

**Mental Health Care in South Africa 1904 to 2004:  
Legislation Influencing Ethical Patient Care**

**Dr. Gale Barbara Ure  
Student Number: 0616991E**

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**Supervisor: Donna Knapp van Bogaert**

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I the undersigned, hereby declare that

**Mental Health Care in South Africa 1904 to 2004:  
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is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of references.

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signature

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date

## Dedication

This research is dedicated

- To all of the mental health practitioners and service users that I have met and worked with over the past eleven years. They have provided more insight and given greater significance to an often forgotten area in the field of human rights than all of the scholarly writings on the subject.
- To Craig and Duncan who continue to be supportive of my bizarre interest in obscure topics.
- To my supervisor Donna, who poked and prodded through all of my excuses until I handed in my report. Thank you! Thank you! Thank you for all of the patience and the care. I really appreciate the time and effort.

## **Abstract**

*Mental health in South Africa has undergone many changes since the pioneering work of colonial doctors in the early 1900's. With the advent of a human rights based constitution in the 1990's, mental health was forced to review its methods of care and the political motivation behind many long-term hospitalisations. Because of these practices, government mental health structures maintain and fund institutions that warehouse a legacy of institutionalised and disenfranchised patients from the apartheid era. A number of these patients have been hospitalised for over forty years – some without an appropriate psychiatric diagnosis. Many of these patients cannot be discharged back into the community, as their families have been lost over time. Many patients are institutionalised to the extent that they are unable to manage even the most menial of personal tasks and thus cannot leave the safety of the centres in which they are housed.*

*International developments in the field of Eugenics underpinned much of the sweeping social change that was embraced by Europe and the USA. Germany based many of its policies of eradication of the 'unfit' on eugenic principles that could comfortably accommodate the rejection of racial differences. The profound effect that eugenics exercised in the medical and social spheres internationally drove the development of many apartheid-based government policies in South*

*Africa. These included reform in the areas of education, mental health, social development, group areas etc. This research report briefly explores some of the social, medical, political and legislative influences active in the field of mental health from 1904 to 2004.*

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## 1 Introduction

The political incorrectness of using words like *deviant*, *feeble-minded*, *defective*, *imbecile* or *idiot* to describe persons with medical conditions or personality disorders, fills our South African 21<sup>st</sup> century democracy with abhorrence. There was however, from around the 1880's to the 1950's, a time when medical tomes were filled with these terms, as they were considered valid descriptions of 'problem' people with mental health and social issues. Much of the foundational legislation across the world in Western countries used these terms to describe and identify such difficult groups of people within their greater populations.

The 1950's heralded the introduction of neuroleptics, which made it possible to treat patients within their communities with less disruption and economic drain. Such drugs controlled the most bizarre psychiatric symptoms, and there was a growing confidence that community treatment could be globally achieved. Moreover, the cost of maintaining the mentally ill in institutions could be lessened, thus relieving governments of the financial burden of care.

In the 1960's, Erving Goffman wrote *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (1961) the seminal text on institutionalism and Ken Kesey's film *One flew over the Cuckoo's Nest* brought mental illness to public attention. Concurrently, Michel Foucault's *Birth of the Clinic* and *Madness and Civilisation* as well as the input of prominent anti-psychiatry activist Thomas Szasz introduced a critique of clinical mental health practice common in the West. Szasz argued that the process of involuntary committal to psychiatric hospitals and forced administration of psychiatric medications was a removal of the most basic of human rights – that of freedom and autonomy. Set in the 1960's, the time when human rights became a popular public cry and cause, a growing awareness of humane and rights orientated care for the mentally ill led to the formulation of the ideals of preventative treatment and community based care. Moreover, the advent of welfare states in the West in the mid 1960's set the scene for more state

intervention in the area of social concerns and rights. The disabled, the mentally ill, and the intellectually disabled became the focus of new legislative reform. Through such movements, the practice of psychiatry became highlighted in the public forum.

Psychiatry has had a difficult road when it is examined from a political and socio-historic perspective, whether in South Africa or internationally. The nature of psychiatry, insofar as it exercises coercive rights over members of the community and society at large, is the basis of a great deal of social and political power. Psychiatry as a medical specialty is not inherently subversive or politically driven and is not in itself intending towards harm. It is nevertheless the province of the treatment of the mentally ill, the intellectually disabled, and the pathologically dangerous and difficult in our communities. Generally, the public is afraid of these people and their effect on the immediate community. The clinical (and by connotation - ethical and acceptable) control and removal of these groups for the safety, convenience and economic benefit of the greater population is an attractive option when compared to other, harsher alternatives.

The solution in the middle 20<sup>th</sup> century was institutionalisation, and this was often lifelong. Other more radical ideas which certainly embraced, and these involved permanent removal and eradication of these people from society. The idea of clinically managing persons who deviate from the norm, the uplifting of the human race and the eradication of pain and suffering is beguiling to medicine. The possibility of manipulating changes in the human condition by legislating control and care, and these for the better of the functional and voting public, as harsh as it may seem, is a serious consideration for any government. Forays into social manipulation have taken psychiatry into abuse of human rights, euthanasia, sterilisation and political manipulation and control (Chung, 2002, Dowbiggin, 1997, Gosney, 1929, Ross, 2006).

There are "problem people". They are, and always have been in need of resources, containment, and in a number of cases, state intervention to prevent

either harm to self or to prevent public harm. Worldwide, there are processes and legislation in place for involuntary treatment which facilitate the forced removal of mentally ill persons from society. Psychiatry then takes the role of the arm of the state in ensuring that appropriate treatment is provided – but in an environment of coercion. Psychiatry perhaps more than any other healthcare practice, has an inherent dual loyalty by its own nature because a psychiatrist has a duty to his / her patient and a duty to protect society and this is often made operational through a third party, usually the State. It is a requirement that a psychiatrist protect both client interest, and the interests of society within the gamut of the law. Unlike moral laws, the ‘gamut of the law’ may vary from time to time and from place to place. It is because of this that we can identify a less altruistically orientated side to psychiatry.

Many countries have utilised mental health practice as a political tool to control dissident factions. These practices have been both punitive and for gain. They have also been utilised to maintain institutional hierarchies and power structures. These power structures have in turn maintained the political *status quo* and a means of retaining established institutional and power structures.<sup>i</sup>

It would make sense that the South African government would also use the “best interests of society” viz. mental health or mental illness as a political tool. This would certainly be a realistic assumption, given that during apartheid human rights abuses were commonplace. And this was indeed so. However, it was not an instant shift of politics and policies. Academic disciplines for example, the social sciences, played a major role in the development of the discriminatory principles which formed the basis of apartheid. The role and function of professional persons charged with determining the mental health or mental illness of others also played a role in human rights abuse.

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<sup>i</sup> The utilization of psychiatry as a political tool has historical links to both social and political structures. See for example, Russia, France and Brazil (Adams, 1990), America (Dowbiggin, 1997; Ross, 2006), Germany (Weiss, 1987; Burleigh, 1994) and Sino-Japan (Chung, 2002).

It is documented that after democratisation in 1994, there were over 15 000 people in Smith Mitchell custodial care hospitals around South Africa (Porteus, 1998, American Association for the Advancement of Science, 2007). Many of these had been removed from their families and communities for over 47 years. These people were “institutionalised” and could not be discharged into the community as their social and other skills were irreparably damaged. Many did not have diagnoses, or their diagnoses were incorrect or inappropriate (Royal College of Psychiatrists, 1979). Were they victims of political mental hygiene programmes?

Given the international propensity for using mental health as a political tool – and with South Africa’s human rights abuse record - it makes sense to investigate South Africa’s mental health policies and practice in its social-political and historical context, highlighting pertinent legislation.

In Chapter one, I will review the first years of the Cape colony and identify the early interplay of society, health and prevailing ideologies within the framework of a developing mental health paradigm.

Chapter two will describe the difference between racialised medicine – or the practice of medicine on the grounds of broader socially discriminatory practices; and racist medicine, which is the practice of medicine based on ‘medically’ or ‘scientifically justified’ grounds.

In Chapter three I will touch on religious reinforcement of racial difference from a social perspective. This is important as it sets the tone for how religion began to underpin and validate socio-political, economic and scientific developments in mental health, as South Africa moved through its infancy towards independence.

Chapter four will describe the introduction of the Mental Hygiene Movement both internationally and locally, as the formalisation of the discriminatory practice of mental health.

In Chapter five the development of apartheid structures using social sciences developments will be described and expanded. South African doctors joined the worldwide movement towards Eugenics and mental hygiene, many with great personal recognition and success. The Mental Health Act of 1973 provided a platform for political abuse by legal structures, abuse which was perpetuated by the medical practitioners in mental health facilities.

Finally, I will conclude with some thoughts concerning the ease with which mental health practitioners turned a blind eye to physical illness and wrongly diagnosed symptoms – allowing their patients to die. All the while officially reporting that the standard of care was of an exemplary standard. I question when the step-by-step practice of a speciality outweighs the ethical obligations to do the right thing by a patient in need – even if it does not fall under a specific ambit of practice.

## **2 The Medicalisation of Mental Health in Early Cape Town**

From the 1600's to the middle 1700's, the most prevalent disorders found amongst the settlers in the Cape were hypervitaminosis, alcoholism, exhaustion, and venereal disease. Mental disease followed as a result of many of these. The population was too small to warrant special facilities for "lunatics"- the commonly used term of the time. Because of the context of the colony, the large number of slaves and the continuous arrival of mentally ill sailors who arrived in port, an grudging tolerance of 'lunatics' occurred. Mentally ill persons were either kept in the slave lodge, the convict station on Robben Island or in the ordinary general hospital (Minde, 1974). People were, however, not generally sensitive to the woes of the mentally ill, often becoming physically aggressive (Minde, 1974).

The large number of slaves in the colony and the black indigenous peoples greatly outnumbered the whites. No doubt to maintain power, intensified aggressive and sadistic acts towards both of these groups, were common with the excuse that both groups were considered 'less than human' – in keeping with the ideology of the time. There were no legal reprisals for this type of behaviour. Behavioural and lifestyle differences, considered socially acceptable today were not tolerated often on religious grounds<sup>ii</sup>.

In the Cape, Western medicine as practiced during the 1600-1700's was an extension of both the ideology and political endeavour of the time, a conglomeration of class perceptions and practice within colony politics.

