apparent sanity was evidence of their inferiority (Minde, 1975a, pp. 405-409).

Dr JT Dunston, the first psychiatry lecturer at the University of the Witwatersrand, was instrumental in starting the Mental Hygiene Association in South Africa. This followed visits to Europe and the United States of America in 1922. He reportedly returned to South Africa with many 'novel' ideas (Minde, 1975a, pp. 405-409). These ‘novel ideas’ had their grounding in the eugenics movement, which was a particular ideology prominent in many Western countries at that time. This movement was aimed at eliminating social problems by preventing the breeding of both physical and mental traits which were considered to be undesirable. In 1922, the eugenics movement focused on 'race betterment' and the 'eradication of degeneracy'. Forced sterilizations and mass institutionalization were two methods suggested to curb clinical and social problems. Intellectual disability, mental illness, criminal behaviours and poverty amongst others were societal ills it was believed could be cured by ‘scientific’ or medical means (Kaufman, 1997; Klausen, 1997, pp. 27-50) .

## HENDRIK FRENSCH (HF) VERWOERD

In the same year, Dr Hendrik Verwoerd was in Germany and was significantly influenced by the same eugenically-based mental health principles. These would become the foundation for his social work and later political careers. He took those principles to Stellenbosch University where he took up the first chair of Sociology. It was in this way that mental health practice in South Africa was underpinned by the same international eugenic and racially biased tenets which were popular in the United Kingdom, Europe and the United States. The idea that scientifically based evolutionary principles could be adopted as a social theory fed into the social, economic and political thinking of the time. Cumulatively, they formed the foundational thinking that gave rise to Crimes against Humanity, such as the Holocaust and Apartheid (Miller, 1993, pp. 634-661; Venter, 1999, pp. 415-442).

HF Verwoerd was born in the Netherlands in 1901 and moved to South African in 1903 with his parents. In 1917 he completed his schooling, and followed this by completing his PHD in psychology, cum laude, at Stellenbosch University in 1924 at the age of 23. He received a grant to pursue his post graduate studies in Germany and attended Berlin, Leipzig and Hamburg Universities. After his return to South Africa, he visited the United States and Great Britain in 1927. His exposure to systems in Germany did not appear to have had a significant effect on his academic thinking or practices, especially those foundational principles from Germany which led to large scale attempts at genocide by the Germans. It did, however, give his psychological career a more professional outlook, which had not been present

before. His thinking became far more analytical and he became more technical after his visit to Germany. This methodical thinking and his focus on having an epistemological underpinning for substantiating ideas and processes became central to his decision-making. Having been exposed to psychometric testing in the USA, and the many ways in which the results could be applied—for example, in mental, vocational and capacity testing—he developed a specific interest. He broadened his exposure by visiting Harvard, Pennsylvania and Yale Universities, amongst others. He returned to South Africa with many of the tests that had been developed by psychologists in the United States. The textbooks and reference material prescribed by Verwoerd were either German or American, as South Africa did not produce its own tertiary educational material for its educational facilities. (Miller, 1993, pp. 634-661).

The apartheid foundations in mental health and the socially separate environment he supported should be understood in the context of his background and the South African socio-political milieu at the time. His introduction to international education and practices in the social sciences expanded his potential repertoire of solutions to South African public problems. There was any number of models from other countries in the developed world (Miller, 1993, pp. 634-661; Hepple, 1967, pp. 24-35). An intrinsic difference between Verwoerd and other leading social scientists of the period was his political ambition. He made a rapid ascent in the world of academia. He was offered the Social Work and Sociology Chair at the University of Stellenbosch in 1932, on the back of the findings of the Carnegie Corporation report on the Poor White Problem, which had identified the necessity for an academic and policy unit to focus on alleviating White poverty (Bell, 2000, pp. 481-508). Verwoerd was actively involved in the Poor White Commission and had been a major contributor to the project. Not simply focusing on identifying social trends, he was interested in individual, distinctive issues (Miller, 1993, pp. 634-661). Verwoerd became a figure of importance in the area of social welfare. It is worth noting that prior to 1937 he had no interest in ethnic separatism, nor did his offensive contain any really noteworthy racial fundamentalism. He had a genuine interest in merging both English and Afrikaans speaking South Africans by reducing White poverty using a scientific approach. His aim was a valid attempt to unite English and Afrikaans speaking Whites via a social science approach geared at the reduction of White poverty (Lelyveld, 1985, pp. 81-119). He developed a reputation for being an expert on American social welfare models. Between 1930 and 1934 there was a general absorption of socio-scientific advances from the USA. South African academics travelled to their sister universities in the USA to learn and contribute to the developments that were occurring. Many sat on international social welfare committees, which included Verwoerd and representatives from sociology, psychology and religion.

International scholars also flocked to South Africa, one of these being John Dewey, who was a staunch proponent of the use of social science to manage and control society. He lectured at Stellenbosch in 1934 (Miller, 1993, pp. 634-661).

Verwoerd's bias towards the American social welfare model was possibly partially due to the funding provided by the Carnegie Corporation, as well as the Corporation's approval of the types of social assistance and programmes which were being developed in South Africa. There were advances being made in England, Germany and France around the same time, which were not made part of the teaching of social work or the development of social policy in South African institutions. In an example of Verwoerd's emphasis on the application of the American model to the South African context, he refused to employ the first South African student to acquire their PhD in sociology, because he specifically wanted the incumbent to have experience of American social thinking and not those of European schools. Geoff Cronje, the rejected student went on to become an advocate of the advantages of apartheid (Miller, 1993, pp. 634-661).

Verwoerd's policies made a shift to a racialised position in the 1950s and 1960s. There had been a number of developments in the political arena, and as his ambitions were leaning in that direction, his thinking followed suit. Initially, Verwoerd's ideal social structure did not have racial groups as separate entities, but rather that there was a composite societal picture made up out of all South Africans in specific racial roles. He had a formidable personality, and his ideas became the main subjects of the committees on which he sat. They also received a great deal of media attention. He began to develop a reputation based, not only on his research output and his ability as an educator—which had already earned him acclaim as a respected scientist—but also on his ability to identify, research and provide solutions to problems which required his personal input. This made him both a powerful and influential public figure. His influence over developments in the mental health sector became very important to later political and health institution developments (Miller, 1993, pp. 634-661).

Verwoerd moved away from teaching in 1936 to take on the role of editor of *Die Burger*. He continued to publish, however, and in 1935 produced three articles on the elimination of poverty in the Transvaal. He made an, up till then, uncharacteristic shift in ideology from that of the USA model, which he had followed for all of the previous years. Instead, he not only praised, but emphasized the value of German social vocational programmes over those of the Americans. His alignment with German thinking was further exposed in 1936, when he took part in anti-Semitic protests in Cape Town. From 1937 his position shifted to incorporate a more racially biased underpinning. The question does arise as to whether Verwoerd's

political ambitions had led him to hide his personal ideals during his years of teaching. He does seem have used his Carnegie involvement opportunistically to further his goals by being politically flexible (Hepple, 1967, pp. 42-56).

Verwoerd's death at the hands of a White, schizophrenic parliamentary messenger was perhaps a fitting end to a man who had called on South Africans to be prepared to die for their beliefs. Ironically, his death was not the result of a 'savage' Black onslaught or 'communist invasion'. The attack had come from the quarter of the mentally ill. Verwoerd's first, and failed assassination attempt in 1960, had been by David Beresford Pratt, who, like Tsafendas, was ostensibly mentally ill and who had also been committed to a mental hospital. He committed suicide in 1961 (Wolf, 2012). Tsafendas' actions reintroduced psychiatry as a significant branch of science in South Africa. The 1973 Mental Health Act was an overreaction to the perceived dangerousness of mental patients (Hepple, 1967, pp. 198-208).

## DR WILLIAM DARLEY-HARTLEY

Born in Sheffield in Britain in 1855, Dr Darley-Hartley studied medicine at Guys Hospital in London. He settled in the Cape Colony in 1878, but later relocated to East London. He served in the armed forces at the rank of Surgeon Captain in a number of skirmishes, which ranged from those against the indigenous Black tribes in the area to those against the Boers in the Anglo Boer War. In 1882, having become interested in local politics he was voted onto the Town Council in East London. This did not last and he resigned in the December of that year. He moved to Cathcart in 1884, where he established a number of journals, which ranged in diversity from the *Farmers Chronicle*, to the *South African Freemason*. In 1884 he started the *South African Medical Journal* as a private venture, but this failed (Tankard, 2009).

Dr Darley-Hartley went on to found, edit, own and publish the South African Medical Review (SAMR), the first journal of its kind in Southern Africa. He was an active and influential member of the medical profession in South Africa, as well as a dynamic member of the British Medical Association (BMA). He received the first gold medal awarded to a member of the South African Medical Association for 'distinguished services to the medical profession in South Africa'. Most of the articles which were published in the SAMR came from members of the regional branches of the BMA, and a number of these members held positions of both social and political power. Amongst these contributors were T. Duncan Greenlees, the then Medical Superintendent of Grahamstown Asylum, A Moll, consultant on mental and nervous diseases to the Transvaal Education Department and J. T. Dunston, Medical Superintendent

of the Pretoria Asylum (Ure, 2009). Using the SAMR as a vehicle, it was possible to bolster both the eugenics movement and, by association, the mental hygiene movement around the country. A number of articles were submitted by doctors who specialized in mental illness. Darley-Hartley was, as Verwoerd after him, very politically active. In 1886 he became a founder member of the Frontier Medical Association, for example. He supported British supremacy in the Republic, and was also an originator of the British Colonial League, which in 1898 had supported Cecil John Rhodes in the elections (Klausen, 1997, pp. 27-50).

The ongoing professional discussions that were taking place in the national journal around eugenic thinking provide an understanding of the stance that mental health professionals adopted at the time. As editor of the Medical Review, Darley-Hartley played a pivotal role in not only acting as a conduit for sharing information, but also in providing commentary on what the regional chapters were voicing. As a believer that in order to increase the strength of a nation, the management of both social and of individual health were vital, he also believed that they were the domain of men of science. His feeling was that they were decisive and could make the right decisions without 'nibbling' around issues. His inaugural editorial for the SAMR explained what he saw as the role that medical professionals had to play in the politics of a developing nation:

> *It seems to us that medical training has much to do with the attainment of political eminence by medical men. First, we must have higher education... Second, receive logical training... The man accustomed to diagnose the diseases of the individual body, and to guide his therapeutics accordingly, consciously or unconsciously follows the same lines of thought in diagnosing and treating the ailment of the body politic. Again, medical men have an enormous advantage over almost all others, in the fact that their daily work brings them into contact with every class of the people, gives them a knowledge of the wants of all ... And lastly, your medical man soon finds out in practice how disastrous 'nibbling' treatment is, and in politics he invariably goes right through a question and take up the responsibility of a definite position just as he has to do when he is face to face with a case requiring operation* (Klausen, 1997, pp. 27-50)

A further example of the thinking around national health and the individual was provided in an article by Dr Lilian Robinson in 1911. Hailing from the Natal chapter of the BMA, she wrote a report titled 'An Address on the Medical Inspection of Schools'. In it she praised public health school hygiene programmes as a scientific tool for identifying those children that were considered incapable of remaining in society. Robinson noted in her report that children who were 'feebleminded', blind or epileptic should be 'hunted and placed in institutions in order that they may be trained to fulfil their duties to citizenship in their degree, instead of remaining a burden to themselves and an element of weakness to society as a whole' (Klausen, 1997, pp. 27-50).

## T DUNCAN GREENLEES

T. Duncan Greenlees, Medical Superintendent of the Grahamstown Asylum, authored the first article published in the South African Medical Review, which insisted that immorality be viewed as a grave risk to both cultural and national health. One of the more outspoken members of the medical profession, in most of his articles published in the SAMR, he actively supported the practice of negative eugenics in cases of mental illness. He believed that doctors were obliged to intervene and prevent the marriage of mentally ill people, 'for we can't justify the risks of generating a stock of idiots and imbeciles.' He described marriage as being like producing cattle and stated that 'if such a plan were carried out although there might be fewer geniuses and idiots, the race would certainly be healthier and happier'. Greenlees also urged that legislation be put in place that would prevent 'dysgenic' marriages, insisting that if this did not occur, there would be dire consequences in the future. In another article he highlighted the link between State spending and 'degeneracy', describing a context where people 'possessing possibly little more intellect than is required to procreate their own species, are allowed to populate the world with monstrosities that ultimately become a burden on the state' (Greenlees, 1903, pp. 121-125; Klausen, 1997, pp. 27-50; Swartz, 1995, pp. 399-415). In 1907 he published an article called 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility'. In it, Greenlees reflected that medical professionals had a dual loyalty. This statement was made in the context of promoting interventions that were intended to prevent 'neurotic' and 'imbecilic' people from passing on their 'tainted germ-plasm'. He stated that:

> *…I believe we have a duty to perform to the State as well as to the patients – a duty that ... if we failed to carry out, we should be failing the highest ideals we have of our profession. Failure to prevent dysgenic marriages or, when they did occur, failure to institutionalize 'idiots' or 'cretinous' children meant they would grow up to be 'useless members of society and a burden on the family or state'* (Klausen, 1997, pp. 27-50).

As shown in the segment above, Greenlees felt that the state could spare no expense to exterminate what he saw as a potential tidal wave of defective individuals descending on society. He took this position on preferential utilitarian grounds, insisting that prevention programmes were necessary to ensure 'the greatest good for the greatest number'. (Klausen, 1997, pp. 27-50).

## WILFRED WATKINS-PITCHFORD

Dr Wilfred Watkins-Pitchford first presented eugenic articles to the South African Medical Congresses in 1908. Watkins-Pitchford was the President of the Public Health Section of the

Congress in East London. In his Presidential address to the South African Medical Congress in 1908, 'Hygiene in South Africa', he combined both the social context of the practice of medicine with that of nation building under the umbrella of medical practice. He believed that doctors had a unique role to play in developing the nation. He linked this political end with that of the doctor's role in building both strong minds and bodies for the future of the State, and this he linked to the economic value in ensuring that all of the citizens of the country could contribute to the financial growth of the nation as a whole, claiming that 'the healthiest are also the wealthiest' (Klausen, 1997, pp. 27-50).

Both Greenlees and Watkins-Pitchford shared sentiments that were common to the readers and contributors to the SAMR at the time. These were simply that health was a contributing factor to the national economy, and that there was a scientific link between immorality and racial feebleness. The generalized fear of 'feeblemindedness' had many influential followers in the medical fraternity of South Africa, including a number of presidents of regional chapters of the British Medical Association and early mental health's two most influential members T. Duncan Greenlees and J. T. Dunston.

Most doctors who supported eugenics were specialists (specifically in the area of mental illness), and were in the top ranks of teaching positions in Universities and high ranking members of a range of medical associations. This would indicate that this group was more politically motivated and ambitious than the average doctor. They also held far more influence than their less ambitious peers. These men represented specialists in the medical profession in South Africa and legitimized policy which promoted the application of eugenic principles in broader society. These were also the men producing influential writing in scientific journals and thereby influencing a far larger group of professionals.

## INTERNATIONAL EUGENICS

Eugenic practices in psychiatry were not the exception during the early to mid-20$^{th}$ century. Japan, Germany, Brazil, Russia and France (Adams, 1990; Chung, 2002) and China (Human Rights Watch, 2002) all had well established eugenic programmes in place. Mental Health and social issues lent themselves to eugenic thinking on a number of levels. The United States contributed a substantial amount of research financing and input to accumulating the body of knowledge aimed at the study and management of the insane, the criminal and 'feebleminded' (Black, 2003, pp. 3-185; Dowbiggin, 1997, pp. 133-191).

While present writing has adopted the buzzwords of ''master race'' in respect of German policies and Nazi connotations when eugenics is discussed, this has also been done with

regard to South African eugenics and mental health care. It does appear that, except in Germany—where a full blown programme of euthanasia and eradication was put in place both prior to and during the years of the second world war—the rest of the world had focused on management and control, rather than active and immediate eradication. There were certainly proponents of the termination of these persons from some quarters outside of Germany (for example, Lorthrop Stoddard, a Eugenicist and board member of the Birth Control League of America, the forerunner of Planned Parenthood) (Stoddard, 1932, pp. 1-116), but they were not publicly a majority, and certainly did not make their feelings known in public to the same degree.

In spite of the apparent correlation, there was no attempt to segregate the purportedly more intelligent and racially exemplary examples of members of society in the participating countries to act as foundations of a master race or to elevate the 'less exemplary' examples, which was the process being undertaken in Germany. Racial characteristics were not being selected and bred into the population, although there was a concerted effort to prevent certain traits and characteristics from being increased and introduced into normal bloodlines. This included those of the lower classes, who were by no means being eradicated, but less functional members of the community, who were perceived to be a drain on economic resources, were certainly being targeted for segregation on both health and economic grounds. To quote Professor Irving Fischer of Yale University, when discussing social economics:

> *The statistics of the feeble-minded, insane, criminals, epileptics, inebriates, diseased, blind, deaf, deformed and dependent classes are not reassuring, even though we keep up our courage by noting that the increasing institutionalization of these classes gives the appearance of an increase which in actual fact may be non-existent because institutionalization makes it possible to collect these statistics. In Massachusetts thirty-five per cent of the state income goes in support of state institutions and Mr Laughlin, the secretary of this association, who compiled the government report on defectives, delinquents and dependents; estimates that seventy-five per cent of the inmates have bad heredity. The cost of maintaining these institutions in the United States in 1915 was eighty-one millions of dollars. This takes no account of the town and county care, while all the official costs fail to take into account the cost to families and associates, the keeping back of school children by the backward children, the cost from fires of pyro-maniacs, the cost from thievery of kleptomaniacs, the cost from crime, vice, etc., of paranoiacs, maniacs and paretics*[12] *and the loss of services of able bodied men and women drained away from other use to take care of the defectives, delinquents and dependents.* (Leonard, 2005).

[12] Outdated form of the term 'paresis' or partial paralysis. This is often seen as a late manifestation of syphilis. Symptoms include progressive dementia and paralysis. From TheFreeDictionary by Farlex Inc. 2003-2012. Princeton University.

## STERILIZATION

Sterilization of 'less desirable' members of society was commonplace. In South Africa this included great numbers of Black women as a method of containing apartheid political structures. The actual numbers of both these 'normal' women and those considered to be mentally or socially unstable that were sterilized are not known. Management of the reproductive choices of women in South Africa was seen as a political imperative and it is important to understand that this extended so far that there are records of the attempted development of an anti-fertility vaccine by the South African Defence Force to be used against Black women (Editorial, 2000; Fullard, 2004). It can certainly be inferred that the numbers of mentally ill and intellectually disabled persons who were sterilized in South Africa would be similar to those of, for example, the USA and Britain. The number of persons sterilized internationally on the grounds of 'feeblemindedness' was 70 000 in the United States, for example and in Europe, countries including Finland, Denmark and Sweden all developed similar sterilization laws in the 1930s and 1940s (Lopez-Munoz, et al., 2007, pp. 791-806).

South African medical practitioners were openly in favour of the practice, believing that it was so simple a procedure that it had no 'life altering' effects on the person 'in the slightest degree'. In the publication of the Presidential address to the Orange Free State and Basutoland branches of the British Medical Association by C H Bidwell, MRCS, LRCP entitled 'The Question of Sterilization of the 'Mental Defect' published in the SAMR, Bidwell wrote below of the benefits of the procedure, one of the which was the humanity it endowed by allowing patients freedom from institutionalization.

> *The operation of sterilization can be considered a method of treatment as well as a eugenic measure. I have found evidence, and been assured by those devoting themselves to work in mental hospitals, that improvement has followed the operation of sterilization, and more particularly in case of eroticism and sexual perversion, but it is generally recognized that to do much good, this treatment must be applied early. Sterilization can be effected by X-rays, and in this manner it could probably be carried out with fewer objections on the part of the patient and their relatives, as there always seems to be opposition to any operation.*
>
> *…One of the chief arguments in favour of sterilization is its economy as compared to segregation, and the liberty one could then allow the patient. The supporters of sterilization do not suggest that this is a panacea for all mental evil, but maintain from a humane point of view (as well as economic) that if only a certain number could obtain their freedom, this operation should be legalized and practiced upon suitable case.*

> *…Again. the opponent of sterilization assert that after this operation 'women would be able to practice prostitution with impunity as regards the risk of pregnancy, but prostitution has always existed, and will, I fear, continue to exist, and, when one reads the report from "A Review of the Conditions of Defectives in Poor Law Institutions", and learns of the number of illegitimate children that are born the mothers being mentally defective, surely sterilization would be better (even if prostitution did follow, with its evil of venereal disease) than that these illegitimate feeble-minded children should be brought into the world.* (Bidwell, Undated, pp. 175-177)

As can be seen from the continuation of this address below, the obfuscation of what was considered social and intellectual deviance makes for a very rocky foundation on which to base a need for legislation advocating medically motivated sterilization, which this address was doing.

> *… The two chief reasons for placing the feebleminded in institutions may be included under two headings;*
>
> 1. *The prevention of delinquency, vagrancy, prostitution, etc.*
> 2. *The prevention of propagation by persons who will probably produce inferior children.*
>
> *It seems to be generally admitted that heredity is undoubtedly the cause of the increase of the mentally affected. It has never been known for two mentally defective individuals to become the parents of a normal child and it is asserted that no less than two thirds of all feeble-mindedness is due to heredity.* (Bidwell, Undated, pp. 175-177)

Furthermore, colleagues were quoted to give credence to the need.

> *…Dr Swift said to me that though he does not agree that sterilization should be carried out as a routine measure. (and not being the greatest supporter of sterilization would suggest it as a routine), still he thought it would be a good method in individual-cases where practically the only reason for segregation was the eugenic one and the patients are not antisocial, or vicious, and can manage to support themselves. And it is for these cases that I am bringing the matter before you to-night, namely, to get freedom and liberty for this particular class.*
>
> *…Dr Gibbons, who has evidently studied this subject very deeply and thoroughly, says that in his opinion there is only one way of doing permanent good. And that is by sterilization of the mentally defective, and he puts this under two heads:*
>
> 1. *Sterilization of children.*
> 2. *Sterilization of adults.*
>
> *If all treatment for the mentally defective child up to the age of 6 years has proved not to benefit the child, and there is no doubt that the child is mentally defective, then the child ought to be prevented from becoming a parent, and thus*

> *being the means of bringing into the world children more or less defective. With reference to the sterilization of adults, Dr Gibbons points out that it would only be necessary to deal with adults for a certain time for the reason that all defective children would previously have been sterilized.* (Bidwell, Undated, pp. 175-177)

The concept of 'sterilization' encompasses a number of threads, which run through mental health as oppositional elements. If we view the act of sterilization and the rights infringements which would be perceived to have gone with it using present day ethical thinking, and we compare it to the statements made about the rights infringement of not allowing a 'mental defective' to have his freedom for the greater good of society at large, we could be lured into thinking that the patient's wellbeing is the focus of the need for sterilization. But when we view the additional statements that this would need to occur on the grounds of his being likely to procreate and produce more 'defectives', who commit social and moral 'crimes', there is doubt as to the validity of sterilization being in the interests of the 'defective' person. Additional to that is the theme of economics and cost that is often brought into discussions around 'defectives' and their control and containment. The financial (and obviously State) cost of this type of social management is very high, and covers housing, pensions, disability and unemployment insurance and medical services and hospitals. In this case cost became the principal driver behind the acts of sterilization and this was not in the best interests of the patient, but rather in the best interests of the state (Duncan, 1990; Pellegrino, 1999, pp. 243-266; Leonard, 2005).

While we may not be prepared to accept that clinical practitioners would be prone to act in a preferentially utilitarian manner[13], this was often the case. A simplistic example would be the use of legal structures to control unwanted pregnancy in intellectually disabled and mentally ill persons. There was a racial skewing to the number of sterilizations performed in South Africa from 1977 to 1989, under Section 4 of the Abortion and Sterilization Act (2 of 1975). According to a report of the Department of National Health and Population Development (Nash & Navias, 1992, pp. 437-440), the incidence of White women sterilized nationally was considerably higher than that of Black and Coloured women. This data, in retrospect, indicates that the motivation for sterilization was based on factors other than those of simply ensuring that procreation did not occur.

[13] In a way that serves the greater good of a preferred section of the population.

Table 1: Total number of patients sterilised under Section 4 of the Abortion and Sterilization Act (2 of 1975) from 1977 to 1989.

| No of Patients | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Year** | **White** | **Black** | **Coloured** | **Asiatic** | **Total** | **Female** | **Male** |
| **1977** | 33 | 16 | 25 | 0 | 74 | No Data | |
| **1978** | 49 | 7 | 10 | 4 | 70 | | |
| **1979** | 54 | 12 | 12 | 6 | 84 | | |
| **1980** | 65 | 11 | 33 | 4 | 113 | 105 | 8 |
| **1981** | 73 | 19 | 15 | 4 | 111 | 107 | 4 |
| **1982** | 49 | 9 | 12 | 4 | 74 | 70 | 4 |
| **1983** | 80 | 20 | 15 | 11 | 126 | 121 | 5 |
| **1984** | 93 | 19 | 49 | 12 | 173 | 165 | 8 |
| **1985** | 127 | 22 | 53 | 31 | 233 | 202 | 31 |
| **1986** | 93 | 26 | 47 | 36 | 202 | 189 | 13 |
| **1987** | 107 | 38 | 40 | 25 | 210 | 192 | 18 |
| **1988** | 94 | 39 | 32 | 17 | 182 | 165 | 17 |
| **1989** | 87 | 25 | 22 | 19 | 153 | 127 | 26 |
| **Total** | **1004** | **263** | **365** | **173** | **1805** | **1443** | **134** |

Social reasons, economics and lack of full time caregiver support were some of the reasons given for the need to sterilize intellectually disabled individuals. The prevention of pregnancy, due to the inability of the person to exercise personal judgment or defend themselves against sexual abuse, obviously was the most reported. Black and Coloured patients appear to have been markedly underrepresented in national health department statistics, although this could be attributed to both the cost of applying for a court order and access to appropriate legal knowledge and social structures to make applications under the Act. Additional issues of antilock of trust and rejection of what were perceived as population control measures can be added as contributing to the low numbers of legal Black sterilizations. This lack of access may have resulted in a concomitant escalation in the rate of illegal abortions and institutional and state sterilizations without consent (Kaufman, 1997).

The present day *General Ethical Guidelines for the Health Care Professions* has, as one of its core ethical values and standards, the following ‘‘*Professional competence and self-improvement: Health care practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice.* (Health Professions Council of South Africa, 2008). If we measure the ethical values of the practitioners and practices of the period covered by this chapter, we might be very surprised. In terms of their skills, regardless of how our present day medicine and practices may have changed, they were seen as some of the best of their profession. They were giving papers at conferences

both nationally and abroad, contributing to peer journals, again both nationally and internationally. Their treatment methods were regarded as some of the most advanced in the world of psychiatry. There was a major drive to provide services for patients. While we would certainly, in retrospect, like to criticize these practitioners' racist values as being aberrant, they weren't. Were they justified? Not in terms of the thinking of the time. They were viewed with respect by their peers in the international mental health community. Were they ethical by the standards of the time? Yes and no. If the primary responsibility of the practitioner was to save the state money, then no, the practitioners' first priority should have been to their patients. If they were acting in the best interests of their patients, who were perceived as being defective, and they were sincerely of the belief that what they were doing was at the highest level of their skill according to their training and the positions of their peers, then yes, they were. The answer to the question can be reduced to the values of the practitioners, and whether values are relative or absolute. They clearly, shift in relation to a number of factors. The concept of 'situational ethics' (Roth & Bluglass, 1985, pp. 188-189) supposes that values are fluid and relative to a context and allows for practitioners of an era to be seen as ethical within their professional context, but also to allow them to viewed as unethical in a different era and context.

# CHAPTER 3: THE UNDESIRABLES

This chapter will frame the concepts of contagion and disease in terms of historic medical thinking. It will provide an overview of how segregation practices in medicine—predominantly to prevent contagion—became linked to the political processes of segregation and apartheid.

Mental health in the early days of the Cape needs to be appreciated as having been at the level of an outpost on the outskirts of civilization. The population of settlers in the Cape in 1652 numbered 100 men and 25 women and children. In 1661 this had increased to 144, and this number had risen to 289 by 1679. The settlers had no formal built accommodation, and the badly built shacks exposed them to all manner of bad weather conditions. There were often food shortages. Illness and health issues were common, with dysentery, scurvy and beri-beri being the main cause of death amongst the colonists (Minde, 1974a, pp. 1270-1272).

> ***My own view is that this planet is used as a penal colony, lunatic asylum and dumping ground by a superior civilization, to get rid of the undesirable and unfit. I can't prove it, but you can't disprove it either.***
>
> ***Christopher Hitchens***
> *(Hitchens, n.d.)*

Identifying which of the disorders reported in the texts of the time were those of mental illness is difficult. Pellagra, would have produced symptoms of delirium, for example, and was often interpreted as mental illness. Incorrect or outdated identification of symptoms of illness as mental illness is a theme that continues throughout the history of South African mental health. Further confounding effects on the interpretation of mental health were the severe Calvinist influences combined with multicultural superstition in the melting pot of the colony (Minde, 1974a, pp. 1270-1272).

A further theme that was to have a profound effect on the development and provision of medical and social services in South Africa was that introduced by the pathologising of the use and abuse of alcohol. In the 1600s beer was considered to be a foodstuff, and certainly provided a number of an adult person's daily requirement of vitamins and minerals. Within a very short time of the Cape having been colonized, the Dutch East India company had provided hops plants for the development of viticulture, and within a further period taverns and canteens had sprung up around the Goede Hoop. The fermented liquids ushered in a social context of drunkenness in the harsh and unforgiving circumstances (Ure, 2010). Brawling, stabbings and murders were the order of the day, and innkeepers in the Cape quickly developed a well-documented reputation for immoral and criminal behaviour. Justice

for criminal and socially inappropriate behaviours was harsh and torture was a commonplace part of the judicial process. Whippings, branding and beheadings were all part of the legal repertoire. Conduct, which we find barbaric by today's standards, was used to maintain law and order (Minde, 1974a, pp. 1270-1272).

Within this context and where this cruelty was commonplace, both slaves and 'lunatics', who were seen as inferior beings by the general colonial population, could be targets of aggression with little fear of punishment. Demonic possession was still believed to be the cause of mental disease and this thinking remained popular until the end of the 18th century. Because of the small population of the Cape, facilities for 'lunatics' were neither considered to be a priority nor a necessity, and the general perceptions of the causes and content of mental illness made it even less likely that provision of these would be a critical consideration. From the 1600s to the late 1800s, Robben Island played a role in the segregation of criminals and mental patients from the general population of the colony. There was no attempt to run a formal mental institution on Robben Island until the British occupied the Union in the late 1800s and early 1900s (Minde, 1974a, pp. 1270-1272).

## CONTAGION & SEGREGATION

Prevention of exposure of members of society to contagious disease is not a recent national concern (Phillips, 2012). HIV/ Aids has highlighted both the short term and long term effects of not engaging with the spread of disease in an appropriate and effective manner (Ainsworth, 1998, pp. 18-21; WHO, 2011). Concern about the cost of dealing with contagion, the number of deaths which may be incurred and the potential social breakdown which can occur, has been cause for concern since the influx of people into close confines of towns and cities during the industrial revolution. Colonization brought its own precarious health tightropes, as local disease and imported infections competed with the colonizers' contagion, often transported thousands of miles to Africa, like the common cold and venereal disease (Smith R. E., 2013; Jochelson, 1990).

As with the present time, prevention fell to the state to enforce measures to limit the exposure of people to infection, as well as to contain outbreaks of potential harm from disease. Lack of understanding of numerous clinical disorders and their potential for spreading often led to inaccurate theorizing and even more erroneous treatment regimens being developed. As mechanisms causing spread were not understood, and in the case of mental illness and disability, greatly misinterpreted, the reasons for hospitalization and exclusion from greater society were based on fear, religious interpretations of good versus evil and plain, stigmatizing ignorance.

To illustrate this, in the late 1800s to the 1970s numerous so-called 'Ugly Laws'' were promulgated internationally to allow state powers to contain and conceal members of society that they felt should be out of sight of decent persons. These laws, sometimes termed an 'unsightly beggar ordinance' meant that these persons could be forced to remain out of sight of the community at large because of their disabilities, illness and or physical defects, often out of fear of contagion. One such ordinance in Chicago in the USA stipulated:

> *No person who is diseased, maimed, mutilated or in any way deformed so as to be an unsightly, disgusting or improper is to be allowed in or on the public ways or other public places in this city, or shall therein or thereon expose himself to public view, under penalty of not less than one dollar nor more than fifty dollars for each offence. (Chicago Municipal Code, Section 36034)*

South Africa did not escape this thinking, or the promulgation of similar legislation to manage 'these' people. While this is not a treatise on sexually transmitted disease, the links between historical thinking around sexually transmitted disease, mental illness and intellectual disability, which are linked by inference, are important for understanding health's power base in terms of the state's political position on exclusion of unwanted members. Blame for outbreaks and the transmission of disease have to be placed somewhere. When the first deadly outbreaks of syphilis were seen in Western Europe, the Italians blamed the French, calling it 'the French disease'. The French termed it the Italian disease and the English, the French disease. Worldwide sexism appears to have become manifest in the blaming of STD's on loose and immoral women (Mbali, 2001; Lowndes, 1882).

Venereal disease and more specifically syphilis had common links with diagnosed mental illness, not, as one might first imagine, because of the residual cognitive deterioration which occurs further along in the disease, but rather the notion that contracting it occurred through moral impropriety and participation in immoral acts, a view that later became a cornerstone of the South African Immorality Act (South African Government, 1957). Sexually transmitted diseases were largely the domain of the socially stigmatized, but were also a matter of political significance. Racial and class sensitivities introduced a need for control and interventions to curb what was potentially a threat to the stability and welfare of the outpost, given its distance from the mother country. Added to this was a propensity for colonizing militia to become rapidly infected with venereal disease (Levine, 1994). The situation in South Africa, especially in the early 1900s and certainly because of the steady migration of both miners from both within and external to the South African borders, led to slum areas forming in the Transvaal, for example. Poor Afrikaner farmers were also flooding to the cities to try and find work in order to survive. The stage was set for poor Whites and migrant workers to become infected en masse. Infected people, both Black and White, were

dismissed from their places of employment, and were often forced to turn to thievery and prostitution to survive. Living in close proximity was a major social factor that aided the spread of the disease to all parts of the country. Alcohol, which formed the basis of slum entertainment, also contributed to the growth of prostitution and an increase in interracial sexual relationships (Ure, 2010; Van Onselen, 2001, pp. 309-368; Jochelson, 1990).

## THE 'LOCK'-UP, HEALTHY ALTERNATIVE

The British imported the concept of the Lock hospital during their occupation of South Africa to manage the spread of syphilis among their troops stationed in the country. This was similar to how they had dealt with contamination of their troops in India during the colonization of that country. Because there was no effective treatment for syphilis, management included removal from society and the infected person's freedom to spread the disease being curtailed. The administration of a number of toxic substances that included mercury were also used, in the hope that they could halt the course of infection (Levine, 1994, pp. 579-602).

Removing undesirable people from society forcibly on health grounds became acceptable practice with the emergence of Lock Hospitals. These facilities and their operations were not matters of public knowledge or intervention, but seen very much as 'necessary evils' for use by less moral and upstanding members of society. Lock Hospitals admitted persons who had contracted venereal disease, through prostitution or through immoral acts, a number of which were considered to be mental illness and/ or intellectual disability (Jochelson, 1990; Harrison, 2012; Lowndes, 1882).

> *Lock Hospitals have a special interest for the medical profession and the public quite apart from the special character of the diseases treated within their walls. Indeed, their very existence is a matter of accident. They owe it to the extreme foresight and benevolence of their founders, who established them in spite of much discouragement and many difficulties. As we shall see presently, the maintenance of these hospitals is a work of great difficulty, and any extension of them on the voluntary principle apparently quite out of the question. Now, it would be entirely contrary to the proverbial benevolence of this country if there were not very strong reasons for this apparent negligence, and one chief reason is not far to seek. These hospitals being built and maintained for persons suffering from venereal diseases, it follows as a natural consequence that the female patients will be mostly common prostitutes, and the male patients' men who have been guilty of some recent act of immorality. In other words, lock hospitals are principally for the reception and treatment of persons suffering from diseases, the direct result of their own vicious indulgence. This is why they enjoy so little of the liberality so lavishly bestowed upon other hospitals and infirmaries, both general and special. Other circumstances tend to strengthen this loss of*

> *support. For obvious reasons, those who are entrusted with the management of these hospitals cannot advocate their claims for support from the charitably disposed so publicly as in the case of other charitable institutions. Of these latter, the only ones which can in any way be compared with lock hospitals are homes and refuges for fallen women, which, however, differ from them in many important points which need not be discussed here. Again, Lock Hospitals can never be open to the inspection of the public, nor can they ever be the objects of public entertainments, annual dinners, concerts, or bazaars. Their claims cannot be specially pleaded from pulpit or platform. Their work must be begun and carried on silently and unnoticed, save by the very few* (Lowndes, 1882).

As described by Lowndes above, the work of these facilities was hidden from the public eye so as not to offend the sensibilities of respectable people. Often linked to poor houses, asylums and infirmaries, these facilities had the complex duty of segregating the diseased person from others in society, who may contract disease, protecting the sensibilities of the public from what would have been the extreme embarrassments of for example, a wife being infected with venereal disease by her husband, and the additional social and religious mandate to turn the so-called wicked and immoral from an evil path to the path of goodness. This thinking was linked to class perceptions of behaviour and what was considered to be scandalous and not done by persons of good breeding. In a further section of a report from Lowndes in 1887 on the good works that these facilities provided, he states

> *The report gives the most favourable results of the Asylum, Servants' Home, and Mission to Female Out-Patients, which show that the hospital assists very much towards the future moral and social welfare of its patients, as well as in promoting their bodily cure. Among the patients are married women who have been infected by their husbands and females who have only recently fallen, many of them being very young.*

About a lock skin and disease hospital he said

> *The Committee have reason to believe that the public now recognize the sanitary and moral advantages of hospitals devoted to the special purpose for which this was originally instituted in 1819; at the same time they wish to correct the impression which still prevails that the hospital is provided for the relief of the most abandoned, and to state that their efforts are rather devoted to assist those who are the innocent victims of vice, and those who have been more sinned against than sinning, and to those who are anxious to escape from situations of vice and disease. Innocent wives and young children form a large percentage of the persons treated.*

And

> *The class of patients received into the hospital is principally composed of those who have never known the advantages of sympathy and cleanliness, and who are taught, for the first time, habits of self-respect, regularity, and decency. Under the influence of spiritual, as well as bodily, comfort, they are encouraged by the*

> *motherly tenderness and shrewd sagacity of the matron to give up their wicked life, and assisted to commence an honest and virtuous career* (Lowndes, 1882).