Because of the social-political intercourse with Europe, European medical progress had far-reaching social ramifications in South Africa. For example, the use of Western medicine in colony settings has been criticised as having been detrimental to colonised peoples, as both slaves and persons of colour were subject to inequality in both the provision of and access to healthcare when compared to whites (Deacon, 2000). On the other hand, some Western medical advancement in technology benefited both the early white colonists and, although to a lesser extent, slaves and the black population. Colony medicine has been perceived as being loaded with both negative and positive value. It has also been touted as being detrimental to indigenous peoples by allowing for culturally different and often inadequate treatment approaches. On the other hand, it was ethically necessary to assist the colonised people with needed help and care, albeit with racist underpinnings.

Local practice of mental health care was in line with that practiced in the rest of the Western world, with a supporting colonial ideology. Colonial ideologies were relatively uniform across the Western world and were by no means

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<sup>ii</sup> Homosexuality in the colony, for example, was perceived as an abominable crime, with the result that even accusations of sodomy often resulted in death, as described in Minde (1974).

homogenous to a specific country such as South Africa or India. To explore whether there were mental health practices which were utilised to aid racist politics and practices within South Africa, however, there needs to be clear differentiation between racist medicine – or the practice of medicine on the grounds of broader socially discriminatory practices; and medical racism - the practice of medicine based on medically justified grounds. This is the topic of the following section.

### **3 Racist Medicine versus Racialised Medicine in South Africa**

The principle behind racist scientific and medical development was the elevation of racist discourse and practice to the level of acceptable and generally accepted scientific theory. These theories then formed the basis for many medical practices, which were accepted as being both medically and scientifically justified. They were certainly in line with acceptable social practices of the time. The acceptance by the scientific community of educated, reasonable and often religious white men who were ‘pillars of their communities’ provided the vindication for their use as a basis for the practice of inequitable medicine. In South Africa, racist medicine and medical racism were combined and inseparable in the process of mental health care development. Importantly, both racist medicine and racialised medicine can include eugenic or genetic practices (Deacon, 2000).

The advent of the racialised, gender-disparate and class-specific medical ‘gentleman’ occurred when Britain took over the colony from the Dutch at the beginning of the 19<sup>th</sup> century<sup>iii</sup>. These medical practitioners were predominately white, male, middle class professionals who looked to their associates in England before looking to their colleagues in the Cape. In this way, the ‘colonialist mentality’ was sustained. Amongst other disadvantages, the bonds

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<sup>iii</sup> Black and female doctors were very rare, as women were rarely admitted to European medical schools and black doctors were rarely found outside of missionary hospitals. There were no legal limitations to the admission of black male or female candidates to the profession - it simply was not done socially!

to the mother country led to greater delay in the creation of medical schools in the colonies of the Cape, Australia, India and Canada. Traditional Eurocentric medical training usually involved socially and economically prominent colonial families sending their sons overseas - often unaffordable for ordinary colony families (Deacon, 2000). The prevailing social stratification in medicine was maintained by this.

Racism in the Union was a relatively amorphous concept during the early 1900's. The unequal treatment relations between black patients and white doctors were more often than not, based on economic discrepancy. Doctors charged for medical treatment, and black patients could frequently not afford it. Class relations and resource management with scarce funds led to segregation of medical services and reduction in services to less affluent society members. Government and missionary hospitals were therefore the main point of contact between black patients and white doctors. The prevailing custodial model of practice behind these institutions was the basis for segregated treatment. However, here it is important to note that racial discrimination was not reserved only for practices which targeted the black population of South Africa, but were also practices which targeted poor whites – specifically members of the Afrikaner group. There was a significant change in practice from one methodology to the other over time<sup>iv</sup>.

Racist medicine in colonial society as in Europe and USA was unconditionally accepted by medical institutions. It bears comment, however, that the actual care cannot be described as unethical simply on the grounds of its retrospectively anti-humanist practices. Western hospitals separated the homeless, the insane and the contagious from society as a social necessity, and this was not always purely a racially motivated action. In the early 1900's there were no generally successful treatments for the mentally ill, which meant

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<sup>iv</sup> Medical racism was practiced until the 1950's, when political machinations led to a change to a legislated racist medicine, a detailed description will follow later in the report.

that the opportunities for the mentally ill person to commit harm to the general public, or for the public to harm the mentally ill person, were high. The differences in custodial treatment were often based on concepts of economic and capacity entitlement, and were only later justified with scientific arguments around lesser requirements for lesser persons.

Psychiatry as a specialty had always treated black and white patients differently, with theoretical scientific influence for this only provided in the very late 1800's (Koren, 1912). One of the theories that developed, for example was that black patients fared better with the use of physical therapy rather than psychological therapies because of their lower intellectual developmental capacity (Carothers, 1953).. Many of these theories developed from within institutions where doctors treated large numbers of black patients, and where these prejudicial practices were often recursively confirmed and reaffirmed by the environment, facility conditions and socio-economic and political factors (Deacon, 2000).

In the early history of South Africa, there were blurred functional lines between hospitals, prisons and holding areas for the destitute, where prisons were often used as 'hospitals' for those patients perceived to be dangerous to others, and hospitals were often places to hold the destitute and the inebriate. Some patients were institutionalised because they were homeless. In addition, various and varied provincial Lunacy laws prior to 1916 were enacted, with little uniformity in process. Moreover, there was less personal involvement on the part of the medical practitioner, and this lack of individualisation provided additional grounds for discriminatory treatment. This grouping of social categories later led to the development of separate facilities for black and white mental patients. (Deacon, 2000).

Thus we can see ways in which medical racism – or separate theories of mental illness, leprosy, and epilepsy, for example, did not affect the trajectory of racial discrimination, but simply justified and reinforced differential treatment of

specific illness based on race. A practice which was already in place, but motivated largely by economics. As I will show in the next section, it was also reinforced by religious institutions such as the Dutch Reformed Church.

#### **4 Religious Institutional Reinforcement of Racism in Early South Africa**

The issue of insanity has always been a contextually complex component of social life. The interpretation of madness throughout the ages has ranged from that of criminality, evil and the rejection of social difference - to mentally ill persons being revered and sought out as indicative of the ability to predict the future or to relay important messages from the gods. It should be no surprise then, that prior to the ascendancy of medical thinking as the province of care for the less socially functional of society, the mentally ill and those who deviated from the social norms of the time were the province of religion and charitable organisations. Treatment was pragmatic. If the person's behaviour and the repercussions of their behaviour could not be contained with charity, prayer and love, they became the jurisdiction of the law and correctional services to protect society. The obviously deviant and often randomly violent behaviours displayed by these persons provided the basis for the thinking that persons who display madness were inhabited by demons. Demons, representing evil largely fell under the domain of things religious.

Psychiatry, unlike other branches of physical medicine where the imperfection or illness can most often be visualised, has always incorporated aspects of moral value judgments of good or bad linked to socio-cultural perceptions of the symptoms of mental illness. These, and changes in these, have been dependent on the interrelationship and flux of the socio-political and institutional structures of the time. Good and bad as foundation constructs, the same value judgments as utilised by psychiatry and science, have also always been the guiding influence of various religious orders. Religious institutions in South Africa all played a role in the shaping of social norms. Importantly amongst these, from the 1920's on, the Dutch Reformed Church in South Africa began to

play an increasingly political role in the development of racially negative perceptions.

Such perceptions were based on religious ideology<sup>v</sup> and involved a blatantly political move to improve the circumstances of poor white Afrikaners who were then moving to the towns to escape depressed economic circumstances (Lelyveld, 1985). 'Good' as a concept and in line with social norms of the early Union, was delineated as having Christian virtues versus "heathen" vices. The former later developed into positive value being placed on being "white, Christian and civilised" as opposed to the latter as a negative value of being "coloured, heathen, and inferior". The social justification for the development of racial segregation was therefore sanctioned by the most powerful of institutions – the church – and by implication - God.

As above, we see ways in which the ideas found in medical racism can be supported by social institutions. In the history of South Africa, ideas such as demonic possession, and racial superiority in the hands of powerful social institutions helped to shape the course of the treatment of mentally ill patients and mental health care legislation in times to come.

**Summary** I have shown that in the early days of South Africa, the treatment of mental illness was largely a reflection of Western views interpreted locally in a colonial mentality and generalised medical ignorance of disease causation. Because of this, the mentally ill were often regarded as criminals or deviants and treated in accordance with the times - jailed or isolated from society. It was, of course a politically and socially complex time as the ideologies of the

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<sup>v</sup> The basis of separatism based on racial superiority or inferiority, was born from the exclusivity which the Afrikaners brought to play in their bid to cement an Afrikaner based national consciousness. This exclusivity began with being God's "chosen" people; the Afrikaner was specifically good in comparison to outsider groups being bad. Good and evil were clearly defined by colour. Segregation for the good of all thus became an administrative issue, and management of economic threats became a yardstick for measurement of social deviance and mental illness (Ritner, 1967)

Afrikaner and English colonists were in grave conflict, additionally the customs of slaves and blacks were an enigma. Early on, blatant racism was not an issue. Economics largely determined who would and who would not receive general medical care. The influence of the Dutch Reformed Church – in its own way determined to give Afrikaner peoples political, psychological and social support on religious grounds – served to influence the treatment of the mentally ill as not only different, but demonic as well and was influential in reinforcing early tendencies towards racism..

## **5 Curing Social Ills Through Science.**

Appropriate diagnosis of symptoms is vital to treatment of persons with mental illness. What formed the greater platform for mental health practice were the combinations, overlaps and often wildly flawed misdiagnoses of criminal and behavioural problems and symptoms of genuine mental illness. As there were no clear medical definitions of these outside of the perceived deviance of behaviour according to the religious practices or social norms of the times, they were lumped together as broader socially discriminatory practices under a single umbrella called 'mental hygiene'. This was often done to demonstrate an enlightened, faith-based and humanist approach to the enlightened, reasonable and compassionate treatment of deviant persons while providing security to society at large (Rich, 1990, Rosen, 2004). This jumble of social concern and pseudoscience can clearly be seen in the discriminatory development of the social sciences in South Africa (Fleisch, 1995, Miller, 1993).