In South Africa, the implementation of lock hospitals and the corresponding promulgation of the Contagious Diseases Act of 1885 led to district surgeons being given the authority to place both men and women under treatment for syphilis without their consent (SAMJ, 1886, p. 64). It was not a giant leap for the same concept of segregation to occur with those people considered to be pariahs in society. There are a number of cross cutting hermeneutic pathways which intersect both international and South African social and health processes at the time. Some of these elements include those of interpretations of social propriety and the skewing of the thinking of class into that of a scientific category. This same thinking continued into the theories of racial disparity, which underpinned the applications of racist notions around social and health matters during the apartheid epoch. The sign of 'contagion' underpins the majority of the thinking around 'lesser persons', in terms of breeding, hygiene and the moral plane of elevation through birth (class). This class disparity was obviously accompanied by a significant corresponding economic inequality, which provides another and allied sign associated with the concomitant areas of this study.

If we apply our understanding of the law, social and scientific thinking at the time, we can certainly understand the stigma of the time, which extended to cover religious dogmatism as well as historic gender and class discrimination. It is also possible to put this thinking into the context of mental illness. What is noteworthy is the ethically driven bias to, on the one hand, care for these 'poor' people and on the other, change the characteristics of being dirty and indecent and wicked to those of 'good' citizens or to remove them so that they were unable to contaminate anyone else. The links between what was considered to be mental illness and pathological behaviour in the acquisition of venereal disease, for example, could be extended to establish the 'wrongness' of interracial relationships (South African Government, 1957). Separation of the visually and observably deficient from the rest of the community, and preferential utilitarianism, reinforced the role of leaders of communities to take the responsibility for protecting their constituents. This required state structures and infrastructures that were provided to manage social issues. Facilities designed to undertake social and medical segregation were a design conglomeration of architectural developments that did not emerge from clinical, treatment or care underpinnings, but rather from prisons and epidemiological isolation sites (Stott, 2013). The transmogrification of various types of facility for the socially miscreant changed to meet new political, social and economic challenges following the historical developments that culminated in South African institutional psychiatry. Jeremy Bentham, in his description of the ultimate prison environment for criminals, the Panopticon, overlapped the needs of both medical and school facilities with

these control-based institutions with the intention of 'managing' the residents in a suitable and purportedly humane, albeit restricted environment (Bentham, 1843). These extended to any facilities where people had been separated from the community because of their undesirable nature or condition.

> *Why not, as well as to the Asylum, the Magdalen, and the Lock Hospital, in London? The scene would be more picturesque; the occasion not less interesting and affecting. The prospect of contributions that might be collected here as there, will bind the manager to the observance of every rule that can contribute to keep the establishment in a state of exemplary neatness and cleanliness, while the profit of them will pay him for the expense and trouble. Building, furniture, apparel, persons, everything, must be kept as nice as a Dutch house.* (Bentham, 1843, pp. 13-113)

These wider debates included those of power relations, as described by Foucault, but also introduced the additional concept of provision of social care with value and purpose within the controls of the built environment. This introduction of the combined role of a restrictive space with a care and socially uplifting, protective base for the forced care of the mentally and socially ill fitted the clinical model of forced care, and thereafter, Lock Hospitals became a feature of the South African clinical landscape. These were transformed into mental health and TB facilities once a cure of syphilis was found (Deacon, 1996; Jochelson, 1990; Swartz, 1995).

As previously untreatable conditions became more responsive to pharmacological developments in the health field, so the lock facilities where these patients had previously occupied became available for other uses, and these were tailor-made for Smith Mitchell mental health facilities (Smith, 1996; Minde, 1977a, pp. 549-553).

## RELIGIOUS INFLUENCES

The church played a role in both the structural aspects of institutional care (with the provision of buildings) and the spiritual aspects of saving of souls.

> *The necessity of a chapel to a penitentiary-house is a point rather to be assumed than argued. Under an established church of any persuasion, a system of penitence without the means of regular devotion would be a downright solecism. If religious instruction and exercise be not necessary to the worst, and generally the most ignorant of sinners, to whom else can they be other than superfluous?* (Bentham, 1843)

Understanding morality and ethics over time and what was, and is presently considered 'good' and 'bad' is reliant on interpretation in a specific temporal environment. 'Good'

treatment of 'bad' people could be quite punitive and harsh, for example, seen as being in the person's own best interests in order not to spoil them by being too lenient. If we use the Magdalene Laundries in Ireland as an example, where girls were admitted to a life of harsh and punitive work for perhaps having a baby out of wedlock, we can see that the nuns' treatment of the girls incarcerated in these facilities was harsh to ostensibly instil in them a sense of discipline and morality (Irish Department of Justice & Equality, 2012). The underpinning semiotic [14] here encompasses not only the Catholic rejection of sexual intercourse and pregnancy outside of the Christian sanctity of marriage, but also the concepts of parental shame and community rejection of socially unacceptable behaviours. A further facet of the macrostructure reinforcing the domain of interpretation would be the autocratic and paternalistic aspects imbedded in Irish gender disparities, the lack of power that women and girls have over their own bodies in catholic communities and the absence of reproductive choices (Ferriter, 2009). The biblical case for the placement of girls in these laundries was that Mary Magdalen was healed of her specific affliction, that of 'spectacular' and 'profligate' sin, by the casting out of her seven devils and her belief in God (Hobbes, 1651). The discovery of these laundries recently has caused a furore in the popular press at the often arbitrary removal of the girls' intrinsic rights to freedom and their virtual slave labour for social and religious misdemeanours and petty crimes (McDonald, 2013; Irish Department of Justice & Equality, 2012).

The interpretation of what constituted good and bad behaviours, where behaviourally diverse groups were concerned, is also highlighted in the South African context. It had a profound effect on what medical practitioners saw as their duty to their fellow man in terms of the ethical care they provided. From deep within the same biblical undergrowth—albeit from a Calvinist value system—arose the same paternalistic beneficence. Religious mores in the Union had a profound influence on the development of the content of the 1916 Mental Health Act by including what could only be interpreted as 'sins' in the biblical sense (Nasar, 2013, pp. 385-398; Naicker, Undated).

As an intricate component of social life, insanity has always been problematic in terms of religion. The mention of it in this document is simply that: a mention to contextualize some of the ethical thinking of the time. It is not intended to discuss the links in depth. The interpretation of madness has, over centuries, included elements of criminality and evil, with a corresponding rejection of social and class difference on the one hand, to the other, where insanity is celebrated and sought after as a gift from the gods or ancestors, which allowed for the prediction of the future in form of messages from the beyond (Porter, 2003). Until

[14] Or symbol set.

medical thinking gained primacy and assumed responsibility for the care of the socially needy and dysfunctional, including the mentally ill and those who were unable to conform to the norms of society, their care was the domain of religious organizations. Treatment was pragmatic. There were two methods of care. In the interests of protecting the community, if the person's behaviour did not react to charity, love and prayer, they fell under the ambit of the legal system and correctional services. Because these people often displayed deviant and aggressive behaviours, it can be seen why they were thought to be possessed by demons. Demons were the domain of religion, and in South Africa, religious institutions played an important role in the shaping of social norms (Lelyveld, 1985). From the 1920s onwards, the Dutch Reformed Church in South Africa played an increasingly significant political role in the development of negative racial stereotypes amongst their congregations. These perceptions were formed around religious ideology, and a corresponding need to improve the lot of poor White Afrikaners who were streaming into the towns to escape increasingly difficult economic circumstances. 'Good' as a notion was linked to Christian virtues in the early Union of South Africa and in line with corresponding social norms rejected so called 'heathen' vices. The former, and the ideal, was White, Christian and civilized and carried a positive value in rejection of the latter, negative, 'heathen', primitive and Black. Racial segregation was therefore sanctioned by the church, and by implication, by God, the highest authority. This provided considerable credibility to the ideas originally founded on medical racism, and explains how these concepts came to be supported by social institutions. In South Africa the exploitation of these concepts by powerful social and political protagonists laid a solid foundation for separatism. The underlying agenda of the then Afrikaner leadership structures was to consolidate an Afrikaner based national consciousness founded on racial superiority, and conversely, inferiority. The exclusivity was imbedded in the concept of being God's 'chosen'. The Afrikaner was portrayed as being better than other groups, and in this case, good and bad were delineated by colour. (Ritner, 1967, pp. 17-37).

The primacy of the family and the sanctity of marriage were the spine of the planned response to uplift the community. This also formed the mandate for social welfare. The introduction of Christian norms to the mix infused the same good and bad social value system to the mix as were found in the Crusades. Hilberg (1961) expanded on this by demonstrating that the introduction of anti-Semitism was a destructive process, which was also based on the war against good and evil elements in communities where nationalism had a strong foothold. This required not only administrative state structures, but also psychological ones in the community. The citizen is placed in a position to promote good and

to destroy evil. The harder the task, the more moral the person has to be, and the more courage the person must show to overcome it (Hilberg, 1961, pp. 27-131).

## SEGREGATION (APARTHEID)

The term apartheid means segregation. Few other countries have had the concept of segregation play such a determining role in the development of the historical process as in South Africa. The term was not found in any English/ Afrikaans dictionary until 1950 when it was coined by the Nationalist party after Prime Minister Smuts admitted in a speech in 1944 that the traditional South African policy of 'segregasie' (or segregation) had failed. (Landis, 1961, pp. 1-52).

To understand the basic foundations of segregation, the concept of 'race' must be understood. There were four basic groups: White, Black, Yellow and Coloured. Whites comprised English and Afrikaans cultural groups, and were generally referred to as Europeans. They consisted of Dutch and Huguenot Calvinist settlers who had fled religious persecution in Europe. The Afrikaners comprised mainly farmers. The English on the other hand were colonists and Empire builders, and were primarily city dwellers. The Black group consisted of Bantus (all indigenous Black people, often also referred to as 'natives'), Northeast African Hamitic people and Negroid people. Coloureds were descendants of the union between Cape Malays and/ or Europeans and Hottentots or Bantu. The Yellow group was made up of predominantly Indians and Pakistanis, but Indian was used to refer to all Asians indiscriminately. Much of the definition of race rested on pseudoscientific interpretations of racial difference (Landis, 1961, pp. 1-52).

The most important distinction that should be made for a racially segregated system of governance to succeed is the one between races. It is more specifically a comparison of socially defined groups. Thus, for this discussion, 'race' and 'racial differences' will be used in the same context as that used in Pettigrew, and that is in its most relative sense. Hilberg made a distinction between the type of racism which drove firstly, the American process and secondly, that which drove the German process of eradication of the Jews. He explains it as a functional difference. The Americans (and it can be seen, the South Africans) identified a racial group, and then attributed social behaviour patterns to that group, for example, the Negro. The Germans identified a group with ethnic characteristics and attributes, and then pinned a racial quality to that group, in this case, Jews (Hilberg, 1961; Hitler, 1943; Burleigh, 2001).

Racial differentiation was problematic in South Africa, simply because there was no clear cut distinction which could be made between groups who could all demonstrate a range of colour differentiation, sometimes even between members of a single family. And because there was no scientific method of distinguishing these characteristics, apartheid distinction, and the legislation that accompanied it, was sometimes erratic. Shapiro, in an article entitled 'Blood groups and Skin Colour' in the Journal for Medicine, (1953) said the following, which gives a glimpse of the difficulties in defining race:

> *Where, for the purposes of legal classification, the question arises whether a person is White, Coloured, Negroid or Asiatic, the policeman and the tram conductor, unencumbered by biological lore, can make an assessment with greater conviction, and certainly with fewer reservations than can the geneticist, or anthropologist. Indeed the evidence of the scientist on the subject of race can only prove to be an embarrassment to the Courts if not to himself.* (Landis, 1961, pp. 1-52).
>
> *"White person" means any person who in appearance obviously is or who by general acceptance and repute is a White person.* (South African Government, 1957).

## DISEASE AND CONTAGION

The discovery of transmissible bacteria due to sanitary problems was the catalyst for scientific intervention and input of State health establishments. Segregation also became a viable choice for disease control, when there were financial implications to care (Deacon, 1996). While tuberculosis was a real concern after the discovery of gold and diamonds in the Union, the understanding of contagion and disease had been a matter of public health concern that began with the spread and containment of syphilis amongst the settlers and indigenous population of Southern Africa. David Livingstone, the 19th century British missionary and explorer, noted in correspondence that the incidence of syphilis was common nearest to the coast and was not found in the interior. Venereal syphilis amongst Coloured women driven to prostitution by the lack of available employment in the domestic and laundry sector by the freeing of slaves escalated markedly after the 1830s. The pauper hospital authorities in Cape Town, where a number of these women were held, insisted that the cost of their care be offset by their forced labour while in prison (Jochelson, 1990).

## RACE AS GROUNDS FOR SEGREGATION

By the 20th century, a definite picture of segregation and separateness was in place, not entirely due to colour or culture, but one that also emphasized the discrepancies around

access to economic, legislative and political power. This was a situation that was mirrored throughout western medicine, but with specific emphasis on mental health. This thinking was not merely third world racialised medical thinking. The WHO in 1953 provides insight into the period's operational systems, for example, and this included the rationale for sending Black patients for psychiatric care. The basic criteria for sending black patients to mental institutions included knowledge that, firstly, facilities were available and that, secondly, authorities would assist in getting the deranged person to the facility, and would do the administration. Reasons for many admissions included violence in the home, chronic and intractable symptoms and (to quote) ''propinquity to Europeans who insist on segregation (as with squatters on European farms)'' (Carothers, 1953, pp. 24-25). Carothers went further to explain that Africans were riddled with disease, usually more than one when compared to the European of the time. This also had implications for medical practice and the teaching of medical practice as a social phenomenon.

Multiplicity of causation is particularly striking in African hospital practice and has been well expressed by Gelfand, who says that ''whilst the European medical student is taught, as a rule, not to diagnose more than one disease, he must forget the instruction when he is dealing with a Native. Infection of one sort or another is seldom absent in the African, sane or insane, so that, although its psychiatric importance in general is unquestionably large, the role it plays in particular cases is often obscure'' (Carothers, 1953, pp. 24-25).

There was also a difference in diagnosis between public versus private care facilities. Most of the figures published around diagnoses and treatment of the lower social groups during the time period under discussion were sourced from public hospitals. If the patient was of a higher social income group, he had access to private care. In private care, reports of this type of illness were most often not reported in public research, especially if it was a sexually transmitted disease, for example syphilis. Deaths due to this illness were often not reported due to the shame of the diagnoses especially in those persons of a better social class (Pettigrew & Pettigrew, 1963, pp. 315-333).

Studies in the US, however, often demonstrated that the higher rates of admissions of Negroes were due to the low social status of the Negro rather than some biological or genetic difference due to 'race' (Pettigrew & Pettigrew, 1963, pp. 315-333).

## RACIST VERSUS RACIALIZED MEDICINE

Racist discourse provided the impetus for the development of social and medical theory behind racialized scientific practice. These reinforced a number of scientific practices that

could be both explained and 'justified' by the contemporary norms and practices. Medical practitioners and members of the scientific community, who were predominantly European, religious and well educated were also held in high regard as members of their communities. Their embracing of disparate treatment methods for different race groups gave credence to the practices. South Africa combined racist medicine and medical racism in the development of national mental health care provision. Both of these embraced eugenic or genetic principles (Deacon, 2000, pp. 190-206) .

Predominately White, male and middle class, medical professionals maintained the 'colonist mentality' of medical practice by deferring to colleagues in Europe rather than those based in the Cape. Interaction between local practitioners was predominantly social, including their contributions to the start of the formalized South African Medical Journal in 1884

> *Some 40 or 50 years, ago, however, it was the custom of the medical men then in practice in Cape Town, some dozen in number, to meet in each other's houses in rotation about once a month, the host for the evening providing a paper, which was followed by a discussion, and usually by a supper or something of that nature, the meetings being of a most cordial and friendly description* (Herman, 1884, p. 11).

This changed with the development of South African educational institutions, although these rigid links to international universities was to delay the need to promote the creation of medical schools in colonies like the Cape, Australia, India and Canada. Socially well-connected and wealthy colonial families would send their sons overseas to study traditional Eurocentric medicine, which was financially out of reach of ordinary colony families. (Deacon, 2000, pp. 190-206).

The concept of racism in the Union was still relatively nebulous during the early 1900s. The inequality of treatment between Black and White patients was often on grounds of economic incongruity, and not on the basis of race. Doctors charged for their services and Black patients could simply not afford the fees. This discrepancy was linked to class differences, which in turn led to segregation and reduction in services to less prosperous members of the community. State and missionary hospitals provided the venue for contact between Black patients and White doctors. Because of the dominant custodial model of practice within these institutions, segregation of treatment was the norm. The reduced service was not necessarily due to racial discrimination, where Black patients were discriminated against. These discriminatory practices extended to poor Whites as well, and especially those of the Afrikaner group. Migration of both poor White Afrikaners and Black migrant labourers to the cities to find work increased both the disease and crime rates of both groups. Temporary liaisons and casual sex spread disease, and the illegitimate birth rate

increased to a rate as high as 70%. Syphilis was seen in almost 20% of healthy African women seen in antenatal clinics (Jochelson, 1990, pp. 1-24).

## OTHERNESS OF THE BLACK PATIENT

There is a solid theme of otherness that runs through the texts of South Africa over the period under review. International thinking was not different, and provides an inferred way for South Africa to have inculcated some of the global ideation that accompanied development of legislation and political mores of the time. Otherness, by definition, is dissimilarity or difference between concepts and not as a reference to an unknown concept. Sir John Foster, K.B.E., Q.C., M.P., in his 'Enquiry into the Practice and Effects of Scientology' as recently in our history as 1971, puts it quite succinctly, albeit in the bigoted fashion of the day:

> *... The attitude of the general public in Britain to foreigners—and to a good many other questions—demonstrates conflicting feelings of friendliness and hostility. On the one hand, there is the centuries-old insular tradition of contempt for Dagoes, Frogs, Wops and other lesser breeds without the law, who should be allowed to come here only for brief periods on sufferance, and then go home where they came from and trouble us no more. On the other hand, there is the equally old tradition of welcome and hospitality, founded on a desire to learn from others, to widen our horizons, to enrich our experience and especially to help those who suffer persecution in their own countries...* (Foster, 1971)

This otherness became the focus of far more stringent church interference in the development of the South African political landscape. 'Baasskap'', which was the substructure of the traditional master/ servant relationship, and which was governed by legal principles put in Acts, was being overtaken by a more rigid course into racial management of total physical racial segregation (Ritner, 1967, pp. 17-37).

Clinical concepts of otherness were based on more sinister thinking. From as far there had been evidence provided to demonstrate that the Black was markedly different in a qualitative sense. Their strength and apparent ability to withstand harm was considered remarkable, as Impey describes below.

> *I have had the good fortune to meet with a few cases, which show that the natives of this Colony can survive injuries, which would prove fatal to individuals of almost any other nationality. Without referring to the successful results of some of their most barbarous operations, such as men amputating their own legs and arms with knives and pieces of hoop sharpened on rough stones, I shall give a short account of at least two most remarkable cases which prove that the natives have an excessive amount of vitality and can stand very severe injuries*

> *especially to their skulls, without any apparent discomfort. I have seen a native man fall from a bridge, a height of 70 feet, on his head into a sort of sandy shingle, with no ill results. After shaking his head and dusting off the dust and looking up at the place from which he fell with a somewhat astonished look, he only resumed his work."*(Impey, Undated, pp. 91-92)

Black people's perceived above normal strength, combined with an assumed lack of intellectual capacity, provided a solid foundation for academics to make statements about their need for separate stream education and amenities. The rhetoric surrounding Black males' purportedly voracious sexual appetites and the attendant White fear that their women would become a target of these should the Black be uncontrolled also formed part of the mythology. Research served a largely manipulative purpose, that of being able to demonstrate the differences and the proofs which were being expounded by pseudoscience (Du Bois, 1943, pp. 362-387; Graves Jr & Johnson, 1995, pp. 277-294).

The use of racial stereotypes found a variety of expressions in psychiatry. These were often used to justify certain methods of care, or the provision of limited or no care on the grounds of racial difference. One of the proponents of this was the then Commissioner of Mental Health, Dr A M Lamont, who from 1961 to 1970 had initiated the government's contractual use of Smith Mitchell facilities. Dehumanizing statements degraded Blacks in their entirety as persons and not only in the context of mental health care in South Africa during this period.

Moral philosophy has developed to a point over time where there is a common ethical language with which practitioners can communicate about ethical matters. These are relatively static at any point in time in history, but when these need to be viewed in a different temporal epoch, there is often misunderstanding. Interpretation of this language depends largely on the shared and common understanding of the context of the time and the questions or statements being made to ground them as a valuable source of knowledge, despite them being, perhaps, an anathema to modern uses or understandings of the meanings of the words themselves.

If we interrogate the previous chapter, for example, it becomes increasingly clear that language, labelling and the semiotic understandings that these invoke are fluid and not static, and that in spite of their present negative connotations, were in common use a medical terminology in previous times; and the contexts in which they were used—to refer to the ethical care of patients—no less valid than more politically correct terminology used today. This disjunction in the value of a term does not detract from the fact that these were regarded as ethical usage of terms at the time.

Were they used to defend a marked distortion in what was considered equity of care? Of course. But as in the previous chapter on Eugenics, this differentiation was valid, and certainly ethical and in the best interests of both patients and society at large according to the science of the time.

# CHAPTER 4: FRAMING LEGISLATION

In this chapter I trace the role of legislation, the judiciary and the policeman on the ground in the promulgation and application of the laws upholding and maintaining unethical care for institutionalized patients in South Africa. I will include how the previous scientific and social principles not only 'validated' the legislation of the time, but made it possible to build a segregation management system using the socio-political situation of the country as grounding. I identify various historic events that underpinned the development of these laws, and show how these drove further promulgation of statutes which sustained both apartheid practices and unethical mental health practice well after the 1994 transition to a democratic dispensation.

> ***Law and order exist for the purpose of establishing justice and when they fail in this purpose they become the dangerously structured dams that block the flow of social progress.***
>
> ***Martin Luther King, Jr.***
> *(King, n.d.)*

The development of the South African apartheid legislative framework took place on a steadily regressive course to that of developments on the world legal stage. While the world moved towards a modern theory and philosophy of law, the then Union of South Africa embraced the existing universal trend with 'doggedness and devotion'. The rejection of the modern shift, and this fixed adherence to the outdated thinking provided a counter-philosophy which was to be known as *apartheid* (Landis, 1961, pp. 1-52).

Hermeneutics in the field of law and legal science is considered to be iconoclastic, and critical legal hermeneutics, such as it is, derives from other areas of the social sciences, including those of linguistics, sociology and psychology. Medical law, and especially in the area of mental health, upholds this thinking on a far broader scale, as mental illness is not able to loosen its association with political, economic, and cultural effects. This confluence of influences and the loss of ability to derive a 'true' objectivity, or singular legal meaning of textual interpretation is an anathema to black letter law. Black letter law refers to certain basic principles of the law that are accepted by legal practitioners as being without doubt. As can be seen, the hermeneutic approach introduces an element of

diverse interpretation which is influenced by contextual circumstances. This position of law upholds the thinking that the law has opened numerous discourses that raise more issues around interpretation than they settle (Goodrich, 1988).

The above can be used to argue that there is no possibility of a unitary body of law at the level of social systems, as these are interpreted at the level of the courts, and practitioners. Realist legal hermeneutics posited that, regardless of the presence of written norms, the indeterminacy of legal meaning prioritizes the act of judgment and court practices as discretionary acts of applying law is affirmed as a creative process, rather than a strictly rule driven process of science (Goodrich, 1988). A simplistic example of this would be the judiciary's interpretations of apartheid law in South Africa, and perceived utilitarian benefits of the interpretation of one law differently for each cultural group (Clark & Crawford, 1994).

One of the foremost objectives of critical legal hermeneutics has been to challenge the neutrality of the law, locating the arguments within critical race theory and philosophical phenomenology, which describes the power elements unpinning the concepts of ethnicity, gender and politics. Chanock (2001) describes the law as a *'range of possibilities, questions and choices which are always present in a situation of multi-vocality which claims to have only one authoritative voice'* (Chanock, 2001). In South Africa we are very aware that there are a number of voices that have at different times been denied legal capacity. These have been persons of colour, women, the poor and the disabled.

The disabled, and more specifically the mentally ill, have been disenfranchised to a further degree, and that is that the law has been given the power to remove and limit their rights, based on a perception of dangerousness and potential for harm. The dangerousness and harm argument has been flexible in that it has been interpreted from different power perspectives over time (Lidz & Mulvey, 1995, pp. 41-48), and has been variously used to remove persons from their societies. This perception has been created by a contextual discourse between politicians, expert members of the public and scientific community, lawyers and religious leaders. These all form part of the 'legal culture' as they evoke rules and sanctions (Chanock, 2001).

Dangerousness and harm, for example, commonly the domain of psychiatry and the motivation for removal of a person from society for care and treatment, have variously been used by social welfare agencies, education and mental health (both psychology and psychiatry) to incite fear of contagion, disability, social deterioration and religious damnation, where these have been used to connote evil and Babylonian discord with the final stage being moral meltdown. This thinking also formed the basis of the initial foundations for separation of racial groups. There was a need to formalize the process as a political

mandate, and to do this with credibility, legislation was promulgated to ensure that these could be enforced nationally. The law separated into one to provide for the needs of Whites, and another for the perceived needs of Blacks. These included legislation in common law and in statutes which both promulgated and maintained discriminatory practice. Chanock has identified two separate systems of legal development in South African Law up to 1936. Maintaining law and order, and public policing were a very large part of SA social life, as were the concepts of coercion and control. Legal powers of administrative law were delegated to the local magistrates in towns around the country. This meant that the daily application of the law and matters of social application, for example, admission of the mentally ill to psychiatric hospitals and 'rehabilitation' centres, was a duty that very often fell to courts which were both inept and regressive in their thinking. (Chanock, 2001, p. 32).

Within the ambit of legal statute development, and the actual practice of law, we have an enforced dichotomy of legal language versus the inequity and social diversity of application. This basically means that the law – which is largely a written (and therefore one-dimensional and an absolute entity) – has often met with conflicting and politically antithetical social circumstances in practice. The discretionary nature of textual interpretation depending on the diversity of circumstances promotes a differing performance space for each instance of use, based on precedent interpretation.

The hermeneutic process of interpretation takes the semiotic of the process of admission to a mental health institution and investigates the workings of various legal indicators for admission to a place which was not a jail for a criminal offence. These 'lesser-but-criminal offences' were found in other statues than simply those of criminal procedure. The consequences of breaking these were imposed by law, and this meant that they had far larger implications for the average man in the street. A number of the laws in South Africa sent persons to work farms, refuges and institutions for social reasons. This was very often done without notification of the person's family that they were being sent, and the time frames of social penalties were very often unspecified or vague. A number of the laws in operation in the 1960s were very outdated, and were in opposition to the international movement towards a humanist approach to relationships between people. One of these, for example, was the Cape Province Masters and Servants Act of 1856, which was still utilized in the early sixties to attach criminal liability to breach of individual employment contract (Landis, 1962, pp. 437-500).

The use of Bantustans as reservations in which to locate various tribal groups was to take on a far more sinister role once this was linked to the Smith Mitchell facilities which were set up there. The aim of the South Africa government prior to 1936 was to identify homeland areas

which could be allocated to various tribal groups, which would then be overseen by puppet governments that were actually operated by the White South African parliament. To quote Hepple:

> *This meant that the millions of Africans living and working in the urban and industrial areas of the country were being given a patently fictitious right to choose their government. Instead of being allowed to participate in the election of the parliament which actually ruled them, they were to vote for the election of a government (with limited functions) in a distant Bantustan which they had very likely never seen and probably never would'* (Hepple, 1967, p. 188).

The concept of Bantustans was simplistic but effective, in that Black South Africans could live freely in the Bantustan of their origin, enjoying all of the citizenship rights that this entailed. Their forays into White South Africa were as 'interchangeable work units', in order to provide work services to the South African public. These workers could move from their homelands as migrant workers only, and all of the elderly, young children or the disabled were to remain within the homelands as 'superfluous appendages' (Jewkes, 1984). The Promotion of Bantu Self-Government Act allowed for a White commissioner in each homeland to act as the South African representative. While this may have appeared to provide the homelands with powers of self-governance, this had no substance, as, while tribal leaders ran the basic services and structures, they had little substantive power. These homelands still fell under the overall umbrella of the South African government (Hepple, 1967, pp. 187-189).

The management of the Bantustan labour force was based on a system of 'endorsements out' of South African White urban areas if the person was declared 'idle' or 'undesirable'. One of the most disturbing pieces of legislation—the Proclamation about Rehabilitation Institutions in Bantu Homelands' of 1975— allowed for persons to be sent to the homelands (sometimes for infringements as small as not carrying a passbook) for 'treatment' aimed at improving the physical and moral condition of inmates by 'fostering an awareness in regard to the observance of, and the necessity for, the laws of the country' and 'reorienting them to the traditions, culture, customs and system of government of the national unit to which they belong'. It is impossible to see this as anything other than political abuse, where any African who did not accept the 'necessity for' the laws of apartheid, required a compulsory improvement in his or her mental condition (read as attitude adjustment). This was ostensibly considered a 'mental illness' (Jewkes, 1984).

With Smith Mitchell's involvement in providing ''rehabilitation facilities'' in the homelands, the actual value of these facilities to the South African government as a means of using psychiatry as a political tool for behavioural control of errant community members becomes

apparent. They were to manage those natives who had erred in South Africa, and who required ''adjustment'' to ensure that they remained viable as unskilled labour, or were simply incarcerated so that they caused no further inconvenience to South African society. These facilities have been described as 'human warehouses' and 'the South African version of a Dickensian Workhouse' (Jewkes, 1984). The purpose of these institutions was outlined clearly in Proclamation R133 in the Government Gazette of June 6, 1975.

> *The inmates of an institution shall be detained for the purpose of improving their physical, mental and moral condition by*
>
> a) *Training them in habits of industry and work;*
> b) *Re-orientating them to the traditions, culture, customs and system of government of the national unit to which they belong;*
> c) *Generally cultivating in them habits of social adaptation in the community and good citizenship including the fostering of awareness in regard to the observance of, and the necessity for, the laws of the country* (Duncan, 1975, pp. 11-13).

What it also provided was a space outside of South Africa where Black disobedience for political misdemeanours against White government policies, for example pass offences, public drunkenness, unemployment etcetera, which did not fit South African social ideals, could be dealt with[15]. The additional positive to this was that the South African government was never seen to be involved and was never required to take responsibility for behaviours or outcomes that could be considered criminal. It simply fell on the Bantustans' management of their own people. In response to a question about the excessively high levels of mortality amongst old persons and children in Ekulhengeni, a Smith Mitchell facility in one of the Bantustans outside of Natal, the then Minister of Health replied that Ekulhengeni was 'situated in the Ciskei and does not fall within the jurisdiction of the Republic of South Africa.' (Jewkes, 1984).[16]

[15] A present example of this has been the use of Guantanamo Bay as an incarceration and torture facility outside of the USA, thus allowing the state to participate in what would be ordinarily considered human rights abuse on American soil. The movement of these prisoners to Guantanamo was merely a shift in legislative space, to one which did not have the same legislation in place to protect these same prisoners from abuse (Amnesty International, 2006).

[16] Neglecting to mention in this statement that the South African government both held the contracts for these services and was responsible for paying for them.

The regulations attached to Proclamation R133 gave the central government responsibility for setting up and running these institutions under the Bantu Urban Areas Consolidation Act and the Bantu Labour Act. The regulations had a slight deviation on the South African Mental Health Act, which called for reception, treatment and containment of the mentally ill, in that the homelands' facilities were required to provide for the reception, treatment and *training* of the persons admitted (Duncan, 1975, pp. 11-13).

## THE ROLE OF THE SOUTH AFRICAN POLICEMAN

While poor Whites were being seen more and more to require 'rehabilitation' for being unable to help themselves and for being 'weak minded people' as described by the Supreme Court in 1926, as time progressed, the policeman's and judge's roles began changing from moral and social intervention into that of ensuring that threats to White rule were reduced. This included imposing penalties for offences that were largely contrived, but geared towards a more focused strategy to bringing about the segregated society supported by a controlled Black labour force (Chanock, 2001).

Legal culture in the SA national context has to begin with the role of the policeman on the ground and their role in the national context. The initial role of the constabulary in Transvaal was based on models from Ireland, the British North West, and France. The police force at this time fell under Lord Baden Powell. The initial responsibility of the force, was to provide a buffering role between the ''permanent and outstanding menace'' of the ''dense masses of semi civilized Bantu'', and White criminality in the forms of both crime and resistance to British rule. This resistance had the looming prospect of Boer rebellion if the occupation was not a success. For this reason, the constabulary was militarized; with access to civil auxiliary reinforcements should they become necessary. From an economic perspective, South Africa's growth and development potential and the perception of its international creditworthiness needed protection in order to continue to draw investors to the Union (Chanock, 2001, pp. 43-46).

As the impending threats from these quarters withdrew as the country stabilized, so the role of the police shifted to that of including the ambit of watchdog, which policed left wing political organizations within the country. These were seen as being the new threat to stability and voter concern. The police became more concerned with statutory crimes than with those of common law. These were specific to South African discriminatory control mechanisms, and included those of pass control, moral behaviour and curfew management. Policing the Masters and Servants and the Liquor acts formed a very large part of policing activities (Chanock, 2001, p. 46).

In 1912, the task of policing the country split along two lines. The first was that of a militarized force, whose aim was to protect the state and public order and which did not have ordinary policing skills, for example, those of investigating crime. The second was an investigatory force that was concerned with ordinary crime. This was to lead to issues as time progressed. Chanock points out that an additional problem was that neither force had the ‘’necessary linguistic capabilities for any form of detective work’’. In 1918, for example, one magistrate commented that the policemen in his district’s knowledge of police duty and elementary law was nil; and another commented that many were unable to ‘’make out an intelligent report in any language’’ (Chanock, 2001, p. 47).

This situation and the extensive powers of the on-the-ground policeman continued into the 1973 Mental Health Act, by providing the policeman with powers to apply for a reception order for admission to an institution without the patient being present for collateral observation. This is illustrated below.

> *13. Medical practitioner shall report mentally ill person who is dangerous. If a medical practitioner is of the opinion that any person examined or treated by him is mentally ill to such a degree that he is a danger to others, he shall forthwith in writing report his opinion to the magistrate of the district in which such person is, or, if the magistrate is not readily available, to a police official who shall forthwith lay the said report before the magistrate concerned.*
>
> *14. Duty of police official in certain circumstances. (1) If a police official reasonably believes that any person-*
>
> *(a) not wandering at large is mentally ill and-*
> *(i) is being neglected or ill-treated by any person having the care or custody of him; or*
> *(ii) is not under safe and proper supervision, care or control; or*
> *(b) is mentally ill and is wandering at large and is unable to take care of himself,*
>
> *such police official shall forthwith apply for a reception order in respect of such person or cause such an application to be made.*
>
> *(2) If a police official reasonably believes that a person is mentally ill and is a danger to himself or to others, such police official shall apprehend and detain such person and forthwith report the matter to a magistrate of the district in which such person is.*
>
> *15. Magistrate may require certain persons to be brought before him. (1) Any magistrate may-*

> *(a) on sworn information that a person within the district of such magistrate is wandering at large and is unable to take care of himself, or is a danger to others, and that he is believed to be mentally ill; or*
> *(b) on receipt of a report under section 13 or 14 (2),*
>
> *require a police official to bring or to apprehend and bring such person before a magistrate of the district in question and, whether or not the magistrate so requires such person to be brought before a magistrate, deal with him, as the circumstances may require, as a person in respect of whom an application had been made for a reception order or as a person in respect of whom an urgency application had been made under this Chapter, and the person giving the sworn information under paragraph (a) and the person making the report under paragraph (b) shall for the purposes of this Chapter be deemed to have signed the application for a reception order or the urgency application, as the case may be.* (South African Government, 1973)

A number of policemen were recruited from the ranks of the ‘’poor Whites’’ in an attempt to provide them with an honourable career. Chanock (2001) quotes the chief Magistrate at the time as saying *‘’to fill the ranks from the more uneducated White class may be a way of relief to that class but it is not fair to either the European or the Coloured community.’’*

This elevation (which was meant to improve the life situations of predominantly poor White men) had the result of empowering an eminently unsuitable group of people with influence and authority, which was very often abused. The police were inefficient, inadequately educated, and in many cases, illiterate. There was a lack of legal training and partiality was shown to family and friends. Reports also indicate that in terms of prosecutions, the policeman’s requirement of an inherent sense of fairness and impartiality were being ‘’compromised’’ (Chanock, 2001, p. 52).

The most notorious section of the Urban Areas Act, and the one which provided the policeman on the ground with the power to enforce social behaviours was Act 25 of 1945, Section 29 (1), which was superseded by Act no 54 of 1952 Section 36. This section empowered any officer to arrest an African in an urban area without a warrant

> *‘’on the belief that he is an ‘idle’ or ‘undesirable’ person and to bring him before a magistrate or native commissioner, to whom he shall then be required to ‘give a good and satisfactory account of himself…’ the African may be held ‘idle’ if he is habitually unemployed and has no sufficient honest means of livelihood, or if through his own misconduct or default he fails to support himself or his legal dependents, or if he habitually begs or induces others to beg for him. He made be found to be 'undesirable’ if he has been convicted of certain crimes or has failed to depart from an urban area as required, or, if a female, she has entered a proscribed area without documents or failed to produce them on demand. If found ‘’idle’ or ‘undesirable’ the African may be removed and sent to his home, to*

> *a work colony, farm colony, refuge, rescue home, or other similar institution, or to any other indicated place , or the African may enter an employment contract with such employer and under such terms as the commissioner or magistrate approved.'* (Landis, 1961, pp. 1-52)

The above observations illustrate the lack of sophistication of the knowledge of the legal apparatus that was required for the policeman to not only apprehend perpetrators but using the power structures of the time, incarcerate persons with a supposed mental illness. The level of knowledge which he/ she required to properly utilize the legal process to provide care and treatment to mentally ill persons was lacking. What occurred instead was an absolute dereliction of both proper procedure and knowledge to assist disabled and vulnerable groups who were faced with what is, in retrospect, the possibility of a lifetime incarceration in an institution.

The policeman on the ground's lack of education also played a role in the policing of race issues. These were social constructs, with underpinning religious values and segregation policies that hinged around issues of illegal alcohol use and abuse, immorality and crossing of racial area demarcations, often without the carrying of a pass and in contravention of the Group Areas Act. The policeman's knowledge and interpretation of the racial elements of legislation is questionable as the interpretation of the legislation itself was inconsistent. This lent itself to many different rationalizations of how the letter of the law actually worked.

The competence of the community police officer in the apartheid mental health context is a vital component of the invalid hospitalization process, especially when it came to involuntary, state and certified patients of the time. The policeman's role in society was a powerful one, in that he was very often the only testimony present to provide for the magistrate's sentencing of apartheid constructions rather than issues of common law (Chanock, 2001, pp. 46-47). We can certainly assume that the context of a forced removal from the community by a correctional officer played more of a role in admissions of this particular group than an actual diagnosis of illness (Landis, 1961, pp. 1-52).

Policing and control of the public's use of alcohol, for example was a large part of the policeman's day-to-day function (Van Onselen, 2001, pp. 13-60; Chanock, 2001, pp. 46-50). The Liquor Bill of 1926 not only prevented Black persons from working or coming into contact with alcohol, but also prevented them from access to establishments that sold alcohol, and from having alcohol in their possession (Chanock, 2001). This was obviously problematic, as low alcoholic traditional beer was being made, sold and drunk wherever labourers, villages or communal gatherings of people occurred, both in the townships and outside. Criminalizing of this aspect of Black culture brought a new issue to the fore, that of

the policeman on the ground's having to police the use and abuse of the substance, manage delinquent traditional manufacturers of the drink, and prosecute the drinkers (Van Onselen, 2001; Ure, 2009, pp. 306-313).

The numbers of young Black men sent to Smith Mitchell facilities for rehabilitation, after being picked up by the police for public inebriation, can easily account for the high numbers of chronic long term patients seen in these facilities. Linked to this are also persons who could not give a good account of themselves because they were migrants from neighbouring African countries, who did not understand or speak the language in common use in South Africa. This was mostly Afrikaans, as the policeman on the ground was also likely a beneficiary of government's attempt to uplift poor Whites in the community (Chanock, 2001).

One of the roles of public policing was the protection of White suburbs from the 'threat' of the Black 'locations'. It was even possible to call on reserves of White males across all classes to engage in this protective duty. The most arrests made by the urban police force were for drunkenness, however. A further supposed duty of policemen was to control the morals of young girls, and to enter ''certain places to rescue young girls and to help them in times of danger and temptation'' (Chanock, 2001).

If we analyse the comments that the various human rights agencies made around the process of admission for these patients, we can see the flaws in the system long before the person is admitted to the chronic care facility. This flaw is in the interpretation of the law, coupled with the power given to an officer to arrest a person without a warrant, if he is perceived to be undesirable or idle. Magistrates and judges merely ratified what was an already corrupt process as it was less onerous than following an equitable procedure. To identify how the process failed in terms of the running of long term mental health facility admissions, requires a theoretical underpinning from supply chain management. The question 'why?' is answered simply that mental health, as with any other health treatment process, requires an operational process, from advent to end. Patients require an individual assessment and plan for their care and treatment, and these necessitate differentiated service delivery principles which are customer driven (in this case the Mental Health Care Service User has individual needs and inputs). Analysis of the process of mental health care requires an operational paradigm to sit on comfortably. Clinical care is systematic, and consists of a number of routine progressions, which drive forward movement through care to completion. It is necessary to identify where this process became derailed to the detriment of patient ethical care and wellbeing.

In this case, identification of the erroneous admissions of patients for reasons other than for a purely psychiatric diagnosis is a serious breach of the aim of mental healthcare. To

understand the effect the policeman on the ground had on the admissions of psychiatric patients, we need to illustrate that he had certain inherent deficits, which allowed him to fail in the required performance of his duty at the time. International rights organizations provide statements that speak to the results of erroneous admissions, but not to the root cause of how they could have occurred so frequently and across the country in numerous facilities. There was no 'eugenic master plan' to guide what occurred seemingly organically. Despite this most basic and obvious flaw in the process, members of the psychiatric community continued to insist that this was not the case. The insistence that persons in psychiatric institutions all had diagnoses and that no patients were admitted directly to Smith Mitchell facilities (Moross, 1977; Department of Health, 1977) The following section of the Mental Health Act of 1973 is clear that this could indeed occur

> *24. Director-General may order removal to institution of patient detained or mentally ill. (1)*
> *The Director-General may, at any time after a reception order has been issued for the detention of a patient or the court has ordered the detention of a person as mentally ill, in the prescribed form authorize the removal of such patient or person to some other institution or place, to be detained there until discharged or removed to some other institution or place.*

## MENTAL HEALTH LEGISLATION

In modern times, use of terms such as *'lunatic'*, *deviant, 'feebleminded'*, *defective, 'imbecile'* or *'idiot'* to describe afflictions and disabilities is politically incorrect to an extraordinary degree. It speaks to the heart of human dignity and worth. In the present, the use of these terms fills right minded people with abhorrence. Our history, both of medicine and law, is filled with these terms, from the 1880s to the 1950s however. They are terms used in the same way then that we use terms now to describe valid conditions and descriptions of problems and to identify persons with specific clinical or behavioural anomalies. These terms were taught in international universities in the disciplines of both medicine and law. (Ure, 2009).

The earliest mental health legislation concerned with Lunacy in the Cape was that which dealt with the property and estate administration of minors and 'lunatics'. This was laid out in Ordinance No 3 of 1837. The Lunacy Act 20 of 1879 provided for the 'safe custody of persons dangerously insane', and 'care and custody of persons of unsound mind'. The law concerning the mentally ill in South Africa was fragmented, however, and made no pretence of operating on any one standard of care. Until Union in 1910, each province had its own legislation in place to manage this aspect of governance. In the Orange Free State, for

example, the *Wet oor Krankzinnigheid*, No 4 of 1893 simply systemized the current practices. After occupation by the British, the Act was replaced with OFS Ordinance 13 of 1906, which provided for the following:

1. It allowed for urgent cases to be admitted with less red tape;
2. A magistrate could detain a person found wandering around for one month if he was thought to be a 'lunatic'. The same applied to a person who did not have proper care;
3. Provision was made for care of a 'lunatic's' property and administration;
4. Voluntary boarders could give three days' notice if they chose to leave the facility;
5. The Asylum board had powers to make rules to:
    - Guide visitors;
    - Set guidelines for payment of accommodation for patients
    - Duties and discipline of officials employed by the facility;
    - Govern the internal management of the asylum

The ordinance was replaced by the Mental Disorders Act of 1916 (Minde, 1974c, pp. 2327-2330).

In Natal, The Custody of Lunatics Act, No 1 of 1869 was used to govern the business of 'lunatics' in the province. One of the issues with the Act was that a person could only be detained if they were considered to be 'dangerously insane'. This effectively meant that a person could not be admitted for observation, and voluntary patients could not be admitted to a psychiatric facility for care (Minde, 1975b, pp. 322-326).

In 1891, the Lunacy Act 35 of 1891 was promulgated in the Cape, a much improved piece of legislation which had had the following six parts:

> ***Part One. Proceedings for dangerous lunatics*** *– This provided for a period of detention of 28 days, during which 2 medical certificates were to be put before the Attorney-General for acquisition of a permanent detention order.*
>
> ***Part Two***. ***Provisions relating to criminal lunatics*** *– The court could find a person guilty but insane, and remand the person to detention until the Governor's pleasure is known.*
>
> ***Part Three****. Lunatics who are not dangerous or criminal – Again 2 certificates could be provided for a person suspected of being mentally ill, and a magistrate could remand the person for care until a detention order was received from the Attorney-General for permanent care.*
>
> ***Part four. Made provision for the care and administration of a lunatic's personal property*** *– This allowed the court to appoint a curator bonis to oversee the lunatic's property. It also laid down the powers of such a person.*

***Part Five**. Made provision for offences and penalties under the Act.*

***Part Six**. Provided for various other provisions.*

Further amendments to the Act occurred in 1910. In 1916 the Act was replaced by the Mental Disorders Act 38 which remained in place until 1973. This Act was valid across the whole Union and rendered the various provincial Acts moot. (Minde, 1974b, pp. 1629-1632).

The 1916 Act had the additional role of providing amalgamating management of all mental health facilities in the Union under the Commissioner for Mental Hygiene. The first Commissioner who was very influential in drawing up this act was Dr J T Dunston, whose ideological position has been discussed previously. The Act encompassed seven classes of mental disorder. It is possible to link some of the classes to present day mental health categorizations as identified in the ICD-10 and the DSM 4-R, which are presently used for diagnostic purposes. For example:

> **Class I:** A *person suffering from mental disorder that is to say, a person who, owing to some form of mental disorder, is incapable of managing himself or his affairs.*

This class of person would have been more of a social problem than that of a mentally ill person. Any person who had not been exposed to management of their own affairs (and this could have easily included women during this era) for example, in the area of money management, or in terms of conditions of marriage in community of property, being considered a minor, requiring one's husband's approval before entering into contracts (World Health Organization, 1975).

> ***Class II:** A person mentally infirm, that is to say, a person who through mental infirmity arising from age or the decay of his faculties, is incapable of managing himself or his affairs.*

This person would have age related dementia or deterioration common to advancing years. They might suffer from memory loss, cognitive decline in the form of reduced executive function and other issues common to older persons.

> **Class III:** *An idiot, that is to say a person so deeply defective in mind from birth, or from an early age as to be unable to guard himself against common physical dangers.*

This person would, by present standards be qualified as having an intellectual disability which would be classified as profound and chronic. He/ she would be considered for institutional care because of their inability to maintain their own safety. They would require

assistance with crossing the road, staying away from situations which would be hazardous, for example, going with strangers, eating and drinking unknown substances etc.

> **Class *IV:*** *An imbecile, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy and who, although capable of guarding himself against common dangers, is incapable of managing himself or his affairs, or, if he is a child, of being taught to do so.*

A modern understanding of intellectual disability would preclude this person from being suitable for placement in an institution as, with suitable environmental modification, they could live in the open community with minimal assistance. Day care facilities, employment equity practices and special work accommodation would ensure that this person was integrated into their community.

> **Class V** *A feebleminded person, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility so that he is incapable of competing on equal terms with his normal fellows or of managing himself and his affairs with ordinary prudence and who requires care, supervision and control for his own protection or for the protection of others or if he is a child, appears by reason of such defectiveness to be permanently incapable of receiving proper benefit from the instruction at ordinary schools*.

This classification went on to be the legislative foundation for a number of social and political interventions in both education and social welfare. These persons were considered to be sub-normal in their ability to study and reach standardised educational levels. They could be placed in educational training institutions as a treatment intervention because of their perceived inability to learn (Fleisch, 1995, pp. 349-372).

> ***Class VI:*** *A moral imbecile, that is to say, a person who from an early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect. An epileptic, that is to say, a person suffering from epilepsy who is a danger to himself or others or incapable of managing himself or his affairs.*

The category of 'moral imbecile' embraced a number of social and sexual behaviours that were considered to overstep the bounds of both religious and national cultural norms and behaviours of the European in the early 20$^{th}$ century. Masturbation was one of these (the term of the time was 'self-pollution') and was described in the text below written by Professor T W Shannon, a leader in the field of international Eugenics. Masturbation as we recall, was considered to be one of the foremost causes of epilepsy. Shannon, who also laid the blame for the spread of masturbation at the door of 'servants' and persons of 'low morals'—including other boys—described self-pollution as follows

> *… By far the worst form, of venereal indulgence is self-pollution, or, as it is called by medical writers, onanism or masturbation. And it is incomparably the worst for several important reasons.*
>
> *Its Evil Effects.—It is wholly unnatural, and, in every respect, does violence to nature. The mental action, and the power of the imagination on the genital organs, forcing a vital stimulation of the parts, which is reflected over the whole nervous system, are exceedingly intense and injurious; and consequently the reciprocal influences between the brain and the genital organs become extremely powerful, irresistible and destructive. The general, prolonged and rigid tension of the muscular and nervous tissues is excessively severe and violent. In short, the consentaneous effort and concentrated energy of all the powers of the human system to this single forced effect cause the most ruinous irritation, violence, exhaustion and debility to the system.*
>
> *Youth Suffers Most.—All who are acquainted with the science of human life are well aware that all excesses and injuries of every kind are far more pernicious and permanent in their effects on the youthful and growing body than when all the organs and parts are completely developed, and the constitution and general economy fully and firmly established. This is the great reason why many men who fall into ruinous habits, after they are twenty-five or thirty years of age, will live on, in spite of those habits, by the virtues of a well-established and vigorous constitution, till they arrive at what we commonly call old age; while the children of the same men, following their fathers' evil example and forming those ruinous habits when very young, become early victims and fall prematurely into the grave.*
>
> *Where Boys Frequently Learn.—The common notion that boys are generally ignorant in relation to this matter and that we ought not to remove that ignorance is wholly incorrect. Most boys do know about this, even if they do not practice it. Servants and people of loose morals often become the secret teachers of children in this debasing sin. But it is more frequently communicated from boy to boy. One corrupt boy will corrupt many others…* (Shannon, 1919, pp. 244-275).

Masturbation, then termed 'onanism', was reported in medical schools as being the organic cause of degeneracy. In 1899 Harry Clay Sharp, a prison physician in Jeffersonville, Indiana, and led by concerns about degeneracy caused by masturbation, implemented a program to vasectomize prisoners. This was done without the consent of the prisoners. The United States, led by Sharp's initiative, mandated the compulsory sterilization of ''degenerates'' in prisons across the continent. Enacted in 1907, this was the first eugenic sterilization law promulgated in America (Carlson, 2013).

Charles Locock's influence in the arena of bromides as medication for onanism and sexual maladies extended to women who displayed what he termed catamential or hysteriform epileptic seizures. This medication was introduced and widely used in asylums to reduce the expression of these patients' sexuality, which he saw as being a symptom of epilepsy (Eadie, 2012, pp. 274-279).

The category of 'moral imbecile' in the both South African and international mental health legislation of the time both medicalized and criminalized a number of behaviours which are now considered not only acceptable, but very normal, these include for example, both masturbation and homosexuality (Eadie, 2012, pp. 274-279; van Zyl, et al., 1999).

The above illustrates that the shifts in what were diagnostic categories can be very fluid – depending on the dialogue between social structures and clinical perceptions (American Psychiatric Association, 1974). Much of the legislation criminalizing homosexuality arose out of diagnosed 'deviance' promulgated by the mental health fraternity[17].

## DIAGNOSTIC & MENTAL HEALTH CLASSIFICATIONS

There is a general notion which comes up regularly in the limited literature around this subject that there was a lack of diagnostic ability exercised by the institutional professional up to the late 1990s (Jones, 2003). The statement is short-sighted if it is made simply as a comparison with present diagnostic categories. These change regularly in reaction to pharmacological and clinical research as well as social norms and expectations. The reduction in clinical expertise which did occur was not identified until after the onset of the 1980s, when the teaching standards and materials used in psychiatry were badly affected by the implementation of sanctions. This was identified by the American Psychiatric Association during their visit in 1978 (Pinderhughes, et al., 1978).

This needs to be explored from two perspectives, because, while the diagnoses may not correlate directly with present day diagnostic categories and symptoms, there was certainly a diagnostic process in place that reflected the science of the epoch. The first perspective reflects on what the criteria were by which one diagnosed mental illness and deviance during that time; and the second reflects how sophisticated the systems were and how accurate the approach to diagnosis was in the racialized period of mental health history and in the racist period of history internationally. By investigating this with a regard to understanding the effects and contexts that arose from these diagnoses, it is possible to understand the diagnostic systems that were being utilized (World Health Organization, 1975; American Psychiatric Association, 1974).

[17] Ronald Bayer, a gay rights activist and psychiatrist was at the forefront of protests against the APA in 1970, which rejected mental health's stance that being gay was a psychiatric disorder. The stance of these protests was in line with the broader ant-psychiatry movement, which had been evolving since the 1960s. Gay Rights activist Frank Kameny took this to the 1971 APA Convention, where he declared, after hijacking the microphone 'Psychiatry is the enemy incarnate. Psychiatry has waged a relentless war of extermination against us. You may take this as a declaration of war against you' (Bayer, 1987).

Then as now, an appropriate initial diagnosis of symptoms is vital to the treatment of persons with mental illness. This was done, to a degree, in most of the institutional systems in South Africa. The interpretation of what constituted mental health symptoms as a broader clinical and social macrostructure confounded a clean, one-dimensional and clinical picture. What came into play was a conglomeration of questionable diagnoses and their correspondingly problematic interpretations and identification of behavioural and symptoms of genuine illness. If there was no specified label for the behaviour or symptom, identification of these problems was situated under the common heading of 'mental hygiene'. These diagnoses were done with the aim of demonstrating a commitment to compassionate and enlightened care of deviant persons and the protection of the community at large (Rich, 1990, pp. 665-686; Rosen, 2004). The terminology of the time had a particularly derogatory character. In retrospect, and from a human rights perspective, it is shocking to hear and read medical practitioners using terms like 'imbecile', 'moron' and 'idiot' when referring to their patients[18].

Labelling has a very specific role to play in the developments around mental health that were seen in South Africa over time. It obviously played a role in the establishment of the terminology used in mental health. Prior to the 1970s language made it possible to splinter groups of persons from the mainstream of society and place them in the position of outsider (Goode, 2011). Once this perception was accepted, it was easy to implement both legislation and practices, and provide services that were considerable less valuable than those given to other members of the community. These were still perceived to be virtuous in that they were given for an altruistic reason, i.e. education, treatment and care, for example. It was an equally valid reason to remove certain services and resources, especially when faced with results of tests that demonstrated that provision of all elements of a service or treatment were going to be wasted on persons who would not benefit from it. An example of how perceptions can have a very real effect on both legislation and service delivery can be seen in this excerpt from Graves & Johnson (1995):

[18] Formal tools for the measurement and classification of intelligence quotients (IQ tests) were developed by French psychologists Alfred Binet and Theodore Simon in 1911 (Gold, 2014), The below table shows both the historic and modern interpretations of levels of retardation.

| Historic Classification | IQ Scores | Equivalent | Definition |
|---|---|---|---|
| Idiot | 0-25 | Profound mental retardation | Severe learning disability |
| Imbecile | 25-50 | Moderate/ Severe mental retardation | Moderate learning disability |
| Moron or Feeble Minded | 50 - 70 | Mild mental retardation | Mild learning disability |
| Normal | 70+ | | |
| Gifted | 130+ | | |

> *Concerned because of Army Alpha IQ data demonstrating the allegedly moronic character of the Jewish race, the eugenicist R. A. Ross wrote in 1914 about the menacing specter of "overliterate" Jews polluting the ranks of professional positions in New York City. Along with other eugenicists, Ross then began to dictate conditions to the country's leading universities. As active members of numerous college admissions and testing boards, they demanded the strict imposition of quotas designed to keep all Jews, Italians, Poles, Mexicans, Blacks, Asians, and other non-Aryan students out of the nation's undergraduate and graduate institutions. Their rationale for imposing these quotas was the belief that "American intelligence is declining, and will proceed with an accelerating rate as the racial mixture becomes more and more extensive".*
>
> *They subsequently fought the integration of the nation's public schools, armed forces, and other societal institutions with all the statistics and figures the budding "science" of mental testing could provide. As Brigham (1923) explained in A Study of American Intelligence,*
>
> > *'... the army mental tests had proven beyond any scientific doubt that, like the American Negroes, the Italians and the Jews were genetically uneducable. It would be a waste of good money even to attempt to try to give these born morons and imbeciles a good Anglo-Saxon education, let alone admit them into our fine medical, law, and engineering graduate schools'. (p. 210)*

By labelling and cementing the concept of otherness, in both racial and social terms, it becomes very clear that in order to begin a process of identifying persons who require a different input and approach (economically, clinically et al) one needs to be able to say that *this* group has the following characteristics and therefore is *this* type of person requiring *this* type of care. While the two systems may have some overlapping characteristics, the criteria for both the identification of deviance and clinical pathology can be very different depending on the desired outcome. These labels begin to define our collective reality as they are provided with a transportation mechanism for dispersing and inculcating this information (Goode, 2011).

## LABELS AS A SOCIAL FORCE

South African mental health was a label-heavy environment. It stands to reason in a country where the concept of 'the other' was the foundation of the social living and working conditions. It was also important that there was a sound scientific reason for the division between one group and another. Science provided this 'proof'.

The subject of 'degeneracy' as a threat to South African national and racial health became the topic of a number of journal articles by Dr T. Duncan Greenlees, then Medical Superintendent of the Grahamstown Asylum. His 1903 article 'Medical, Social and Legal

Aspects of Insanity', insisted that the doctor had an obligation to use negative eugenics to manage the wellness of the community. He opposed cases where mentally ill people chose to marry and felt that it was the doctor's duty to intervene: 'for we can't justify the risks of generating a stock of idiots and imbeciles' (Greenlees, 1903). He supported the promulgation of legislation to prevent these dysgenic marriages, warning that the results would be dire. He also linked the economic consequences of degeneracy to state expenditure. He expressed concern that degenerates 'possessing possibly little more intellect than is required to procreate their own species, are allowed to populate the world with monstrosities that ultimately become a burden on the state.' (Klausen, 1997, pp. 27-50).

> *Through the medicalization of this social branding came the acceptance of an ideology, from the written word, to the verbal speeches such as the one delivered by Dr Wilfred Watkins-Pitchford in his Presidential Address to the South African Medical Congress and it is clear that the medical establishment stood firmly behind their idea of mental hygiene. Health was a valuable asset to the national economy and there was a correlation between degeneracy and racial weakness. This resulted in a consequent deterioration in White national health. Blacks were racially and mentally inferior (Klausen, 1997, pp. 27-50). It was against the backdrop of this type of pseudoscientific thinking and aided by input of such prominent specialists that Mental Disorders Act 38 of 1916 was promulgated (Ure, 2009).*

The methods of diagnosis and foundations of diagnostic thinking were grounded in what was perceived as deviance during that period. The term 'deviance' refers to any behaviour that is in violation of social norms. It is usually of a level of seriousness to warrant condemnation from the majority of society. The label can apply to both criminal and non-criminal behaviours. Behaviours that were labelled as deviant included those of using the services of prostitutes, being homosexual, stealing, lying, alcoholism etc. (Crossman, 2014).

Society characterizes deviance and by so doing creates deviance. These creations (or labels) have a profound effect on the person labelled as 'deviant'. These persons, by association with the label, were then limited in terms of their participation and ability to influence the workings of broader society. This labelling puts the 'deviant' in the position of 'outsider', and they are excluded from mainstream social activities on these grounds (Raybeck, 1988, pp. 371-397).

Throughout the period under review there have been subtle shifts in semiotic interpretation of the concepts of lunacy and the symptoms that were the identifiers for these concepts. This process of creating a larger meaning map by identifying interactions of symbols is termed labelling theory (Raybeck, 1988, pp. 371-397). Labelling theory has been used in this

research as it provides both a viable explanation for the attachment of medical labels to moral and societal behaviours and circumstances that would otherwise be complex to connect using only a linear clinical interpretation.

What this aims to achieve is to identify how people derive meanings by combining a person's societally imposed labels. The theory posits that behaviours are deviant only when society labels them as such. Society is identified as conforming members of society, and these members provide the interpretations of behaviours as deviance, thus providing the context in which these labels can be attached to individuals. The distinctions between deviance and non-deviance are also rationalized by these conforming members. Labelling theory interrogates which individuals or organizations attach which labels to whom, why these labelled persons may be performing these specific actions and what the resultant effect is on the persons who have been labelled (Raybeck, 1988, pp. 371-397). The effect of labelling on the South African historical macro-environment has given rise to many studies, from those which investigate the effect of identifying 'otherness' in racial groups to the national embarkation on the critical path to apartheid and beyond that these may have initiated (Deacon, 1996, pp. 287-308; Dubow, 1992, pp. 209-237).

One of the most profound questions which this theory of labelling will answer will be to identify those persons who, for one reason or another, became the amorphous 'society' who imposed the most significant labels on which the legislation, clinical process and structures were based. These individuals are by their position in society considered to be powerful – and comprise politicians, judges, religious leaders, police officers, medical doctors etc. (Raybeck, 1988, pp. 371-397).

Over the years spanned by this research, the list of labelled persons has expanded to include homosexuals, persons of colour, cultural groups (for example Afrikaners), drug addicts, disabled persons, alcoholics, criminals, delinquents, prostitutes, sex offenders, retarded persons and psychiatric patients. It has also contracted more recently to exclude those disorders that are now perceived to be discriminatory and in conflict with basic human rights, again in line with more modern scientific and social thinking (Raybeck, 1988, pp. 371-397).

Social research indicates that persons with negative labels have been linked to having lower self-images, are likely to act in a manner which is self-rejecting, and which can also be a motivating reason to act more pathologically in reaction to the label. Resistance to change can also be explained by the phenomenon that people who accept the labelling of others, regardless of the correctness of the label, find it difficult to alter their own perceptions of the labelled person regardless of proof to the contrary (Raybeck, 1988, pp. 371-397).

Mental Hygiene functioned on the back of three broad diagnostic categories. These were 1) Neurosis, 2) Psychosis or 3) the Psychopathic Personality (Carroll, 1947).

The Psychopathic Personality was a loose term used to describe persons who were maladjusted, but who did not fit the category of neuroses or psychoses, but did appear to correlate with lower socioeconomic levels. They were

> *'those who do not conform in their conduct to the dictates of society as a whole, or who, by reason of repeated acquisitive, sexual, pugnacious or statutory offences, together with poor work records and irresponsibility, as considered to be troublemakers…'* (Carroll, 1947, p. 7)

Degeneracy, which was a major concern of eugenicists, was concerned with the hereditary nature of the ''natural born criminal''. Samuel Holmes, for example, in his chapter on heritability of criminal behaviours in the book Crime and Delinquency in 1921, describes some of the traits which were found in Italian criminals. These included, amongst many others: insensibility to pain, acute sight, tattooing, excessive idleness and love of orgies. References to popular sayings from scholarly sources in academic texts show that these were acceptable ways to differentiate the criminal from the common man, for example: ''there is nothing worse under heaven than a scanty beard and a colourless face'', ''the squint eyed are on all sides accursed'', 'Beware of him who looks away when he speaks to you'' (Holmes, 1921).

Eugenic thinking contributed to a number of the interpretations of cause and effect of certain disorders. A further excerpt from Holmes illustrates the thinking of the time that both insanity and epilepsy were combined under an umbrella interpretation.

> *Lombroso recognized, especially in his later writings, that certain criminals are to be regarded as pathological products rather than cases of atavism. An important role is attributed to insanity and especially epilepsy in the causation of crime, and the effort is made to establish a fundamental relationship between epilepsy and the atavistic traits of the born criminal. Criminality… is an atavistic phenomenon which is provoked by morbid causes of which the fundamental manifestation is epilepsy. It is true that criminality can be provoked by other diseases… but it is epilepsy which gives to it, by its gravity, the most extended basis.* (Holmes, 1921, pp. 75-76)

Epilepsy was not the only contributor to supposed antisocial behaviour. 'Feeblemindedness', and by this we can interpret any behaviours which were perceived to be unthinking, ill-advised or in contradiction to parental, State or religious dictates, covered pretty much all behaviours that were considered to be inconvenient and in contravention with societal morals. Neurosis was also a common term for rebellious or anti-establishment thinking, and

women were very often the target for intervention based on their behaviour becoming inconvenient or publically embarrassing. This socially embarrassing behaviour could range from becoming pregnant out of wedlock, sex outside of marriage and a particular anathema in South Africa; love across the colour bar (Wagner, et al., 2008).

There were also gender specific diagnoses. Women, who were considered minors up to being given the vote in 1930 (for White women with a corresponding exclusion of all Black women from that date) (Meintjies, 1996, pp. 47-64)), were undereducated and who were voiceless and rights-less were a target for legislative management of their morals and religious adherence. In the 1920s, the following was written by an eminent scholar, Dr Abraham Flexner, who stated, as a matter of professional opinion, when asked to comment on congenitally defective parenting related to the behaviour that was demonstrated by 'feebleminded' women who had turned to prostitution:

> *Characteristic traits, external and internal, mark the scarlet woman; she has a distinctive gait, smile, leer, she is lazy, salacious, pleasure loving, easily led, fond of liquor, heedless of the future and usually devoid of moral sense* (Holmes, 1921).

The obsolete 1916 Act remained in use and with few amendments for over 57 years as did the treatment, which was custodial, remaining largely unchanged. In 1973 the Mental Health Act was updated (ostensibly using the England and Wales Mental Health Acts of 1959 to modernize the South African mental health process). This was ostensibly in reaction to the van Wyk Report, which recommended more rigid management of State patients in the aftermath of the assassination of HF Verwoerd (World Health Organization, 1983).

There were lip-service changes made to the various acts, which affected persons with mental hygiene and social issues. In 1944, for example, *Amendments to the Mental Health Act* substituted the expression 'moral imbecile' with the term 'socially defective person' and this label was expanded to incorporate the diagnosis 'psychopath'.

South Africa updated its mental health legislation to integrate the modern 1973s international diagnostic system. *The Mental Health Act of 1973* was touted as being a progressive step towards modernizing the mental health arena. Mental illness was described in blanket terms, providing a legal clinical process for assessment, admission and treatment instead of specifying classes of disorders. Voluntary patients were included in the Act for the first time, and it was thought that these would form most of the admissions to mental hospitals. The application age for reception orders was reduced to 18 years old from 21. Admission to psychiatric institutions became a legal process rather than a clinical one. Broad discretionary

authority as to where and when patients were committed was given to magistrates. This allowed for patients to be admitted anywhere in the country. Special schools were available for retarded children, and provision was made for patients to be committed to relatives if it was appropriate. South Africa appears to have taken a mishmash of international thinking and applied it to the various perceived needs of the country when it came to diagnoses and classification of mental illness. For example, in the US, a Mental Health Act requirement was for the various states to house the poor (not necessarily only those that were insane) in accommodations which ranged from alms-houses to poor farms run by private persons and poor houses. This meant that the spectrum of social issues and medical conditions from 'idiots, epileptics' and 'demented inebriates' were now candidates for involuntary admission. ''Pauper idiots'' were a class of illiterate person that was unable to find employment, largely due to lack of education (Koren, 1912).

Immigrants, including both Russian and Lithuanian Jews, were not spoken to in their language of origin, but were spoken to in English, which they often did not understand. Afrikaans had a similar reaction from the predominantly English speaking medical fraternity. Afrikaans was perceived to be the language of ignorant, poor Whites and Brown people. The power structures that were woven into the social fabric of the country were reproduced in the asylum system. Both classifications of patients admitted to asylums and segregation of these patients were done on grounds of a far larger picture of racial thinking and stereotyping (Swartz, 1995, pp. 399-415).

People were most likely to come to the attention of the authorities because of difficulties being experienced at work or if they were acting in such a manner that they could be considered a threat to public safety. This safety was inclusive of the moral safety and protection that a number of pieces of legislation undertook to uphold. There was a definite difference between a concept of dangerousness and that of colonial paranoia around the fear of the Coloured person, often associated with a perceived sexual threat to White women (Swartz, 1995, pp. 399-415).

## COERCION AS A NATIONAL CONTEXT

The State had extensive and real powers to thwart threats to Nationalist leadership. It dealt with resistance and was able to muzzle critics and to quell dissidents. It was also able to maintain and to encourage an environment of fear amongst impending or real opponents of the regime. The discretionary powers vested in the police and other legal entities instituted an element of arbitrariness and lawlessness, typical of modem oppressive administrations. The rule of law was strictly maintained, even if the laws themselves were open to abuse or

written in such a way as to maintain narrow racial constructs. (Moodie, 1994, pp. 1-40). This is particularly visible in the state's handling of the Scientology/ psychotherapy debacle in the early 1970s.

Recent critical legal discourse has found various 'central fractures' and 'fault lines' that highlight the difference between the rights of the individual versus community values. These divisions highlight the competing political nature of human association and the inability of the law to suppose that there can be a single, consensual interpretation of jurisprudence, even in principle (Minow, 1987, pp. 1860-1915)

Legal decision making as a method of control is comprised of more than just rules. Realism acknowledges that there are other mechanisms at play that have an effect on application of the law. There are cracks and imperfections within the legal foundation that reflect sometimes competing political visions of human association. These most often reflect individual rather than community and social values. Ronald Dworkin has expressed a need for coherence and veracity in the law, which can accommodate the concept of an interpretive community (Dworkin, 2011, pp. 409-411). This also and perhaps, over-ambitiously, follows the assumption that there can be a single interpretation which eschews the political. To quote Brown and McCormick, 1998:

> *Taking an overall view, the project of establishing the rule of law as an independent base for the critique and control of state action is put in serious doubt, since interpretation is through-and-through political; and appeals to the rule of law can themselves be moves in a political game, expressions of ideology rather than of higher values. It may be that in the end legal philosophy is faced, today as at its beginnings, with this dilemma: either legal reasoning and moral reasoning have that kind of in-principle objectivity proposed by natural law theory in its rationalist versions, or the theatre of law is simply a theatre presenting endlessly the power-play of rival wills and visions of the good. Many have sought a third way, not yet with acknowledged success.* (Brown & MacCormick, 1998)

Without any fanfare, coercion in South African social life had inveigled itself into all aspects of legal, political and medical healthcare in SA from the late nineteenth century. In order to understand why this has had an effect on mental health in South Africa, two motifs will be examined. The first is that of the initial restraint and admission process (finding and picking up) of the mental health patient, most often by the policeman on the ground, followed by the appearance before a magistrate for involuntary admission (or sectioning) to a psychiatric facility; and the second is the reported coercion of institutional mental health personnel to adhere to the racial policies and processes within mental health care, and by doing so, perpetuating human rights abuses in these institutions for over fifty years (Airaksinen, 1988, p. vii; Chanock, 2001).

Let us clarify that being South African and working in a South African psychiatric facility was not the hotbed of coercion and authoritarianism that has been described, after the fact, by the TRC (Citizens Commission on Human Rights South Africa, 1997), using the apartheid driven use of psychiatry for political gain as suggested in the CCHR document submitted (Amnesty International, 2010) or in Jones (2003) that fingers big business as the villains of the piece. It was an economic or career trade off in most cases. For students and educators working in these environments, it was an opportunity to work with some of the best known South African academics at the time, which was a good start for a future career. Sanctions, which had isolated South African academic institutions and reduced the number of international opportunities available to qualifying students, ensured that ambitious South African students were seen as aspiring and significant members of the profession within the South African mental health fraternity. A number of practitioners (after 1994) indicated that their participation in systems which latterly have been exposed as being in contravention of human rights maxims, and who had passively stood by while these practices occurred, insisted that they had been employed in an environment of coercion and fear of reprisals. The implication being that there would have been negative consequences for truly ethical behaviour. This is largely implausible. A number stayed on in the public sector after qualifying, when private practice was definitely an option, and their practice of their specialty remained in line with that which they were taught in those same 'unethical' facilities. This is borne out by the content of articles written in the various South African medical journals from the 1960s and 70s right up to 2004. Mental health practitioners who did not approve of what was going on left (usually the continent). This exit behaviour was rarely, if ever, reported as being because of the conditions in the hospitals and sub-standard, rights deficient patient care, it was usually for bigger picture political or social reasons and most often in the cast of male clinicians to avoid military conscription (Anon., 2001; Office of the High Commissioner, 2012).

The legal interpretation of coercive activity does not necessarily allow the mental health professionals trained at that time, or who were employed in the faculties, the defence of intimidation. If we are to investigate whether there was an external coercive element to the ethical breakdown between patient care and practitioners, we must find that it is unlikely, given the general definition of coercion below:

> *Coercion is recognized as a defence in prosecutions for crimes other than murder. If an accused can establish that he or she committed a crime as a result of the coercion imposed by another the defendant will be acquitted on the charge as a Matter of Law. He or she will not be excused for the crime if there was only fear of minor physical injury, damage to reputation, or property loss. (The Gale Group, Inc, 2008)*

Coercion can be described as certain forms of social control that are a subset of some types of exercise of power. This is not always aggressive or unnecessary. An example of this could be Section 27 of the South African Constitution, which allows for a limitation of rights to freedom if there is a threat of social or personal harm occurring due to mental illness (Rosenbaum, 1986, p. 3).

Coercion does not often occur at higher levels of authority. There needs to be a level of practical coercion which enforces legislation and rules promulgated by the higher levels of power. In a structure that is required to exercise power, the lowest positions of persons of power are more noteworthy than those of the superior agents of the system. This equates to the actual power structure being driven by minions, as Airaksinen describes ''state power implies that its efficient agents identify themselves with the state and forget their own interests'' (Airaksinen, 1988, pp. 14-15).

In order to protect the medical staff of psychiatric facilities and the on-the-ground policeman from prosecution for engaging in obviously coercive and oppressive behaviours, sections were added to the legal apparatus to indemnify the persons who were to carry out these activities. These indemnities extended to cover the prisons, police (Dugard, 1978), and any person working in a psychiatric institution from investigation.

The law can be neutral on ethical issues, or it can be used to endorse ethical behaviours. Laws may also enable actions that are not necessarily ethically right, and examples of this are those in the previous chapter, such as laws around slavery in previous centuries. The ethics of a specific action are established separately from the legality of conduct. In apartheid South Africa, this is clearly the case, as legislation was in place to ensure the process of government of the apartheid regime occurred as seamlessly as possible. As with legislation promulgated in Germany prior to, and during WWII with regard to the treatment of those persons who were considered undesirable, the construction of the apartheid legal system was almost entirely devoted to providing legitimacy to an ethically unsound process of inequality. Disabled persons, and those persons who were legislated as being disabled by virtue of social or segregational improprieties, were treated unethically if the law was adhered to.

# CHAPTER 5: HAND IN GLOVE

I will show how for profit business was used initially to provide an economically viable solution to a need for mental health service in the South African Union. I will also show how this service changed over time to provide a more sinister, politically motivated service with which the South African government could manage misdemeanours and social improprieties within the apartheid system.

> **The involuntary character of psychiatric treatment is at odds with the spirit and ethics of medicine itself.**
> **Kate Millett** (Millett, n.d.)

## STATE HEALTH & PRIVATE HEALTHCARE

In 1962 Smith Mitchell was contracted by the Department of Health to provide accommodation and treatment to patients certified under the Mental Disorders Act (1916). Later, patients were admitted under Sections 8 or 16 of the Mental Health Act 1973. Initially contracted, despite claims from government to the contrary, to provide for predominantly Black patients, few Whites were placed in these institutions (Minde, 1977a).