The lack of ability of science to pin down the obvious causes of mental instability led to broad acceptance of the eugenic viewpoint, which became increasingly popular, in South Africa, Europe and the USA (Adams, 1990, Bell, 2000, Carroll, 1947, Franks, 2005, Gosney, 1929, Kerr, 2002, Popenoe, 1935). The belief that breeding led to certain traits being passed down through the generations, and that bloodlines carried mental illness and intellectual weakness from era to era did appear to be valuable in providing solutions to many community afflictions. It became imperative that good blood was maintained, and bad blood be prevented from wholly diffusing into the

community. This outlook was expanded to include social problems which had economic repercussions, for example, laziness, unemployment and feeble-mindedness. These indicated the need for state intervention and the attendant requirement for costly social services. It became necessary to devise legislation to deal appropriately with these challenges. In South Africa, politically motivated legislation was being slotted into place.<sup>vi</sup>

Historically, before and certainly during the apartheid years, the social and mental illness criteria overlapped to such a degree that any relative deviance or difference in behaviour or physical makeup could carry the interpretation of mental or illness or intellectual disability and be treated as grounds for social isolation. Psychiatrists were therefore heavily reliant on social and interpersonal reporting of symptoms by third parties before admitting a mentally ill person into custodial care. The public was involved in the process by the media and science reporting, and embraced the prospect of social change through medical interventions. The idea that medicine could provide the means to correct social ills resulted in the 'eugenics movement' which swept many Western countries and served to both reinforce the prevailing ideologies in South Africa and influence mental health policies and practice. This is the subject of the next section.

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<sup>vi</sup> There was also a nebulous area where physical disabilities and medical conditions could crop up as 'mental disability' requiring institutionalisation and removal from society. Deafness, for example, was often cited as a tandem diagnosis to intellectual disability or behavioural issues requiring removal from society (National Archives SA, 1877). This segregation of physically disabled persons appears to have been under the label of 'defective persons', a label which covered a number of areas of difference. These perceived differences were usually those of either economic – as in those persons who received institutional relief or colonial grants - or social inconvenience value. The poor were also included in definitions of mental aberration (National Archives SA, 1913), as they formed a large segment of the socially ostracised population.

### **5.1 The International Mental Hygiene Movement**

Worldwide, psychiatrists were seen as pioneers leading the way to a better future for humankind. For example, Dr S. Grondin, the president of the Quebec Medical Society described the excitement at the advances made in psychiatry as well as the enthusiastic public response in his opening address to the American Psychiatric Association at their seventy-eighth annual meeting.

*“...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 entirely new situations which give us the utmost confidence 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 ... We can only congratulate ourselves upon the happy results of these organizations [eugenic societies] of our present time...and we surely foresee how this particular one opening to-day will fully answer its purpose.....*

*(American Psychiatric Association, 1922a)*

Social developments now need to be placed in context. The European world, up until the late 1800's was in a state of scientific discovery and expansion. Humanism was gaining ground as the European world's ideology of choice. Scientific funding was increasing because of a perceived need to increase and exploit knowledge, rather than to improve service as an aim in and of itself for the good of all. Religious tenets were losing ground as the basis on which to base understanding of human behaviour, and a mechanistic view of mankind's and societies function and the causes of societal events was becoming the accepted and sought after norm.

Politics and economics were also beginning to play a far greater and more influential role in the workings of the developing world. Colony countries were

opening up as independent economic powers and the people, who were motivated to conquer these worlds and develop functional economies, were no longer succession nobility, but were rather the strong, intelligent and courageous from all strata of society. Economics and industrialisation became the driving social and political force. The actual cost of supporting dysfunctional elements within communities became a political and policy concern.<sup>vii</sup>

Against this backdrop, new government structures arose, bringing with them the need to acquire votes, and the need to address problems for political gain – specifically social problems. Criminal problems were one thing - there were judicial and prison structures in place - but social problems had different repercussions for the fabric and functioning of the basis of society. Social intervention and protectionism became a demand of the general public seeking absence of disruption and it fell on governmental offices bearers to address these issues.

Science was developing along lines which offered not only an explanation for the breakdown of society, but was also in the process of devising methods of containing those destructive elements perceived to be the root cause. Scientific development and momentum of research is generated by need, and funding is provided on the same grounds. The foundation theories of eminent scientists led to the funding of research projects which aimed to pinpoint and alleviate these social ills.<sup>viii</sup> Increased governmental intervention into the domain previously held by the social sciences and religion took place, even in South Africa.

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<sup>vii</sup> The 1929 depression in Germany, for example sparked widespread investigation into the elimination of elements who could not work or maintain and support themselves, and who were considered to be a burden on society (Hillberg, 1961; Weiss, 1987).

<sup>viii</sup> Much of this funding was provided by private philanthropic organizations and persons, for example, the Carnegie Institution, Rockefeller Foundation and the Kellogg Company, which had a genuine interest in the improvement of the human circumstance, albeit biased as to which humans qualified (Bell, 2000; Black, 2003).

Specific targets of eugenically based mental hygiene programmes were the disabled and non-contributing members of society who were perceived to be burdensome, both financially and socially. Also, the definition of persons targeted for governmental intervention needs to be perceived in the language utilised to describe the view of these persons at the time. Some of the terms utilised were, for example, *deviants*, *idiots* and *morons*.<sup>ix</sup>

In almost all cases of mental illness, or intellectual disability, however, it is certainly accurate to say that the greatest financial burden falls to the state, for hospitalisation, staffing, care, administration etc. There is also the added inconvenience that caregivers often do not have the resources, knowledge or time to care for these persons. The state was required to protect the community from persons who may cause harm through aggression due to illness, substance use, homelessness etc. Provision of service, containment and continued research was expensive and administratively complex. This complexity was exacerbated by the fact that criminality and mental deviance often overlapped, both in policy and in professional spheres.

In South Africa, *The South African National Council for Mental Hygiene* from 1924, for example, was responsible for treatment of medical delinquents for the criminal court system (Miscellaneous, 1928 - 1934), but these often included instances of errant poor whites, the unemployed and substance abusers.

International funding agencies were involved in South African mental health strategies and interventions as far back as 1914 and covered the combined fields of social welfare, health and corrections interchangeably (National Archives SA, 1914). Developments in eugenic thinking provided a solid

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<sup>ix</sup> These were not specifically medical or legal terminology, but rather social vernacular and obviously critical and demeaning. This is clearly a topic which could be extensively expanded. For the purposes of this research report, however, it will suffice that the language utilised for description of these persons in the legislation of the time was both culturally derogatory and socially negative in connotation.

foundation for policy development and service delivery to promote a national and social ideal of care which mirrored that being promoted internationally.

In many countries discrimination and prejudice around 1922 was based, not on the seeming negatives based on skin colour, but rather on the perceived inability of some groups of people to provide for themselves, to follow eurocentrically prescribed social norms, to be functional and productive members of a community making some positive contribution.<sup>x</sup>

The early eugenics texts were not primarily concerned with racial characteristics, but rather with *deficits* in social functioning which could be passed on to subsequent generations and which could be a burden, chiefly economic, on society. In *Applied Eugenics* (Popenoe, 1935) describes the focus of eugenic concerns around defective persons as follows:

*In modern industrial conditions, the low grade worker is less useful than before. A moron who is able to do no more than push a single lever on a single machine all his life may be an asset to some kinds of industry, but is not an asset to society as a whole... The man of greatest use to society, even in the lowest grades of industry from now on, is the man with intelligence and adaptability*

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<sup>x</sup> In the US, for example, this perceived inability also included persons of low financial means, immigrants, persons with language deficits (not speaking the language of the country of habitation), limited education, and with social backgrounds which were also considered deficient. Legislation was implemented to control immigrants to achieve specific eugenic targets, both physical and mental. President Hoover's 'Committee on Social Trends' in 1933, stated that "This policy selects a physical type which closely resembles the prevailing stock in our country, for about 85% of whites in the United States were from strains originating in Northwest Europe where Nordics predominate..." However, Popenoe and Johnson were concerned that "The National Origins provision is, in itself far from adequate to establish selective immigration along eugenic lines. It should at least be supplemented by providing that, under the various national quotas, only individuals will be admitted who are above the average of the present American population, in terms of health and intelligence (Popenoe, 1935).

*enough to turn rapidly from one type of work to another as science and industry progress.”*

Concerns about the degeneration of Western/ European races were put into context by Professor Irving Fisher of Yale University in 1921. Citing the costs of institutionalising defective persons in the USA, he puts the blame squarely on bad heredity.<sup>xi</sup> Many eugenics texts which dealt with “problem people” began with the cost of care of these individuals as justification for institutionalisation, sterilisation, or euthanasia (Fisher, 1921, Gosney, 1929, Popenoe, 1935, Tannsjö, 1998, Weiss, 1987). Early family studies provided proof of what was a new and exciting field of medical research. Complex charts of disreputable families’ pedigrees were constructed to demonstrate the biological basis of deviant and defective lineage. The popular press created a context for the average person to understand – principally that the mental and social ills of society were hereditary and passed on from generation to generation, but were also identifiable and therefore containable.

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<sup>xi</sup> *“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 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.” (Fisher, 1921).*

There were instances where the conclusion could be drawn that there was a hereditary basis to the presence of deviance. This was demonstrated in studies of family trees where the lack of achievement, deviance and mental illness were the norm rather than the exception.<sup>xii</sup> Along with later studies, (Popenoe, 1935), demonstrated that in line with the thinking of the day, segregation and eradication by sterilisation and the more radical methods of euthanasia might in fact aid the human race to maintain healthy blood stock. It was not an elaborate leap of faith to postulate that those persons with less than desirable breeding, less access to finances and appropriate services might become social problems – for example criminals and the unemployed or homeless.

**Summary** In this chapter, I have shown the basis of the mental hygiene movements beyond South Africa. Studies being done at that time provided sufficient momentum for the inception of mental hygiene strategies in most Eurocentric countries, and, by association, in their colonies. In South Africa, the mental hygiene movement as a formalised process was concerned with aspects of neurology, psychiatry, social work, psychology, the intellectually disabled and the behaviourally challenged as blanket “medical” concerns. However, they often led directly into social problems and in this assimilation mental health care workers in particular became enmeshed. How this developed will be overviewed in the following chapter.

## **6 The Mental Hygiene Movement in South Africa**

In South Africa, psychiatry and the social sciences began to play a pivotal role in the development of segregationist and eradication policies in both medicine and governmental social policymaking. Naturally, social problems did not escape the South African colony. An ‘Africanised’ psychiatry was not being developed with any real enthusiasm, perhaps because of the socio-magical connotations of the causes for illness and the curse - removal system for cure utilised by indigenous Africans themselves. The Eurocentric view, shared in

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<sup>xii</sup> For example see the famous Kallikak and Jukes study (Black, 2003; Dowbiggin, 1997; Kerr, 2002)

South Africa around the black African's 'primitive personality' - in vogue from around the 1900 to 1960 - was fundamental in how treatment modalities developed (Carothers, 1953).