The Smith Mitchell Group was to make made considerable profits from government per capita payments for the containment of these patients. Substantial profits were also made from both hiring out of the patients for contracted labour, and savings from the use of patient labour to build and maintain the institutions in which they were housed. Patients did not benefit from this labour, as they were not paid wages. Income for each private facility was guaranteed at 90% occupancy even if government could not keep the institutions filled to capacity. It was thus in the state's best interest to keep the facilities full. Discriminatory practices ensured that further savings were made, for example by reducing care and resources to Black patients. These all ensured that profits were maintained at high levels for the company. (World Health Organization, 1983).

In the early 1980s a number of external enquiries were undertaken by the Red Cross, The World Health Organization, the Royal College of Psychiatrists and the APA in response to a report by a 1977 memorandum from Dr Walter H Bradshaw to the Executive Committee of the APA. Dr Bradshaw was the Chairperson of the Committee of Black Psychiatrists of the APA. The memorandum, which was to be later responded to by Dr H Moross of South Africa, in terms repudiating the allegations as a political assault, insisted that between 8000 and 9000 Africans receiving psychiatric care were in compulsory detention in privately owned Smith Mitchell facilities funded by the Department of Health. This care was

substandard and tantamount to human rights abuse. The mental health system had become a political tool used by the apartheid government to manage Black South Africans (Jewkes, 1984; Pinderhughes, et al., 1978).

There was a complicated relationship between the Department of Health and Smith Mitchell, and later, under new ownership, Lifecare. While the contracts were drawn up to provide services to the department, a complex discourse was taking place between the Department of Health, its corporate partners of Smith Mitchell and Lifecare and the various international bodies who were actively engaged in critique of institutional mental health services in South Africa. The first important narrative was that Smith Mitchell, and later its various incarnations, were never to be a permanent feature of the national Department of Health's psychiatric landscape. From as far back as Minde's history in the early 1970s, the state had been promising to build new psychiatric facilities to replace the decrepit, degenerating facilities which formed the 'temporary' housing for these patients (Smith, 1996; Minde, 1977a, pp. 549-553). These new facilities never materialized. The inference here is that, while the department could not deny being aware of the appalling state of both their own chronic facilities and the Smith Mitchell centres, they were always given lip service as being only an impermanent, albeit necessary, evil until better services were provided (Minde, 1977a, pp. 549-553).

This stance from their only customer also meant that at no time were Smith Mitchell, or Lifecare required to improve these buildings and amenities to anything other than the most rudimentary of structures, as it would have been nonsensical to spend money on uplifting these buildings. The department was as loath to spend extra funds on paying the service provider for a better quality service and upgrading these 'temporary' facilities. This was one of the contractual conditions of the services that the company supplied, that the department would not spend extra funding on uplifting the quality of the infrastructure or staffing. The company, obviously as a profit making unit, did not see why it should spend money on what were effectively short term contracts. This continued through into the 21st century (Porteus, et al., 1998).

While these facilities were inspected, it did not make sense that a high level of care or modern and progressive therapies would be expected from these 'impermanent' enterprises. There are a number of comments around the facilities 'doing the best they can with limited resources' which appear in some texts, which is actually absurd in light of the continued and substantial profits which the company was reporting while providing this mediocre care. An example would be the 24% profit made by Afrox (who owned Lifecare at that time) on its healthcare business in 2001, an increase of nine percent up on the previous year (The

Centre for Health Policy, 1998; Afrox Limited, 2001). This increase at no time reflected improvements or advancements in the services provided to chronic psychiatric patients. This throws into question how valid these inspections were, as both the various Departments of Health and Social Development made no demands on a quality output.

Smith Mitchell was set up in such a way as to remain two degrees away from any links to abuses or deficits in the services provided. This was done by ensuring that each facility was registered as a separate business entity in its own right, and that the business entity of Smith Mitchell was simply visible as the accountants and business management of various businesses. Smith Mitchell was based in its own building, and effectively owned no mental health facilities, themselves. The facilities operations often functioned according to outdated contracts and gentleman's agreements from year to year, and sometimes even from month to month. The same position was rearticulated over forty years of mental health care in South Africa (Porteus, et al., 1998). In a response to a query from MP Mr J W F Wiley to the then Minister of Health around the finance and the complaints of abuses in mental health in 1978, the response was as follows:

> *Question:*
>
> a) *'What total amount has been paid in subsidy to the institutions registered with his Department and owned by Smith, Mitchell and Company?*
> b) *When was the first subsidy paid in respect of an institution run by this company and*
> c) *What was the amount of the subsidy in respect of instructions owned by the company in each subsequent financial year?*
>
> *Response:*
>
> (a) *None; (b) & (c) fall away.*
>
> *Smith, Mitchell and Company does not own any institution but is a company which performs secretarial duties inter alia on behalf of owners of institutions in which patients are accommodated. In this regard I wish to correct a further misconception, namely that the Department of Health does not pay subsidies to the owners of these institutions, but pays compensation in full at a daily tariff per patient approved by the Treasury in respect of the services rendered to patients.* (Department of Health, 1977)

There was a formal understanding between the state and Smith Mitchell that, while the department was paying for the services provided by Smith Mitchell, Smith Mitchell was not required to provide any extra services which may have reduced the profit made by Smith Mitchell. This benefit in financial gain extended to the Department in that it was not required to become involved to any great extent in how the company spent its money, and it was able

to veto any increases in salaries or improvement in facilities, etc. that would increase costs. The department remained solely responsible for the trained psychiatric, psychology, medical and the majority of the registered nursing personnel covering Smith Mitchell facilities in White areas. This effectively meant that Smith Mitchell accepted no responsibility for any quality of care elements. This extended from staff allocations to any services where there were any financial implications (Jones, 2003).

There were few resources provided by the department to manage the physical health status of patients admitted to these facilities, with the resultant outcome that a great number of the patients within the facilities died of physical illness as result of neglect and the lack of timeous identification and treatment of symptoms. While this situation was slightly better under the initial contracts of the 1960s to the early 1970s, once the company assumed control over the entire provision of service, this service, and the provision of medication, experienced and well trained personnel, equipment and emergency supplies and transport to acute facilities for ill patients became a rarity based on cost. The absence of appropriate health care and staffing in the Smith Mitchell facilities would have contributed to the excessively high rate of lifestyle diseases, which were being experienced by non-White racial groups interred at the facilities. The absence of records of health statistics for both the Department of Health and for the Smith Mitchell facilities is indicative of the lack of recognition of the need for them by the body politick (Susser & Cherry, 1982, pp. 455-475; Pinderhughes, et al., 1978; World Health Organization, 1983)

In 1977 an international enquiry was launched into the inequality of care between Blacks and Whites in long term psychiatric facilities. The WHO submitted a report to the South African Government in the same year. In response to the report, the South African Department of Health extended an open invitation, in 1979, to any international bodies who were interested in investigating the abuse claims themselves. There was a catch to the invitation, however. A 1976 amendment to the 1973 Act gave the South African government powers to prosecute any person giving evidence of substandard psychiatric services. This section of the Act also provided a blanket indemnity to all mental health care professionals involved in the care of these institutional psychiatric patients. Unlike any other medical professionals, mental health care practitioners could not effectively change or report human rights abuses in psychiatric institutions by law, but neither could they be prosecuted for perpetuating substandard care (World Health Organization, 1983).

In response to the invitation, in 1978, the APA assembled a small team to investigate the allegations and, after having given assurances by their South African counterparts that they would not be prosecuted, arrived in the country to see for themselves. They were not permitted to visit any state facilities, where predominantly White patients were treated, but they were permitted access to Smith Mitchell facilities, where Black patients were accommodated (The Centre for Health Policy, 1998; Pinderhughes, et al., 1978).

The on-going reticence of the Department of Health to sign a long term contract with Smith Mitchell was borne out of the supposed long term planning of the South African government to build mental health facilities around the country, which facilities never materialized. While previous research has tended towards the belief that the temporary nature of the contracts between government and Smith Mitchell left Smith Mitchell at the mercy of Department of Health policies, this was not the case. There was sufficient input from ministerial level to ensure that, whilst departmental staff were involved in the day to day operations of the facilities, many senior officials had both personal involvement, as in the case of Dr H Moross in his role as clinical advisor; and financial interests as in the case of Dr Connie Mulder, that may have gone a long way to ensuring that there was little to no interference or criticism in the manner in which Smith Mitchell ran their operations (Department of Health, 1977; Minde, 1977a, pp. 549-553).

Smith Mitchell would not have found the Department of Health requirements onerous, however, as they benefitted from the protective umbrella that the Department of Health was required to hold over their dealings with the company, indirectly to protect themselves from international sanction, but also because they were part of the apartheid machine. This protectionism came in the form of strong legislation developed to protect the service provider (Smith Mitchell) and the Department. As a result, the Mental Health Act 1973 exonerated any person in mental health for behaviours which may have been considered to have been in good faith, but which may have not been acceptable to standards bodies as so-called provision of healthcare (Pinderhughes, et al., 1978). This same Act prevented any patients or outsiders from laying complaints against mental health facilities outside of a period of 30 days. No complaints could be laid outside of this time frame (South African Government, 1973).

Comparisons can be made to other countries in terms of mental health service provision using private providers. The United States had states that contracted out their mental health care to independent private contractors. Montana, for example, was one of these. One of the very obvious differences between the types of contracts that were put into place between SA and the US was a specification of quality of care – to quote

> *The contract must not continue beyond a period of two years. The contractor must furnish all necessary attendants and assistants required by the medical and other departments of the asylum, well ventilated, properly warmed and suitable rooms or apartments, wholesome food and comfortable clothing for the patients, and the necessary medicine and medical attendance* (Koren, 1912, p. 151).

In the case of Smith Mitchell however, the contract periods ran from year to year, were very rarely renegotiated and had no evaluation or monitoring of service level procedures built in to ensure that the services provided were of an appropriate standard, which could be expected from a private company. This would have gone a long way to ensuring a higher level of quality than what occurred over time. Instead, the services were of a low quality even though the company maintained a substantial profit margin (Porteus, et al., 1998; Afrox Limited, 2001).

Smith Mitchell facilities were subject to the Urban Areas Act, 46 of 1959, which forbade hospitals, clubs, churches and other institutions for Africans to be built or operated outside of 'native' locations. This meant that, when Smith Mitchell embarked on expanding their business to include the care of more and more Black patients, their facilities needed to be not only far enough away from urban areas to ensure that they would not be a problem to license, but that they remained within the law which separated cultural groups and racially specific areas from each other. The Urban Areas act 25 of 1945 and Act 36 of 1957 both made it a criminal offence conduct an institution in violation of the above provisions (Landis, 1961, pp. 1-52). Because of this the company made use of old mine hostels and disused Lock facilities located outside of White urban areas.

## UNETHICAL PRACTICES

Senior management links to pharmaceutical companies, and Smith Mitchell's questionable business methods, led to allegations which arose as recently as 1986. Rumours that the business was paying kickbacks to doctors, who prescribed their medications, were investigated by the South African Medical and Dental Council. Sales of drugs under investigation in Australia, produced by Alphapharm and Protea Pharmaceuticals, a subsidiary of Tabatznick Holdings, were made to both State and Smith Mitchell facilities to use on their patients. There were allegations of unethical and non-consensual testing of drugs in South Africa on South African patients, which were under development in Australia, but which were not yet approved. Links between Smith Mitchell's senior management and their families to Protea Pharmaceuticals, Alphapharm and RX Pharmaceuticals were made. There were numerous claims of gifts and kickbacks to National Party members which led to

Smith Mitchell being awarded valuable government pharmaceutical contracts and which added to the profits made by the holding company (Jones, 2003).

The response to Smith Mitchell being contracted to provide mental health services in South Africa had been met with relief by mental health service providers in the mid-1970s, although, as early as that, there were concerns that the system may be open to abuse. This appeared to be unfounded, when high ranking psychiatrists praised the services being provided in these facilities. These same psychiatrists were often employed by Smith Mitchell, were colleagues of, and had strong links to both academic institutions and government departments at the forefront of mental health services.

> *Such a system is open to abuse. Disquieting reports have recently appeared from the USA of senile patients in privately run homes being systematically underfed and neglected, but nothing like this has ever been reported in South Africa. On the contrary, in a recent letter in the South African Medical Journal' a retired professor of the Department of Psychiatry of the Witwatersrand University highly praised the scheme after visiting a number of sanatoria* (Minde, 1977a, pp. 549-553)

The extent of the company's links to government departments extended from national health to senior labour, corrections and mining officials. Licensing was rarely a problem due to the relationships, from ministers holding shares in the company, which Smith Mitchell had with various individuals in state service. This practice was obviously a perverse incentive to improve the company's chances of increased tariffs. While the department appears to have had a great influence on the care provided to patients of the facilities, it is also clear that downscaling and removal of service provision, failure of provision and inadequate supply was done in collusion between the two parties with great emphasis on the financial implications to Smith Mitchell (Deeley, 1975; Jones, 2003).

## THE BUSINESS OF BUSINESS—IS BUSINESS

Expectations and provision of care in mental health institutions cannot be divorced from the political and social environment present from the 1900s to the 1940s, and then extending into the ethos of apartheid after Union to 2004. The economic pressures, however, remained relatively static for this entire period. Persons with disabilities were costly for both social and organs of state to maintain, and whatever the human rights dispensations or motivations keeping them at home or in facilities, their ultimate prognosis was that they would never be totally productive and self-supporting. This effectively meant that funds would always need to be spent in ensuring that the mentally ill had either institutional care or community care to manage their functioning in the community (NYSED.Gov, 2013; Hamber & Rock, 1993).

The niche market had been identified serendipitously as far back as 1948 by a Dr M Kuper who, after WWII, required beds for TB patients he was treating. The need for these beds was expressed to Tom Smith, a then shareholder in the accounting firm of Smith Mitchell and Co. with whom he had served in the South African Air Force. There was a recognised need for the State to provide appropriate patient care for TB patients. Care for TB patients in Johannesburg was restricted to one government hospital, Rietfontein, which was bursting at the seams and could not admit any further patients for treatment. Admission of these patients to other facilities was not ideal, as it exposed non-TB patients to the risk of cross infection (Smith, 1996).

The provision of private institutional TB care ran a parallel course to that of psychiatric care, although Smith Mitchell was originally contracted to provide care for TB sufferers. The problem with TB treatment was certainly not a new one. South Africa's relationship with the disease extended as far back as the 1700s, when colonists, settlers and missionaries, who had already been infected during the great TB epidemic sweeping Europe and North America, came to the continent of Africa to experience the benefits of the sun and fresh air. The indigenous population of South Africa, who were non-immune, swiftly succumbed to the disease (TB Facts.org, 2013; Health Systems Trust, 2000, pp. 1-16).

When gold mining got into full swing on the Reef in the late 1800s, the development of TB escalated to epidemic proportions. The conditions of the miners, which included overcrowded living in badly ventilated hostels, poor nutritional status, silica dust and stress, all contributed to this phenomenon. When miners became ill, they returned to their families and in this way the disease extended into the rural areas. By 1930 it is estimated that the Black population of the country had a 60% infection rate. By 1953 the rate of active disease was presumed to be 780 per 100 000 of the population in some parts of the country (Health Systems Trust, 2000, pp. 1-16).

These rates peaked at around 1960, and then dropped sharply in the early 1970s, which can be explained by the rise of independent states. This effectively meant that figures of the disease in these areas were not reported in official South African documentation. Apartheid legislation was directly linked to the spread and severity of TB in the Union. Rural poverty and rapid urbanization created an ideal environment for percolating the widespread epidemic (Health Systems Trust, 2000).

Into this uncontrolled disease platform, came Eurocentric treatment and social segregationist thinking, which formed the basis of institutional management of health issues, and which was to have a profound effect on launching HF Verwoerd into a career which would

ultimately label him ‘the architect of apartheid’ although somewhat erroneously. There were two main thrusts.

The first was that of the Carnegie Inquiry into poverty in South Africa, and the interpretations of the results by the South African academics and politicians who were privy to the outcomes. The mass migration of both Afrikaner farmers and Black migrant mineworkers had resulted in pockets of poverty and areas where contagion was a given (Van Onselen, 2001, pp. 13-113).

The original idea for private institutional care germinated in 1948. After discussion with Dr Kuper, who himself had been in and out of TB hospitals suffering from the disease, and with whom he had served in the South African Air Force, Tom Smith, one of the founding shareholders of the Smith Mitchell Group, became intrigued with the lack of service provision to these people (Smith, 1996).

Smith Mitchell & Co was a partnership of three chartered accounts, T P Smith, J H Randall and D. J. Stirling. The firm acted as secretaries providing management services for a group of hospitals ‘on behalf of private enterprise’. In the 1970s the company evolved into the Smith Mitchell Group and in 1982 the Smith Mitchell Organization (PTY) Ltd ( (Moross, 1977; Smith, 1996). The initial group of shareholders in the enterprise was Mr D Tabatznik, Dr M Kuper, Mr R Lurie, Mr W Aronsohn, Dr L Adler, Mr T P Smith, Mr T Sussman and Dr G Hoffman (Smith T. P., 1996).

Seeing the opportunity to expand their business into ownership of health facilities in the chronic care and long-term care arena, the company investigated the possibility of pursuing this avenue of business development. Services were traditionally maintained by government institutions, but to provide them within their own organizations was costly, so outsourcing to a company that offered these systems was a boon. Up to this period, referrals were from local authorities, and the services were only provided to Whites (Smith T. P., 1996).

Smith Mitchell originally moved into the provision of services for Black and Coloured TB patients. There were very few care services for these groups, and they operated on a waiting list for a bed for treatment becoming open in one of the hospitals (where the institutional stay for TB care was around 2 years). The waiting list meant that when a patient was eventually able to secure a bed, they had often already died. The shift proved to be complicated, because Blacks could not be treated in White areas unless they had previously inhabited specific premises for 15 years prior. The apartheid motivation behind this thinking was that more Blacks would be introduced to White areas, which defeated the object of removing Blacks from White municipalities back to the rural areas. This effectively made the choice of

abandoned mine hospitals and compounds the ideal choice, as they were often far enough outside of the perimeter boundaries of White areas to cause little concern about contravention of the Group Areas Act (Smith, 1996).

The company approached a Mr Smuts, the District Native Commissioner in Johannesburg, who consulted with HF Verwoerd (who was the then Minister of Native Affairs) directly to intercede. Verwoerd wrote to the Germiston City Council requesting that the company be permitted to utilize the old Knights Hospital, which they had originally refused on grounds of introducing more Blacks to the area. The request was for temporary usage, as it was always an understanding between government and Smith Mitchell that no long term contracts were necessary because the services would be null once government had built their own facilities to provide mental health care. Smith Mitchell had to reapply annually for their license because there was always the understanding that within a couple of years Blacks would return to their homelands. A further complication came in the form of the identified buildings being property of the various mining consortiums on the Rand. While the company had approached the Mining Commissioner with the request to utilize the Knights facility, there were a number of red tape issues. The company opened the facility anyway. Official permission was received many years later (Smith T. P., 1996).

The first Smith Mitchell TB hospital for Black patients was Knights Hospital, which provided 402 beds. This facility was to diversify and house psychiatric patients in later years. The company had identified a niche market, and a cost effective solution to a state problem that would generate substantial profits for the care of Black patients. This profit was far higher than that which could be gleaned from the care of Whites. Smith Mitchell began to actively solicit facilities and opportunities where high numbers of Black patients could be treated for substantially lower capital outlay and higher profits. As new tuberculosis drugs were developed, and treatment regimens changed to meet new developments in care, so did the company's business model. The need for facilities to house psychiatric patients overtook those of TB, and so the company ensured that all of the facilities that had previously housed TB patients could be utilized to meet the demand to accommodate the mentally ill (Smith T. P., 1996).

The Smith Mitchell foray into mental health services began with a question put to the Minister of Police in Parliament by Helen Suzman as to whether there were any psychiatric patients being detained in the Newlands Police Station. The minister acknowledged that there were. The then Commissioner of Mental Hygiene contacted Smith Mitchell within days to request whether the company was able to provide beds for mental health patients in the same way that they were providing beds for TB patients. While the business had no

experience with psychiatry at all, the promise of thousands of beds, with the opportunity for making a very large profit lead to the company to take investigating the possibility of sourcing beds very seriously (Smith T. P., 1996).

Table 1: Smith Mitchell Facilities & Bed Numbers up to and after 1973

| | Black | | | |
|---|---|---|---|---|
| Facility Name & Province | **Opened** | **Number of beds** | **Closed** | **Beds after 1973** |
| Allanridge Chest, Welkom, OFS | 1960 | 550 | 1976 | 400 |
| Kirkwood Chest | 1960 | 150 | 1977 | |
| Kirkwood Sanatorium, PE, A-Section | 1979 | 400 | | 706 |
| Kirkwood Sanatorium PE B-Section | 1985 | 300 | | |
| **Randfontein South Complex, Randfontein, TVL (1963)** | 1964 | | | |
| **i) Homelake (1964)** | 1964 | | | 280 |
| **ii) Millsite (1968)** | 1964 | | | 175 |
| **iii) Randfontein (1964)** | | | | 760 |
| **iv) Randmore** | | | | 380 |
| **v) Randaf (1963)** | | | | 1575 |
| **vi) Randwest (1963)** | | | | 1130 |
| **vii) Randwest (children)** | 1975 | | | 400 |
| **Waverley Sanatorium, Germiston, TVL (1972)** | | | | 520 |
| **Waverley (children)** | | | | 200 |
| | | | | |
| **Homeland** | | | | |
| **Ekuhlengeni, KwaZulu Natal (1975)** | | | | 1300 |
| **Ekuhlengeni (children)** | | | | |
| **Poloko, Thaba 'Nchu, Bophuthatswana (1973)** | | | | 1200 |
| Poloko (children) | 1973 | 1200 | | 680 |
| Thabamoopo (Black adults & children) | 1972 | 1200 | | 1240 |
| | | | | |
| | | | | |
| **White** | | | | |
| **Hillbrow Lodge Halfway House, Jhb, TVL (1974)** | | | | 60 |
| **Majestic Hotel, Kalk Bay, Cape (1974-82)** | | | | 170 |
| **Simmer, Germiston, TVL (1969-78)** | | | | 255 |

| | |
|---|---|
| **Struisbult, Daggafontein, TVL (1961-1987)** | 100 |
| **Turrets, Johan[n]esburg, TVL (1974-1978)** | 131 |
| **Witpoort, Brakpan, TVL (1978)** | 386 |
| | |
| **Indian and Coloured** | |
| **East Rand, Benoni, TVL (1975)** | 450 |
| **East Rand (children)** | 50 |
| **Springfield, Durban, Natal (1964)** | 250 |
| **Total Beds*** | 11872 |

* This number increased dramatically into the 1980's before pressure from government reduced beds into the 1990's and early 2000's.

One of these opportunities came in the shape of the Modder B hospital and compound in Benoni. While this facility had originally been bought and funded by the South African National Tuberculosis Association, the offer by Smith Mitchell to run the facility was accepted gratefully by an organization that felt that they were unqualified to run it. The company was contracted to provide acute care services utilizing the hospital, and the compound to provide convalescent care. The East Rand Chest Hospital, as the facility was named, opened in September 1954 and added 240 beds to the Smith Mitchell stable. Further TB hospitals were opened by the company to meet this demand. The expansion to include mental health facilities rode on the back of success with providing TB care to vast numbers of patients for little financial input. Some of the initial customers of the Smith Mitchell & Co TB services were the Defence Force, SA Railways and the Johannesburg Municipality. By 1952 the company had 160 TB beds for White patients in the Johannesburg and surrounding areas (Smith, 1996). Acceptance of this shift into private chronic intuitional care was greeted with approval from the mental health fraternity as a way to provide mental health services where there had previously been a grave lack of service (Minde, 1977a, pp. 549-553)

International research into the provision of mental health care to involuntary patients had been shown to be extremely lucrative, even if the level of care provided was not up to an acceptable standard (Irish Department of Justice & Equality, 2012; Andrews & Scull, 2003). South African mental institutions mirrored those private lunatic asylums in the UK, which sprang up very quickly in response to a demand for the public provision of accommodation for 'pauper lunatics'. The heydays of private institutions internationally were the eighteenth and nineteenth centuries but this had died off by the 20th. These accommodations were very often provided by lay proprietors, who were simply providing the service for personal

financial gain. Facilities were very rudimentary, and were often run down and on the verge of collapse. Medications were experimental, and based on a hodgepodge of knowledge, which combined natural remedies, emerging and often fatal scientific thinking and the support of religious dogma. These remedies were often put together by lay persons who controlled the patients' daily activities. They did not have training or any type of 'expert' knowledge, but were the informal historic pioneers of mental health treatment. These facilities were closed or were taken over by medical personnel over time, and some were even accused of providing good and kindly care, although these were usually run by religious groups. These were few and far between, however (Andrews & Scull, 2003; Parry-Jones, 1972; Hurst, 1976, p. 1036).

The concept of managed healthcare is being used around the world today as the most utilitarian method of service delivery for the greatest amount of care for the citizens of countries with government sponsored health services. In South Africa, the advent of a National Health Insurance is being promoted as the most potentially successful health provision methodology to implement in our very needy health environment. Appropriate and financially sound management is always a prerequisite for the best possible service delivery. For profit healthcare, however, is not bolstered by the same magnanimous incentives. The profit motivation does not mean that there will be quality of care, only that there will be adequate care. The 'best possible' care is not an option. The less fortunate, who have to make do with services provided on behalf of the state, rarely have a valid voice, largely due to the nature of the illness, and are therefore at the mercy of the unscrupulous. This is particularly true of disenfranchised or vulnerable patients who are involuntarily placed in mental health institutions (Roth, 1985, pp. 1-9).

For profit care is linked to the concept of incentives for increased profit. And this was a particularly easy area to exploit. In Smith Mitchell facilities, for example, and with reference to the patient profile and reasons for the admission of users, a great number of users were functional, normal persons. They were a captive population with neither rights to freedom nor rights to appeal, based on their certifications and mental health status. The number of faulty diagnoses in an environment where this exploitation was imminently possible is troubling (Haysom, et al., 1990).

A number of these patients were hired out to local business and industry as contract workers, which tends to reinforce that these patients were incorrectly diagnosed. As with farm labourers, who were paid in alcohol during the use of the Dop System (Louw, 2008), the profit of the business owner was far in excess of what the worker was paid, swelling coffers, while effectively harming the workers. In mental institutions, patients were paid in

sweets and tobacco, the value of which was far under the amount that the work was worth, leaving aside the health and nutritional aspects completely. While it was stated that the company invested the remainder in 'African trust funds for the benefit of Blacks' (Deeley, 1975) this did not occur[19].

The exploitation of psychiatric patients was the norm in long term institutions. The workers, who were known as 'Wet and Dirties', were hired out to laundries and farms that required strong, unskilled labour. This was a common practice both nationally and internationally and was often punitive, being a supposed penance for prior misdemeanours committed, which had caused them to be institutionalised. The reasoning was that the mentally ill person, who had often been admitted for social reasons and not those of a health condition, required a strict and structured environment. The Magdalene Laundries are one such very recent example. Using psychiatric patients for work that was hard and unpleasant and that paid employees would turn their noses up at extends back to the days of Robben Island in the late 1800s and early 1900s. During that time the working day was often as long as 14 hours (Minde, 1974b, pp. 1629-1632).

The *London Observer* in 1975 ran an article that highlighted a number of human rights abuses, which promoted profit making rather than therapeutic interventions. David Tabatznik, Chairman of the Smith Mitchell group, was frank in his position on the company being in the business for profit or they would not be in it. Additionally, the thinking that was intended to place the company in an altruistic light, perhaps was the rider that 'the firm maintains that but for its interest—whatever the motive—many of the less well-off mentally ill in South Africa (principally non-Whites) would get no treatment or care' (Deeley, 1975). This 'something rather than nothing' attitude is what underpinned institutional service provision until well in to the 2000s (Caldicott, et al., 1990). A quote from the Royal College of Psychiatrist (1990) in the context of psychiatric service provision report states:

> 'There was also a criticism of the College from an individual for failing to appreciate the benefits which apartheid had brought to Black South Africans' (Caldicott, et al., 1990).

And in the APA report:

> the APA committee was informed by an elected official of the South African government that if there was continued objection of Smith Mitchell facilities, they

[19] The Department of Health report of 1977 refers to the funds as being used for the training of black mental health personnel, which was certainly unethical (Department of Health, 1977), and Platman (1981/ 82) refers to a Trust being held at Randwest Complex where these funds were used to train staff of the Company (Platman & Thomas, 1981/ 82).

> would be closed and Blacks would have nothing. (Pinderhughes, et al., 1978; Jewkes, 1984)

These statements cannot defend the type of care by extending the utilitarian argument that all persons requiring mental health care were provided with care according to what was available on limited budgets, as this was not true. The profits reflected by the company's shareholder pay-outs and annual reports, when correlated with comments made in research reports, indicate that a number of elements of care, as well as provision of services to uphold basic human dignity were not provided. One can certainly infer that this was due to basic services being withheld to augment disbursement (Porteus, et al., 1998; Afrox Limited, 2001).

Further accusations that were corroborated by the APA report and later admitted by the Department of Health (Psychiatric News, 1997) were that:

- Thousands of African patients died needlessly because of a lack of adequate medical and general health care. Treatment was simply not given. Elderly patients were merely left to die. This was due in part to the lack of formal training of the Black nursing assistants who made up the majority of the staff. The lack of trained physicians and nursing staff to any minimal staff to patient ratio in all probability explained the high death rate;
- The buildings were inferior, and there were qualitative differences between those for Blacks and those for Whites. Blacks did not receive toilet paper or have washbasins, and the latrines were grossly inadequate. The Department of Health responded that these inferior conditions mirrored those of the socio-economic conditions from which the patients had come, and that it made them feel more at home. The provision of squat toilets for African patients was because this was their preference. The lack of toilet paper was explained as being because staff stole what was purchased—the argument apparently being that patients were deprived because of staff actions and managements lack of ability to manage this;
- The majority of Black patients did not have sheets, whereas all White patients did;
- Wards were overcrowded in Black facilities and ventilation was inadequate, which promoted diseases like TB;
- African patients were hosed down in group showers, sharing a single washcloth and soap between numerous patients;
- Black patients were provided with inadequate clothing for the weather conditions and most did not receive shoes. Although it was stated that special clothing was provided for

winter, staff of the facilities indicated that this was not true. White patients received both adequate clothing and shoes.

- Although adequate calories were provided for Blacks, the food quality was inferior to that of White patients.
- Patients were engaged in a considerable amount of work around the facilities, which the company would otherwise have to pay for. Minimal compensation was provided for any of the work done, which was considered to be exploitative, and money earned was controlled by the Company. There were reports of work being done by patients for staff outside of the hospital premises, for no pay or cigarettes and sweets;
- Patient records were minimal and often incompatible with the diagnosis.

(Platman & Thomas, 1981/ 82; World Health Organization, 1983; Pinderhughes, et al., 1978)

Use of the supposedly ethical argument that lesser, abusive care is preferable to no care cannot be justified by any rational moral argument when taking the above into account. It highlights the issue that the patient was not the focus of the care, but rather that the customer was the entity being served, which decries the argument that a person may not be used as a means to an end. The patient was an obvious means to an end for the company (i.e. a source of profit), and Smith Mitchell was a means to an end for government high ranking staff members in terms of personal wealth accumulation. They had psychiatric patients who required care and Smith Mitchell purported to give it to them (both government and the company knew that this was not the case). This is borne out by the ongoing denial by government employees, and specifically by Dr Schalk van der Merwe the then Minister of Health, that this was a not a permanent arrangement, but that new facilities were planned to provide the appropriate care. These were projected to be available in the following 15 years from the report (1975) – but by 2004, this had still not become a reality (Deeley, 1975). At the time of the quote the Smith Mitchell facilities had already been in operation since 1963 and the newspaper had reported this in 1975 (Khumalo, 2012).

The provision of medical personnel by government (people employed by government, who also spent some time working in Smith Mitchell facilities) ensured that government only paid one salary for provision of care across a number of facilities. The hours spent in each, however, were insufficient (Pinderhughes, et al., 1978). The savings had a direct impact on patient care. New innovations, up to date treatment methods, new medications etc., were therefore rarely of benefit to patients. Archaic and outdated methods of practice continued in these facilities well into the late 1990s and early 2000s (Platman & Thomas, 1981/ 82; Khumalo, 2012).

It needs to be remembered that, on the most basic level of corporate function, any service that can be rendered without having to spend money on the provision of items, increases profit margins. It must therefore be assumed that the failure to provide the most basic of services was directly in proportion to the amount of money saved on budget. This can be illustrated by the following example. Mats on the concrete floor of unfurnished wards were provided for sleeping, especially for Black patients. In 1970, there was one bed for every 470 White patients, with a corresponding one bed for every 1800 non-White patients (Deeley, 1975; Platman & Thomas, 1981/ 82). The facility would save their budgets on both the beds which they did not purchase, and the linen and laundry services which they also did not provide. This 'saved' amount would then be written back to profit.

None of these matters would have been investigated on any meaningful or legal level. The contracts of Smith Mitchells and the SA Government, while not being clear cut or formal, included a number of 'gentleman's agreements', which prevented monitoring, auditing or evaluation of specific areas of care. It also allowed for Smith Mitchell to fly under public scrutiny, as any issues which arose out of international concerns were dealt with on a high level in South African government. This collusion was very useful for the company, as it was never directly confronted about its role in patient abuses. It was always defended on a 'big brother' level.

Kant's maxim of never using a person as a means to an end, but always also as an end in himself is especially pertinent in the case of an involuntary, institutionalized mentally ill patent. As well as the stigma of the illness, they are also vulnerable to exploitation, not just as individuals, but as a group. In Smith Mitchell facilities, and later in Lifecare, the concept of the individual patient was a foreign one, from service delivery to therapeutic service provision. The concept of how much effort should be put into providing care is an important discussion in the provision of any level of health care to a population that is vulnerable on both a legal and a social level. So what kind of care do we feel that the Smith Mitchell/ Lifecare patient was obliged to receive by virtue of the laxly written contracts?

In legal contracts, the concept of 'best effort' implies the highest level of obligation. This level of care however is costly; the service goes 'above and beyond' and is of the maximum quality. Provision of this level of care is onerous and may also result in a reduced profit level. Best effort means literally leaving no stone unturned in the pursuit of achieving the best contracted result (Maclaws, 2012). In medical care, and in this case, mental health care, this would have meant that the right number of staff would have needed to be employed, the environment would have needed to be improved, and the facilities would have needed to be provided to ensure that effective programmes could have been provided. This level of

service was certainly neither aimed for nor achieved by either the private company or the state. An ethical provision of care would of necessity have required an acceptable level of service provision, which would have put the provision of care above that of the companies or state's own economic interests. The requirement of a best effort, however, never requires that the service provider sacrifice its own economic interest, just that they take a little less in profit.

So did the company or the state provide 'reasonable' care (this would fit with the statements around 'the inferior care is preferable to no care at all' statements that were made)? The notion of what counts as reasonable is problematic. It requires the use of sound judgment, and whether a reasonable person would have provided that level of care. So one must ask then, was there 'reasonable effort' involved in achieving the objectives of provision of the service. The answer is no.

While companies are not required to sacrifice themselves to provide a contracted service to their client, the interest of the other party must dominate. This is where the primacy of the health needs of the patient got lost in the corporate machine. The company provided their service to the State, and not to the patient. The needs of the state were therefore met. These were to keep costs down, to provide a removal facility to the homelands for patients that were politically persona non grata and finally, in the case of the directors who were shareholders in the business, to ensure that highest share pay-outs were received. This did not extend to the wellbeing of the patient (Department of Health, 1977; Haysom, et al., 1990; Smith Mitchell & the Department of Health, 1975).

Government bodies however, have a diluted best efforts standard, as these allow public policy concerns to displace it (Maclaws, 2012). While this may have potentially beneficial outcomes for the present day if government manages their obligations and resources well, it stands to reason that, in apartheid years, and certainly in terms of the then racist public policy, the requirements for service provision under this principle would be far less desirable. This would be due to the requirement that only Whites were to receive appropriate service, making government and government funded service institutions instrumental in funding mediocre care for Blacks the desired level of service delivery. This would also effectively mean that lesser care would be seen as appropriate service delivery for persons perceived as inferior (Department of Health, 1977). In this case, the concept of 'what the client finds acceptable' as the measurement of appropriate service delivery does not necessarily provide a service that puts all patients first.

Contract conditions between the Department of Health and Smith Mitchell, for example, have an embedded proviso that the company should not be compromised by having to spend

extra funds on staffing and that staffing should not be provided outside of what will provide a profit, and no service should be offered that could be deemed to reduce the company's profit. The service users and the desired standard or level of care to be provided to users is never discussed as a contractual requirement except in the most vague and simplistic of terms. Of the services offered by both provincial and Smith Mitchell/ Lifecare, staff interviewed by outside investigators all insisted that they would have offered a different and better service if there was more funding. This flies in the face of the reasonableness argument. If we say that as reasonable people in the same position, and in this case all of the professionals working in these facilities could be considered to be reasonable people, were either saying that they were offering this superior standard service or insisting that they should be offering more and a better service but were not provided with the resources (Caldicott, et al., 1990; Pinderhughes, et al., 1978; Platman & Thomas, 1981/ 82)

## APARTHEID OVERTURNED & THE NEW DEMOCRACY INVESTIGATES

After 48 years of a system that had fought accusations of mediocre care, inhumane facilities and unethical clinical practices, in the late 1990s, after the democratic elections in 1994, the Department of Health initiated an investigation into institutional mental health care, this time with no protectionist and segregation agendas. The findings validated the majority of the findings of the professional organizations that had occurred over past 30 years. This investigation, culminated in the Department admitting that

> *We are deeply concerned about the findings of this committee and will implement measures to address this situation* (Department of Health, 1996).

Amongst the findings of the committee were that:

- Several facilities were unsuitable for provision of patient care. There was a general failure to ensure the physical integrity of the buildings with numerous findings that a number of walls were crumbling;
- Basic hygiene standards were not being met;
- Basic accommodation requirements—nutritional food, privacy, heating, hot water etcetera—were not being provided in a number of facilities, especially those provided for Black patients;
- There was a management culture of discriminatory practices and racial discrimination;
- Record keeping and standardization of protocols was sub-standard;
- Staff discipline and training were not managed, there were also no measures in place to monitor or discipline staff;
- Admission and discharge policies were mutable or absent;

- Adverse patient incidents including deaths had no formal mechanisms to facilitate investigation and reporting;
- Patient safety standards were not present (Department of Health, 1996)

The following allegations of human rights abuse were found to have a solid basis across the majority of facilities. These covered the broader process of service provision to chronic psychiatric patients in South Africa:

- Both sexual and physical abuse of patients were identified;
- Racial discrimination and other discriminatory practices were part of the culture of mental health facilities;
- Punitive actions perpetrated on patients, which included seclusion, withholding food, beatings etcetera;
- Use of restraints without clinical directives or record keeping;
- Inappropriate patient labour;
- Loss of personal property;
- ECT use/ overuse without guidelines and/ or sedation;
- Indefinite institutionalization without regular medical review
- There were allegations of drug trials and experimentation without appropriate patient consent, or ethical oversight which came to light after the investigation, and which were tabled for further review.
- The private service provider—Lifecare—failed to deliver patient care, or provide facilities at acceptable health standards along with the above issues. All of these had been denied by the South African government and the private provider over the entire contractual period (Department of Health, 1996; Porteus, et al., 1998; Psychiatric News, 1997).

Implementation of the Mental Health Act of 1973, which had effectively both potentiated and protected a number of human rights violations by both government officials and mental health practitioners, inadequacies, and Whitewashing which occurred at mental health facilities needed to change to suit the new South African Bill of Rights. Resources allocated to mental health were differentiated and this had resulted in staff deficiencies, overcrowding, structural failures and disparities in resource allocations (Department of Health, 1996). All of this had been done to provide another arm to the apartheid machine, a way of handling lesser delinquencies and social misdemeanours to maintain a political power base. As Foucault explains

> *But the peculiarity of the disciplines is that they try to define in relation to the multiplicities a tactics of power that fulfils three criteria: firstly, to obtain the exercise of power at the lowest possible cost (economically, by the low expenditure it involves; politically, by its discretion, its low exteriorization, its*

> *relative invisibility, the little resistance it arouses); secondly, to bring the effects of this social power to their maximum intensity and to extend them as far as possible, without either failure or interval; thirdly, to link this 'economic' growth of power with the output of the apparatuses (educational, military, industrial or medical) within which it is exercised; in short, to increase both the docility and the utility of all the elements of the system.* (Foucault, 1979)

The above quote places the South African institutional system into context. The facilities were operated on the lowest amount per patient per day with the daily amount for a Black patient being less than half that of a White in some cases (Porteus, et al., 1998). The power relations that function within the provision of private for profit institutional health care are born from the need to generate ever increasing profit margins, while ensuring that the semblance of therapeutic value remains intact. Budgets are made tighter, and provision becomes a juggling act between keeping patients within the confines of the facility to maintain an environment of control, both to protect the staff from incidents and to ensure that incidents do not occur which will encourage speculation as to the quality of the care being given, and possible litigation. What this effectively means is that the health of the users is steadily eroded to encompass the now difficult to manage and maintain primary goals of the hospital managers i.e. their performance and bonuses (Legassick, 1974).

The requirements of Smith Mitchell laid down by the Department of Health were not that there was a need to provide a best effort of care. The most that was required was that reasonable effort was exercised, and that the measure was cost management, not quality of care or value to the patient. There was no significant legal obligation imposed on the business as a service provider which necessitated proof that reasonable service was being provided for payment of their monthly per patient day tariff (Dlukulu, 1994).

When comparing pure capitalism and socialism in the provision of metal health care during the research period, a model that Smith Mitchell did not hesitate to acknowledge that it utilized, it is important to note some specific differences in practice that came into play. These applied to not only the business practices of the company, and the input of government, but also applied to the company's use of patients as a means to an end, and the use of the money generated by these (Diffen, 2012). While there will always be too few resources for the number of persons for whom the service is designed, the proposition that the funds and services will be managed to provide the most equitable service under the circumstances is the most reasonable one.

Doing the right thing only when it is in one's self-interest simply isn't ethics. It is a deliberate investment after careful consideration where the motivation is personal gain. This is the nature of business. For-profit mental healthcare during the time of this research was not

bolstered by some magnanimous need to help government provide a good service to the disabled. The profit margins, especially if we consider that the amounts paid by the Department of Health were already low, could in all probability never have provided a good-enough service. If profit was still to be made over and above that, the service was doomed to be mediocre from the start. There was no imperative to provide an ethical service, only to ensure that the customer or the South African government received a service within which to manage a difficult segment of the population with ease. The law approved the service and its mandates, which provided the company with the relevant protections. Patients' ethical care wasn't compromised. It was simply never there as a requirement of the service. Why did the company (and the Department of Health) claim virtue in providing this care through the investigations and negative findings? This is the real question. It would have been a more positive sign of ethical business operation if the company had admitted culpability and resolved to behave ethically going forward. Instead they remained silent and absent from international threats of sanctions to the TRC hearings in the new democracy. Does this silence imply a belief in ethical neutrality?

# CHAPTER 6: DERAILING HISTORY

Chapter 6 will show how the church of Scientology became involved in the process of mental health care in South Africa, and also how L Ron Hubbard, the founder of the church, supported the Apartheid vision of the South African Government. The church was instrumental in bringing the abuses in the Smith Mitchell facilities to the attention of the international Human rights bodies. The chapter will also cover how this intervention on the part of antipsychiatry and the Citizens Commission for Human Rights (a wing of the Church of Scientology) had an effect on how the objectives of the psychology board were adapted to prevent the Church from being able to practice in South Africa.

> **In the past, men created witches: now they create mental patients.**
>
> **Thomas Szasz** (Szasz, n.d.)

The relationship between the Church of Scientology and the South African Department of Health played a very significant role in the initial rejection of the international complaints by the SA government, and the lack of follow up of the alarms raised by numerous organizations around the world. Another confounding issue was the connection of Scientology to the antipsychiatry movement, which was unpopular with traditional psychiatry because of its rejection of the methods and ethos of coerced mental health care, and this further served to muddy the waters in terms of isolating specific threads of dialogue that moved through this period in mental health.

The failure on the part of the international human rights watchdogs to act decisively on complaints from this organization has continued into modern times, with the same ant-psychiatry position being continued by the CCHR, although in the present openly for their own agendas and propaganda. The Truth and Reconciliation Committee for example, was provided with a lengthy document compiled by the Citizens Commission for Human Rights (CCHR) on the purported abuses of psychiatry in South Africa, and little investigation was done to verify the information within it. The CCHR reiterated their accusations that under the yoke of the South African government, psychiatry was a cog in the apartheid repression machine. Little discussion was generated by the document, no persons from the various provincial mental health departments were called, past or present, and none attended of their own volition. No Lifecare (previously Smith Mitchell) management attended the hearings, past or present. The status quo remained just that. It was a remarkably similar non-event to that which had occurred in the 1980s in response to international concerns

about the patient care in mental health institutions (Jewkes, 1984; Citizens Commission on Human Rights, 2004; Truth & Reconcilliation Commission, 1997).

There was a general failure to react on even an investigatory level to the rumours, allegations and counter allegations about the South African government's perpetuation of the human rights abuses that were taking place in the locked down facilities on the outskirts of mining towns around the country and in homeland-managed rehabilitation facilities. Nobody opened the dialogue again in the Truth and Reconciliation hearings, in spite of a submission by the CCHR, which raised a number of valid issues which were present during the apartheid years; and there had certainly never been closure to the complaints and reports in the late 1970s and early 1980s by professional organizations. They were simply set aside and never revisited. The content of the Mental Health hearings noticeably lacked substance, despite the acknowledgement of their validity by the Department of Health just a few years earlier (Psychiatric News, 1997; Department of Health, 2013). The issues had ostensibly simply resolved themselves by outlasting the furore and then faded away behind the barrage of complications and smokescreens, which the Nationalist South African government had set in place to defend its position. Lifecare recoiled to share the refuge and maintain its alliance with the South African Department of Health and hence maintain its business links without missing a beat (Khumalo, 2012; Kimberly, 2012; Ure, 2009).

By retreating from an area of human rights where there were obvious issues, the world's largest humanitarian organizations, including the WHO and the International Red Cross, the Royal College of Psychiatrists and American Psychiatric Association, let down some of the most vulnerable members of South African society in the 1980s. The large number of institutionalized mentally ill patients in Smith Mitchell facilities in the 1980s remained behind dilapidated concrete walls in mine hostels, both within South Africa and also within the borders of the homelands and Bantustans, out of sight, sans rights and forgotten (Ure, 2009).

What had happened? International human rights organizations were coming into their own as watchdogs of the downtrodden, the poor and the disenfranchised during the 1960s. Populist politics and community mobilization were gaining momentum in the United States and Europe, and were proving very successful in bringing to global and national governments' attention the various needs of the community on the ground. Social change was taking place and the world was struggling to keep up. The Holocaust had demonstrated that human rights abuses on a grand scale could take place, and that the type of evil which had occurred had done so because human beings had stopped paying attention to the

behaviours of their fellow men, or the plight of their fellow men, and in many cases, had simply turned a blind eye and pleaded ignorance (Arendt, 2006).

In the wake of the new world humanism, came critique of both the use of psychiatry as a means to political ends, and also a rejection of the inherently coercive and compelling nature of psychiatry in itself. The anti-psychiatry movement was born of the outright rejection of the concept of legally, socially and medically sanctioned limitation of human rights. In essence, that another person or body could make a decision to remove a person from their home and family, for periods which were undefined by law, and to attempt to alter their perceptions as an individual without consent[20]. A number of organizations and conferences ratified this position at various conferences held around the world. This right to personhood and dignity, the most basic of human rights, was arbitrarily and often frivolously removed—very frequently as a response to the exercising of other persons human rights—those of freedom of movement and freedom of speech (Rissmiller & Rissmiller, 2006; Ticktin, 2010).

It is interesting to note that a number of the modern texts written around mental health and the possibilities of abuse are underpinned by documentation from, or written and published by the Citizens Commission for Human Rights. This organization, an offshoot of the Church of Scientology, has a long history with psychiatry in South Africa, but certainly not the blameless and morally elevated one which has seen its mention in the majority of texts around failure of the mental health system. It is very tempting to use documentation which strongly and aggressively puts its position over as fact, and a number of writers have used this organization's position as a foundation for absolute proof that abuse occurred but that Scientology, as an organization, were at the forefront of not only identifying this abuse, but in being instrumental in its downfall in the new human rights dispensation. This is not correct (Jones, 2003; Citizens Commission on Human Rights, 2004; Citizens Commission on Human Rights South Africa, 1997).

## UNDERSTANDING THE ANTI-PSYCHIATRY MOVEMENT

In the 1960s, *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (1961) the seminal text on institutionalism, written by Erving Goffman, together with Ken Kesey's novel *One Flew Over the Cuckoo's Nest,* (later made into a classic film by Milos Forman) introduced mental illness to populist scrutiny. At the same time, philosopher Michel Foucault's works Birth *of the Clinic* (Foucault, 1973) and *Madness and Civilization* (Foucault, 1965) became a voice against institutionalism and incarceration

[20] Ironically, this is also a description of what Sea Org, a wing of the Church of Scientology is alleged to do in the present day (Behar, 1991).

as tools of power and government. Thomas Szasz, a leading antipsychiatry activist, joined him in criticizing traditional Western mental health practice (Szasz, 1974). Szasz felt that forced administration of psychiatric medication, and coerced admission to mental health hospitals removed both freedom and autonomy, two of the most basic of the human rights (Leifer, 2000). The 1960s became a time for fighting causes, and this had led to a growing awareness of the need for disability rights. Legislative reform for the mentally ill and intellectually disabled became a focus of rights groups. The increase of welfare spending in states of the USA provided a platform for further government intervention in social concerns. (Rissmiller & Rissmiller, 2006).

Over the past sixty years antipsychiatry, which began as an alternative movement of influential individual psychiatrists and sociologists who were opposed to the perceived abuses that were being perpetrated by biological psychiatry in the name of science, changed to become an ex-patient consumerist movement confronting aspects of treatment which were considered to be authoritarian. These aspects included pharmacological treatment, where patients were prescribed high doses of neuroleptics, psychosurgery and numerous courses of electroconvulsive therapy. It was predominantly aimed at the involuntary admission of psychiatric patients to state institutions (Rissmiller & Rissmiller, 2006). The original protest became part of the international counterculture that was rebelling against all perceived social injustice, whether it was political, sexual or racial.

'Anti-psychiatry' was first used by Bernhard Beyer in 1912 to refer to the tone and content of an article in a clinical journal. The term was coined to refer to a movement against coercive mental health practices by a South African psychoanalyst in 1966 named David Cooper (Ticktin, 2010; Cooper, 1967; Cooper, 1978). The movement at that time was already quite solidly part of the mental health landscape internationally. The most well-known proponents of the movement were R D Laing in the United Kingdom, Michel Foucault in France, Thomas Szasz in the USA and Franco Basaglia in Italy. The basic tenet of the movement was the concept that personal contexts and expressions of reality were separate from any hegemonic classification of normalcy enforced by organized psychiatry. The movement lost its broader base and by doing this, began to die a natural death. Its relationship to the other progressive organizations, which provided support by both association and by intersecting memberships to other coalitions, was waning in the wake of the worldwide shift towards a more conservative political landscape. The relevance of these organizations, which were largely anti-establishment, was decreasing (Rissmiller & Rissmiller, 2006).

The mental health consumerist movement provided the ailing antipsychiatry alliance with the popular collaborator it needed for regeneration. The movement achieved widespread mental

health reforms internationally. This was achieved through political advocacy, the forming of alliances and lobbying of conservative politicians who were not in favour of civil disobedience. This was the situation in the USA, at any rate (Rissmiller & Rissmiller, 2006).

On the broader international front, there were a number of voices coming from both civil society pressure groups and mental health professional circles. Tomas Szasz for example, was a fierce advocate of the separation of the roles of state and psychiatry, very much in line with the principle of separation of state and the church. South Africa had instances of both of these and was becoming a clear example of why both religion and psychiatry should not be considered part of the mechanisms of state. Szasz's particular stance was concerned with mind control operations ostensibly run by state, certainly in 1971 (Leifer, 2000). In South Africa, where the populist movement is focused on issues of social service provision and basic service delivery of water, housing etc., the issue of mental health and the resulting issues are, and always have been, very far down on the social agenda. There is the additional issue that changes in the mental health arena have not been driven by practitioners or by consumers – but by state structures – often in the interest of saving on their budgeted care (Behar, 1991; Jones, 2003).

While the present day Church of Scientology has been recognized as a religion in a number of countries such as the USA, South Africa, Australia, and Sweden amongst others, at the time of the exposure of the conditions in the Smith Mitchell facilities, the cult was still in its infancy, and its credibility was limited to those persons who were believers. It consists of a body of beliefs and subsequent practices which were formulated by L Ron Hubbard in the early fifties, and which shaped the basis of a self-help system that he had devised as an offshoot of a series of science fiction books which he had written. A quote from L. Ron Hubbard's biography (Corydon, Jnr, & Ambry, 1995)

> *Writing science fiction for about a penny a word is no way to make a living. If you really want to make a million, the quickest way is to start your own religion*

can be seen to sum up the general underpinnings of Scientology as a religious construct.

Scientology's supposed cosmogony dates back to a 75 million year old history of tyrannical space leaders, specifically Xenu, the ruler of the Galactic Confederacy, space travel and long lived 'thetans' (Dawson & Cowan, 2004; Lewis J. R., 2009). While the present day version of Scientology has gained some authenticity and credibility as a social cult structure, in the past the church's beliefs and practices did incline the average, reasonable person to place them on the lunatic fringe. Later and more pragmatic articles on the cult have exposed

alleged intimidation, infiltrating and breaking and entering of various state offices in order to block investigations into activities of the cult (Behar, 1991).

The parallels between the aggressive stances of both the Church of Scientology and the South African Department of Health are clear. Scientology was prepared to take any legal (or some alleged illegal) actions within their power and the SA government called on its national legal muscle. Ultimately, the competition ended with the cult of Scientology being discredited with severe restrictions being placed on its operation, especially in the area of 'auditing'. The South African government was already a well-established legal heavyweight, to the detriment of the psychiatric patients who were the actual forgotten victims behind all of the posturing (Kotze, 1972; Department of Health, 1978).

## HEALTH PROFESSIONS COUNCIL

The controversial spin off of Scientology's involvement in the information disclosure saga was to change the course of psychological practice in South Africa from that point on. While it would have appeared to be autocratic and punitive to simply ban the CCHR and perhaps get the same response from the international health community as the country got from the banning of other organizations and certain individuals, alternative measures were required to terminate the interference of Scientology permanently. In the true South African way of legislating to control, the management of the business of therapy was structured to prevent Scientology from qualifying to practice.

The CCHR's present material which details the exposure of racist use of psychiatric facilities for political control neglects to confront the thinking and positions of the head of the organization during that era. To quote L Ron Hubbard's own statements to Dr H F Verwoerd around the relocation of Blacks into Soweto, for example, he had the following to say, commending the South African leader for his forced relocation strategies:

> *Having viewed slum clearance projects in most major cities of the world, may I state that you have conceived and created in the Johannesburg townships what is probably the most impressive and adequate resettlement activity in existence. Any criticism of it could only be engaged upon by scoundrels or madmen and I know now your enemies to be both. 7th November 1960, Johannesburg* (Kotze, 1972).
>
> *Those who understand are never swayed by vicious writing in the English press.* (Kotze, 1972, p. 59)

The remark about the viciousness of the English press is clearly L Ron's attempt to align his own experience of rejection by the English Press, who were not only rejecting Dianetics and Scientology's maxims, but were scathingly belittling of the church's leader himself (Foster,

1971; Kotze, 1972)., The English press were not the only detractors of Scientology and L Ron Hubbard, however.

It is certainly worthwhile to note that in the present arsenal of published Scientology advertising documentation, there are numerous referrals in the cult's texts aimed at rejection of apartheid practices, coupling these with the horror of Nazi genocide. These have formed the basis of their marketing and recruiting campaigns for a number of years.

It is also worthwhile to note that the South African government was not initially against Scientology and Dianetics, in principle, as disclosed by Mr Hubbard in his comment:

> *'And I wish to thank the South African government for its forbearance and ex Minister of Health Herzog for his sense of justice and fair play in his 1968 pro-Scientology decision'* (Kotze, 1972, p. 60)

He was also to blatantly politicize the link between acceptance versus rejection of Scientology and the acceptance of the Nationalist Party's politics over that of the United Party by making the pivotal stance that of rejection of those that did supported psychiatry as being of an unacceptable political standpoint.

> *… Dr Radford and Dr Fischer (Who are called on by the media when adverse comments are required against Scientology) … are two United Party Members. The United Party supports psychiatry in South Africa.* (Kotze, 1972, p. 61)

Scientology as an organization, and certainly the leadership, was not against the racial segregation policies of the South African government by any means. It is clear that while the SA Government saw the Church of Scientology as a cult, and not a church in the Calvinist sense of the Afrikaner, the rejection of the basic tenets of Scientology was never made, and the ultimate rejection of their practices came in the form of rejection of their 'auditing' or therapy practices (Kotze, 1972).

*Freedom Magazine*, the mouthpiece of the CCHR, tells the story of the discovery and exposure of abused psychiatric patients in the Smith Mitchell facilities. This discovery was the starting point of the CCHR sending the information to various international bodies. There are certainly discrepancies in the claims made by CCHR, and especially if they are read in context and with the Department of Health's report on the same incident. The most important one was that the actual context of the discovery according to the CCHR was that a man walking his dog happened on a facility (walled and secured) and saw patients in inhumane circumstances. The discrepancy is that pictures from the interior of the facilities were produced in both the international press and in the CCHR's magazine—and these were obviously taken from the inside of the facility—to which the dog-walker had no access. The

Department of Health, however, indicated in their official survey report that a member of the cult broke into offices of the Department of Health and removed photographs from their own files. This is the more plausible explanation:

> *(2) During May 1976 the house of a director of Smith Mitchell and company was illegally entered and various documents were removed and later returned. A person identified by a servant o the director was later arrested in the offices of Scientology in Johannesburg.*
>
> *(3) By the above means, the 'information' in the regard of treatment of mentally ill patients in South Africa was obtained.* (Department of Health, 1978)

This person was apparently apprehended and jailed. Scientology's alleged aggressive and illegal methods made it possible to discredit the organization by focusing on the criminal actions of the reporting body. Scientology has gained a reputation for invasion of personal property, breaking and entering, litigation and intimidation according to the present popular press, and this also appeared to be common behaviour of the organization in its early years (Behar, 1991; Lewis, 2009).

The Department followed the rest of the world and proceeded with an enquiry into the cult and its activities. The focus of the formal South African mental health fraternity turned to the practice of 'auditing' which at the time was referred to as a therapeutic process by Scientologists. Therapy in South Africa was a relatively new phenomenon, and this was where the State commission targeted their intervention. The Psychology Board of the HPCSA was required to formalize structures, which made it illegal for any person other than a HPCSA board certified psychologist to engage in psychotherapy, or to state that they provided such a service. This hamstrung the cult's proselytizing arm, which required that their members become involved in a process of self-exploration. This need for exploration was founded on audit results that demonstrated the person's need to belong to the cult for assistance or 'therapy'. The Commission's recommendations were that a registration body be set up to ensure that only formally trained persons become psychologists and psychotherapists, and that only these trained persons be legally able to practice as psychologists and psychotherapists in South Africa. The Commission used the example of legislation already passed in Victoria, Australia. Scientology was banned in Australia in the 1970s, and remained so into the early 21st century (Kotze, 1972; Foster, 1971).

The basic principles of Scientology's 'Fair Game' system of interacting with people or organizations which they felt were adversaries does indicate that the Department of Health may have been correct in their claim that a person had been arrested in connection with breaking and entering to steal 'evidence' of wrong-doing, as the organization made no secret

of the fact that this kind of action was an option when people stood in the way of their operations (Kotze, 1972; Foster, 1971). This method of information gathering left the organization without the ability to prove their allegations against the Smith Mitchell organization, because, while the photographs in their propaganda material which they used in their complaint may look like a typical psychiatric institution of the time, the organization could not come forward with a source, an area or the name of the facility without fear of implicating itself in criminal activity (Citizens Commission on Human Rights South Africa, 1997).

## THE NEW 'THERAPIST' IN SOUTH AFRICAN PSYCHIATRY

Another change in the South African mental health landscape in reaction to the involvement of the church of Scientology was to prevent anyone from doing 'therapy', except those persons who were registered with the Health Professions Council of South Africa (HPCSA). This would legislate the church of Scientology out of their main practice, that of assessing potential members for deficits (auditing) and then providing therapy to alleviate their problems with Dianetics (the process of therapy as practiced by Scientologists and for which payment was required). The Van Wyk Commission, which was initiated to review the mental health system, and using the Kotze Commission's report into the practice of Scientology, recommended that the practice of therapy be legislated to protect the unsuspecting public from 'unqualified' people professing to be therapists (Kotze, 1972).

This meant greater autonomy and responsibility fell to psychologists as mental health practitioners, elevating their status substantially. The change in both status and the increased level of autonomy that the changes to the HPCSA heaped onto Psychology did not get the most positive reaction from medical practitioners, especially those in the mental health arena. Psychotherapy had originally been the primary domain of the psychiatrist. Minde (1975) gave voice to the generalized concerns of mental health specialists

> *The recommendation of the Van Wyk Commission for a greater role for psychologists is open to criticism.*
>
> > *In Paragraph 2.16.5 the Report states: 'Full recognition of the Clinical psychologist would entail the right to examine and treat patient not referred to him by a medical practitioner'.*
>
> *This would not be wise. There are clinical psychologists quite capable of doing psychotherapy, but the Commission appears to suggest that psychotherapy is primarily a task for the psychologist. Neither the history of psychotherapy, nor the present situation, bears this out. All the great psychotherapists of the past have*

> *been psychiatrists: Freud, Adler, Jung, Bleuler, are some of the names that come to mind. The leader of the school of behaviour therapy in the USA is Joseph Wolpe, a psychiatrist (originally from Johannesburg). In this country the only psychologists who have made worthwhile contributions to the literature of psychotherapy were Lazarus and Rachman. The psychologist, however good he may be at psychotherapy, has a narrower outlook largely limited to the school he adheres to and is unable to diagnose an underlying organic condition which may be contributing to the symptomatology. The psychologist should treat only patients referred to him by a medical practitioner or should refer all patients who come directly to him to a physician for opinion before commencing treatment* (Minde, 1977a, pp. 549-553).

The decision to expand the role of the psychologist received a negative reaction and was not without criticism from the psychiatric fraternity. It needs to be remembered that the role of the psychiatrist during this time was of both therapist and specialist clinician, and there was a strong feeling of protectionism that comes to the fore in reaction to a decision in which the psychiatrists in South Africa were not consulted. The suggestion that psychologists would independently take over the role of therapist from psychiatrists cut deeply into the ego of the psychiatrist in practice at the time. Minde's reaction to the proposal by the Kotze report mirrored those of psychiatrists throughout South Africa. The decision was made to revise the role of the psychologist to control an outside influence into the operations of the practice of mental health regardless of these objections. Minde states this objection, in no uncertain terms, clearly outlining the feelings of the clinical community's feelings of the lesser significance of allied professionals role and value in the mental health care field (Minde, 1977a, pp. 549-553).

With this legislated promotion came an additional and more expanded scope of practice, which would allow a therapist to practice in their own capacity, and not simply as a supervised adjunct to a clinical mental health practitioner. While this may have appeared to be a practical solution for the national Department of Health, psychiatrically trained doctors felt that their role as psychological expert was being threatened, and there was public dissent from those who felt that psychology should not be entrusted with this role. The legislation was promulgated anyway (Minde, 1977a, pp. 549-553).

Another result of the clash between the Church of Scientology and the Department of Health came in a loss of business for Scientology. In response to the Kotze report on Scientology, there was a formalizing of the role and functions of the professional psychologist. This formalization would effectively exclude Scientology from being able to state that it was offering a psychotherapeutic service, making such claims illegal on a clinical level, but also ensuring that the Church could not conduct the bulk of its business in the country: to proselytize and increase its followers and in this way, it's income. The reason for this was

quite simply that the educational and registration requirements to allow for one to perform psychotherapy would to be governed by legislation (Kotze, 1972).

The position of the report raises interesting questions. The South African government was not averse to putting banning orders into operation, but they did not feel the need to ban Scientology. It would be interesting to understand the motivation to refrain from banning the practice, although the issue may have been religious freedom. Banning orders were already a common part of the South African politico-legal landscape, with the Communist Party having been banned in 1950.

In addition to this and because of the practice of 'fair game' in which Scientologists engaged to bring practitioners or targets into disrepute, there was the legislation against third party identification, investigation or intervention in perceived state or state funded wrongdoing. The State retaliated with changes to the legislation to prevent outside agencies and private persons from public investigation or security checking third parties. The newly promulgated legislation effectively blocked all attempts at disclosure and effectively made it well-nigh impossible to report any of the identified issues within the institutions run or funded by the Department of Health or Smith Mitchell. The powers politick acted as an effective barrier to further disclosures or whistleblowing in the mental health arena (Kotze, 1972).

International organizations backed away from the aggressive and obviously litigious stance of the South African government with alacrity. No further references were made with regard to the conditions in these facilities until the CCHR re-emerged as the hero of the piece after 1994. This came in the form of their supposed involvement in the exposure of South African human rights abuse by psychiatry that continues to this day in their public relations promotional material. They have excluded pertinent details, however, such as L Ron Hubbard's racist thinking (Citizens Commission on Human Rights, 2004).

There is a definite ethical shift between the original interactions between the South African government and the Church of Scientology in South Africa and the acceptance of the legitimacy of the church after 1994. The original behaviours of the Church could be seen to be essentially moral, in that the members of the church were of the belief that they were fighting for the rights of the psychiatric patients in these facilities. This is commendable. Albeit that the rationale for the stance of the organization was based on really questionable foundations, the intent and moral position – to help potentially wrongly institutionalized patients—could not have been more righteous.

The Department of Health rightly identified that the cult was using the findings for their propaganda agenda on the back of the international apartheid wagon. This went a long way

to expanding their credibility into the mainstream social arena with the western world. The antipsychiatry movement gained momentum as a valid social voice, especially in the United States of America (Department of Health, 1978). In South Africa, however, antipsychiatry has never gained acceptance as a patient option in mental health.

The ethical position of the Church of Scientology changes from the 1970s to 2004. In the 1970s their position does appear to be on the side of institutionalized psychiatric patients. Their behaviour, albeit that the methods were questionable, was aimed at changing the system of institutionalization of psychiatric patients to allow them freedom of choice and less coercive treatment. This they did through engaging with bodies that may have sufficient authority to take this battle to the South African government. Over time, and certainly with the change in political dispensation, history appears to shift Scientology's 'ethics' into a position of open self-interest and through this, organizational advancement. This would indicate that the so-called ethical motives of the organization were actually a deliberate investment for the mother organization's aggrandizement. Scientology's involvement in the TRC hearings was not ethical, but rather a public relations exercise.

# CHAPTER 7: ETHICS: THE FINAL ANALYSIS

> **I do not believe in immortality of the individual, and I consider ethics to be an exclusively human concern with no superhuman authority behind it.**
>
> **Albert Einstein**
> (Einstein, n.d.)

There has been extensive research and findings around the use of psychiatry and psychiatric institutions in other countries as a means to expand and compel political submission and adherence. These include countries such as Japan, China, German, France, Brazil and Russia USSR. These countries all had formal State established programmes with specific aims of furthering the interests of the political power by using psychiatry as a weapon (Chung, 2002; Human Rights Watch, 2002; Adams, 1990). Some of the uses extended to experiments aimed at both mind and behavioural control. There is certainly sufficient documentation to indicate that psychiatry has certainly been seen as a tool of control. In the USA, the Central Intelligence Agency has been implicated in numerous government funded research initiatives around forced mind control and behavioural change, particularly during the Cold War with Russia (Ross, 2006).

South Africa did not have a formal programme of psychiatric control and abuse in place as in the aforementioned countries. The Republic's abuses were conducted as a result of the context of a politically abusive societal structure and paradigm, and as such, the actual mistreatments were far more intrinsic to general human rights abuse than specifically that of psychiatry. The actual structure and ethos of psychiatry (or mental health) was perverted to enable its use as a political tool, as were the practitioners. Institutional care was certainly provided to further the aims of the apartheid system, and there was intentional maltreatment on a social and emotional level, without the alleged potential for a positive mental or health outcome for the patient, especially in the homelands by the private mental health companies employed by the state (Jewkes, 1984).

There are many allegations and some instances of both physical and sexual abuse of institutionalized psychiatric patients, both long term and short term (Mental Health in need of a boost, 2006). These are often not followed up to a successful conviction of the perpetrators. It is clear that justice has never really been done, especially on the part of the

State in terms of restitution for many years of never taking a stand to rectify identified issues. The present day continues to bring regular articles about patient neglect in terms of service delivery.

While the war of words and egos has raged across the continents, a group of patients sat in the sun, day after day after day, some for over fifty years for no reason except that they had no passbook and could not speak Afrikaans to the arresting policeman (Chanock, 2001; Jewkes, 1984; Pinderhughes, et al., 1978). To put this into perspective, Nelson Mandela was in jail for 27 years, and he had a criminal trial that resulted in him being incarcerated. He was released from prison in the change of government. Patients in Smith Mitchell facilities were admitted for social misdemeanours, many of which no longer even qualify as misdemeanours in our present legal system. A number have spent over 40 years institutionalized, and most will never be discharged. The majority have lost all social and community skills that would allow them to negotiate reintegration back into a drastically changed world. And so we ask the question again: did abuse take place? Were these people treated unethically? And if it wasn't active, targeted abuse – what form did it take?

## INSTITUTIONALISM AS HUMAN RIGHTS ABUSE

Institutionalism begins with degradation by neglect, neglect of the person's basic rights to freedom: freedom of choice, place of residence and right down to the choice of what clothing to wear. The consequences of institutional life, and certainly for as long as the patients remained in private facilities have been documented, are a gradual breakdown of ordinary skills of daily life. Ironically the term has fallen into disuse internationally because the concept of institutionalism and its actual presence in the world of mental health care is supposed to have been largely eradicated by the implementation of new, more human practices.

Institutionalism is a term the actual meaning of which has almost fallen out of common diagnostic usage, except for a generalized application to denote a marked lack of ability to cope with social norms in the open community in chronic and often hospitalized patients. The term in modern times is used to describe a person who displays iatrogenic behaviours that have been inculcated due to long term involuntary placements in a psychiatric facility. This person may also have been subject to numerous admissions in psychiatric facilities because of what is commonly termed revolving door syndrome. As international focus has moved to community care, the significance of the term as a need for treatment or input on a clinical level has essentially become obsolete, as the actual process of long term institutional placement and care has become less of an option for patients under deinstitutionalization

and a human rights based mental health care ethos (WHO, 2013; Starke, 2010; Fisher, et al., 1992).

Institutionalism, as it is presently termed, has lost the scientific impetus of study that was being conducted by the social sciences and allied medical professionals from the early 1900s. This research was largely driven by social workers and anthropologists who were intrigued by the social implications of institutionalism, and the deterioration in this functioning that was being seen in long term placements and chronic mental health patients. This phenomenon was given a variety of names, which ranged from the Social Breakdown Syndrome (Gruenberg, 1967), to institutional stasis (Eyman, 1915). It has been compared to bedsores of the mind with the term reflecting stultifying boredom and cognitive breakdown (Lewis, 1917; Barton, 1959; Barton, 1961; Wirt, 1999)

Identifying what abuse actually occurred in chronic mental health facilities is irrevocably tied into understanding the outcome of living behind walls with little to no stimulation year after year, as a great number of patients did.

> Institutionalism *is the syndrome (or group of symptoms) that results from the process of institutionalization. It is characterized by apathy, lethargy, passivity, and the muting of self-initiative, compliance and submissiveness, dependence on institutional structure and contingencies, social withdrawal and isolation, an internalization of the norms of institutional culture, and a diminished sense of self-worth and personal value* (Belcher & Rife, 1989; Wirt, 1999)

Being lost in the institutional mental health system has specifically dehumanizing effects. The patient loses the incentive to take responsibility for themselves and their lives, because they lose ability to function in the real world outside the walls. Institutionalism causes a social breakdown where deterioration appears more or less independently of the underlying disorder, and then becomes part of the patient's symptomatic picture in time. The patient learns to comply with the rules of the facility to stay out of trouble, and then has difficulty changing their behaviour in other settings, for example in their home environment. Over time residents are stripped of their social roles and normal identities, losing their input into bringing up their children, what happens to their belongings and decision making generally. They begin to adopt the official or staff views of themselves and try to act out the role of the perfect patient. They become isolated from family and friends, identify with fellow patients, rather than their home community, anticipate staff demands, and strive to 'fit in,' to 'settle down,' and to become a 'good patient' (Belcher & Rife, 1989; Barton, 1959; Gruenberg, 1967; Wirt, 1999).

The basic structure of warehouse type facilities causes de-individuation and this is what makes long stay institutions vastly different from other organizations and residences. The numbers of residents are in excess of that of a large family and the daily routine is regimented. The physical and social environment is focused on the lowest common denominator, which means that activities are simplistic and, for a higher functioning patient, both demeaning and stultifying. It is a place in which the majority of the activities of daily life are carried out in one unit or area, with the patients rarely leaving this contained space. Work, recreation and sleeping are all carried out in the same place. The day's routine runs according to tight schedules and is highly regimented. There are pre-arranged times for each activity and these are planned by a group of officials according to work procedures and operational strictures. The compulsory activities are presented and run in such a manner as to fulfil the role of the institution. (Wirt, 1999).

There are certain characteristics of institutions that are indistinguishable. All personal belongings of the patients are confiscated. The bed capacity is very large, resulting in de-individuation. This is exacerbated by the drab and standardized physical environment and the lack of privacy. There is an absence of stimulation, and the patients have no choice or control over this. The daily activities are rigid and forced idleness is the norm. There is a reduction in the ability to engage in meaningful relationships. The facilities are in remote locations, resulting in a reduced number of visits from family due to the long distances and the cost of travel. This results in dissolution of social networks and isolation of patients from their communities and families (Belcher & Rife, 1989; Wirt, 1999).

The staff is authoritarian, and there is a low staff to patient ratio. Training is limited and results in staff being disempowered. Many of the very young or very old are often in poor health. The lack of stimulation results in compromised cognitive function over time. They have comorbid physical illness, and poor coping skills. They may have a lack of mobility and low self-efficacy. Patients are not encouraged to complain about the staff or the organization, or to be resourceful for fear of reprisals. This punishment can occur with the use of restraints, isolation, beatings, increased medication etc. Rather than inquiring into possible environmental causes or issues in a personal relationship which may be the cause of a patient's agitation, staff send patients to the isolation unit, provide chemical restraint, beat them or medicate them. The result of this on the patient is a general loss of identity over time. They begin to accept the label of patient and/ or inmate. They become isolated, and lose their sense of human purpose (Belcher & Rife, 1989; Wirt, 1999).

## POLITICAL ABUSE

The statement 'political abuse of psychiatry' is not confined to the incarceration of persons confined to detention in psychiatric institutions because of their opposition to the prevailing political thinking. This is a narrow interpretation. It goes far further when the medical profession works hand in glove with a minority government in deliberately perpetrating conditions of extreme deprivation and disadvantage of the majority of its population. This is a clear abuse of the science of psychiatry and the ethos of ethical health care (Jewkes, 1984).

Platman (1982) voices the following concerns over use of the Smith Mitchell facilities to control pass-book offences, identifying an essential crack in the ethical practice of mental health care:

> *Furthermore, recent legislation concerning the 'rehabilitation' of African pass-law offenders seems to equate the non-observance of the Apartheid laws with mental disorders. The new Mental Health Act of 1973, by removing the restriction of the 'socially defective' to mental hospitals as certified psychiatric patients, may have opened the way for the transfer of such offenders to these private institutions. (Platman & Thomas, 1981/ 82)*

The APA identified the core issues behind the abuse of mentally patients

> *Health Professionals who were not directly involved in abuses were also deeply compromised by apartheid. Clinicians tolerated segregated services, gross inequities in treatment resources, terribly overcrowded facilities for the Black majority and other facets of a dual health care system as part of normal life. Most failed to take action to protest human rights violations by their colleagues.*
>
> *The conduct of the leaders of health professional organizations was in many respects the most egregious of all. These individuals occupied positions of power and prestige and could more safely speak out in support of medical ethics and human rights. Instead, the White leadership of the health professions generally allied itself with the apartheid state and, until very late in the day, went out of its way to avoid challenging overt discrimination in health, forced relocations and detention of children* (Chapman & Rubenstein, 1998)*.*

The patients were rarely referred to in the Department of Health's or Smith Mitchell/ Lifecare's documents or comments—where such document or comments existed—other than as numbers, units of cost, or service or staff requirements. In the rare facilities where there were rudimentary programmes, they were organized groups with limited individual treatment provided for patients. These were mainly found in facilities where there were White patients. Black facilities provided few to no therapeutic programmes (Jones, 2012; Moross, 1967; Moross, 1967b; Caldicott, et al., 1990).