In 'The African Mind in Health and Disease' for example, the African's 'primitive mind' is compared to that of the European insane community and those of children (Carothers, 1953). Africans who acted out of the prevailing social norms were perceived as irresponsible and immature rather than having symptoms of mental illness – symptoms of mental illness as perceived by the European community, that is.

Interestingly, the Afrikaners, as far back as 1835 and up to the 1920's, were generally viewed by the English in very much the same light as the black African and this included symptoms of mental illness (Lelyveld, 1985). An example of the overlap of cultural and medical contextual thinking was a paper given by Dr J T Dunston, then commissioner in *Mental Disorders for the Union of South Africa* to the American Psychiatric Association in 1922 entitled "The Problem of the Feeble-minded in South Africa". According to this paper, no true case of paranoia had been seen in a 'native', possibly due to 'inferior mentality' (American Psychiatric Association, 1922b). Later studies demonstrated the inferiority of the white Afrikaner intellect as compared with that of the white English. This reinforced the already skewed perceptions of the medical fraternity, who were at that time, mainly English.

The protection of civil society and the concept of moral management to overcome mental degeneracy became the province of medicine and the social sciences (Klausen, 1997). This was known both in South Africa and the USA as "social engineering" (Miller, 1993). Social engineering requires engineers and predominately the English speaking medical practitioners in South Africa held eugenic views, making them ideal for the position. <sup>xiii</sup>

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<sup>xiii</sup> English speaking doctors were proud members of the Empire's colonial medical fraternity, and the general context of the medical teaching in Europe was eugenic by the early 1900's.

## **6.1 Social Engineers : Principal Players in the South African Mental Hygiene Movement**

There were a number of principal players in the medical and social science fraternity that greatly influenced the mental hygiene movement and respective legislation in South Africa.<sup>xiv</sup>

The first figure is **Dr J T Dunston**, an English medical doctor. He became one of South Africa's most formidable foundation influences of the mental hygiene movement.<sup>xv</sup> In 1912 he was one of four persons requested to comment on the situation on mental health with regard to mental hospitals in South Africa. He played a primary role in developing the *Mental Disorders Act of 1916*. He held the position of Commissioner of Mental Disorder and Defective Persons for the Union, which he assumed in 1916, a title which was later changed to the Commissioner of Mental Hygiene to reflect international trends in 1924,

Dunston arguably exercised more influence over the shaping of the scientific and medical thinking underpinning the social and mental hygiene systems than did H F Verwoerd. Although he officially retired in 1931, he was reappointed to

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Most were members of the British Medical Association, as there was no specifically southern Africa association in play at that time. The South African Medical Association became autonomous from its British affiliation in 1927. The Social engineering, Eugenics, and Mental Hygiene movements popular internationally at the time were interpreted by many prominent colonial doctors and brought back to SA for implementation.

<sup>xiv</sup> The word count of this research report does to permit me to describe in detail their careers however, if the reader is interested, I have extensive work on all the influential figures I mention.

<sup>xv</sup> Having worked in English mental hospitals for a number of years, he started his career in mental hygiene in South Africa as assistant medical officer of Pretoria Lunatic Asylum in 1905. His second application was that of medical officer to the New Central Prison in Pretoria in 1906, Dunston was instead given the post of Acting Superintendent of the Pretoria Lunatic Asylum. In 1908 he became medical superintendent. Nineteen fourteen saw Dunston become inspector of asylums in the Cape Province while acting as the superintendent of Valkenburg Asylum National Archives SA 1905b; 1906b; 1906a; 1914a; 1916; 1924; 1931a; 1931b; 19055).

the position of Commissioner and held the post until 1951.<sup>xvi</sup> Under primarily his influence, two driving concepts of moral management came to the fore – fear of the poor white Afrikaner as a social and cultural contaminant; and the concept of feeble-mindedness as a bloodline or genetic contaminant. ‘Deviants’ and the ‘feeble-minded’ were his specialised areas.

In a paper entitled “The Problem of the Feeble-minded”, presented to the Pretoria Branch of the British Medical Association in 1914 he explained his position. He believed that the two distinguishing features of feeble-mindedness were economic and social failure; while these persons may be able to earn a living, they would not be able to compete on equal footing with ‘their normal fellows’ (Dunston, 1914). He felt that the full extent of a person’s life should be investigated when making this diagnosis, which included the aspects of morality, ‘sexual qualities’ and family history.<sup>xvii</sup>

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<sup>xvi</sup> As the driving force behind the psychiatric thrust of the South African Mental Hygiene movement, He was also an eminent psychiatrist and member of the American Psychiatric Association. As a member of this society, Dunston participated in conference activities as did most other clinicians. On his retirement the number of statutory admissions had trebled, services had extended markedly and facilities had increased in number. Two new psychiatric hospitals were built, and extra facilities for the feeble-minded were provided. Under Dunston’s leadership, there was a corresponding development of extra-institutional and work facilities for both government and provincial departments concerned with mental disorder and defect (Minde, 1975).

<sup>xvii</sup> Klausen (1997: 27-50) describes Dunston’s position: “Dunston related feeble-mindedness to national health by declaring that every thinking person considers feeble-mindedness to be a matter of ‘outstanding importance’. He believed feeble-mindedness could explain the existence of ‘social diseases’ such as criminality, pauperism, prostitution, alcoholism, illegitimacy, and epilepsy. In short, undesirable social behaviours (by standards of white middle-class morality) were medicalised by deeming them symptoms of a vaguely defined disease. Dunston likened the feeble-minded to ‘a plague’ and believed that such people were so great a cost and moral danger to the community that they should be ‘stamped out’, with no expense spared in dealing with the problem. It would be justified by ‘the resulting economy, quite apart from ... increased happiness and health, and diminished misery, ‘poverty, and sickness’. Feeble-mindedness in the majority of cases, he said, was caused by heredity and, accordingly, he prescribed the usual eugenic treatments, including compulsory segregation from puberty onward on farms or

**Hendrik Frensch Verwoerd**<sup>xviii</sup> has been accused of almost single-handedly having undertaken the task of engineering or architecting apartheid, and thus the system which put an entire nation of non-white people in South Africa into oppression. This is not a correct assumption, regardless of the latter outcome. Verwoerd's training and exposure to mental healthcare was, along with other social scientists and medical practitioners, in line with the European and American thinking which underpinned his university education. Verwoerd's contribution to the segregationist practices in mental health needs to be understood in the context of both his upbringing and early exposure to the socio-political situation in South Africa. This coupled with his exposure to international teaching and developments in the social sciences, led him to devise social interventions for the country which were in line with those being implemented elsewhere (Miller, 1993, Hepple, 1967). Perhaps what separated

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specifically designed 'Colonies', restrictions on marriage, and sterilization, all for the good of the nation."

<sup>xviii</sup> HF Verwoerd was born in 1901 and moved to South Africa with his parents from the Netherlands in 1903. He completed his schooling in 1917 and at the age of 23 in 1924 he completed his PHD in psychology *cum laude* at the University of Stellenbosch. He accepted a grant to continue his post graduate studies in Germany and was exposed to the thinking of the Universities of Berlin, Leipzig and Hamburg. In 1927 on his return to South Africa, he visited both the United States and Great Britain. It does not appear that his time in Germany did anything other than imbue his psychological training with a professional veneer which it had not shown before. He was not visibly or academically influenced by the practices which were being developed and which would later become the foundation for wide-scale attempts at genocide. What did occur after his visit to Germany was that he became far more technically and analytically orientated. His concern with the scientific background for the substantiating of ideas and methods became important. His personal outlook appears to have been far more influenced by his visit to the USA. Psychometric testing and the areas in which to apply them, for example in mental, vocational and ability testing were of specific interest to him, and he returned to South Africa with tests utilised by psychologists in the USA. He visited Universities in Harvard, Pennsylvania, Yale amongst others, as well as other prominent psychological laboratories. As South Africa was not producing appropriate literature for tertiary educational facilities at this time, all of the text books and reference material prescribed by Verwoerd for his students were either German or American (Miller, 1993).

him from many of the other prominent 'social engineers' of the time was that they were not beguiled by the cauldron of political power.

Social science was of greatest interest to Verwoerd. In 1932 he was offered the chair of Sociology and Social Work at the University of Stellenbosch. This position was in reaction to a report for the *Poor White Commission* sponsored by the Carnegie Corporation on the need for a dedicated academic and policy unit to address the problem of white poverty (Bell, 2000). He then channelled all of his energies into this work. Rather than describing social phenomena, he addressed his teaching to look at specific and individual problems (Miller, 1993).<sup>xix</sup> He was steadily rising to prominence as a leading figure in the social welfare movement. Interestingly, prior to 1937, his thrust was not ethnic separatism and neither did it have any arguably significant racial foundations. His aim was a valid attempt to unite both English and Afrikaners via a social science approach geared at the alleviation of white poverty (Lelyveld, 1985). Verwoerd became known as an expert in American social welfare systems<sup>xx</sup> when he could have utilised the European developments in the field instead (Miller 1993: 656-657).<sup>xxi</sup> The Carnegie Corporations financial input and support of the of the social

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<sup>xix</sup> Between 1930 and 1934 there was a general absorption of socio-scientific developments from the USA, with a number of academics going to the states on field learning trips to absorb the developments and to contribute to the scientific strides being made. Many of these were on social welfare committees with Verwoerd and included both sociologists, psychologists and religious leaders. There was reciprocal movement from the USA to South Africa, with a prominent sociologist, John Dewey who was a campaigner for the use of social science to secure judicious control over society lecturing at Stellenbosch in 1934 (Miller, 1993).

<sup>xx</sup> American sociology was concerned with the amelioration of social problems rather than broad scale social change. There was a great reliance on research data as solid foundation for scientific thinking.

<sup>xxi</sup> There were a number of important advances made in France, Germany and England during this time which were not included in South African social work teaching or policy development Verwoerd in a noteworthy move refused to hire the first South African with a PhD in sociology on the grounds that he required knowledge of American sociology and not continental schools. The student, Geoff Cronje, later utilised his knowledge to argue for the benefits of apartheid

assistance programmes in South Africa was also a factor in his bias towards American methods.<sup>xxii</sup>

In the 1950's and 1960's Verwoerd's policies took on racial denotations because of developments in the political arena and his budding aspirations in that direction. The different racial groupings were not perceived as separate units in Verwoerd's initial conception of social structure; all groups were seen as intertwined in the fabric of South African society. His personality and ideas dominated committee proceedings and attracted the attention of the media. His research output and teaching acumen gained him a reputation in the scientific community, while his participation and ability to formulate research problems which required his personal participation to solve made him a formidable public figure. His import in the development in the mental health sector is obvious.