There were the defensive denials of high ranking and respected mental health professionals and government leaders against the accusations of inadequate care, all carried out by blinkered and often self-serving individuals with personal agendas of self-preservation and professional self-interest. These strategies were often to simply bolster the personal character of the professionals involved in the accusations, and in turn, prevent aspersions being cast on colleagues and peers (Hurst, 1976; Department of Health, 1977)

The ethical blind spot of all of the investigations, conferences, both nationally and internationally—namely, the corrupt link between the political and clinical—was clearly shown by the lack of participation of the Medical and Dental Council in exploration of its own complicity in the identified unethical care, the most public having been the death of Steve Biko (Chapman & Rubenstein, 1998); and the absence of the Directorate of the Department of Mental Health, despite their having apologized to the APA for ignoring the abuses which had been reported, stating that after reinvestigating the observations and recommendations made by the Association, that 'most of the contents of this investigation were, in all likelihood, correct' (Psychiatric News, 1997).

Dr Jean Spurlock, one of the APA members involved in compiling the report of 1978 stated, on the receipt of the apology – 'I can't help but wonder what took them so long… I question how much things have really changed when it comes to the [mental[21]] health services in South Africa' (Psychiatric News, 1997). She added that if the recommendations had been listened to initially, the abuses would have terminated at that time. The Department of Health, South Africa had effectively called the APA investigative team and all of the other investigative teams from numerous organizations liars (Pinderhughes, et al., 1978; Caldicott, et al., 1990; Jewkes, 1984).

The incongruence of the 1994 apology in relation to the previous decades numerous denials, public rebuttals and statements, can be seen in the following comparison in Jewkes (1984) where the Society of Psychiatrists of South Africa (SPSA) stated:

> *representatives of the Society of Psychiatrists (of South Africa) have inspected these institutions over the past couple of years and have found no support for allegations of inadequate psychiatric care, or exploitation of the patients (Jewkes, 1984)*

Apartheid government health officials made comparative statements

[21] My addition

> *the institutions were visited regularly by medical inspectors and nursing staff of the head office of the Department of Health. Patients and conditions in the institutions are daily seen and observed and reported by psychiatrist and medical practitioners in the employment of the department of health (Jewkes, 1984)*

## ABDICATION OF DUTY

The most indefensible abuse was the South African Society of Psychiatry's (SPSA) professional stance, taken in rejection of the Smith Mitchell facilities practices by publically snubbing contact with the facilities. Mental health practitioners effectively turned their backs as a professional association on what were obvious abuses and helpless, vulnerable patients. All of this occurred in the name of rejecting a political system in order to 'stay in the gang'. Except that the Association knew that they were abandoning their patients, and they understood that their patients were vulnerable and unable to defend themselves by virtue of their legal status.

SPSA's agenda for this was a suggestion to the Royal College of Psychiatrist that they should

> *consider adopting the policy of 'Selective Support'. This would mean eschewing official contact with any organizations or individuals in South Africa that continue to support apartheid, while maintaining active professional relationships with those who advocate ending apartheid and the development of an integrated unitary mental health service, and who can be seen to be working towards those ends (Caldicott, et al., 1990).*

The Royal College of Psychiatrists met with the Chief Director: Health Care and the Deputy Director of Mental Health, who stated that they

> *were keen to inform the team of recent improvements which they indicated had been made to the standard of care offered by the Life-Care (previously Smith-Mitchell) organization. The team was shown an album of pictures of ward facilities in support of this claim. (Caldicott, et al., 1990)*

The position of the members of the Society on Smith Mitchell facilities in the Royal College of Psychiatrists visiting team reads (and is a contradiction of both SPSA's and the Department of Health's statements previously):

> *It was further stated that Smith Mitchell facilities were regularly inspected by SPSA who—(comment- in contradiction of a following statement) 'found no*

> *support for allegations of inadequate psychiatric care' and that 'extensive and advanced psychiatric services were given to all South Africans without reference to colour or creed'*
>
> *The team had been informed that the SPSA 'supervised' the (Smith-Mitchell) organization, but the SPSA stressed that the responsibility for psychiatric care has not been theirs and unanimously recommended that Smith-Mitchell institutions not be regarded as hospitals for the care and treatment of chronically mentally ill patients. The Society distanced itself completely from the treatment and handling of these patients in these institutions.* (Caldicott, et al., 1990)

They turned away from the majority of institutionalized patients in the Republic. And then, the area of human rights abuse firmly put out of sight and mind, the Association aligned its self with the Declaration of Hawaii (World Psychiatric Association, 1978), and later, the Declaration of Madrid (Okasha, 2002) , both of which contained very clear clauses on ethical behaviour.

> *As a practitioner of medicine and a member of society, the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal duties of every man and woman. A keen conscience and personal judgment is essential for ethical behaviour.*
>
> 1. *The aim of psychiatry is to promote health and personal autonomy and growth. To the best of his or her ability, consistent with accepted scientific and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources…*
> 2. *…Every patient must be offered the best therapy available and be treated with the solicitude and respect due to the dignity of all human beings and to their autonomy over their own lives and health…*
> 3. *…The psychiatrist must never use the possibilities of the profession for maltreatment of individuals or groups, and should be concerned never to let inappropriate personal desires, feelings or prejudices interfere with the treatment…*
> 4. *The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to scientific or ethical principles the psychiatrist must refuse to co-operate. (World Psychiatric Association, 1978)*

On the one hand, South African psychiatrists were voicing their commitment to ethical principles espoused by their peers, and on the other, they shifted the plight of thousands of patients out of their ambit with no backward glance, or with no further reference to the present. The psychiatrists of South Africa chose to only selectively apply ethics to certain patients, and to ignore those who were obviously victims of the state.

By 2004 there had been no significant changes to the system of long-stay, warehoused psychiatric patients in private facilities (Chapman & Rubenstein, 1998), despite a statement from the head of the Mental Health Directorate, that there was a multifaceted plan in place (Psychiatric News, 1997). This proved to be inaccurate and only in 2013 was a human rights based Mental Health action plan to intrinsically alter the same system as that which was in place in the 1970s signed into being by the Department of Health (World Health Organization, 2013; Department of Health, 2013). Standards had not been developed, the rights of long-stay institutionalized patients were the same, resources were inadequate and research was only done in provinces where there was a strong academic mental health presence. The rest of the country remained in limbo.

These offences, which included use of psychiatry and psychiatric institutions for political goals, neglect, discrimination, segregation and lifelong social removal of people and human rights abuse, have been forgotten with time. There has been no ethical introspection of the processes and outcomes of the 100 years of mental health under discussion as one would have supposed might occur after the TRC. The focus of the international bodies that raised the initial alarms unintentionally derailed investigation of the valid issues by linking their primary concerns to a simplistic clinical motive. That being said, were the tools of psychiatry - medication, psychiatric personnel and psychiatric practices - used to perform acts of abuse on individuals to further the cause of apartheid? And the answer would be – except in relatively rare cases of practitioner/ patient (pathological abuse) - no. Patient files, which certainly showed that there were deficits in care, show that clinical personnel performed rudimentary mental health care duties for the patients under their care (Platman & Thomas, 1981/ 82).

But this does not identify the real effects of, or deficits in ethical care. These were not necessarily clinical--they were iatrogenic. Degradation of basic human skills in environments where the purpose (mental health care) was not the rationale for the stay, but rather payment for full beds, care limited to ensure profit and facilities which were neglected and far below standard for basic comfort. They were the results of years of institutionalization and neglect. Were these actions unethical? Absolutely.

After the Amendment of the 1973 Mental Health Act after 1987 (one year after the Soweto riots), it became possible for institutions to move patients from other states (read ‘independent homelands’).

> *To amend the Mental Health Act, 1973, so as to delete certain obsolete definitions; to provide for entering into agreements with other States relating to the detention, reception and treatment of patients and persons from such other States in institutions in the Republic, and their discharge from such institutions;*

*and to exclude the territory of South West Africa from the application of the Act; and to provide for matters connected therewith.*

1. *Amendment of section 1 of Act 18 of 1973, as amended by section 1 of Act 10 of 1978, section 1 of Act 38 of 1981, section 1 of Act 3 of 1984, section 2 of Act 34 of 1986, section 1 of Act 55 of 1987 and section 6 of Act 51 of 1991.-Section 1 of the Mental Health Act, 1973 (hereinafter referred to as the principal Act), is hereby amended by the deletion of the definitions of 'province' and 'Republic'.*
2. *Substitution of heading to Chapter 5 of Act 18 of 1973.-The following heading is hereby substituted for the heading to Chapter 5 of the principal Act: 'PATIENTS AND PERSONS FROM OTHER STATES'*

*Substitution of section 42A of Act 18 of 1973, as inserted by section 4 of Act 38 of 1981.-*

*The following section is hereby substituted for section 42A of the principal Act: 'Minister may enter into agreements relating to detention, reception, treatment and discharge of patients and persons from other States'*

*42A. (1) The Minister may, on such conditions as he may deem fit, but subject to the provisions of this Act and any other law, and in consultation with the Minister of Finance, enter into an agreement with any other State providing for-*

- *a) the detention in an institution in the Republic of any person who is charged in such a State of an offence specified in such agreement, for the purposes of examination of and report on the mental condition of such person;*
- *b) the continued detention in an institution in the Republic and discharge from such an institution of a person who, after an examination referred to in paragraph (a), is found to be mentally ill;*
- *c) the reception and treatment of a patient from such a State in an institution in the Republic and his discharge from such an institution.*
    - *a. No such agreement or amendment thereof shall be of force or effect- until it has been published by the State President by proclamation in the Gazette.*

During the Watergate Probe, one of the most important questions that was asked over and over again was: 'What did President Nixon know and when did he know it?' We make our judgment on his ethical conduct based on the answer to those questions. Our discussion would not be complete without touching on the concept of intention. Knowledge of a person's own moral obligations is usually a prerequisite for imposing blame for unethical action. Ironically, it is also the traditional form of a legal defence of insanity, that a criminal defendant either did not know that the nature or the quality of the act, or was not aware that it was wrong. Did South African mental health practitioners and government mental health structures know that what they were doing was wrong?

Of course they did. The two entities can't be separated. On the one hand the SPSA were distancing themselves from the unethical practices that were putting them into bad repute, while sitting on the same Boards and government advisory committees which were putting

the 1973 Mental Health Legislation into place, for example (Caldicott, et al., 1990; Jewkes, 1984). This effectively makes these players in the period covered by this research less ethical than a person (for example a nursing assistant in a facility) who may have carried out actions that were the result of these decision makers, because they may not have had knowledge that these actions were wrong.

> ***Madness is rare in individuals - but in groups, parties, nations, and ages it is the rule.***
>
> ***Friedrich Nietzsche***
> *(Nietzshe, n.d.)*

Does the 1994 apology to the APA about not believing or acting on the contents of their report exonerate the State from its prior unethical behaviour (Psychiatric News, 1997)? No, it does not. While confession may be good for the soul, at no time does it negate moral responsibility. If we remove motive as a moral imperative in this case, we must then view the results of the behaviour of both state and practitioners as being absolutely unethical—as were the results—continuing human rights abuses. It also bears repeating that while this apology occurred in 1994, an action plan to address these issues in mental health care has only been put in place as recently as 2013. (Department of Health, 2013; Department of Health, 2013).

One of the most saddening aspects of this research is to identify that there were so many critical abuses carried out on institutionalized patients, from forced social isolation for life for little more than not carrying a passbook or urinating in public, to being unemployed or even more appalling, to not being able to communicate in the two official languages of South Africa while inebriated and having been sent for ‘rehabilitation’, never to be seen again by family or friends. Diagnoses like ‘appears to be retarded’ amongst other vague findings might very well be rationale for many a lost life. Death just quietly closes this chapter of history as those patients die of old age now behind the same crumbling, decaying walls.

## THE AFTERMATH

The tragedy of unethical mental health care is unfinished business in South Africa. It remains so because in a way it defies explanation. This research has sought to explain the accumulation of events and players that brought mental health to the point where unethical systems are still in place after more than half a century. No person or body feels accountable for, or has felt the need to change any of the existing unethical systems with any kind of urgency. While the unethical care may be mitigated to a degree by virtue of a reduction in institutional beds, for these patients it has never been addressed. As these patients are getting older, and are becoming a smaller and more depleted group over the years through

ill health and natural attrition, the issue will simply resolve itself. They will die alone, forgotten and neglected, degradation over time. Justice will never be served.

Three significant events occurred after the mid-1980s which effectively shifted chronic, institutionalized mental health patients, or, in the case of the erroneously diagnosed victims of the apartheid systems, political machinations into human rights limbo, into a forgotten space where they were to remain, forgotten and neglected, until many of them died. In dying, these patients effectively removed the problem of finding an accountable party to take responsibility for the real-time loss of these decades of these people's lives and to ensure that some form of justice is done.

These events were

1. The use of private facilities in the homelands used for the shifting of undesirable Blacks out of the South African White only areas into rehabilitation facilities where they could be safely incarcerated without having to go through criminal court processes. These facilities formed the basis of the control of social problems which Blacks encountered in Whites only areas.
2. The involvement of the rising Scientology movement, whose anti-psychiatry stance, and whose ideations and beliefs considered by many to be bizarre, were sufficient to ensure that, although their concerns not only had some merit and were valid, could be easily discredited on the basis of the lack of international credibility of the organization and its followers. This ad hominum rejection of the cult itself was sufficient to ensure that the complaints and alerts to the abuses that were occurring were nullified. While the cult was certainly instrumental in bringing the situation to the attention of international watchdogs, it was not considered as having weight until the late 1990s when the Church of Scientology, using the information as propaganda, and became, by their own admission, the organization which had 'exposed the use of psychiatry in apartheid abuses' (Citizens Commission on Human Rights, 2004).
3. The distancing of the Association of Psychiatrists in South Africa from Smith Mitchell facilities, in spite of the knowledge that this group of patients were unable to stand up for themselves, a situation which has remained in place till the present (Jewkes, 1984). This could possibly be one of the most significant reasons that these patients became unwitting pariahs to the psychiatric fraternity's zealous need to show their rejection of the situation of which they were an integral part.

## 1994, 2004: THE ELEPHANT IN THE ROOM

There is an interesting anomaly that has occurred in the present iteration of mental health care. On the one hand the Department of Health has made promises to address the issue of mental health in South Africa since the 1990s; on the other, the beds of the previously Smith Mitchell/ Lifecare are still in use. They are, however, rarely included or specifically alluded to in official mental health bed numbers to the extent that they are often left out of discussions and planning around future mental health services and proposed restructuring. Neither are they included in statistical investigations into services. The people housed in these institutional long stay chronic facilities infrequently form part of the dialogue around what will happen to them in the future. They have simply been forgotten, or composited under a single statement about providing community facilities in preference to long hospital stays (Department of Health, 2013; Janse van Rensburg, 2013).

The following quote from Minde in 1977 is rather prophetic, in that it shows that mental health has come full circle and while in its day was innovative and cutting edge thinking at the cusp of the darkest days of apartheid, and predicts a slow and tedious path hampered by inactivity (Jones, 2003).

> *'Let us now look briefly at the gloomier side. The lifeblood of any mental health service is finance, and the prospect for this in the foreseeable future is not bright. South Africa is going through an economic recession, the price of gold has fallen and defence will require large sums in the years ahead. So there will be little to spare for mental health services, which in the state's eyes have a low priority. A new mental hospital costs millions, so none is likely to be built in the near future. We will thus have to make the best of existing facilities for some time to come. Let us therefore use the favourable features described to improve the quality of the service. We should aim at increasing the turnover of patient inside the hospitals, and at handling more and more patients extramurally. The psychotropic drugs make this quite feasible.* (Minde, 1977a, pp. 549-553).

It would be wonderful to end this research by reporting that this retrospective analysis can document a radical shift from Minde's 1977 comments. But this is not the case. Provinces utilizing Smith Mitchell, then Lifecare institutions continue to follow the same outdated process and practices. Staffing remains in line to profit the company rather than serve the needs of the patients (Porteus, et al., 1998), which purely by virtue of the lack of staff to patient ratios remains unable to provide appropriate service to mitigate the present deficits or, more importantly, attempt to reverse the iatrogenic effects of both unnecessary and inappropriate care. Both newspapers and politicians have commented or reported on the situation periodically to the present (Kimberly, 2012), with the somnambulant response of national mental health being well in line with the sedentary pace it adopted from the late

1970s to 1994. Bearing in mind that it took years to promulgate a new Mental Health Act from that of the notorious Act of 1973 to the 2004 Act and then until 2013 to come up with a plan to underpin this same Act. It also does not seem to have been as an independent initiative of the South African Department of Mental Health, but rather as part of a global move initiated by the WHO in promulgating an international action plan (Department of Health, 2013; World Health Organization, 2013).

Why has there been no accountability for this? The legislation offered a blanket amnesty for staff in these facilities. In response to the accusation of institutional abuse – the Mental Health Act of 1973 reduced the possibility of allegations and sanctions by removing the means to voice concerns. These included:

> *66A. Prohibition of sketches and photographs and of publication thereof and of false information.-Any person-*
>
> *(a) not being a member of the Newspaper Press Union of South Africa, who, without the authority in writing of the Director-General-*
>
> *(i) sketches or photographs or causes to be sketched or photographed any institution, portion of an institution, patient or group of patients, whether within or outside any institution; or*
>
> *(ii) publishes or causes to be published in any manner whatsoever any sketch or photograph of any patient or group of patients, whether such sketch or photograph was made or taken before or after the issue of a reception order in respect of the patient or in respect of any patient of the group of patients, or of any institution or portion of an institution; or*
>
> *(b) who publishes or causes to be published in any manner whatsoever any false information concerning the detention, treatment, behaviour or experience in an institution of any patient or any person who was a patient, or concerning the administration of any institution, knowing the same to be false, or without taking reasonable steps to verify such information (the onus of proving that reasonable steps were taken to verify such information being upon the accused), shall be guilty of an offence and liable on conviction to a fine not exceeding one thousand rand or to imprisonment for a period not exceeding one year or to such imprisonment without the option of a fine or to both such fine and such imprisonment.*
>
> *CHAPTER 11*
>
> *GENERAL*
>
> *68. No liability in respect of act done in good faith under this Act.-(1) A person who in good faith and with reasonable care performs any act under any provision of this Act shall not be civilly or criminally liable in respect thereof.*

According to the above section of the Act, the expectation of appropriate quality care was not present and therefore neither could there be complaint, penalty or consequence. A simple interpretation of the content is that if the staff were less than competent, but well-meaning, and the services reasonably acceptable, there was no liability on any person. This effectively writes into law that there was no expectation of an appropriate level of care that would be of therapeutic value to the client, but that a minimum level of input, as long as it was not provided with malicious intent, was sufficient. This provides a more than acceptable platform for Smith Mitchell to deliver their contractual obligations to the Department on the most basic level. It also provided a legal basis for neglect by professionals and students who may have noticed that the care for Black patients was substandard. It did not necessarily have to be valuable to the patient. It simply had to be presented in good faith—and what professional would ever say that they ever offered care in bad faith?

> *(2) In any proceedings against any person in respect of any such act the burden of proving that he acted without good faith or without reasonable care shall lie upon the plaintiff.*
>
> *(3) Any proceedings taken against any such person for any such act may, upon application to the court in which they are taken, be stayed if the court is satisfied that there is no reasonable ground for alleging want of good faith or reasonable care, or that the proceedings are frivolous or vexatious.*
>
> *(4) No such proceedings shall be commenced after the expiry of three months after the act complained of, or, in the case of a continuance of the cause of action, after the expiry of three months with effect from the termination thereof: Provided that in estimating the said period of three months so limited for the commencement of proceedings, no account shall be taken of any time or times during which the person wronged was lawfully under detention as a mentally ill person or was ignorant of the facts which constitute the cause of action.* [22]

The 1973 Act provided the get out of jail free card for abuse or negligent care by institutional staff and the institutions themselves by providing a legal catch 22 for persons seeking justice. If taken together, two sections of the Act prevented complaints and the ability to prosecute and extract justice for any mismanagement, abuse or inappropriate care provided by any mental health facility.

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22 *[Editorial Note: S. 68 (4) has been declared unconstitutional and invalid as set out in the Constitutional Court Order published under Government Notice No. R.1041 in Government Gazette 22750 of 19 October, 2001. Please note that this declaration of invalidity is valid for and applies to all actions that were instituted on or before 27 April, 1994 and have not yet prescribed before 27 April, 1994 and have not yet at the time of issuing this order been finally disposed of in accordance with a binding decision of a competent court or a valid settlement.] (5) Nothing in this section shall be construed as depriving any person of any defence which he would have independently of this section.*

The Mental Health Care Act 17 of 2004 has also failed to make it possible for abuse in the mental health care environment—especially that of the chronic institutional environment—to be addressed in any other manner than by separate individual civil or criminal court for actions or behaviours by mental health personnel. The argument to this may be that there are mental health review boards which provide the oversight to involuntary patients which will allow for recourse in the case of abuse. There is certainly a process for reporting abuse. But there are no penalties set out in the Act for specific abuses related to inferior care or institutional ineptitude.

## THE DEAFENING SILENCE

Another noteworthy semiotic thread which meanders through this research is that of loud and strident defence of the level and standard of care in the heyday of apartheid – by both government officials and eminent academics—all of whom had links to Smith Mitchell and Lifecare; and the sudden silence which became the tell-tale feature of mental health post 1994. Examples of this are present in the absolute absence of the persons or companies links to the institutions and patients of this era of disgrace (Afrox Limited, 2001; SAMJ, 1979).

Dr Hymie Moross died in 1979. He was a well-respected psychiatrist, having been active both nationally and internationally in the mental health field, specifically as the superintendent of Tara Hospital. His obituary was a humbling testament to a man who had been an instrument of change in the field, as well as a fiery defender of South African psychiatry (SAMJ, 1979).

> *On his retirement after 22 years as superintendent of Tara, the Transvaal Provincial Administration accorded him the singular honour of changing the name of the hospital which he had made a showpiece of South African Psychiatry to 'Tara, the H Moross Centre'. After his retirement he remained active in the field of psychiatry, and very recently defended South African psychiatry against politically motivated attacks at a meeting of the World Psychiatric Association.*

What exactly were these 'politically motivated' attacks? Why wasn't Dr Moross' very public link to Smith Mitchell mentioned in his obituary? Dr Moross, the then Medical Administrative Adviser of the Smith Mitchell group, in his Introduction to a report on the investigation into the alleged abuses in the Smith Mitchell facilities initiated by the Church of Scientology and reported by the APA had defended the care in the institutions, stating:

*Ladies and Gentlemen,*

*I am the Medical Adviser to the Smith Mitchell Group and I wish to thank you for giving me the opportunity to bring to your notice certain information concerning this group and the alleged abuses. Dr Bradshaw has asked for time for these abuses to be discussed and he has made three recommendations:-*

- *Distribution of a Memorandum*
- *Active presentation of the data*
- *Assistance from the APA for various investigative efforts*

*At the onset, I must say that I find myself in complete agreement with Dr Bradshaw's recommendations. I feel sure that if I had been given such information setting out these abuses I too would have felt that it was essential that it be discussed in open forum and investigated.*

*However, ONE MUST SEE THIS INFORMATION FOR WHAT IT IS.*
*It all emanates from the same source, one central organization, one which is not only anti Smith Mitchell but anti psychiatry generally and I think that that fact is well known to the people assembled here today. So we see this criticism as criticism not only of the Smith Mitchell group, but of the World Psychiatric Association as well.*

*We believe that we fulfil one of your requirements, viz. THE NEED TO HOSPITALIZE CERTAIN PATIENTS.*
*Of course you would accept this proposal but you would want to know more about the standards maintained at these institutions. Since the initial criticism on a global scale we have entertained many visitors, some of them eminent people, and we have been investigated by the Red Cross. This investigation took place in November/ December 1976, and at this point I wish to quote from 'Hansard' (the official transcription of proceedings in the South African Parliament) which reports on Wednesday 1st June 1977, the statements by the Hon. The minister of Health (Dr S van der Merwe) :-*

> *They (the IRC) told me that as for the charge that political opponents are being detained in these institutions, it was something which they rejected. They saw no evidence of it. Nor did they see any need to examine our mental health institutions any further. They will bring out a report; it will still be published.*

*This report was in fact receive shortly after in the form of an aide memoire dated 26th May 1977 and sent to the Minister by the international committee of the Red Cross. The final words of the memoire read as follows:-*

> *… The ICRC delegates did not find, in any of the psychiatric institutions which they visited, any patients hospitalised for any other than medical reasons.*

> *On the same day, the minister referred to the visit of Professor T C N Gibbens, a world renowned psychiatrist. I quote again from 'Hansard':-*
>
> > *We also have the benefit of the testimony of a prominent psychiatrist who visited these places of his own accord and had the following to say about them – 'as far as my personal observations were concerned, there is nothing medically or ethically undesirable in the Smith Mitchell institutions which I visited'. This person was afforded an opportunity of visiting all the institutions and we gave him the right to forward to all the data which he collected to the WHO completely unrevised.*
>
> *We do not claim to be perfect but we do say that we are a dynamic organization, constantly evolving and constantly on the lookout for ways to improve.*
>
> *We too would like to take an active role in correcting the misconception and we can see no better way than to invite two members of your executive to fly out to South Africa at our expense to visit these institutions. As with the International Red Cross they could lay down their own conditions in advance* (Moross, 1977)

The Red Cross did not visit any facilities in the Homelands (or Bantustans). In these institutions, The Proclamation About Rehabilitation Institutions in Bantu Homelands' laid down that the aim of treatment was to 'improve the physical, mental and moral condition of (inmates) by 'fostering of an awareness in regard to the observance of, and the necessity for, the laws of the country' and 'reorientating them to the traditions, culture, customs and systems of government of the national unit to which they belong.' (Jewkes, 1984).

The independent and organizational reports which were carried out and reported in the APA report, the Brazzaville reports and the Platman report do not bear out the previous accolades and assurances provided by Dr Moross. In spite of his firm belief in the new systems which were ostensibly in place, the facilities owned and operated by the group continued to provide substandard and negligent care. And he defended Smith Mitchell to international mental health bodies with authority and indignation (Moross, 1977).

Tara was, in fact, a wonderful example of what could be done in the field of psychiatric rehabilitation, and certainly deserved recognition (SAMJ, 1984). It sadly also provides a solid example of the discrepancies between facilities run for White patients versus those for Blacks both during apartheid and beyond, and certainly those which were provided for economically wealthy White patients and those provided for indigent and Black patients. Tara – both geographically positioned in a particularly wealthy suburb of Johannesburg and provided with the referral stream for White patients in White hospitals demonstrates that the class differentiation maintained by apartheid practice was relatively simple to maintain within healthcare service provision.

Figure 2: 1976 Mental Health Practitioner Staffing Comparisons per Number of Beds: Tara Hospital vs Randfontein Sanatorium (World Health Organization, 1983, p. 240)

| Tara Hospital | | Randfontein Sanatorium | |
|---|---|---|---|
| Beds: 150 White patients only | | **Beds: 3200 Black patients** | |
| **Psychiatrists** | 6 | Psychiatrists (part-time) | 2 |
| **Physicians** | 10 | Medical officer (part-time) | 1 |
| **Clinical psychologists** | 12 | Clinical psychologists | 0 |
| **Occupational therapists** | 8 | Occupational therapists | 1 |
| **Social Workers** | 4 | Social Workers | 1 |
| Total | **40** | **Total** | **5** |
| | | | |
| **Nurses** | Unspecified | Nurses | 21 |
| | number | Nursing Assistants | 164 |
| | | | |

The above table demonstrates clearly the bias of treatment of White patients at Tara versus warehousing of Black patients in the Randfontein Smith Mitchell facility. The numbers of both medical therapy staff geared towards physical wellness and psychosocial rehabilitation is clearly shown. This dichotomy reflects the general situation in psychiatry nationally at that time.

There is the additional peer cronyism and the defence of substandard practice ad hominem over ethical behaviours. This is a common fault amongst practitioners, especially those who have risen to high levels within the specialty with other specialists who are friends and colleagues. This is not a leap, although there is little research into this specific phenomenon (Conover, 2012). The word peer implies that the ideation of a group of persons is similar, both in their beliefs and in their practices. These beliefs and practices are both alike and closed. Closed infers that they are specific to this group. They are open to both critique and rejection by other groups. When these groups are age and time specific, they tend, especially if they are the majority group to maintain their identity by rejecting change as being antithetical. In order to belong, to be included and defended within the exclusive and closed boundaries of the group there needs to be active support of the other members of the group. These groups often included both national and international members of associations and specialist societies, in this case in the field of mental health. This is shown by the example letter below, sent by Professor Emeritus L A Hurst of the University of the Witwatersrand Department of Psychiatry to the South African Medical Journal (Hurst, 1976)

***To the Editor**: It is a privilege to live in a country that has pioneered, in two waves, major advances in contemporary psychiatry, with emphasis on human concern for the psychologically handicapped. The conclusion of World War II brought the first wave of advance, focusing the spirit of teamwork that had developed in the course of the war, into the service of civilian psychiatry, at the sophisticated interdisciplinary community-orientated psychiatric service that has evolved at Tara - The H. Moross Centre, internationally acclaimed as one of South Africa's most distinguished contributions to medicine as well as a matter of general national pride. But this is not the subject of the present communication, although a forerunner to it. The theme of this letter is the second wave of advance enshrined in the extension of the State mental hospital services of the country in the form of sanatoria run by the Smith, Mitchell organization that incorporates the services of State psychiatrists and nursing personnel. It is worth noting that a common factor to the two waves of psychiatric advance is the person of Dr H. Moross, with his medical administrative ability and human concern. Destiny has decreed that his contribution should be at the two ends of the psychiatric spectrum, for at Tara - The H. Moross Centre, his central interest had been the milder disturbances, the neuroses and personality disorders, and now with Smith, Mitchell he has been guiding the enhancement of the quality of life and the rehabilitation of White and Black psychiatric patients whose disease was formerly classed as chronic or incurable. I have recently had the opportunity of seeing something of this work, at 6 of the Smith, Mitchell sanatoria. The Smith, Mitchell psychiatric service is divided into two main categories, the 'chronic' psychotic, and the aged or geriatric patient. Already 14 sanatoria are spread throughout South Africa and the Bantu homelands; in addition, the group has 4 homes for the aged which render a service for and on behalf of the Department of Social Welfare and Pensions. My visits with Dr Moross have been supplemented by perusing meticulous administrative clinical and pilot research reports made available to me from Waverley and from one of the old age homes at Struisbulthawe.*

*Waverley is a sanatorium for non-White male and female long-term psychiatric patients. Its main objective is the strengthening of patients' residual psychological and/or physical competence, with a view to their ultimate discharge from the sanatorium; or, failing this, the improvement of their quality of life in the sanatorium. In the rehabilitation program discriminating attention is given to activities during recreation and leisure, diversional therapy, industrial occupation therapy, occupational therapy relevant to daily living conditions in a Black community, and assessment of home conditions by a social worker, who orientates relatives to accept the mental patient as having been a sick person. The carefully structured program of conditions is diverse and highly imaginative.*

*A different program is prepared for each day of the week. One fascinating policy with deep roots in interpersonal psychology is the daily allocation of the same group of patients (approximately 24 in number) to an enrolled nursing assistant. This system is rendered vivid by the nursing assistant wearing a distinctive band, the same colour as the clothing worn by her group of patients. The group forms a housekeeping team which is responsible, on a monthly basis, for bed-making and ward cleaning - so that the wards are clean and vacated by 09h30 daily.*

*A 4-months' research assessment of the program issued no fewer than 8 salient conclusions relating to such matters as intimate knowledge of the patient, avoidance of neglect of the patient and recognition of claims to promotion to other activities, the discussion of personal hygiene and the administration of medicines, adherence to the daily program written on a Blackboard, the incentive provided by competition between different groups, and its therapeutic effect.*

*At Struisbulthawe the therapeutic occupation program has as its aim the optimum independence of the aged, more specifically their capacity to live a more satisfactory and abundant life within the limits of their physical, mental and emotional limitations and environment. In addition to the provision of extensive leisure time and specialized therapeutic activities, particular attention has been devoted to the following items of special relevance to the handicapped aged patients: bed movements, correct wheel-chair activities, suitable walking aids, bath movements and aids, toilet management and aids, eating and dressing activities for stroke patients, chair movements, and habit training for incontinent patients.*

*Practical details such as length of walking sticks and the proportion of chairs are not overlooked, and the sensitivity of patients in areas such as toilet training is ever in the forefront of attention and concern, and an activation program is in full swing. While the foregoing descriptive summary gives an idea of the encouraging therapeutic atmosphere prevailing at one of the Smith, Mitchell sanatoria and at one of its geriatric units, the pilot character of the development is recognized. The new philosophy is, however, spreading to the organization's other sanatoria and geriatric units, with consequent improvement in their therapeutic climates. This means that what we have termed the second wave of contemporary psychiatric advance enshrined in the Smith, Mitchell projects is well on its way in South Africa. Let us give it the encouragement and support it so richly deserves.*

*L. A. Hurst*
*Dept of Psychiatry Professor Emeritus*
*University of the Witwatersrand*
*Johannesburg*

Little if any of the ‘advances’ ever took place, and the subsequent rejection of Smith Mitchell facilities by SPSA on the grounds of inferior care does little to validate the contents of the letter above. Owners of the mental health business prior to 2004 also neglect to mention their involvement with these businesses in the present. Afrox very proudly lists its achievements from 1928 to 2007 on its webpage. Among these were the various awards for governance, accolades for CSI projects and the like (Afrox Limited, 2001).

In their company Annual Reports for the various holding companies of the Smith Mitchell/ Lifecare group, however, there is not mention made of the chronic mental healthcare business. The following excerpt from the Afrox 2001 annual report has only the following to say about a 10000 bed business to its shareholders:

> *Afrox Healthcare acquired Afrox's 55 percent stake in Lifecare as the company fits more comfortably under the healthcare umbrella. Lifecare's 22 long-stay chronic care hospitals and two acute care hospitals accommodate 10 000 patients. These special health services facilities operate under contract to provincial government* (Afrox Limited, 2001).

In the present manifestation of a lack in mental health service for chronic and institutionalized patients, this stance has shifted with the lip service given by the Department of Health to removing these same institutions and replacing them with community facilities, provided and supported by government. These have again not materialized in any significant way since 1994. These same facilities remain the only placements available for mentally ill users requiring structured accommodation outside of acute facilities. From 1994 to 2013, the system of per patient day care, substandard service was maintained without change to policy or practice, especially in private facilities (Porteus, et al., 1998). Patients, after the Department apologized to the APA, after the TRC acknowledged that there were abuses and after the new Act of 2004 was promulgated, remained in the same institutionalized environments with the same deficient care. The Platman report ended with

> *It was evident that many of the patients in the Company facilities did not need to be there. They were not obviously psychotic and were not a danger to self or others. Some were now former psychotic patients in remissions, some were epileptics (controlled and uncontrolled) without psychosis, some were old and others had only social problems. Many did not require ongoing treatment.*

Too late for John Nkosi[23], who died in 2005 after admission in 1983 for public drunkenness, or for Eunice Mulale[24] admitted in 1987 for 'appearing to be retarded' and who also died in 2005. A cumulative number of 40 human life years lost, alone and far from family and friends.

[23] Not his real name
[24] Not her real name

# CHAPTER 9: CONCLUSION

In this thesis, I located ethics and ethical behaviours within specific time periods and thinking. I showed that depending on the time, behaviours which would indicate ethical professional care can change. I also demonstrated the difficulties in applying present day standards to past ethical care. It was also possible to show the incongruence which can surface when analysing historic documents, and the difficulties that researchers may encounter when making ethical judgements retrospectively because of this.

I was also able to show the effects that both international and national social and scientific developments had on the provision of mental health services, with special attention to Eugenic thinking. I identified the main protagonists of the movement in South Africa and explained their contributions to mental health. There was also a spinoff effect which occurred in the political and legal spheres which was identified and dealt with in more detail.

The concepts of contagion and disease, the fear of contamination and the lack of effective treatment formed the basis of the preference for institutional and lockup care. I demonstrated how these became entwined in the seemingly unrelated political, religious, legislative and social thinking.

I illustrated how legislation was necessary to implement and maintain a number of mental health care initiatives introduced by the South African government, and how, when apartheid became the underpinning principle of a number of Acts and legislation, these could be defended by the scientific and social institutions of the time. This basic foundation made it possible to inculcate segregation practices into healthcare as 'right' professional practice. This belief could be established by considering the defences and actions provided by the practitioners of the time in a number of public contexts.

I introduced the concept of business becoming a perverse partner in the service provision of mental health care services to the state. I was also able to show that it was possible for the South African government to use psychiatry to commit apartheid human rights offences through a number of indirect structures which included the use of independent homelands and big business.

Once the abuses put in place had been identified by external rights structures, I established that the presence of a problematic organization (the CCHR) and an unpopular social organization (the antipsychiatry movement), perceived to be unscientific and against social mores, had the effect of diverting attention from the actual issue – that of patient abuse. The

shift in attention meant that the organizations that had raised the alarm, and those international bodies that had reacted to the abuse complaints bore the brunt of the South African government's rejection. The abusive context remained in place.

I discussed how neglect and abdication can be as abusive as the commission of a physical act. I also show that systems that maintain a situation which allows for omission of the ingredients required for ethical care (insufficient funds, lack of competent staffing and prejudiced professional management) can be as destructive as material abuse. I explained the intrinsic harm of institutionalism - that of eroding the personhood of patients in these facilities. I then linked the degradation by neglect within these facilities to the mental health practitioners of the time extricating themselves from being associated with them by walking away. I highlighted that these patients were abandoned to the system in order to protect their professional reputations, and that this continued to 2004.

# ANNEXURE A

In this chapter I will provide the backstory to the period covered by this research. There were a number of developments in mental health in South Africa and the world. Everything from medication to thinking about the way that the mentally ill impacted on society was in play. I will begin by placing the care of the insane into the colonization of the Cape. I will then focus on the growth of the profession, the building of psychiatric institutions, the advent of university education for mental health professionals and the formalisation of psychiatric nursing in colleges. I will show that, while the developments of the treatments may seem barbaric by present standards, these were cutting edge for the time. This period could be seen as the golden age of South African Mental Health.

The story of mental health care in South Africa begins with colonisation of the country by the Dutch East India Company in the 1600s. The accommodations in which the settlers lived were crudely built shacks. They drank copious amounts of alcohol, specifically a beverage called Arrack (which Van Riebeek was constantly requesting the Dutch East India Company to replenish) and beer, which was part of their daily diet, providing a number of the required vitamins the settlers needed. Hop plants and distilling equipment were later sent to the colony to enable the settlers to manufacture their own alcoholic drinks. Viticulture soon started up, and with this came a greater variety of beverages that were produced In the Cape and its surrounds (Minde, 1974a, pp. 1270-1272).

The environment was aggressive and dangerous, with beatings and stabbings occurring regularly. Religion was Calvinist fire and brimstone type, and justice was severe and punishment harsh. Common punishments were whipping, branding, breaking on the wheel and beheading, very often carried out in public. Homosexuality was seen as a specifically abominable crime, and punishment was usually death. Against this backdrop, it is not unreasonable that lunacy (as it was called) at the Cape was perceived with the same intolerance and insensitivity. Prior to the 1700s lunacy was often perceived to be caused by demonic possession (Merkel, 2003, p. 5). The French Revolution, towards the end of the 1800s heralded the birth of the modern concept of mental illness as initiated by a French physician Dr Philippe Pinel. The European population at the Cape was considered too small to warrant special care for anyone thought to be mentally ill. The Dutch East India Company therefore made no effort to supply resources for the care of any sufferers. The population of mentally ill persons of the Cape during this time was made up of sailors passing around the Cape. The diagnosis of mental illness was common because venereal diseases,

hypervitaminosis, infection, alcoholism and exhaustion were commonplace. There were no Lunacy laws to allow for management of these persons, although these were in place in other developed countries. Any person suffering from a mental disorder was confined in the ordinary hospital, the slave lodge or the convict station on Robben Island. Three hospitals were built by the Dutch East India Company in the Cape. The first hospital accommodation specifically designed for mental patients was during Simon van der Stel's time and was situated at the upper end of what are now Adderly and St George's Streets. It was opened in 1699. The hospital was designed to house 500 patients, but could take 750 at a push. It only catered for soldiers and sailors employed by the Company. A ward was later added for mental patients, which included officers and crew of the passing ships (Minde, 1974a, pp. 1270-1272).

> *It was moreover decided as a useful and orderly measure to build on to one of the wings as soon as possible a small enclosed apartment for locking up the mad who are now and then found in the hospital, and with whom at present we are embarrassed.*
>
> *April 12th 1711. Decided that the Chief Surgeons house and an apartment for the mentally diseased to be built* (Minde, 1974a, pp. 1270-1272)*.*

The Slave Lodge was initially accommodation for the slaves utilized in the Cape by van Riebeeck's Household. Males, females and children were separated into different sections of the lodge. Accommodation was provided for convicts in the Attic, and the Lodge also rented small rooms to mentally ill persons at a charge to their families, who also had to supply them with food (Minde, 1974a, pp. 1270-1272).

Robben Island began as a convict settlement. It was started by Jan van Riebeeck soon after arriving at the Cape. Slaves were sent to the Island as punishment. Khoikhoi/ Hottentots who came into conflict with the law were also sent to the island, as were Whites who committed crimes. While there are records of mental patients being sent to the island during the time of the Dutch East India Company, it was not run as a 'lunatic' asylum, and this practice of housing patients in the Lodge continued for a limited time after the occupation of the British in 1806 (Minde, 1974b, pp. 1629-1632; Minde, 1974a, pp. 1270-1272).

After the abolition of slavery in the 19th century, The Lodge became a home for infirm persons, predominantly those who had been slaves. The Somerset Hospital could not house all of the 'lunatics' and in 1834 part of the lodge was made into a 'lunatic' ward for 30 patients. These patients were predominantly those that were considered neither violent nor dangerous (Swartz, 1995, pp. 399-415). From 1845 policy was to concentrate all mental patients on Robben Island. After the opening of Somerset Hospital, Robben Island housed a

combination of the chronically sick, 'lunatics' and lepers (Swartz, 1995, pp. 399-415). Once the infirm old patients housed in the Lodge died, the building was converted to Judges Chambers. The building housed a courtroom for trials, and was to become known as the Old Supreme Court Building (Minde, 1974b, pp. 1629-1632).

Segregation of patients in the Cape was done on the basis of both class and gender, and not necessarily on racial grounds. Economy played an important part in class distinction. Asylums accommodated both Black and White patients. Informal segregation policies were based on classifications such as those of the 'better class' of paying patients being separated from those of 'incontinent, aggressive' patients, who were most often Black and the patients able to do manual labour versus those who were not able to work. For example, the separation of male and female patients was attempted, although not always achieved (Swartz, 1995, pp. 399-415).

In the late 1800s the British were in political control of the Cape. In 1910 the Union of South Africa was formed, however, it wasn't until 1930s that there was a marginal shift in ethos around the care of mental patients. Because demonic possession was still popularly considered to be the cause of mental illness (Merkel, 2003), the care of the insane was restricted to detention, with the intention of simply protecting society. The patient's own wellbeing was of no great consideration, although there was a belief that the more harshly the patient was treated, the more likely it was that the demons would be made uncomfortable enough to flee the host body. There was a development towards ethical care of 'lunatics' in the early 1803 in the form of a Code developed by Thomas Percival, a medical doctor in Britain. With regard to the care of psychiatric patients he wrote:

> *A physician, who attends an asylum for insanity, is under an obligation of honour as well as of humanity to secure for the unhappy sufferers, committed to his charge, all the tenderness and indulgence compatible with steady and effectual government. And the strait waistcoat, with other improvements in modern practice, now preclude the necessity of coercion by corporal punishment* (Percival, 1803).

While this appears to be progressive for the time, sadly, Percival also ratifies the *'beating of a lunatic, in such a manner as the circumstances may require'*. This Code formed the foundation of the American Medical Association's ethical code adopted in 1847 (Lopez-Munoz, et al., 2007, pp. 791-806).

This goes a long way to explaining why a blind eye was turned to the cruelty and abuse metered out to mental patients. The conditions in these patients' accommodations were appalling. Chained to iron rings driven into the walls, in foul, dark and unsanitary cells

infested with vermin, the patients were often covered in sores and riddled with disease. They were frequently held for the period of their natural lives and their deaths were a merciful end to the abuse. The staff employed by these facilities were also most often dysfunctional specimens of humanity, for example, ex-criminals and alcoholics. The cruelty demonstrated by these persons extended from charging the general public to attend the asylums on the weekends (where the patients were used to provide entertainment to the public for payment), to stealing the patients' rations for sale outside of the institution. These practices were not restricted to South Africa, but were common practice in the major centres around the world (Minde, 1974b, pp. 1629-1632).

## THE GREATER CAPE (WEST & EAST)

The shift towards more humane care came when the 1792 developments of Pinel in France had begun filtering through the world of mental asylums in Europe and the Americas. Being over 6000 miles from the seat of change in mental health, the Cape was slow to begin to change its outdated methods of dealing with the mentally ill. Use of the Slave Lodge, the Hospital and Robben Island continued for a number of years. A further facility—the Somerset Hospital—was built with some space given over to 'lunatics' in 1826. This space didn't have beds or bedding, leaving the patients to sleep on the floor. There were also reports of the patients being beaten with the intention of intimidating them to keep them under control. In 1836, a ward was especially built onto the Somerset Hospital between the Surgeons' accommodation and the leper ward. The single cells had grates instead of ceilings for ventilation. Reports from the facility indicated that the Lunatic Keeper's alcoholic habits at this time led to his dismissal. As Cape Town was the only place in the country to provide accommodation for 'lunatics', patients often had to travel for long distances for admission. In 1834 for example, 10 patients travelled 600 miles from Grahamstown for care (Minde, 1974b, pp. 1629-1632).

Somerset Hospital employed the first 'lunatic' nurse in the Union in 1832 and in 1838 the hospital purchased straightjackets for the 37 patients housed in the facility. The per-patient day tariff for each patient was 2 shillings 3 pence for Whites and 18 pence for Coloureds. The hospital deteriorated steadily after 1854, becoming unfit to house patients. In 1862 a new hospital opened, called the New Somerset Hospital, until 1938 when Groote Schuur Hospital was opened. While Somerset was unfit to house patients, it remained in use as a home for patients with senile dementia amidst numerous scandals about substandard care and structural defects within its rotting and dank walls (Minde, 1974b, pp. 1629-1632).

In 1834 the first medical officer was appointed to see to the 'lunatics' on Robben Island. Once the British assumed control in the Cape, accurate records were kept of all persons who were placed on the island 'in consequence of lunacy or other causes'. By 1840 Robben Island had all but ceased to be a convict station. 'Lunatics', lepers and the chronically ill were all housed at the station during that time. The mental hospital section opened in March 1846. In 1848 the 'lunatic' section held 78 mental patients. The logistics of admitting and maintaining patients on the island were startling. It took a five-oared boat, manned by convicts four hours, to row across from the mainland. Steam boats replaced the manual method later. Communication between the island and the mainland was by pigeon, with communication in inclement weather being impossible for days at a time. In 1900 a telephone was installed to aid communication. Lighting remained by oil lamp throughout the period of use (Minde, 1974b, pp. 1629-1632).

As increasing numbers of patients were admitted, so 'temporary' buildings were assembled. These buildings were to become permanent. Insufficient single cells were available, leaving unsuitable patients in the wards. There were numerous fights and injuries because of this. Over a period further buildings were added: a stone building for 20 male patients in 1864, and a wood and iron building for females in 1901, for example. The 19th century heralded a better quality of care for the patients, although this is relative. Noteworthy was the care for physical ailments, provision of knives and forks for most patients, sheets for the beds and the purchase of books. Opportunities for recreation and occupation were seldom made available. The patients looked forward to times when a family member managed to smuggle in a bottle of brandy from the mainland on visiting days. The food was unsatisfactory, with all meat being boiled. Staff sold their rations to any patient who could afford them. Towels and soap were insufficient, and were provided only rarely. When a patient misbehaved it was not unheard of to remove his meals for a week. The hard work on the island was done by patients, working in hot and unpleasant conditions for a working day 14 hours long (Minde, 1974b, pp. 1629-1632).

Medication, consisted of large quantities of bromides that often caused psychosis even if the patient had recovered, and hypnotics and sedatives that were the staples in the pharmaceutical arsenal. Doctors in the 19th century, and especially those in the Cape, used mercury-based calomel[25] well into the 20th century (Darley-Hartley, 1887, p. 186). While this may appear extreme today, it was an accepted treatment conversely both for diarrhoea and constipation. An extract from the South African Medical Journal (SAMJ) of 1886 reads

[25] The American Heritage Dictionary of the English Language describes Calomel as 'A colourless, White or brown tasteless compound, $Hg_2Cl_2$, used as a purgative and insecticide. Also called mercurous chloride'.

> *In several journals lately, testimony has been given to the efficacy of small and frequent doses of calomel in diarrhoea. Dr Muner of Philadelphia gives infants one-twentieth to one-eighth of a grain every half hour, combined with one-twelfth to one-fourth of a grain of Dovers Powder'* (SAMJ, 1886, p. 55) .

Dosages for adult psychiatric patients were somewhat different. These were sometimes prescribed in very large quantities, which caused mercury poisoning. There are cases where patients in mental institutions were given this medication for punitive reasons (Minde, 1974b). Use of these medications was not considered quackery. Rather, their use was regarded as cutting edge medical care. Members of the South African Medical Association contributed articles on the use of both mercury based medications and the use of arsenic in treatment for patients to the SAMJ. William Darley Hartley for example, the founding editor of the South African Medical Review, submitted numerous peer reviewed articles on the uses of a number of potions into the 1900s (Darley-Hartley, 1887, p. 186; Darley-Hartley, 1889, p. 7).

After an inspection in 1871, the buildings were considered to be obviously unfit for patient habitation, and the suggestion was to build a new facility on the mainland. Despite these suggestions and the state of the buildings, nothing occurred until 1913, when the decision was made to transfer patients to the mainland. While this occurred, patients were still admitted to the island, resulting in the numbers of admitted patients remaining the same (414). White patients were the first to be re-housed, which occurred by 1916. Black patients were finally removed and the facility closed in 1920 (Minde, 1974b, pp. 1629-1632).

Mental health began an expansion after 1872, with new hospitals being established further inland. Diamonds had been discovered, leading to rapid growth in both the economy and the size of suburban towns and cities. With this came an influx of White immigrants. This initiated a corresponding influx of non-White immigrants to the diamond fields, where there was ample work (Van Onselen, 2001, pp. 205-274).

One of the first facilities, which opened in 1876, was in Grahamstown. Originally named the Grahamstown Lunatic Asylum and then the Grahamstown Mental Hospital, it is still known by the name Fort England Hospital today. It was originally a barracks that was taken over from the military authorities during the time that Grahamstown was a fortified city. With the shifting of the border to the Kei River, the buildings became available for alternative use. During the early 1900s the facility also catered for a number of White 'mental defectives'. The ward that housed them formed part of the actual facility and the children were certified. These children were only transferred to an appropriate facility in 1920. By 1969 the facility housed 798 patients. The facility was a conglomeration of private houses, public

thoroughfares and facility buildings, which was not an ideal situation as the public and patients were indistinguishable. The solution was to purchase the private properties within the hospital's logical perimeter, which was done. The newly acquired land provided sufficient space for further extensions, growing of vegetables and a substantial area for grazing cattle. Additional land was acquired in 1914, and in 1952 a new facility for non-Whites was completed (Minde, 1974b, pp. 1629-1632).

Because of the growing number of mental patients, further facilities were required. The Kowie Hospital (previously the Port Alfred Mental Hospital/ Asylum) was opened in the abandoned convict barracks, built of brick lined galvanized iron in Port Alfred in 1888. The facility took and housed male and female mixed race patients. It was an infinitely unsuitable building, which was acknowledged pretty much from its opening. Water was scarce, and in times of drought, water was transported to the facility by rail, which occurred from 1919 to 1920. The lack of waterborne sewerage meant that a bucket system was in use, and this was both expensive and unhygienic. Electricity was only provided for the facility in 1930. A parliamentary select committee on the Treatment of Lunatics condemned the building in 1913, proposing that it be closed. This was never carried out. Government's lack of motivation to spend money on building new institutions meant that it remained in operation. In 1964 the facility was still being utilized, housing a total of 530 Black patients. The last White male patient had been admitted in 1915, and the last White female patient admitted was in 1922. While no patients were directly admitted to the facility, overflows from the surrounding hospitals were sent there (Minde, 1974b, pp. 1629-1632).

Valkenberg Hospital near Cape Town was originally the Porter reformatory building that was converted into a mental hospital for 40 White male and 25 White female patients. The original buildings of the reformatory were farm buildings, which had been converted. The Valkenberg Farm was on an estate of 200 acres, and had been purchased by the government in 1881. The hospital opened in 1891. More ground was acquired in 1912, and further ground, in the form of the Old Plague Camp in Uitvlugt, which bordered Valkenberg, was added for a Coloured section. In 1917 a separate ward was added to the original buildings for military cases. The ward was absorbed into the rest of the hospital at the end of the war. By 1950 the facility housed close on 2000 patients. In the early 1970s the figure was averaged to be around 1911. The facility was always overcrowded. After World War II (WWII) the department considered selling the facility to be used as a housing estate (Minde, 1974b, pp. 1629-1632), but the facility remains in operation until the present.

Tower Hospital, also known as the Fort Beaufort Mental Hospital/ Asylum was utilized for non-White patients only. It was originally an abandoned and derelict military barracks, and

was opened as a mental hospital in 1894. The facility was expanded with the subsequent absorption of a neighbouring facility that had been used as a Lock Hospital. More expansion was necessary, and this came in the form of a previously unused building—known as the Telegraph Department--being converted into a female ward in 1897. In 1908 further land was purchased to provide extra space for male patients. Huts were built to house them and later an infirmary was added. This section was named Conry's Annex. In 1913 another ward was added to house an extra 60 male patients. Tuberculosis, which proved to be a real issue for the facility's patients, accounted for at least half of the patient deaths between 1916 and 1919. This continued until modern drugs for TB became available. The facility was also recommended for scrapping by a Parliamentary Committee that declared it as being unfit for purpose. Ideally, a new facility should have been built by the municipality with funding they received from government, but rather than spend the funds on a chronic facility, when there was a need for an acute facility, they used the 216 morgen for a new acute hospital. Discussion turned to using the existing hospital for chronic patients, but the demand for acute beds precluded this from happening. By 1949 there were 2 349 patients housed in this facility, but the number dropped by the late 1960s as new facilities had become available in Natal and Bophuthatswana. The overcrowding that occurred both during and after WWII caused life threatening health problems. In 1942 there were 270 cases of dysentery, and in 1946 a severe drought caused a shortage of vegetables and various cases of hypervitaminosis manifested themselves amongst the patients. These included beri beri, pellagra and scurvy. Over a number of years, up to the late 1960s, a new facility emerged on the grounds of the Fort Beaufort Hospital, with the grounds having been developed by using the patients as labour. This included the female patients who were involved in agricultural pursuits (Minde, 1974b, pp. 1629-1632).

Komani Hospital (Queenstown Mental Hospital), which opened in 1922, was the first modern hospital in the country designed to be use specific. It was built on a large piece of land, and a great deal of planning and work went into planting the trees, establishing a farm and a nursery, and making the roads. The facility operated as a working farm, even having its own butchery. A radical shift from the institutionalized containment environments of other facilities, Komani boasted a tuck-shop for patients to purchase small luxuries and a recreation committee that organized entertainment on a weekly basis. This included concerts, piano recitals, poetry recitations, singing—and for those who were interested in rugby—trips on the bus to town to watch matches on weekends. The facility housed only White patients. A volunteer organization, the Friends of Komani, was actively involved in the activities of the facility, taking patients out on weekends, visiting them in the facility, inviting them to their homes for meals and taking them to church and to the cinema. Integration and

involvement in community activities ensured that the general morale of the hospital remained high (Minde, 1974b, pp. 1629-1632).

## DEVELOPING TREATMENT

The 1920s ushered in a new era of innovative treatments for the psychiatrically ill. Treatment of schizophrenia had produced some interesting regimens, which included prolonged narcosis using barbiturates, somnifen (a mixture of diethyl and dipropenyl-barbituric acid and diethylamine produced by the Hoffmann-LaRoche company), opiates and sodium amatol; induction of fever using malaria, administering high frequency currents, injection of foreign protein, producing aseptic meningitis and inducing seizures using various medications. None of these therapies was reliable, and results were often difficult to predict (Easton, 1938, pp. 229-236).

Malarial treatment, for the paralyzed mentally ill person, had been discovered in Vienna by Von Wagner-Jauregg in 1887. 'Pyrotherapy', as the treatment was termed, described the potentially therapeutic effects of fever on psychosis. The basis of the treatment was the deliberate infection of patients with various disease strains to induce fever. These included both syphilis and tuberculosis. As far back as 1786, a physician by the name of Roess had recorded some improvements in mental patients after they had been inoculated with smallpox vaccine. Some of the scientific logic that underpinned the development of this therapy was that there were very few epileptics who were also schizophrenic, leading to the supposition that convulsions and mental illness were incompatible. Von Wagner-Jauregg was awarded the Nobel Prize in 1927 for this treatment (Sabbatini, 1998; Gartlehner & Stepper, 2011).

In 1917, Wagner-Jauregg, found the ideal mechanism for inducing controlled spikes of fever in patients, in the form of malaria. The therapy was widely adopted internationally, principally because quinine was available to cure the malaria after the treatment had been completed. The same was the case with syphilis, for which Salvarsan (Farlex Inc, 2012), an arsenical compound synthesized by Paul Erlich was, available for treatment. It was superseded by penicillin in 1943. Wagner-Jauregg was an enthusiastic Nazi, and a great believer in racial hygiene. He served as president of the Austrian League for Racial Regeneration and Heredity and was an advocate of forced sterilization of the mentally ill, criminals and any other person who was considered to be genetically inferior (Gartlehner & Stepper, 2011). This treatment was available in South Africa at Weskoppies Hospital from the 1920s (Minde, 1974b, pp. 1629-1632).

Convulsive therapy is, simply put—the process of inducing an epileptic seizure in a mentally ill person with the view to treating the symptoms of schizophrenia. In order to do this, Laslo Meduna, a 37 year old Hungarian psychiatrist, initially began injecting his patients with a solution of 20% camphor, intramuscularly. While he did not have any success in inducing seizures in the first batch of six patients whom he injected, he demonstrated remarkable resilience and continued his quest, steadily increasing the amount of camphor and the frequency of the administration. Because the camphor proved to be difficult to predict in terms of when the seizures—if any—would occur, Meduna began using Cardiazol instead. Cardiazol was a short acting cardiac stimulant that was more reliable in inducing seizures when required. There were some side effects however, in the form of overwhelming fear before the seizure, joint dislocations and vertebral fractures (Gazdag, et al., 2009, pp. 387-388) . By 1935, the treatment was available in South Africa, as was insulin therapy (Minde, 1974b, pp. 1629-1632).

Insulin therapy was developed by a Polish neurophysiologist named Manfred Sakel, who had inadvertently induced a superficial coma in a woman, who was addicted to morphine, by mistakenly overdosing her on insulin. Her faculties improved remarkably when she regained consciousness. A similar overdose on a further patient, who was diagnosed with psychosis, caused convulsions and improved his faculties. The important treatment, which was the first for schizophrenia, which had up till then had been a debilitating disease, was met with enthusiasm by his peers. It is also seen as being one of the most significant contributions to psychiatry (Sabbatini, 1998).

There is an interesting dichotomy in the chosen negative or positive perceptions that the world holds around experimentation in psychiatry. In an article on the Nuremburg psychiatrists, for example, the same types of experiments as above, and which earned their developers Nobel prizes, were used on prisoners in German prisoner of war camps. Hans Wilhelm Koenig, for example, was studying the effects of electric shock on prisoners and schizoid patients. The conditions of both reported sets of research were similar, no anaesthetic, potential of broken limbs and no consent patient present (Lopez-Munoz, et al., 2007, pp. 791-806). At the Nuremberg trial, these cases were considered abhorrent.

Komani Hospital utilized both pyrotherapy and convulsive therapies for the treatment of its patients. These were essentially cutting edge at the time. By the 1940s electroshock therapy had made its formal appearance in Italy, courtesy of Bini and Cerletti. It had been found that convulsions were of value to schizophrenics, but the convulsions were uncontrollable, unstoppable and dangerous. To the great relief of the patients, electroshock replaced the Cardiazol and insulin treatments at this facility (Minde, 1974b, pp. 1629-1632). Electroshock

had been tested on animals before being tried on human subjects, which was not usually the case in psychiatric medicine and from this the apparatus had been developed which produced repeatable, reliable fits in dogs. One of the advantages of the therapy was that it produced retrograde amnesia, causing patients to lose memory of all of the events immediately prior to the treatment. This meant that patients had few to no negative feelings towards the treatment. The treatment, which was extensively marketed around the world from 1930, gained a keen following, and the results were largely very positive (Sabbatini, 1998).

The term Leucotomy (‘cutting White’) was coined by Antonio Moniz, a Portuguese neurologist who performed the first of what was going to be termed the lobotomy in 1935. It bore little resemblance to the surgical procedure that now bears the name. Moniz drilled two holes into the skull of the patient, where he injected pure alcohol directly into the frontal lobes of the brain. The aim was to damage the tissue, and in so doing, alter the patient’s behaviour. Walter Freeman, who was later to become the most prolific of the physicians performing these operations, was to perfect the operation by drilling holes, but then surgically severing the nerves hat connect the thalamus to the prefrontal cortex, giving rise to the name 'prefrontal lobotomy’. Moniz was to share a Nobel Prize, in 1940, for his contributions to psychosurgery. By the 1950s, the lobotomy was no longer in favour. Although the USSR, Germany and Japan banned the operation in the 1950s, the US, Britain, Scandinavia and South Africa continued the practice into the 1980s (El-Hai, 2005; Krynauw, 1951, pp. 650-658).

## FORMALIZING TRAINING

Formal university education of mental health practitioners in South Africa began with the advent of the Cape Town University Medical School and Groote Schuur neuropsychiatric services in 1923. The building of the New Somerset Hospital housed the clinical section of the medical school. Only outpatient and consultative services were provided, and to a very small number of patients. When Groote Schuur opened in 1938, 16 beds were provided to the department of Neuropsychiatry, although they did not have a ward. Beds were all over the hospital. The majority of the admitted cases were neurological and there were two outpatient days. In 1948 the department was consolidated into its own unit with 30 beds and extra staff. By 1951 the specialty had grown to four specialists, a resident and 2 interns. The inpatient department was admitting 500 patients a month and 5000 were seen on an annual basis.

The departments were split in 1963, and Dr L S Gillis, who had previously been at Tara Hospital in Johannesburg, became the head of psychiatry, arguably shifting the speciality into the modern era, to cite Minde. Further services were developed to meet the changes in the psychiatric model of the time, which included the William Slater Hospital for Alcoholics, and the Heideveld Clinic, which dealt with Coloured alcoholics (Minde, 1975d, pp. 2197-2202). In 1963 the Red Cross War Memorial Children's Hospital was started and a community psychiatric service opened. In 1968 the Casualty department opened at Groote Schuur, which dealt with acute psychiatric emergencies. To these were added outpatient clinics, social clubs for patients and a consultative service. The educational programme was expanded to include training for occupational therapy, social work and psychiatric nurses as well as the 'medical men' who were interested in specializing in psychiatry. Stellenbosch University's Psychiatry Department formalized its operation in the early 1970s. Prior to that, students had attended classes at Valkenberg, and when Stikland hospital was completed in 1963, the students attended classes and practicals there. While the Stellenbosch Medical School was located at Tygerberg, the psychiatry wing had not been completed by the beginning of the 1970s (Minde, 1974b, pp. 1629-1632).

The overlap of state and the psychiatric profession was cemented, when, in the early 1970s the role of the Head of Department of psychiatry in each of the provincial teaching hospitals in South Africa became that of a government employee. This meant that all of the existing state mental health facilities fell under the ambit of this person as a functionary of the state. Each of them reported directly to the Department of Health. In Cape Town this included Valkenberg Hospital, the Alexandra Institution and the Westlake Hospital for mental defectives (Minde, 1975c, pp. 1890-1894). This move was seen to be a valuable one for mental health services in general. The 1973 Mental Health Act made provision for the unified control of provincial mental health services under one person (Minde, 1974b, pp. 1629-1632).

The meshing of state and psychiatric institutions was to have far reaching effects in South Africa. On the international front, the ramifications of psychiatry being a tool of control and treatment, which discriminated against human difference was being rejected on a number of fronts, with the emergence of anti-psychiatry sentiment and growth of the human rights movement (CCHR, 2000; Dugard, 1978).

## DEVELOPMENTS IN PSYCHIATRIC MEDICATION

While various drugs were available to the doctor treating persons with mental illness, these were restricted in what they could adequately alleviate. Medicinal plants, which had formed a large part of the pharmacological armoury, were still making their way onto the pages of the South African Medical Journal as late as the mid-1940s and natural remedies were still in use in some environments internationally. The list of plants used to treat various ailments included Bok Buchu, wild celery and wild dagga (SAMJ, 1948, pp. 69-70; SAMJ, 1886, pp. 74-75). Other, far more toxic and certainly, addictive botanical species were also used, some grown and imported locally from a number of pharmaceutical companies that were springing up in response to the rapid growth of the psychiatric market. These plants included belladonna, alkaloids of opium, jimson weed and hemp, for example (Lopez-Munoz, et al., 2005, pp. 329-343).

Potassium bromide, for example, is the oldest sedative used in medicine, having been first isolated in 1826 in France, and was discovered as having a use in psychiatry 31 years later by Charles Locock, an internist who believed a false theory that epilepsy was caused by masturbation. Based on the premise that, as one of the properties of potassium bromide was a reduction in sexual desire, and therefore a reduction in onanism (masturbation), he felt very strongly that the extent of epilepsy present in the community (the symptoms of this disorder are obviously very different in modern times) required very necessary medical intervention. His rationale was that if masturbation could be controlled, convulsions could be contained. The result, while not necessarily reducing the incidence of masturbation, did control convulsions, and had the additional success of acting as an agent for sedation (Eadie, 2012, pp. 274-279). He was not alone in his beliefs. In 1919, medical specialists were attaching their names to numerous texts which highlighted the link between eugenic thinking and social and religious mores which were being undermined by these ‘sordid’ behaviours (Shannon, 1919). Curing these moral and social ills with chemicals and potions was a focus of practitioners, with the results for alleviating other disorders being largely serendipitous. Ironically, the word serendipity comes from a fairy tale about three princes who came from Serendip (originally known as Ceylon). They were ‘always making discoveries, by accident and sagacity, of things they were not in quest of’, which describes a number of innovations in psychiatric medicine. The Oxford English dictionary defines serendipity as ‘the faculty of making happy and unexpected discoveries by accident’ (Ban, 2006, pp. 335-344).

From Locock’s discovery, and well into the second half of the 19$^{th}$ century, bromides were used as sedation (Lopez-Munoz, et al., 2005, pp. 329-343). They are no longer in use

because of their high levels of toxicity and their relatively low levels of efficacy. Chloral hydrate, however, was found to have hypnotic qualities. After 140 years of use, it is still in use. Lithium had a similarly unintentional beginning. Originally used for the treatment of mood disorders caused by what was mistaken as cerebral gout, the thinking around the substance was that lithium reduced the accumulation of uric acid in the body, which caused the mental illness often linked to occurrences of gout. Because there were no measures for monitoring the toxicity levels of the substance, lithium could not be used in a broad clinical context until the late 1940s, when lithium urate proved to be effective in protecting animals from urea's toxic effects in animals. The resultant lethargy and lack of response to stimuli became the precursor for medication to control psychotic excitement (Ban, 2006, pp. 335-344).

Hypnotics and sedatives were the focus of pharmaceutical innovation in the early 20th century. Beginning with Bayer and Co.'s diethyl-barbituric acid, barbiturates were the single most effective manner of treating psychiatric and neurological disorders of the time. Sleep disorders and epileptic seizures were notably reduced in patients with these ailments. Riding on the success of these drugs came the use of intravenous anaesthesia for minor operations, which was a great breakthrough for surgery. Oxybarbiturates, the most recent incarnation of the family of barbiturates developed over a hundred years ago, are still in use for severe sleep disorders and specific types of epilepsy. (Lopez-Munoz, et al., 2005, pp. 329-343).

Various other psychotropic and anxiolytic medications appeared on the mental health scene around the 1940s. After the discovery of penicillin in 1928, the industry began to develop other antibiotics. One of the serendipitous results of this research was the discovery of meprobamate, which was meant to have antibacterial qualities, but had the more desirable resultant effect of having effective tranquilization and muscle relaxant properties. Later, after it had been registered by E R Squibb for muscle relaxation under mild anaesthesia, it was found to relieve both anxiety and tension. With further development to extend the short duration of the effects of the drug, it became the most widely used drug until the 1960s when diazepam was introduced into use. From the late 1960s and to the end of the 1970s diazepam outsold all other drugs on the market in the US (Ban, 2006, pp. 335-344).

Chlorpromazine, (Largactil) which was to ultimately be used to treat psychosis in paranoid and aggressive psychiatric patients with success, was first used in 1952. While the ultimate result was a tendency to sleep and disinterest in the general surroundings, it did not cause loss of consciousness or loss of intellectual ability. It had a marked influence on the course

of psychotic illness. The drug won the Albert Lasker Award in 1957, having been released in 1953 and having found great favour worldwide (Ban, 2007, pp. 495-500).

Imipramine was the result of a Swiss pharmaceutical company's quest to find a similar type of substance to Chlorpromazine to treat schizophrenia. While the substance that was developed had no effect on schizophrenia, it did have an effect on depressive symptoms. This antidepressant effect ended the development of the use of the medication. The first articles on the use of the drug were published in 1957. While there was strong rejection of the use of chemical treatment for depression in the late 1950s, ongoing use and development of the drug paved the way for development of other, later antidepressants (Ban, 2006, pp. 335-344).

Iproniazid, a monoamine oxidase inhibitor was also presented in 1957 as an antidepressant developed initially as chemotherapy for tuberculosis, the side effects of euphoria and over active behaviour in some patients causing interest in its potential. Monoamine oxidase inhibitors for the treatment of depression paved the way for the development of the scientific discipline of neuropsychopharmacology (Ban, 2006, pp. 335-344). This list is obviously not exhaustive, but demonstrates the often haphazard nature of the process of medication provision and testing on psychiatric subjects. Cocktails of drugs with often debilitating and dangerous side effects were used with little question from peers or associations. Sleep cures were an example. Somnifen, developed and tested by Roche in the 1920s as a sleep cure for schizophrenia resulted in three out of 26 patients dying in the testing phase (Lopez-Munoz, et al., 2005, pp. 329-343).

Safety in both testing and the long term usage of these drugs was never a specific consideration and death of test subjects was commonplace. The peak of usage of barbiturates for psychiatric illness worldwide was during the 1930s and 1940s, reported as having grown in use over this time by over 400%. Their efficacy was limited, however. Death from over dosage was all too common, with both the long term dependence and subsequent deaths of two of the two scientists who announced the first barbiturate to the world, and of Marilyn Monroe, adding to the concerns. From the 1960s the use of barbiturates fell out of favour and now they are only found in combination with mixtures on prescription (Lopez-Munoz, et al., 2005, pp. 329-343).

## THE ORANGE FREE STATE

Back in South Africa, the area around Bloemfontein, which had been annexed by the British during the skirmishes of the Boer War, proved to be too difficult to hold, and the Boers

regained and settled back in. Bloemfontein's only mental hospital was rented by Government in the late 1800s in response to demand that provision be made to care for the mentally ill persons that were being reported to the health services. By 1881 the need was such that a hospital was built, and over the years further additions kept the space up to date with demand. In 1890 non-White quarters were added, 1898 saw a wing for women, 1902 added a wing for White men and 1917 saw a new non-White hospital built to meet demand, while the old hospital was reconverted back into a White's only hospital. In 1897 the breakdown of the nationalities of the patients housed in the facility was *'30 Afrikaners, 2 Duitschers, 4 Engelschen, 1 Belgier, 1 Russ, 24 Kaffers and 4 Hottentotten'*. A psychogeriatric male unit, nursing accommodation and further women's ward was added between the world wars. The criminal section of the hospital was named the Fort, the oldest building in the Bloemfontein, and housed White men. The Free State became a province of the Union in 1910. World War I brought with it severe staff shortages, specifically nursing staff, as few pupil nurses were enrolled due to competition from other war industries. Lowering the entrance requirements for training facilities from a standard 6 (or 14 years old) to standard 5 (12-13) did not improve admissions to a marked degree. By 1969 the hospital had still not acquired a full complement of staff – with 173 of the 301 posts being filled with temporary staff (Minde, 1974c, pp. 2327-2330).

Patients worked in the hospital gardens which produced a great amount of fruit and vegetables, and later on in the 1960s and mid-seventies, expanded into raising prize cattle for both breeding and milk. It was believed by Rd. Kellner, the medical officer, that work was the best therapy for mental illness. He did however, in order to ensure that the impression was not given that patients were overworked, reiterate that they did get a full day off a week. Development in the mid-seventies saw the addition of a golf course and numerous playing fields (Minde, 1974c, pp. 2327-2330).

The diagnoses of mental disorders in the facility ranged from dementia hysterica, dementia phthisica and melancholia attonita. Paranoiacs formed the majority of diagnoses in mental illness. Rd. Kellner, was concerned by the large proportion of 'imbeciles' admitted to the facility, ascribing the high incident to marriage between blood relatives and was known to favour of legislation banning these unions. The Oranje Hospital, as it was known, was linked to the University of the Orange Free State. The Professor of psychiatry at the medical school was also the clinical head of the hospital (Minde, 1974c, pp. 2327-2330).

## NATAL

As with the other provinces, the Head of psychiatry at the medical school was also the head of the psychiatric hospital. Natal University was no different. The first and largest psychiatric hospital in Natal was Town Hill hospital. The second, Fort Napier, was opened in 1927, and effectively fell under the same University head. The colonial nature of the care prior to the building of Town Hill hospital is evident in the charges levied for admission to the local medical facilities. A patient could be admitted for 1 shilling and a penny a day and their Black servants could be accommodated for 7 pence a day. There were only a relatively small number of persons with unsound mind in the province, so the Acting Lieutenant Governor, Mr Bisset, went so far as to write to the then governor of the Cape Colony to request that their 'lunatics' be housed on Robben Island. The request was refused. Because there were only two places to be admitted, to the local hospital or to the local goal, temporary accommodation was erected in the mid-1860s, but ten years later these were unacceptable. Latrines, baths and ventilation were insufficient and caused more issues than they alleviated. This forced the issue, and by 1874 there were decisions being made on building a purely mental health facility to cater for the province (Minde, 1975b, pp. 322-326).

The new Town Hill Hospital in Pietermaritzburg came into use in the 1880s, although the section for natives and Indians had not yet been completed. While the hospital took time to complete, there were continued developments over time. By 1899 the paraffin lights had been replaced by electrical ones, the water supply had been modernized and the sewerage was water-borne. The name of the facility started off as the Lunatic Asylum, Pietermaritzburg, became the Natal Government Asylum in 1913, and in 1916 it became the Pietermaritzburg Mental Hospital. It remained the name of the hospital until 1947. At this time the term 'mental' was deleted from all hospital names, and the facility became Town Hill Hospital, which it remains to this day (Minde, 1975b, pp. 322-326).

As with all of the psychiatric facilities at the time, gardens, nurseries, orchards and cattle were farmed as part of the operating budget to counterbalance the costs of maintaining the patients and the facility. Reports from the medical officer indicated that the inmates worked in the gardens from 7am to 6pm. It is noteworthy, that, in spite of the apparent wealth generated by the facility's farming enterprises in 1887—certainly sufficient to purchase more land and build a residence on an adjoining piece of land for the superintendent—that there was overcrowding in the wards that caused a great number of deaths of non-White patients housed at the facility. Only in 1908, when new wards were opened for the non-White patients, did the mortality rate drop significantly. Dr Hyslop, the superintendent for the facility from the 1880s through to 1910, attributed the drop in deaths to a reduction in overcrowding

and the elimination of the previous unhygienic conditions (Minde, 1975b, pp. 322-326). Ironically, Minde also goes on to state that the hospital was very popular with paying White patients, and that the grounds were one of the draw cards.