In 1936 Verwoerd resigned from teaching to assume editorship of *Die Burger*. In 1935 he published three articles on the eradication of poverty in the Transvaal, where he did an uncharacteristic thing by citing and praising Germany's social vocational programme practices instead of those of America. In 1936 he participated in anti-Semitic protests in Cape Town. After 1937 his views became far more racially biased, and it is perhaps pragmatic to postulate that as an ambitious man, Verwoerd was both opportunistic and politically flexible enough to have held ideals which he concealed while teaching but had not voiced for both scientific and career reasons. The same may be true for the uncharacteristic change in behaviour and stance after leaving teaching. He was required or chose to be to be politically correct in a racially biased government, and he thus performed the role of politician at large as he had dominated the social welfare sphere.

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<sup>xxii</sup> It was the Carnegie Corporations advocacy that social science should play a role in development of governmental social policy. Funds for South African research were provided for this through a grant programme for the Council for educational and Social Research in the 1930's (Miller, 1993; Lelyveld, 1985).

The stage was set for South African social welfare and social sciences to be geared towards potential racial exploitation. It is pertinent to remember that up to the 1930's there was difficulty differentiating social deviance from psychiatric illness, and that social problems were often cause for institutionalisation and psychiatric interventions.

**Dr William Darley-Hartley**<sup>xxiii</sup>, was founder, editor, owner and publisher of the South African Medical Review (SAMR), the first journal of its kind in South Africa. He was an active member of the South African Branch of the British Medical Association (BMA) and was regarded as an influential player in the South African medical profession.<sup>xxiv</sup>

Articles sent to the *SAMR* originated from the South African regional branches of the BMA, and it was via this publication that the eugenics movement, and by implication, the mental hygiene movement gained momentum. Articles were carried from a number of doctors who specialised in mental illness and held positions of socio-political power<sup>xxv</sup>. Darley-Hartley's role as editor and facilitator of the public discussion around eugenic issues is vital to the position that mental health chose to adopt at that time. He, like many, believed that science provided the tools for planned management of individual and social health as well as for the growth of a strong nation.

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<sup>xxiii</sup> He was born in 1854 in the UK and was educated in London. He moved to South Africa in the 1870s, and fought in the Frontier Wars of 1878 and 1879. He was politically very active, becoming a founder member of the British Colonial League, which supported British supremacy and which had supported Cecil John Rhodes in the 1898 elections. He was also a founding member of the Frontier Medical Association in 1886 (Klausen, 1997). .

<sup>xxiv</sup> Darley-Hartley published in a number of journals, was the spokesperson for the medical profession in the Cape, and a member of the Colonial Medical Council from 1904 to 1928, becoming president in that year. He was awarded the first Gold Medal of the Medical Association of South Africa 'for distinguished services to the medical profession in South Africa (Klausen, 1997).

<sup>xxv</sup> These included T. Duncan Greenlees, Medical Superintendent of Grahamstown Asylum, A Moll, consultant in mental and nervous diseases to the Transvaal Education Department and J. T. Dunston, then Medical Superintendent of the Pretoria Asylum.

The prevailing attitude that “science” could cure social and economic problems had a particular appeal to many medical practitioners in South Africa. Under the editorship of Darley-Hartley, the SAMR published and actively supported such views. Some of most interesting articles included one from Dr A. M. Moll, an Afrikaner (or Dutch) doctor who had trained in Utrecht was a consultant in mental and nervous diseases for the Transvaal Education Department in 1919. He firmly believed that it required state intervention in society to prevent feeble-mindedness.

National Health and the individual overlapped yet again in a 1911 article by Dr Lilian Robinson, a member of the Natal Branch of the BMA. In a report titled 'An Address on the Medical Inspection of Schools', Robinson voiced her approval of school hygiene programmes as essential to the science of public health. In her report she addresses the problem of feeble-mindedness<sup>xxvi</sup> firmly. In her view, feeble-minded, blind and epileptic children 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).

The subject of “degeneracy” as a threat to national and racial health raised its head through articles by Dr. T. Duncan Greenlees, then Medical Superintendent

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<sup>xxvi</sup> Here it should be noted that “feeble-mindedness” had become the present day medical equivalent of global warming, and was inciting moral panic - ‘a behaviour or condition on which general social anxiety is focused at a particular historical moment’ (Klausen, 1997). . Social anxiety was appropriate. The Afrikaner and African work seekers influx to urban areas from lost farms was resulting in ever-growing urban slums. Poor whites had sparked concern about the ‘poor white problem’, which threatened social order on two fronts. The competition between poor whites and blacks for scarce jobs could cause possible conflict; or a possible coalition between these two groups along class lines. Trailing these concerns was the reality that racial lines could become distorted, and that the quality of whites as a nation could degenerate if left unchecked.

of the Grahamstown Asylum. His 1903 article 'Medical, Social and Legal Aspects of Insanity', promoted the use of negative eugenics in the case of insanity. He felt that it was a doctor's obligation to manage the issue of marriage of insane people, 'for we can't justify the risks of generating a stock of idiots and imbeciles.' He appealed for legislation preventing dysgenic marriages, warning that the consequences otherwise would be grim. In a further article he linked degeneracy to state expenditure. He expressed regret 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)

In an article published in 1923, J. T. Dunston, the then South African commissioner of Mental Disorders, demonstrated how social observations affected scientific thinking. Using the results of Porteus Maze, Healy and other mental test results – Dunston declared that blacks demonstrated a far lower level of intelligence than did the average white. He also wrote that they demonstrated little foresight or initiative taking, did not learn by experience, had difficulty with temporal constructs (they did not know their own ages), and had limited mechanical aptitude. He pointed out that blacks had no written language, that their art was rudimentary and their dancing had no refined movements. With regard to their mental health, he believed that their apparent sanity was a demonstration of their inferiority, saying

*"I have never seen a case and, so far as I know, no single case of that mental disorder known as paranoia has been reported among them." Blacks had "not the reasoning powers to become paranoics" and, because of their "lack of brain cells," Blacks had been shown by Porteus Knox, Healy, and other mental tests to have an intellectual capacity far lower than the average White." (Dunston, 1923)*

Through the medicalisation of these symbols 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<sup>xxvii</sup> - it is clear that the medical establishment stood firmly behind their idea of mental hygiene. Health was a valuable asset to the national economy, there was a correlation between degeneracy and racial weakness, and a consequent deterioration in white national health, and that blacks were racially inferior (Klausen, 1997). 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.

**Summary** In this chapter I have tried to show the development of the mental hygiene movement in South Africa, specifically, how international movements were grasped and adapted to suit the local social and political context. I have focused on some of the major role players and showed how they, as well as their international counterparts, easily slipped into the notion that science (and medicine) could go beyond its mandate to enter the murky realm of social engineering.

## **7 Mental Health Legislation in South Africa**

Replacing the various provincial Lunacy Acts, *The Mental Disorders Act 38 of 1916* unified control of all mental hospitals in South Africa under the Commissioner for Mental Hygiene. The first Commissioner was Dr J T Dunston, of whose ideological stance we are already aware.

There were seven classes of mental disorder covered under this Act:

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<sup>xxvii</sup> His speech (1908) was entitled 'Hygiene in South Africa' and linked the social aspects of medicine to nation building. Watkins-Pitchford envisioned a specific responsibility for doctors when it came to nation-building. He entrusted doctors with ensuring that the men of the future would have strong bodies and healthy minds. He also charges them with assisting to build a sound economy, quoting that 'the healthiest are also the wealthiest'.

- '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.*
- 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.*
- 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.*
- 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.*
- Class V A feeble-minded 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.*
- 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.*
- Class VII 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.'*

As part of the formalisation of the mental hygiene movement other institutional transformations were envisaged. For example, a departmental committee in 1936 was established to re-evaluate the conditions in mental institutions and to make recommendations. Specific hospitals were nominated as separate amenities for racial groups at this time.<sup>xxviii</sup>

The 1916 Act remained virtually unchanged for 57 years and the overlap of mentally ill and socially deficient persons continued under the umbrella of mental hygiene.<sup>xxix</sup> The treatment of persons with mental illness remained unchanged, with the focus remaining on custodial care.

### **7.1 Treatment Shifts and Politics**

As planning a successful treatment begins with accurate diagnostic assessment, the texts used for teaching and diagnostic purposes were important.<sup>xxx</sup> The advent of new diagnostic categories and the widespread uniform use of the *Diagnostic and Statistical Manual of Mental Disorders* (or DSM) diagnostic categories across South Africa meant that diagnosis could shift from the social “mish mash” to the purely clinical. These categories essentially allowed for the identification of social problems which had previously

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<sup>xxviii</sup> Fort Napier hospital, for example, was to be set aside for black patients only, while Townhill hospital was to be reserved for whites only. This did not occur, as funding became problematic at the advent of WWII. To uphold social policy and legislation, wards were segregated instead (Minde, 1975)..

<sup>xxix</sup> One change was that terminology was altered to keep pace with changing political and international norms. In 1944, *Amendments to the Act* replaced the term ‘moral imbecile’ with the term ‘socially defective person’, for example, and this term was expanded to include the diagnosis of psychopath.

<sup>xxx</sup> The American Psychiatric Association first published its Diagnostic and Statistical Manual of Mental Disorders in 1952. This was the manual utilised by South African teaching institutions and practitioners. The International Classification of Diseases (developed by the World Health Organization) was utilised by other Eurocentric countries. The manual was an attempt to standardize diagnosis and identify uniform cause and effect of mental illness (APA, 1980).

been the domain of the medical fraternity, and prevented the medicalising of social anomalies.

This meant that practitioners practiced medicine, and social issues became the domain of social and political structures. The changes were enthusiastically embraced by the mental health community, who were utilising the most up to date medical methods. It was felt that medical service provision to the mentally ill was of excellent quality.

Ever slow to adjust to change, South Africa only adjusted legislation to incorporate the 'new' diagnostic system in 1973. *The Mental Health Act of 1973* was perceived as being a positive and forward-looking act, unlike the previous. Mental illness became a broad term utilised instead of listing each separate class of defect and disorder. The concept of a voluntary patient was introduced, which it was envisioned most patients would be.

The Act allows for a person applying for a reception order to be only over 18 and not 21 as previously. Admission to psychiatric institutions shifted from medical practitioners to the law. Magistrates were given wide discretionary powers as to when and where they could commit patients, who could be placed in an institution anywhere in the country. Children could be committed to special school or schools with special classes for the mildly retarded, and patients could be committed to a relative instead of hospital if deemed appropriate.