Fort Napier was originally a military post on a hill outside of Pietermaritzburg. In 1928 it became home to non-White patients, and from 1929 it admitted White patients who were transferred from other, overflowing facilities. The buildings were in a state of collapse, and there were many snakes, rats, white ants and other wildlife that were a hazard to the patients and staff. The wards and kitchens were horrendous. The superintend wrote to the Commissioner of mental hygiene to protest the condition of the wards, to which the Commissioner replied

> *'Your severe criticism of the conditions under which patients have to be treated at Fort Napier cannot, of course, be contradicted. As you know, I agree entirely with you in your condemnation of the present wards.'* (Minde, 1975b, pp. 322-326)

Nothing was done to rectify the conditions that the patients were housed in, however. Despite this, the facility, over the next ten years, grew and changed and treatment programs were developed. These were largely cosmetic and of a commercial nature for running the facility. The lawns need planting, and maize and other crops had to be grown in large quantities. Fruit trees were planted and a dairy herd, oxen, pigs and donkeys were raised. The wards were not improved, and they were often only kept up by the Public works department by patchwork (Minde, 1975b, pp. 322-326). By the end of WWII there was a critical loss of nursing staff, to the extent that Fort Napier's accreditation as a training facility was withdrawn by the Nursing Council in 1950. New nursing accommodation was built to accommodate 140 nurses, and the Council withdrew its removal. The trend of the time, however, was for nurses to live out of the facility, so the new building remained virtually empty. It was later used for other purposes (Minde, 1977a, pp. 210-214).

As with other provinces, the Head of Psychiatry was employed by government, and in Natal, this was no different. The position was onerous, as there was a shortage of psychiatric staff and the Head of the school was also the head of all mental health services in Natal. This shortage included Black psychiatrists, although, by the early 1970s, the first two Black psychiatrists had begun their registrar time at the Natal Medical School (Minde, 1977a, pp. 210-214).

## TRANSVAAL

Weskoppies hospital served the whole of the Transvaal before Union in 1910. Originally called De Krankzinnigen Gesticht te Pretoria during the Republic, British occupation resulted in its renaming to the Pretoria Lunatic Asylum. In 1911 it became the Pretoria Mental Hospital, and in 1947 had its final name change to Weskoppies Hospital. The change in these facilities names was considered important to demonstrate the changes in both ethos and professional position of the new psychiatric hospital in the Republic. The removal of the word 'mental' was an attempt to de-stigmatize mental illness (Minde, 1975e, pp. 367-374).

The first construction of this facility began in 1892 under a 'College van Curatoren' to oversee the building. Prior to this, 'lunatics' were kept in the local gaols, sometimes for many years. President Paul Kruger visited the hospital after its opening in 1892, with the facility holding a sum total of 29 patients. There was only a part-time attending physician, which was escalated to a full time position in 1894. As there were no laws governing 'lunatics' in the Transvaal, the province developed procedures signed off by the Executive Council, which then gave them the force of law. Further developments came after the employment of the first director of the facility, Dr Smeenk, who went on to implement a dispensary, hot water systems, a more scientific system of classification of patients and an expanded occupational therapy program. By 1897, however, the hospital was overcrowded, and because of the threat of war following the Jameson Raid, there was no government funding available to expand the buildings of the facility. By 1898 the hospital was so crowded that males were no longer admitted and the previous system of keeping mental patients in gaol was reinstated (Minde, 1975e, pp. 367-374).

According to Minde (1975) the facility was mentioned in a propaganda pamphlet in Cape Town in 1899[26], containing a story about alleged atrocities committed by the staff of the facility on British citizens. Dr Smeenk himself was linked to reports of the physical abuse of two patients, Messrs' Higginson and Goodwin. After the Pretoria occupation of the British in 1900, the facility was taken over and the staff replaced with British, one of whom was Dr J T Dunston, who was to go on to be the superintendent of the facility and to develop mental health in South Africa more extensively than possibly any other person to date (Minde, 1975e, pp. 367-374).

After Union the hospital grew consistently. In 1911 an administration block was added, opened by General Smuts. The shift from 'lunatic' and 'asylum' to 'patient' and 'hospital' was the starting point of garnering credibility for psychiatry as a specialty. Considered to be at the

[26] The Anglo Boer War was in progress.

forefront of scientific advances in South Africa, the hospital was the first to pioneer malaria treatment for psychiatric patients in South Africa in 1924, and in 1936, was the first to use insulin treatment for schizophrenia (Minde, 1975e, pp. 367-374).

Water transportation was always a problem for the facility, as the grounds were large and the infrastructure for this was limited. Almost from its opening the facility had to build additions to the original buildings. Additional staff houses were built and the 60 acres of land were cultivated. Accommodation was 7 single rooms for White females and 7 White males, but the demand to accommodate Black females was urgent. This shortage was inherited by the British when they acquired the facility after the war. New buildings were commissioned in 1904 to address the shortage, and they were opened in 1907. The structure, which was designed by a Yorkshire architect in the United Kingdom and who had no idea about the South African climate incorporated no verandas or sufficient ventilation for use in the stifling heat (Minde, 1975e, pp. 367-374).

In 1892 the facility housed 29 patients, of whom one was fee paying, and some were children, presumably 'mentally defective'. Seven patients were admitted soon after that, all of whom were implicated in the famous uprising and dynamite explosion in Braamfontein in 1896. A hundred and four patients of the first 175 were White, 28 died and 35 recovered. Patients were from Johannesburg and Pretoria. Numbers rocketed from 1913 and exceeded 1000, and increased even further to 2000 in 1943. Facilities were expanded for Black male patients in 1940, by default, as this accommodation was originally intended for White females, but inadequate staffing made this impossible. By 1969 patient numbers stood at 2012. Activities for these patients were not part of a directed therapeutic programme and incorporated general hospital maintenance and services, mending and sewing, gardening, farm work and mat making (Minde, 1975e, pp. 367-372).

The staff was White, with the first female Coloured attendant employed in 1896. There was a high staff turnover, with Dr Smeenk complaining about having to employ a 16 year old youngster. There was no formal training for mental health staff. Under British occupation this changed to include a greater number of staff, including a matron and deputy matron. The now inculcated overlap of positions made the Head of psychiatry of the University of Pretoria also the Clinical Head of Weskoppies Hospital. The medical superintendent was Dr Phyllis Morgan, the first woman appointed to a superintendent's post in South Africa. She was a graduate of Witwatersrand University. By 1975 the hospital had achieved a totally racially differentiated service, with the staff treating Blacks being Black, clinics for Whites being conducted at external facilities and a clinic for Indians being held in Laudanum, an Indian area in Pretoria. Clinics for adolescents and children were provided, as were consultation

services for the H F Verwoerd hospital and Pretoria Central Prison. These were staffed by psychiatrists on a sessional basis. A nurses training college was opened on the grounds of the hospital (Minde, 1975e, pp. 367-374).

## STERKFONTEIN HOSPITAL

Despite being designed and approved in 1935 and planned for an opening in 1939, Sterkfontein Hospital was only opened in 1943. The setback was due to government delays in building, which were exacerbated by WWII. By 1944 the hospital had not only admitted 243 patients, but had also absorbed 175 mentally disordered Italian prisoners of war and their clinical staff from Zonderwater prisoner of war camp. These prisoners were used to provide building and landscape labour, and during their 'treatment' until the end of the war in 1945, tarmac roads were put down, trees were planted, sports fields developed and occupational therapy areas were built. Further building took place in 1946, with a third Black female block, a White admission block, White hospital block, 4 White villas, main kitchen and store block, nurses home, kitchen block and dining hall being completed. In 1948 students from Witwatersrand University began their clinical instruction at the hospital, which has continued ever since (Minde, 1975e, pp. 367-374).

The number of patients had exceeded 1000 by 1950, and by 1953 the White accommodation was doubled and the Black wards extended. By 1969 the patient numbers had overshot 2000. The hospital was considered to be very modern for its time, being the second youngest hospital in South Africa, with modern amenities and facilities being provided in the White wards. The site of the hospital, which is on a high hill, 'provided a wonderful view of the surrounding country 150m below from the Black Male section'. Sterkfontein fell under the Head of the Department of Psychiatry of the University of Witwatersrand (Minde, 1975e, pp. 367-374).

## THE JOHANNESBURG GENERAL HOSPITAL &

## THE UNIVERSITY OF THE WITWATERSRAND

Although there was a medical school attached to it from 1920, and a practicing private psychiatrist in Johannesburg from 1914, the Johannesburg General Hospital did not have beds allocated to psychiatry until 1929, when an honorary consultant psychiatrist was appointed. In order to admit patients to the hospital, the by then two consultants, who had had to resign their positions to act as assistants in neurology and psychiatry in the Department of Medicine would use this as a ruse to both admit patients to the medical wards

and to offer an outpatient service to their patients. In 1932 nine beds in the casualty department were allocated to the neuropsychiatrists through the goodwill of the sister in charge, and over the next few years more were found and acquired around the hospital until the psychiatric beds numbered 15 spread around the hospital. This was to remain the status quo until 1946 when a division of the department was opened at Tara. The hospital by then was attending to 10 000 psychiatric cases per annum. A further division of the department of neuropsychiatry, that of neurosurgery, was established at the Florence Nightingale Home in 1930. Students no longer had to travel to Weskoppies in Pretoria for practical specialty training, which was far more conducive to study (Minde, 1975e, pp. 367-374).

## TARA HOSPITAL

During World War II South Africa had a great number of soldiers on active duty around the world. By 1942 many had developed psychiatric problems, and the need to treat these men had become pressing. A military facility was opened for these casualties in Potchefstroom, adjacent to Witrand Institution for Mental Defectives. The building was funded by the Department of the Interior, on the proviso that the facility was converted to civilian use and turned into a mental hospital after the war. The Officer Commanding this facility, Major H Moross, began to collect a number of very skilled staff for the all-White facility. He added occupational therapy, psychotherapy, group programmes and group recreational activities. The programmes were European, and were well suited to the White patients of the facility. A number of rehabilitated patients were able to resume military service. The facility provided care for voluntary patients, with the more acutely psychotic cases being certified and transferred to civilian hospitals. Funding was from the state military coffers (Minde, 1975e, pp. 367-374).

At the end of the war the Potchefstroom facility closed, leaving 150 cases requiring treatment, and Tara hospital was provided to handle the overflow of these men. Being situated in the northern suburbs outside of Johannesburg, it was a large estate, which had been taken over during the war as a plastic surgery facility under Dr J Penn. After the war the facility was left empty, and the Department of Defence, which had been left with these 150 psychiatric cases in Potchefstroom, transferred them to Tara under the Red Cross until 1946. Seeing an opportunity to secure a special hospital for civilian care,[27] the hospital was bought by the Transvaal Provincial Hospitals Department. Dr Moross was recalled from duty and spent the rest of his active medical career at this facility (Minde, 1975e, pp. 367-374).

[27] It must be remembered that this civilian care (as was the Johannesburg General Hospital and all health services in central Johannesburg during this period) was for Whites only as they were in historically White areas.

A children's clinic, medical treatment facility, social and vocational activities, as well as recreational pursuits, formed part of the services. Aftercare support facilities were also available once patients had been discharged. Social work visits to the patients' homes after discharge, and liaison with the Department of Labour ensured that patients were supported by auxiliary services after care (Minde, 1975e, pp. 367-374).

## ALCOHOLICS

Alcoholism played a very important role in South African institutional thinking and processes in the same way that it formed an important part of South African life. Its potential to pose a serious problem was identified by various authors from as early as the 17th century. (Minde, 1975d, pp. 2197-2202; Van Onselen, 2001, pp. 47-98). Action against the scourge was initiated by the International Order of Good Templars, which opened a branch in Cape Town in 1873. The Salvation Army appeared close behind. In 1889 the South African Temperance Union initiated their services. In 1911 Parliament stepped in to address the problem, and by 1912, had established institutions for alcoholics, namely a White's only facility in Bavianspoort and a Coloured's only facility in Kluitjies Kraal. A retreat was also set up in Pietermaritzburg. The treatment offered in these facilities was judgmental and autocratic, possibly because the churches, who were the informing bodies for the public at large, were preaching that alcoholics were immoral and ultimately, sinners. The concept of alcoholism being a psychiatric illness was not widely accepted until much later. The success rate of the institutional care was abysmal. (Minde, 1975d, pp. 2197-2202).

As there were no statistics available for the scale of the problem of Black alcoholism, the countries understanding of alcoholism was based on Coloured and White figures provided by the South African National Council on Alcoholism (SANCA). There were two important factors that influenced the number of alcoholics and the alcohol problem in South Africa. Prior to 1961, Black and Coloured persons were not permitted to purchase alcohol by law; the second was the use of the 'tot' or 'dop' system, which worked as follows:

The South African Liquor Act of 1928 contained the following clause, which provided that

> *In the Province of the Cape of Good Hope, any adult bona fide employing in farming operation any native, Asiatic, or Coloured person, may on any one day supply gratis to such native, Asiatic, or Coloured person one and one-half pints of unfortified wine or kaffir-beer, provided that such wine shall be consumed when received in the presence of such employer.*

This 'tot' or 'dop' formed part of the labourer's wages and was of very inferior quality. The ages of the labourers was not a consideration for abstinence, with very young workers also

receiving the tot in lieu of money. The benefit to the farmer was obviously that cash wages were then very much lower than what would have to be paid for a reasonable day's work. By 1975 the system had yet to be abolished, despite the obvious resultant health, crime and family issues that had arisen around this practice (Minde, 1975d, pp. 2197-2202; London, 2003, pp. 59-68).

The Department of Health's involvement in mental health services for alcoholics was dwindling, despite the shift in thinking towards alcoholism being an illness rather than a social or moral problem. Admissions to mental hospitals occurred in cases where the person had developed a co-morbid mental or physical disorder. These disorders included delirium tremens, Korsakoffs psychosis and alcoholic dementia. There was a problem with voluntary admissions of alcoholics which caused frustration and had obvious cost implications for facilities. Once an alcoholic admitted themselves, it was all too often a matter of a couple of hours or days before the craving for alcohol made them discharge themselves. To combat this, in the 1944, Section 52 of the Mental Disorders Act created a class of patient termed an 'inebriate'. This 'inebriate' was loosely defined as any person who habitually drinks or uses alcohol or any narcotic to excess.

> *(1) The Superintendent or person in charge of an institution may receive and detain for treatment therein any inebriate who undertakes in writing to submit himself for a specific period of not less than 6 months for treatment as an inebriate.*
> *(2) Any person so detained may, if he depart from the institution before the expiry of the period for which he has contracted to submit to treatment therein, be arrested without warrant and brought back to the institution and detained therein for the unexpired portion of the said period.*
> *(3) The Commissioner may at any time order that any person detained under subsection (I) shall be discharged from his undertaking and from the institution in which he is being detained* (Minde, 1975d).

In 1969 almost all of the 51 cases admitted under this Act were White. White women rarely made use of this section of the Act to admit themselves for this type of treatment, and neither did persons of colour[28]. From the inception of this clause in the Act, while admissions were high in the first three years, admissions amongst White men dwindled markedly after this. Aftercare was not provided by mental hospitals, and the patients relapsed very soon after discharge (Minde, 1975d, pp. 2197-2202).

Social Welfare had begun to take a more active role in provision of services and input, and the 1973 Mental Health Act, which not only did away with the Inebriates clause, was required

[28] It is worth noting that black persons were more often admitted through the court systems for transfer to an involuntary care facility in either the Bantustans, or within the Borders of South Africa (Duncan, 1975).

to take the leading role in this service. The Department of Social Welfare and Pensions, which prior to 1935 had been a sub-department of the Department of Labour, was made an independent Department with its own Secretary in 1937. One of the activities of this Department was to replace the concept of work colonies and the corresponding work colonies act. Work colonies, were the solution to social problems, which ranged from alcoholism, poverty, prostitution etc. The Act was reworked to cover refuges and rehabilitation centres and was to be the foundation of a more enlightened approach to the treatment of the alcoholic. The Sonderwater Work Colony was converted into the Magaliesoord Refuge for Male Alcoholics. The Department of Coloured Affairs opened the De Novo Rehabilitation Centre in Kraaifontein, which treated male and female alcoholics, and the Heideveld Clinics in Cape Town. The William Slater Hospital provided psychiatric and neuropsychiatric services for this group. There were still no services for Blacks. Cape Town was the only province that provided departmental facilities, with the rest preferring to support existing facilities run by NGOs like SANCA. The private organizations consisted of the South African National Council on Alcoholism and Drug Dependence (SANCA), Alcoholics Anonymous, the Rand Aid Association, the Salvation Army and the Nederduits Gereformeerde Kerk (Dutch Reformed Church) (Minde, 1975e, pp. 2197-2202).

The Second World War saw a marked increase in alcoholism, especially amongst men and women who had seen active service. In 1951, after a visit from the Boston Committee on Alcoholism's chairman Mr Joseph Kaplan, a conference was organized which garnered a great deal of support and international involvement. Three hundred and ten people attended the event, which was held in Pretoria. In attendance was Mrs. Marty Mann, the Director of the Committee on Alcoholism, who was a recognized expert in the field. Representatives from the churches, other temperance societies and the liquor trade sent representatives. Special attention was drawn to the grave consequences of alcoholism to non-Europeans. Marty Mann's speeches were the most influential of the period, with her insistence that government take the lead in forming a national organization with local branches to combat the scourge. She toured the country and this message was repeated in numerous centres. After this conference, a number of further conferences were held up to 1956. Provincial facilities were implemented as an interim measure until the Provincial general hospitals were equipped to undertake treatment. The activities of the South African National Council on Alcoholism had a number of overlapping and corresponding functions with that of the National Council for Mental Health (Minde, 1975d, pp. 2197-2202).

SANCA societies sprang up around the country to meet the demand from 1957. In Pretoria Castle Carey opened with 5 beds, but the demand was far greater. 1958 saw the number of beds increase to 10, and in 1962 it increased yet again with a Social Welfare grant. 1966

saw the first non-White facility open in Pretoria. International involvement and visits from dignitaries from international organizations maintained the momentum of global input and conference participation to share ideas and innovations. In 1968, for example, Mr Pienaar the Director of Castle Carey paid a visit to both the USA and Canada. In 1970 Castle Carey moved to a site outside of the city and the accommodation was expanded to 40 beds for males and 20 for females (Minde, 1975d, pp. 2197-2202).

Johannesburg saw the opening of Phoenix House in 1970, with 12 beds for youthful male addicts. Prior to that the organization provided counselling and information services. In 1973 this increased by a further 12 beds for girls. A crisis clinic and child-parent groups were also conducted by SANCA. The Director of the International Council for Alcohol and Drug Addiction was the opening speaker at a summer school held in 1972. The Western Cape SANCA society did not treat alcoholics. They acted as a conduit to channel patients to the most appropriate facilities, while providing counselling to assist families and employers to support and assist the person with overcoming their problems. Durban operated a facility in Lulama that treated alcoholics, and in 1970 opened 14 beds at Warman House, which catered for drug addicts. Bloemfontein and Klerksdorp also had local SANCA branches, and the society's activities spread to South West Africa (Minde, 1975d, pp. 2197-2202).

Alcoholics Anonymous was started in Akron, Ohio in the USA in 1935 by two alcoholics who found that by supporting each other they were able to overcome their craving for alcohol. Johannesburg, Cape Town and Durban each had a number of groups and meetings. The organization is largely spiritual, and relies on a 'higher power' for restoration of sanity. The association held, and continues to hold, regular meetings. The service extended to the Rhodesias (Minde, 1975d, pp. 2197-2202).

The Rand Aid Association, a general charitable organization, only initiated special services for alcoholics in 1943. Northlea was a facility for 30 male alcoholics. The size proved to be inadequate, and was increased to 100 beds. During its first 10 years of being in operation the facility admitted 1300 men. In the later stages of the programme these men were transferred to Cottesloe Hostel, where they would return to work. The success rate of 42% (a 12 month period of abstinence was considered a success) was reported at the national conference on Alcoholism in 1951. In 1952 the Association opened a retreat for female drug addicts and alcoholics, which had 35 beds. Admissions were Whites only (Minde, 1975d, pp. 2197-2202).

By 1951 the Salvation Army could boast of having already been operating a 'social farm' for inebriates for 60 years in Rondebosch in the Cape. The farm moved to Muldersvlei and catered for 100 male alcoholics. The thrust of their programmes was a combination of

religious and social rehabilitation. Patients were screened shortly after admission by the 1970s, and social work students did their practical training at the facility. In 1974 the facility was renamed Crossroads (Minde, 1975d, pp. 2197-2202).

Churches had long since been involved in the problem of alcoholism, but being of the opinion that the problem was a moral one, lagged behind the scientific movement taking place in the Republic. By 1970, however, the church had accepted that alcoholism was a mental illness and acknowledged the role of the psychiatrist in the role of rehabilitation of substance abuse as a necessary evil. In Pretoria the NG Kerk had opened a home for White male alcoholics, after detoxification, named Staanvas, which could take a total of 37 patients. The programmes were designed to reintegrate the person back into social life in a religious atmosphere. A further treatment centre opened in Parow in the Cape, called Rarnot in 1964. Treatment facilities for women were only provided in 1973 (Minde, 1975d, pp. 2197-2202).

Services for Blacks with substance abuse problems were not provided by Social Welfare services. The overlap between the discourses of mental health and the interpretation of mental health diagnostic categories, which were underpinning the Apartheid political thinking of the time, made the ethos of treatment of Blacks unique from that of the other groups. The resultant way of dealing with these problem people was to remove them from the Republic by sending them to Bantustan rehabilitation facilities or to detain them in facilities in South Africa as psychiatric patients or as 'feebleminded', mentally deficient individuals (Pinderhughes, et al., 1978; Fleisch, 1995, pp. 349-372; Porteus, et al., 1998; Minde, 1975d, pp. 2197-2202).

## SERVICES FOR THE FEEBLEMINDED

The development of intelligence tests in France by Binet and Simon was to inform the establishment of the South African National Council for Mental Health. While unmanageable, intellectually deficient persons eventually made their way into mental institutions, there were no facilities available specifically for this type of person. While White 'defectives' were rarely found in mental facilities, non-White 'defectives' were commonly found in institutions, because there were no specialist facilities for non-Whites in the community, especially in Black township communities. In 1912 at a Baby Week Exhibition in the City Hall in Cape Town, The Child Life Protection Society gave the following message, informed very strongly by the eugenic thinking of the time:

> *We are taking stock of our resources especially of the humanity of which the nation is formed and noting with grave concern evidence of mismanagement and*

> *waste of this, our chief asset. Builders discriminate in the use of material; yet we have built our social fabric in haphazard fashion, and protest when we find soft brick failing to do the work of stone. Our wisdom lies in not only saving our babies and securing for them healthy bodies but in due time in getting the measure of their minds and training them accordingly. The type concerned are worthy of a higher grade than the idiot and the imbecile, and have hitherto been discovered by their failure in social efficiency - the delinquent, the outcast, the pauper. Something is shown too of provision being made abroad and in this country to meet legal enactment: homes for the socially mischievous, farm colonies, industrial training of many description and special schools where sorting-out takes place and individualized teaching develops the merely dull and backward. The very small beginning of such provision in our own country cannot fail to be striking and encouraging.* (Minde, 1975c).

The exhibit demonstrated the testing of types, and the influence of heredity was demonstrated using charts that showed 'how mental defect touches most intimately some of our greatest problems'. In July 1914 the propaganda had had an effect, and at a meeting in Cape Town of the Chief Justice Sir James Rose-Innes and other members, a Mental Deficiency Act was proposed and adopted. Behind the scenes Dr J T Dunstan, who was considered the driver of the promulgation of the Act, was to be the first Commissioner according to the Act (Minde, 1975c, pp. 1716-1720).

Use of the Binet Simon, Terman and other tests proved to be unsuitable for the South African Market, and it was left to a Dr M L Fick to devise the Official Mental Hygiene Individual Scale in 1927 based on the Stanford Revision of the Binet test. Dr Fick attended Harvard and graduated as a Doctor of Education. On his return to South Africa he was made the psychologist to the National Bureau of Educational and Social Research. This test became the standard scale used in South Africa as an aid to the diagnosis of mental deficiency. Dr Dunston was an enthusiastic convert and proceeded to survey mental defectives around the country. The Transvaal Education Department became active in this field, and appointed an inspector of schools, who worked closely with Dr J M Moll, the first psychiatrist in Johannesburg. In the workhouses, reformatories, prisons and children's homes, children, who had come from environments of malnutrition and had been placed in facilities by courts and in terms of the Children's Protection Act were found and miscellaneously diagnosed, often erroneously, as defective. Fick's Official Mental Hygiene Scale was widely adopted as the most accurate test for use in South Africa (Minde, 1975c, pp. 1716-1720).

In the 1920s and 1930s the presence of 'poor Whites' became an anathema to the rising tide of apartheid thinking and White supremacy. These members of the White population were all of rural origin, lived or worked on farms or existed as woodcutters in Knysna and George. By

1936 there were around 300 000 identified in the Republic, and the Synod of the Dutch Reformed Church was extremely troubled by their presence. During a visit in 1927 by the president of the Carnegie Corporation, the church approached him to assist in investigating the problem. The corporation not only agreed, but also undertook to carry the cost of the entire investigation, loaning two sociologists for the task, Dr C W Coulter and Dr K L Butterfield. South Africa provided Professor R W Wilcocks of Stellenbosch University as the psychologist on the Commission. The report was produced in five volumes. The testing showed that while poor White children were of normal intelligence, their scores were lower than that of the White population as a whole. Further investigations were done, which expanded to include physical abnormalities. The Department of Mental Hygiene was tasked with the identification, care, supervision and control of the 'defectives', while the Department of Education would take care of the subnormal cases. The Departments of Education and Mental Hygiene were to work closely together in the development of policies and practice around these two groups. The identification of the need for special institutions for non-White 'defectives' was made during this research. Private enterprise was to become the largest supplier of these services to the South African government (Minde, 1975c).

## INSTITUTIONS FOR DEFECTIVES

The Alexandra Institution in Maitland in the Cape was the oldest facility of its kind in South Africa. It was opened in 1921 on the Nieuwe Molen Estate. The Oude Molen Estate was on the grounds of Valkenberg. During WWI the site was used as a hospital to replace the old Somerset Hospital. The buildings only became ready for occupation by 1914. Because war had just broken out, the facility was used as a military hospital. After the war it was opened as the country's first institution for mental 'defectives'. The first patients were admitted from Valkenberg and the Pretoria Mental Hospital. The total number was 153 and they were all White females. By the end of the war there were 245, of which there were 92 males. Because of the ignorance of the purpose for the facility, a great number of patients were returned to their referring facilities, as they were totally unsuitable for the hopes of what the place would both be and achieve. In the early days the facility provided a number of services that were of value to the residents, including teachers for the younger 'defectives'. Physical and manual skills were the focus, rather than scholastic attainment. The school's operation and success was not a given, and relied very much on the will and enthusiasm of the superintendent. Activities included crafts and manufacture of items for the facility to sell during open days. The 'defectives' themselves did not receive any money raised from the sale of these items. From 1947 the 'defectives' considered to be 'high-grade' became involved in work for outside firms in sheltered workshops, which ranged from making bags

for tobacco firms to cardboard box assembly and rug fringing. Workers earned stipends to spend in the canteen of the facility. As a Whites only facility, the activities and amenities included a crèche for staff children, Christmas parties, picnics, tea-parties, tennis, cricket, dances and cinema shows. A holiday camp was arranged every year, when as many as 250 patients went away for several weeks every summer. Coloured patients from Valkenberg were employed at Alexandra for many years (Minde, 1975c, pp. 1890-1894).

Witrand Institution in Potchefstroom started off as a military camp for British troops in the Transvaal. The buildings were of wood and iron, and these were originally imported from India. After the start of WWI, the British troops were repatriated and the buildings stood empty for a number of years. In 1921 the decision was made to open the facility as a home for 'defectives'. Unlike the Alexandra Institution, Witrand had room for expansion. The buildings were freezing in winter, the water was hard and the pipes were often blocked by lime. There were a number of fires in the wooden buildings and houses. In 1951 a large laundry was installed to manage the considerable amount of washing caused by the dusty roads and environment, after the previous one burnt down in 1945. Teachers were employed to train the children, and there were dining halls, swimming pools and playgrounds. Lower grade adult patients, both male and female did domestic duties in the wards, and higher grade adults worked in the facility laundries, kitchens and sewing room. Young men worked on the farm or in the workshops and with artisans. The military mental hospital which was built adjacent to the 'defective' facility was meant to become a civilian psychiatric facility after WWII, but in 1957 the facility was handed to Witrand as an extension of the facility for 'defectives'. The move from the wood and iron buildings was a major improvement in amenities. A native section was built on the site of the old male quarters, and patients were admitted as overflow from other facilities. The new facility comprised workshops, which included a Blacksmith, boot making, fitting and turning, painting plumbing and tailoring, garages and an upholstery shop. A fully functional farm with piggeries, prize Friesland cattle, poultry, mielie lands, vegetable gardens and nurseries were all run on the labour of the patients. By 1969 the total number of 'defectives' housed in the facility was 2 143 (Minde, 1975c, pp. 1890-1894).

## UMGENI WATERFALLS INSTITUTION

After WWII a hospital, built by the British governor, in Howick in Natal to cater for convalescing soldiers was evacuated. In June 1948 the same facility was taken over by the Department of Health to be used as a facility to house mental 'defectives'. Between 1945 and 1948 the facility had suffered much damage, and had to be extensively renovated for use. In 1949 the facility was opened and accommodated 30 patients who were transferred

from Witrand. Again the all-White patients were provided with occupational therapy departments, a swimming pool, and vegetable garden as well as developed grounds for recreation. Staff also made use of the recreational facilities as the hospital was isolated from Pietermaritzburg by distance. Older children of staff became a schooling problem as the facility grew (Minde, 1975c, pp. 1890-1894).

The institution initially only catered for boys over 9 years of age, although a number of adult native mental patients were transferred to the facility as workers. A female section was opened in 1953, and a further children's ward, with no lower age limit, was opened in 1955. Infants who were only a few days old could be admitted, and doctors would persuade parents to place their children at birth if they had a recognizable defect. Down's syndrome was the predominant diagnosis. Children admitted to these institutions were deprived of much needed maternal love, and because of this often failed to develop and reach their full potential. The mortality rates in this facility and others like it were very high (Minde, 1975c, pp. 1890-1894).

In 1956 an experimental rehabilitation programme was put in place with the input of the SA Rubber Manufacturing Company, a large factory in Howick. A branch workshop of the company staffed entirely by patients was opened. Patients of all levels were trained by company instructors. They packed rubber rings into boxes, for which they were paid piecework rates. Special accommodation was made for the patients who could count, for example, to ensure that all could participate in the project. The rate of payment was at a suitable level for the work done. It was found that the speed and accuracy of the work done could not be correlated to the patient's level of intellectual ability (Minde, 1975c, pp. 1890-1894).

A social programme developed by parents of one of the patients was implemented. Every month the patients were treated to a party organized by the group of volunteers. There were entertainers: ventriloquists, musicians and puppeteers. Patients who were unable to walk were brought to the venue. Visitors were encouraged to 'adopt' individual patients, and visit them between the parties. They were involved in the patients' progress and activities, and would communicate with parents if the patients got ill, especially if they were far away. They raised money and gave a Christmas party every year. Absconding was rare and the behaviour of patients improved. The programme was filmed by the company and shown at conferences. The project was enthusiastically supported by the Managing Director of the rubber company. The facility is unique in that it had its own railway station on a branch line from Howick to Merivale. By 1975 the institution's patient population totalled 395 White

males and 123 White females. One of the features was a ward with a well-equipped playground for White infants and toddlers (Minde, 1975c, pp. 1890-1894).

There was a marked discrepancy between the accommodations and programmes of White and Black patients. While Black patients had been initially transferred to the institution as workers, they were only admitted as patients in 1955, and only due to a major shortage of accommodation in other facilities. A number of dormitories, which were very dilapidated and had not been used since the army had evacuated the base, were identified and used. These dormitories were converted at very little cost, and 1000 patients were able to be accommodated. A large vacant building was made into a dining room, and a single male nurse taught them to sing African songs and say prayers. The process of the patients marching to the dining hall for their meal and intoning a prayer before sitting down, eating their dinner in total silence and then finishing the process with a song recital became a spectacle for the community and visitors. These Black patients were transferred from Umgeni in 1968 to the two homeland hospitals opened by Smith Mitchell (Minde, 1975c, pp. 1890-1894).

Westlake, the only facility intended for Coloured 'defectives' was opened in 1962. It had been in the pipeline and planning stage for around 50 years. Formerly a lock hospital for tuberculosis, the Stals Sanatorium, it had fallen into disuse. It could house around 500 patients, with a 50/ 50 split between males and females. The waiting list, because of the lack of facilities for persons of colour remained excessively long. The facility, which was originally a branch of Valkenberg Hospital was run independently by 1975 (Minde, 1975c, pp. 1890-1894).

Private institutions for 'defectives' were found in many of the larger towns around South Africa. Parents and patrons paid for 'defectives' housed in these facilities, along with funds raised by voluntary organizations. These facilities were licensed, funded and inspected by the Department of Health. One of these facilities, the Woodside Sanctuary in Johannesburg, was started in the 1930s. The Van Wyk Report of 1967 reported that around 1403 patients were housed in these facilities (Minde, 1975c, pp. 1890-1894).

## CRIMINALS, DELINQUENTS & PSYCHOPATHS

The United States of America introduced psychiatric services for delinquents and criminals, which had a profound influence on South African mental health services. Pioneered by Cesare Lombroso in the 19th century, in a study that 'showed' that criminality was a hereditary condition, he believed that criminals possessed distinct physical and mental

characteristics. This theory was debunked after a further research initiative by Dr Charles Goring, who concluded that there was no such thing as a criminal class or physique that identified a criminal. In the early 1970s however, the thinking was that certain disorders could lead to criminal behaviour—with one being encephalitis lethargica, which ostensibly led to some children taking to criminal ways after contracting the disease. Epilepsy was also believed to be related to crime (Minde, 1975e, pp. 2265-2270).

In Minde, (1975) he describes the thinking behind early social notions of the diagnosis of epilepsy:

> *Some authorities believe that an epileptic may commit a criminal act as a substitute for a fit, while in the period immediately after a fit a state of automatism, during which crimes may be committed, may exist'. Furthermore, epileptics are prone to attacks of ungovernable rage, during which they may murder or destroy property. (Minde, 1975e, pp. 2265-2270)*

The link between criminality, heredity and mental illness was to find its impetus in the 20th century, with a number of studies taking place that would influence policy and legislation, as well as having an impact on the practice of psychiatry. In J Lange's book in 1929, he demonstrated that in 10 out of 13 pairs of identical twins with a history of criminal behaviour, both individuals were criminal. Professor H J Eysenk of London University had also demonstrated that heredity played a role in the arrest of children taken from criminal mothers which was 2 ½ times higher than that of the control group of non-criminal mothers. By 1922, delinquent boys who were processed through the courts in the USA, were most likely to be given a psychiatric diagnosis of delinquency. The juvenile court system was deemed to fail these children, and Dr William Healy, the pioneer of the Juvenile Psychopathic Institute in Chicago and the Judge Baker Foundation in Boston and world expert on delinquency, was reported as saying that psychiatric clinics and reformatories should function as institutional mental health facilities and not fall under Correctional Services (Minde, 1975e, pp. 2265-2270).

Dr J T Dunston, the then Commissioner of Mental Hygiene in South Africa, paid a visit to the USA and Canada in 1922 (around the same time that HF Verwoerd attended university) to inspect these facilities. He returned with proposals and policies that he submitted with his next annual report, in which he urged an introduction of these methods to deal with delinquency. He said, on his return

> *Delinquency is becoming recognized as more and more a medical question and that few delinquents can be dealt with properly without the skilled assistance of the psychiatrist. The old method of punishment for the crime committed without*

> *regard for the personality of the individual committing the offence has proved a failure (Minde, 1975e, pp. 2265-2270)*

He classified delinquent children as being of subnormal or borderline intelligence, mentally deficient, psychopathic, psychotic or epileptic, and felt that fully 50% of the children who passed through the court system could be classified as one or the other. Institutional care was certainly the answer, as he had seen that many of these children's 'maladjustments' had been improved or even cured by 'judicious' control of the of their recreational pursuits and interests, and supervision of their attitudes to work and who they chose as companions. He also felt that a removal from the home environment into 'special homes', and not into reformatories or industrial schools, was necessary to ensure that every opportunity was given to these children to improve (Minde, 1975e, pp. 2265-2270).

A further development which impressed Dunston was to have very far reaching consequences for adults (and specifically Black adults) in South Africa at a later time. In the United States of America at Sing Sing Prison, prisoners were examined and sent to various types of institutions that were perceived to be in the prisoners' best interests. These included agricultural prisons, industrial prisons and prisons for mental 'defectives', for example. This also saved the state money. This assessment in effect allowed 'recognition of incurable mental defectiveness and suitable segregation on the first offence', and in South Africa, would include epileptics, 'defective' persons and 'maladjusted individuals' (Minde, 1975e, pp. 2265-2270).

Psychiatrists were appointed to serve in both the Juvenile courts and later, in the adult courts, but this later fell to the psychiatrists attached to the larger psychiatric hospitals, for example, Sterkfontein. The Mental Disorders Act of 1916 was being used more frequently, and this also led to the option for the courts of an accused being sent for forensic observation if his sanity were in question. From 160 patients being sent for observation in 1933, to 2044 patients being sent in 1969, the demand for this service had escalated. With Dunstan's final retirement in 1932, the drive for improvement and reform in the sphere of mental health care diminished. The service that he had put in place remained, but no real growth in the number of services occurred from this period (Minde, 1975e, pp. 2265-2270).

## END OF AN ERA

As can be seen, prior to 1940, there was a major upswing in implementation of the plans to provide institutions that would take care of the eugenic 'problem' in South Africa. Facilities were built and repurposed, programmes were developed and research was in its heyday. The involvement of international bodies and input from world class experts in mental health

had continued to grow. in support of the activities of the South African government and its mental health policies. From the beginning of the decade, however, there had been a steady verbalization of rejection of the use of mental health and psychiatry as a means to, not only justify the segregation of different cultural groups, but also as a tool to underpin legislation which allowed for the forced removal of certain groups on the basis of mental illness, intellectual disability and/ or behavioural abnormalities. From the mid-1960s, with the arrival of the Smith Mitchell facilities, the discourse between the political and mental health began to converge in a place from which institutional mental health and psychiatry wouldn't ever really recover.

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