In the case of a psychiatric patient requiring committal for treatment, modern legislation is meant to provide a platform of justice and fairness to the process of confinement for medical care. In the apartheid era, and during the period of the 1916 Act, however, the law effectively and apparently unintentionally conspired to provide a conduit for citizens without mental illness to be incarcerated for extensive periods for 'treatment'. This was often for what were minor social infringements. This places the legitimacy of the legal system during

this time under scrutiny, as oppressive governments often make use of the law to perform much of the process and practice of coercion (Ellmann, 1994).

The most important mechanism in erroneous detentions and placements was the on-the-ground policeman, who was given far reaching and often inappropriate powers of arrest and court appearance (Deacon, 2000). In the 1916 Act the definitions of the classes of person who could be deemed to have a mental illness made it possible to remove even mildly intellectually impaired persons, or persons with behaviour problems to institutional care. In Chapter 1, Section 6 (f) if a woman was a single mother and considered to fit any of the identifying classes of illness, the birth of an illegitimate child, or pregnancy while unmarried, was considered grounds for institutional care.

A legal concern would arise when if a person was arrested in the community under the influence of a substance – for example alcohol. Inebriation has been cited as one of the primary reason given for many admissions of black males to psychiatric facilities (Royal College of Psychiatrists, 1979). Two additional sources indicate that an excessively large number of long stay patients in custodial facilities may have been admitted for being under the influence of alcohol and or other substances.

The first is the *Tower House Report*, which indicates that the average patient admitted to the hospital was admitted for inebriated behaviour. These patients were often institutionalised for up to, in cases, 47 years (Dartnall, 1998). The second is a report from the APA, where their findings reflect that admissions to psychiatric hospitals were often made without formal medical diagnosis. This tends to indicate that the primary motivation behind many admissions were given by the arresting policeman and the magistrate before whom he appeared (WHO, 1983).

*The Prisons and Reformatories Act No. 13 of 1911* provided for social admissions to mental institutions, and provided a platform for what would

become the future Smith Mitchell long term custodial facilities. Chapter II of the Act, allowed that:

*(2) The Governor-General may establish chronic sick or hospital prisons for the treatment of convicts or prisoners who are sick, or epileptics, or mentally infirm, or who, for any other reason whatever, cannot with advantage be treated in the ordinary prisons or gaols....”*

The psychiatrist was not included in the process of admission from this source, as Chapter III provides a smooth process to immediate admission to gaols, which would have applied specifically to inebriated black patients:

*14. No superintendent or assistant superintendent or gaoler in charge of a gaol shall receive into his custody any person thereat except under*

*(e) in the case of an alleged lunatic, upon the production of an order authorizing or commanding the detention of the alleged lunatic at a gaol and issued under the provisions of any law for the detention of lunatics;*

*(f) In any other case, upon a warrant under the hand of any person authorised thereto by any law, or any order, rule or regulation, having the force of law.”*

In 1952, the *Black (Native) Laws Amendment Act No 54* provided that a person in violation of Section 29 of the *1945 Urn Areas Consolidation Act* could be sent to a rehabilitation centre if found to be idle or undesirable, and in an area designated for whites. No persons sent to a facility under this act could be discharged without input from the Governor-General. The Prisons Department had the duty of overseeing all work relating to the administration of facilities housing these patients.

In 1962, Smith Mitchell, a private hospital group<sup>xxx1</sup>, was given a contract by the Department of Mental Health to house and treat patients certified under the *Mental Disorders Act* – as licensed mental health containment facilities. Patients were later admitted under Sections 8 or 16 of the *Mental Health Act 1973*. This contract was designed to accommodate and treat predominantly African patients, despite government claims that the contracts applied to treatment of both white and black patients equally. Few chronic whites were housed in these institutions. Involuntary and long term committal to private institutions was the predominant form of mental health care for black patients (WHO, 1983).

The Smith-Mitchell Group made a substantial profit from the *per capita* payments from government. Savings were also made from use of patient labour for building maintenance and repair of the institutions. Subcontracting of patient labour to other firms also added to income. Patients did not benefit from this labour. Government income for these private facilities was dependent on the number of patients admitted and retained. Savings, however, were made with the implementation of discriminatory practice, which allowed the reduction in care and resources to black patients to be realised as profit. The system as it was, was open to abuse in line with the social and political abuse already present in the country (WHO, 1983).

A number of repudiating South African statements were made with regard to the lack of equality of service.<sup>xxxii</sup> A no-win situation evolved after a number of international enquiries and a report from the WHO in 1977 into the inequality of

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<sup>xxx1</sup> Which subsequently became Lifecare - now Life Esidemeni facilities.

<sup>xxxii</sup> These were, amongst others, from the *Medical Association of South Africa*, and the Chairman of the *Executive Committee of the Society of Psychiatrists of South Africa*. These were broadly that the political mores of the country had no effect on the treatment of psychiatric patients, which was free from discrimination on any grounds, be they race or religion. The concerns of a number of international agencies hinged on the alarmingly high number of deaths in these institutions (American Association for the Advancement of Science, 2007; WHO, 1983).

treatment between black and white psychiatric patients. In 1979, an open invitation was extended by the South Africa Department of Health to any established international bodies who would be interested in investigating the claims of abuse for themselves.

This was not taken up by international organisations, as a 1976 amendment to the 1973 Act gave the South African government powers to prosecute any person giving evidence of the psychiatric services. This section of the Act also provided a blanket sanction concerning mental health care professionals involved in the care of these 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 (WHO, 1983).

The APA sent out a small investigative committee in 1978 after being given assurances that they would not be prosecuted. They were not allowed to visit government hospitals, although they were permitted access to Smith Mitchell facilities. As white patients were predominantly treated in provincial facilities and black patients were treated in private facilities, their findings indicated that treatment between blacks and whites differed substantially.

This qualitative difference caused deaths of black patients on a scale that drew attention and comment from all of the investigating team members. Not because of overtly abusive practices, but rather from neglect of basic care, and worse, what appeared to be from practitioner incompetence – even in applying a minimal standard of care. The APA reported the following amongst other concerns to the WHO in 1983:

1. Most patients interviewed had never had a physical examination during their hospitalisation;
2. Part time psychiatrists responsible for black patients did not speak any African languages, and often there was no other professional staff member in the hospital who did.

3. The psychiatrist was often forced to make a diagnosis with the aid of an interpreter's rendition of the patient's responses. The interpreter was often a staff member with no psychiatric training – for example, a cleaner.
4. The training of white psychiatrists raised serious questions. Several of the white psychiatrists interviewed did not know what *tardive dyskinesia* was, even though their primary area of care was to maintain chronic psychiatric patients, many of whom were prescribed neuroleptics.
5. Medical records were inadequate, and often demonstrated the inadequacy of care provided to the predominantly black patients. The brief mental status examinations “were often totally incompatible with the recorded diagnosis”.

(WHO, 1983)

The abuse of patients was not specifically actively perpetrated by the psychiatrist – or medical practitioners in mental facilities. It was a combination of the lack of appropriate medical training, translator services and legal structures which permitted long term hospital stays which created a situation where abuse could occur. While integration of racial services was certainly required – the ethos of discharge was missing. Added to this was the lack of appropriate numbers of mental health care personnel in the private hospitals. There were no black psychiatrists to care for the predominantly black hospital population – and there were generally less staff in these hospitals than were found in provincial facilities.

Many of the admissions to hospital were young, black and male. These were diagnosed with substance abuse/ inebriation (Dartnall, 1998). Substance abuse psychosis obviously does not warrant a 47 year hospital stay – and this is where one area of abuse occurred – through overzealous application of outdated methods of treatment and through neglect of patients once they were admitted. The WHO Brazzaville report 1983 provides unreasonably high figures

of diagnoses of schizophrenia than is appropriate (59% compared to 29% in whites).

## **7.2 The Mental Disorders Act**

One of the developments by the *National Council for the Mental Hygiene and Care of the Feeble-minded for the Union of South Africa in 1916* was a *Mental Disorders Act* designed to protect these members of the community – and of course the community from them. In part, this Act was to prevent the feeble-minded – who were not the mentally ill, from admission to either police cells or wards in hospitals, but who were placed in other, partnership facilities for care and containment. Despite this Act, in 1980, numbers quoted by the WHO revealed 7122 mentally ill people in police cells (WHO, 1983).

It needs to be understood that what seemed to be appropriate legal process were certainly in place. In line with international practice persons presumed to have a mental illness were technically given the opportunity to defend their capacity before a magistrate. This process in South Africa however, was limited to appropriate interpretation services and available translation. The magistrate was not required to personally assess the person thought to be ill – and could rely on any person over eighteen to provide reasons why they thought that the person may be mentally ill. Reports from the South African Police Service were often the only witness accounts to so-called insane and dangerous behaviours, and this in itself, severely prejudiced many persons picked up and incarcerated for mental illness and the supposed danger to the public, when this may not have been the case.

The process of committal began most often with detention by the police for behaviour which they felt was indicative of mental illness. The judgments of these police officers were often racially biased and ideologically impaired to the detriment of the patient. The ability of the police to appropriately judge the need for a detention for mental health reasons needs to be considered as highly

prejudicial. The amount of inherent power of judgment given to policemen who often did not have a secondary education was ludicrous.

Policemen were for example given the power to judge to which racial group a person belonged. This process aided the policing of the *Group Areas Act No 41* of 1950, and required a judgment based purely on personal observation and not science. This *ad hoc* methodology is described by Shapiro in the *Journal for Medicine* in 1953 (Landis, 1961):

*“Where, for purposes of legal classification, the question arises whether a person is white, Colored, 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 an embarrassment to the Courts if not to himself.”*

The speed of the hospitalisation process also served to aid inappropriate hospitalisations, as this gave the courts power to immediately incarcerate persons *suspected* of mental illness in long term facilities. Lack of beds in long term institutions meant that patients were transported out of their provinces of origin. Family members and caregivers were often unable to find their family members again. Hospitals confidentiality policies prevented families from being able to contact hospitals to find out if their members had been admitted there.

The *Mental Health Act No. 18 of 1973* contained a number of qualifications which allowed various political and social misinterpretations to occur, which could result in hospitalisation in a long-term institution.

Section 13 of the 1973 Act, possibly as a reaction to the assassination of Dr Verwoerd in 1966, required that any medical practitioner who feared that a patient might be a danger to others be required to report this suspicion to the

nearest magistrate. Failing the availability of a magistrate, the practitioner was required to report to a police official, who would lay the said report before the magistrate on the practitioner's behalf. This meant that a third party would provide information which could certainly be misinterpreted or misrepresented by a non-medical person to a magistrate who would then make a decision based on erroneous information. This process has proved retrospectively to have been the means for numerous and inappropriate long-term custodial placements.

No single piece of legislation was responsible for the human rights abuses which occurred in mental health. There was a general confluence of measures which prepared a platform for these to occur. Legislation was also not independently what led to or which maintained these, but rather the interpretation and enforcement of overlapping, and often and seemingly unrelated legislation which provided the fertile environment for misuse.

Legislation in South Africa developed a racial bias from the late 1800's. The process of baasskap (or boss-ship) provided for policy to maintain generalised white supremacy and an adherence to Western/ European cultural norms. This while being besieged from all sides by a black majority and perceived savage hordes. The policies were largely promulgated to assist with electioneering, which was required to maintain Christian values and South African Nationalism. The implication was that by so doing the norms of civilization as defined by the rest of the modern world would be upheld (Landis, 1961).

The nature and labelling of the separation structures in legislation and politics changed after the World War II. This was in deference to the world's rejection of Germany's blatant racialism and outright segregationist policies and practices. The connotation of segregation in South Africa was "the division of racial groups in order to promote separate development and resource allocation".

**Summary** South African doctors joined the worldwide movement towards Eugenics and mental hygiene, many with great personal recognition and success. Dr J T Dunston, Dr Greenlees and Hendrik Verwoerd were amongst the well-known names. With the formalisation of the movement came the promulgation of the first mental health acts, the first in 1916 and the second in 1973. The Mental Health Act of 1973 provided a platform for political abuse by legal structures, abuse which was maintained and expanded on by the medical practitioners in mental health facilities.

## **8 Apartheid and Reflections**

Apartheid, as description of racial separation was introduced as a political policy in 1944. The name change was in reaction to both the rejection of the Nuremberg, and the acceptance that the previous policies of separation had not been a success. The description of segregation became couched in an almost rights orientated dogma - that of freedom and autonomy of all races to both grow and maintain own culture and lifestyle. The socio-political context of the country and the international drama playing out in Europe and the USA led to far reaching legal reform in South Africa, although this reform was punitive and exclusive rather than democratic and inclusive. As each new threat arose, it generated a political paranoia which had far-reaching legislative effects.

*The Mental Health Act 18 of 1973*, for example, provides a clear directive [ss20 (1-2) & ss21 (1-2)] that court application may be made if there is doubt as to the allegation of the persons mental status. Section 20 allowed the person detained to apply for an enquiry and appeal into the reasons for his detention. This, however, was not possible in many cases, as some legislation was made without inclusion of an appeal process! One of these cases was the *Black (Native) Laws Amendment Act No. 54 of 1952*, where, after being removed from an area where a person has been perceived to be idle, and being sent to a rehabilitation facility, there was no legal recourse to black persons, thus effectively preventing erroneous certifications.

The various Education Acts, and the formal *Black Education Act No 47 of 1953* over time provided clear and appropriate guidelines for care and provision of facilities for persons with intellectual disability – or who were feeble-minded. Reading these acts out of context there is little question of their sincerity to protect and provide service. However, the research of the time was clearly demonstrating an entire stratum of defective persons based on colour, leaving the door open to treat all coloured persons as intellectually disabled or feeble-minded. This in turn provided solid scientific and social grounds for changing the education system to provide a lower level of education for an obviously needy population group. The change to separate education streams for black and white students could therefore be seen to have developed, not necessarily based on colour – but on levels of ability. This was seen as an altruistic act rather than a racist one.

Government Acts from all sectors provided for provision of separate and discriminatory care. With separate doors on busses for whites and blacks in 1953 (*Reservation of Separate Amenities Act No 49 1953*), forced removals from areas designated as white and separate educational facilities *Black Education Act No 47 1953*, segregatory practices were the norm. It was not necessary for the *Mental Health Act of 1973* to contain specifications for racial separation, as these were inherent in the management process and urban structures. Different cost structures for black and white patients reflected the economic perceptions of what patients required by way of treatment (WHO, 1983).

There is no denying that the apartheid system and the abuses which took place caused many psychological and psychiatric problems in the general non-white communities. Dommissie (Dommissie, 1987) describes the end results of injuries and torture, when a number of people “have had to be admitted to psychiatric units for *real* (authors emphasis) mental symptoms following the ‘treatment’ they received at the hands of the security police”. There is no indication in the literature that the psychiatric community in mental health

services were involved in wholesale abuse of psychiatry for political ends, in fact, this is rejected by all of the committees who investigated allegations of political abuse (Royal College of Psychiatrists, 1979, American Association for the Advancement of Science, 2007).

There is therefore consensus that the hospitals and private institutions were not engaged in overt politically motivated psychiatric abuses. So what abuses were taking place in mental health? To investigate these, the political and economic context needs to be borne in mind. Many of the abuses reported were those which were based in the racially and class discriminatory thinking of the previous time, which had been carried over into general practice. This included segregation of patients on racial grounds.

The official segregation and downgrading of black treatment and the introduction of racist medicine around 1950 shifted mental health into an unethical phase driven by political and legislative impetus. Black patients were more likely to be admitted for behaviourally criminalised “symptoms” or be incarcerated after admission by the police than for observed clinical symptoms than were whites. Political and legislative intrusions into mental health care brought a strong shift towards racist and overtly unethical forms of treatment and care or non-caring. The move to punitive, restrictive, and correctionally orientated hospitalisations was a step back to the thinking of before World War II.

The overlapping of social and medical diagnostic categories was a convenient motivation for Smith Mitchell facilities to be utilised. The upliftment of whites became a non-issue as the quashing of ‘obdurate and wilful blacks’ became the politically but certainly not clinically or ethically driven motive for attention. .

### **8.1 Meditations Post-Apartheid**

In 1994, issues of ethics hit mental health practitioners and their processes with a bang. Reasons were demanded for the past behaviour of mental health care

practitioners. Would the reply that things were done just because that was the way of the world at the time suffice? Why not shift blame on the government's racist policies and like the Nazi's say 'I was just following orders'? Indeed, apartheid legislation was in place to verify the pressures under which medical personnel operated in all fields of medicine. Yet, mental health care differed from other areas of medical practice scrutinised post-apartheid.<sup>xxxiii</sup>

The mental health practitioners mandate was to provide care for the mentally ill persons sent to the hospitals by the courts. For example, If a person perceived to be a political dissident is found driving late at night after a curfew without lights, one might be justified in believing that the person could be committing an act against civil society, and be considered acting in a criminal manner. Similarly, if persons are found wondering aimlessly without accommodation and unable to make themselves understood, it would be more likely to suppose that they require care than incarceration, but during apartheid, they would most likely be incarcerated. The tenor of the times was such that most police officers acted wrongly. Many reasons have been put forth, for example, fear for themselves, for political favour, peer-pressure, selfishness or 'moral myopia'. My point is that the system was such that the 'law' in most cases made the determination of who was mentally ill.

For a patient to have been admitted by a magistrate – the situation surrounding the need for a forced admission would have had to be of such magnitude that removal of rights and lack of consultation with the patient would have been an option. Yet we know that the police were operating with a lack of mental health care knowledge and were working in a legal and political context - therefore apartheid reasoning flavoured their court presentations. Arrest of persons for social misdemeanour was and is legally acceptable. Lack of mental health care knowledge permitted the ordinary police officer to make a judgment of mental illness by virtue of the persons being unable to give an appropriate account of himself – often due to inebriation (an offence in itself) or because of language

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<sup>xxxiii</sup> See The Truth & Reconciliation Commission Report on the Health Care Sector.

restraint. This lack of knowledge led to unethical and erroneous court presentations. The courts often relied solely on the officer's testimony and to the social nuisance value or danger presented by the person. Also, having no knowledge of mental health, often not seeing the patient at all, and with rare exceptions a great force in the reigning political order, the magistrates simply continued feeding their own system.

Post-apartheid, we know that many of these incarcerated people, some after 40-odd years, had no diagnosis and woefully few notes written in their files (Royal College of Psychiatrists, 1979). Treatment had been provided in the form of medication and limited and outdated ward programmes. When faced with the two ethical choices – of one ought to perform act x (as in provide up to date and appropriate diagnosis and treatment) or one ought not to perform act x (as in not provide up to date and appropriate diagnosis and treatment) – the tragedy is that the majority of mental health care practitioners had chosen to perform neither with any conviction<sup>xxxiv</sup>.

In psychiatry, as in all branches of medicine, one of the most important tools to providing appropriate treatment is correct diagnosis of the patient. For this, there is a need for collateral information from family or social structures and most importantly communication with the patient to substantiate the collateral. Black patients were most often diagnosed as 'unknown' due to a lack of information. The nursing staff who were predominantly white, often did not understand their patients and were less likely to attempt to elicit information where there were language barriers (Swartz, 1995). Disorganised behaviour and the inability to provide an appropriate account of themselves (as per the *Mental Disorders Act 38 of 1916*) often led to pharmacological treatment for

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<sup>xxxiv</sup> This recursively leads back to the assessment of established practice. Alasdair MacIntyre (2003) who describes 'practice' as 'designating 'a cooperative arrangement in pursuit of goods that are internal to a structured communal life.' Standards at the core of these professions are the determinants of good practice. Perhaps the perception of standards of practice of mental health practitioners was less excellent than believed

schizophrenia . in many cases, no further investigations into possible alternative diagnosis were carried out (WHO, 1983).

Psychiatry is the treatment of persons who already have, at least potentially, some limitation on their rights established by virtue of their illness. Thus, they require special consideration as a vulnerable group. The ethical position of the clinicians caring for this vulnerable group include the obligation to exercise clinical judgments orientated (ethically, morally, and legally) beyond or exceeding ordinary patient care. It is not appropriate, for example, for a surgeon in any field, to force a patient to undergo treatment they do not want. Mental health patients, however, can be forced, by virtue of potential harm to self or others to undergo incarceration or undergo involuntary treatment without recourse, often because of the symptoms present due to their illness.

By 1989, conditions in the Smith Mitchell facilities had improved, although conditions in public institutions were inconsistent (American Association for the Advancement of Science, 2007). In 1995, a further report into conditions and allegations of abuse in these institutions was brought by the (Mental Health and Substance Abuse Committee, 1995). The abuses were numerous, ranging from racial discrimination to deficits in basic hygiene and sanitation facilities.

Another international delegation was sent to South Africa in 1996. This delegation focused on the state of mental health services, rather than human rights elements of care. The findings were that the services had not kept abreast of international trends. The institutional model was the only model utilised. There was no consumer and family participation in services or services provision. The suggestions were that deinstitutionalisation was imperative, and that technical assistance be provided to professionals regarding multi-disciplinary community based systems of mental healthcare, treatment protocols, and support for families and consumers. All of these advances in care were advances which could have been inculcated with South African professional's exposure to international peer practices - had that been possible.

The media focused on the mental health of torture victims and persons in criminal detention, this deflected attention from the majority of patients. Long-term patients remained in both private and state institutions. At this time, following international trends, and without great consultation with mental health care practitioners, The Department of Health began pressurising institutions to begin a process of discharging patients into the community as a matter of urgency.

The 'new' *Mental Health Care Act 17 of 2002* was a reaction to international rejection of institutionalism as abuse of human rights. It was also an attempt to provide a "rainbow nation" solution to the problem of prior psychiatric abuses. The issue of confinement in South Africa has a number of historic milestones, notwithstanding that Nelson Mandela was incarcerated for 27 years prior to becoming president. Interestingly, South Africa's Constitution has one of the most comprehensive sections on the rights of detained persons, possibly as a rejection of incarceration as a human rights abuse because of the period of the persons detained during the struggle years.

The most noteworthy changes to the act are semantic – for example, the *Mental Health Act of 1973* was committed to the 'reception, detention and treatment' of psychiatric patients, and the new Act provides for the 'care, treatment and rehabilitation'. This is reflected in the name – the *Mental Health Care Act 2002* which presents a concept of care versus mental health as a legislative entity.

Unlike the process in countries like the USA and the UK, mental health reform in South Africa has not been driven by social movements or an incensed medical fraternity as in other democratically orientated countries. There has been limited input by human rights NGO's, personal litigation and public attacks on outdated and abusive practices. All of the changes to the system to date have been driven by formal institutions with strong ties to government structures, for example the South Africa Federation of Mental Health (formerly

the Mental Hygiene Association), and with input from universities requested to participate in the drafting of the new policies.

I suggest that the development of the new legislation has been two-fold in purpose: (1) As a preventative measure by government to ensure that the scope for litigation was reduced and (2) to keep up, at least superficially, with mental health trends around the world. This appears to have been done for the sake of appearance rather than for the benefit of the patient. Little in the structure of the services has changed from 1973.

There have been instances in the popular press since the promulgation of the new Act which have highlighted very clearly the discrepancies between legislation and practice. Economics has again become an issue, but rather than a change in service to spread out the costs of certain groups of persons, the number of hospital beds available to all patients has been reduced, ensuring that all public patients are provided with mediocre service, regardless of colour.

The community facilities available to service users in 2007 are substandard. They have no uniform levels of practice and neither is there a uniform minimum standard of service provision for those in need of mental health care. From 2004, the number of patients who have been discharged into the open community from the Lifecare institutions is around nine thousand. They have been released into a system where community service has in fact reduced over time, and which has not been developed to cope with this discharge process. One needs to question the human rights objectives of the discharges in this case. The Constitution provides explicit guidelines with regard to the service provision and treatment imperatives for the disabled, particularly in the healthcare arena. Although the above has not been formally researched, steadily declining services in the mental health field are well known to practitioners.

Mental health care service users affect all aspects of government funding in the areas of social and health service provision and spending. These include for example, housing, provincial treatment for acute health conditions, transport provision, medication provision, and disability grants, to list only a few.

International experience of discharges into the community without simultaneously developing community facilities, committing fiscal resources and providing social service back up has proved to be at best, inefficient and at best disastrous (Lawrence, 2000). One could question the ethics of the legislation promoting deinstitutionalisation. Yet, the law has clearly stated that these persons, if determined not a danger to themselves and others, should be living in the community. The question remains, how are these people diagnosed? If they are not assessed properly then the chances are that we are sending mentally ill or mentally handicapped persons into an abyss of misery particularly given the current crime rates, unemployment, poverty, and HIV.

What is the moral responsibility of a practitioner who discharges an indigent and institutionalised person back into a community without sufficient support? Or is the practitioner simply stepping back, following orders? Ought the government add more responsibilities to already stretched communities? How should we as members of a democratic society respond to this?

What does need to be given cognisance is that there was not a modern ethics in play when we review historic psychiatric practices. There was not a foundation for prevention of human rights abuse. We developed a reactionary ethics borne of hindsight. The events of the day appeared to dictate the rightness and wrongness of actions, just as we capitulate to the beliefs of individuals, groups, and science today. And these may prove to be erroneous yet again. Our ethics may again be called into question. Generally we can say that we still fail to learn from our mistakes, neglect seeing common elements across history, stop paying attention to changes, and back off in reacting when

we are aware of wrongs. These faults lead us to repeat history, to obey the social order like lemmings – again to the sea.

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## **9 Conclusion**

In this research report I have presented an overview of mental health care in South Africa: the legislation influencing patient care. A limitation I did not entirely foresee when I began was in the unravelling of the complex networks of society – complex because they are human. In choosing to present my research in narrative form, I hope that the reader will discern the ethics in the text.

The trial of Josef Eichmann after WWII elicited lengthy commentary from Hannah Arendt that the abuse which occurred in Auschwitz was banal – everyday occurrences - just another day at work. The single issue of banality is not the point here, though. What is important is that, in contradiction of modern legal systems, intent to commit a crime is not a necessary condition for wrongdoing to occur (Arendt, 2006). I have tried to show that wrongdoing can also occur through negligence, from failure to remain abreast of both social and medical developments, from functional ignorance of political and international changes – and implementing them in treatment protocols. However, implementing protocols as a process is not enough.

Herbet Spencer describes a process which moves conduct from an ethically indifferent situation passing to a state of moral decision making. He writes:

*“Conduct in general being thus distinguished from the somewhat larger whole constituted by actions in general, let us next ask what distinction is habitually made between the conduct on which ethical judgments are passed and the remainder of conduct. As already said, a large part of ordinary conduct is indifferent. Shall I walk to the waterfall today? Or shall I ramble along the seashore? Here the ends are ethically indifferent. If I go to the waterfall, shall I go over the moor or take the path through the wood? Here the means*

*are ethically indifferent. And from hour to hour, most of the things we do are not to be judged as either good or bad in respect of either ends or means. No less clear is it that the transition from indifferent acts to acts which are good or bad is gradual. If a friend who is with me has explored the seashore but has not seen the waterfall, the choice of one or other end is no longer ethically indifferent. And if, the waterfall being fixed on as our goal, the way over the moor is too long for his strength, while the shorter way through the wood is not, the choice of means is no longer ethically indifferent. Again, if a probable result of making the one excursion rather than the other, is that I shall not be back in time to keep an appointment, or if taking the longer route entails this risk while taking the shorter does not, the decision in favor of one or other end or means acquires in another way an ethical character; and if the appointment is one of some importance, or one of great importance, or one of life-and-death importance, to self or others, the ethical character becomes pronounced. These instances will sufficiently suggest the truth that conduct with which morality is not concerned, passes into conduct which is moral or immoral, by small degrees and in countless ways.”*

What this suggests is that, combined with Arendt's description of the banality practice, and Spencer's shift from moral indifference to ethical significance, is that there was a period of mental health history where the practice of mental health care was an ethically indifferent specialty. Psychiatry by its own admission and in its own defence was practicing good medicine. At no stage did South African mental health admit to mediocre treatment protocols or lack of sufficient knowledge or skill.

The AAAS (American Association for the Advancement of Science, 2007) describes instances of abuse reported by medical practitioners e.g. the removal of drips from dehydrated patients. The Steve Biko incident is another example

of abuse by medical practitioners. These instances do not appear to apply if the reports from the TRC (de Villiers, 2003), and the AAAS (Chapman, 1998) are taken as the only context of physician practice. Not all clinicians defended the rights of their patients, fought for their rights to minimum standards of care, or were exemplary examples of the Hippocratic Oath in action. In fact, the process of mental healthcare practice in South Africa is very much as described by Arendt, 2006, as 'banal'.

There needs to be a grudging acceptance, no matter how difficult to understand in retrospect, of the lack of comprehension of wrongdoing found in repetitive tasks. This comprehension is borne of understanding of the context and placement of a judgment of either acceptable practice or unacceptable practice as mirrored either by peers, or by international practice and journals. The practice of life on a daily basis, and the practice medicine after university may become predictable, and conditions of work becomes heuristic<sup>xxxv</sup>. Yet understanding that within all that which is very predictability there lies a danger.

Raul Hillberg explains the slow implementation of minor rules, which converge to provide an overall blanket legal ideological framework for an abusive and inhumane society (Hillberg, 1961). The legal structure needed to underpin apartheid took a focused direction for around 30 years, even though the colonial racial and class foundations were present from the pre-1900s. Legislation in

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<sup>xxxv</sup> Daniel Kahneman was an Israeli-born psychologist who's primary interest was human financial decision making. In the late 1960s he began conducting research to increase understanding of how people make economic decisions. This on decision making under uncertainty resulted in the formulation of a new branch of economics, prospect theory. Using surveys and experiments, Kahneman showed that people were incapable of analyzing complex decision situations when the future consequences were uncertain. Instead, they relied on heuristic, or rule-of-thumb, shortcuts. In 2002 he shared the Nobel Prize for Economics with Vernon L. Smith (Kahneman, 2007). This theory has been applied to political decision making, errors in legislation, risk taking behaviors and many other areas where decision making have far reaching consequences.

South Africa's apartheid system was built on a mesh of Acts which had a foundational history spanning a number of years, with the credibility which that brings (Bunting, 1986). One has to pay active attention to the changes and results of these early underpinnings.

Regardless of the protestations that the best treatment was being provided under difficult conditions, all South African mental health care practitioners ought to have recognised the human condition. When faced with a patient coughing, or showing marked deterioration in function, whether mental or physical, there had to be a cognitive decision by the medical practitioner not to follow up on the observable symptoms and not to send for tests, provide a prescription, just not to check up. The markedly high number of deaths amongst these institutionalised psychiatric patients tells a story of neglect of observable symptoms by all of the hospital staff. This is where simple ethical behaviour - respect for others inexorably failed.

In closing, I am reminded of Descartes description of waking as he wrote in *Meditations on First Philosophy* (1584):

*"I am like a prisoner who is enjoying an imaginary freedom while asleep; as he begins to suspect he is asleep, he dreads being woken up, and goes along with the pleasant illusion as long as he can. In the same way, I happily slide back into my own opinions and dread being shaken out of them, for fear that my peaceful sleep be followed by hard labor when I wake, and that I shall have to toil not in the light, but amid the inextricable darkness of the problems I have now raised."*

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