HEALTH & DISEASES - MENTAL HEALTH

1991 - 1992

effect.

Family the focus of mental health plan

Star 17/1/91 88

Medical Reporter

An improvement of only five percent in the mental health of South Africans would save the country's economy R11 million a day, according to the National Council for Mental Health (NCMH).

The saving would be sufficient to pay for the total cost of mental illness in the country.

About 6 million people in the country could be described as mentally unhealthy. As the family is the core unit in society, where essential life skills are learnt, the family is the focus of the council's first public awareness campaign this year, says the NCMH.

On March 2 the opening address at a two-day conference in Johannesburg, on the theme "Family Health is Priceless", will be delivered by the Minister of Health, Dr Rina Venter.

The first day of the conference is aimed at families, while the second, Monday March 4, is aimed at professionals and the business sector.

People who are interested in attending the conference should telephone (011) 725-5800 for more information before February 20.

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902

…, 192 members stood … terms of Prisons Regulation …(1)(hh) read together with section 53 of the Prisons Act, 1959 (Act 8 of 1959) on counts of assault on prisoners. Of these, 121 members were found not guilty whilst 71 members were found guilty and were sentenced in terms of s 53(2) of the Prisons Act.

During 1990, 239 members stood trial in terms of Prisons Regulation 71(1)(hh) read together with section 53 of the Prisons Act, 1959 (Act 8 of 1959) on counts of assault on prisoners. Of these, 182 members were found not guilty whilst 57 members were found guilty and were sentenced in terms of section 53(2) of the Prisons Act.

In respect of 1 929 of the total number of complaints, no substance could be found after thorough investigation to lay charges against any member of the Department. Furthermore, the Attorney-General refused to prosecute in 477 cases. On 31 December 1990, the remaining cases were still being dealt with

(2) (b) Inquiries in terms of the stipulations of Prisons Regulation 77(1) to determine the suitability of members to remain in service, inter alia led to the dismissal of respectively one (1989) and two (1990) members against whom offences of assault on prisoners were recorded.

(c) Besides sentences imposed in terms of section 53 of the Prisons Act, 1959 (Act 8 of 1959) during departmental … members were …rts due to com- … prisoners. Of …e found not … were found … trials, members were seriously warned against such actions and were made aware of the implications thereof on their careers. Furthermore, such inadmissible conduct is duly considered in the competence evaluation of such members.

Medunsa: psychiatric hospital

206. Mr M J ELLIS asked the Minister of National Health:

Whether a psychiatric hospital has been built at the Medical University of Southern Africa; if not, what is being planned in this regard; if so, (a) (i) when and (ii) at what cost was it completed, (b) what is the average bed occupancy rate and (c) what are the future plans for this hospital? B553E

The MINISTER OF NATIONAL HEALTH:

Yes,

(a) (i) a sixty-bed psychiatric unit was completed on 26 October 1989 and

(ii) R3 954 881,04,

(b) the unit is temporarily used as an exchange ward whilst upgrading of various wards in Ga-Rankuwa Hospital are being carried out and

(c) Branch Health Services of the Provincial Administration of the Transvaal proposes to commission this unit as soon as funds become available.

Ratio of beds per medical student

207. Mr M J ELLIS asked the Minister of National Health:

What is the ratio of beds per medical student doing clinical training (a) at the academic hospital complexes attached to the medical faculties in South Africa and (b) at each such hospital complex? B554E

The MINISTER OF NATIONAL HEALTH:

	BEDS PER STUDENT
(a) Provincial Administration of the Cape of Good Hope	: 3,12
Provincial Administration of the Transvaal	: 6,60

	BEDS PER STUDENT
Provincial Administration of Natal	: 6,29
Provincial Administration of the Orange Free State	: 5,27 and
(b) *Provincial Administration of the Cape of Good Hope*	
Groote Schuur	: 3,38
Tygerberg	: 2,88
Provincial Administration of the Transvaal	
University of the Witwatersrand	: 8,80
University of Pretoria	: 4,30
Medical University of Southern Africa	: 6,60
Provincial Administration of Natal	
King Edward VIII	: 6,29
Provincial Administration of the Orange Free State	
Bloemfontein	: 5,27

Algoa Regional Services Council: investigation

223. Mr E W TRENT asked the Minister of Planning, Provincial Affairs and National Housing:

(1) Whether the Finance and Administration Committee of the Algoa Regional Services Council instituted an investigation into the disbursement of funds in 1989 or 1990; if so, when;

(2) whether any members of staff are alleged to be implicated in any irregularities; if so, (a) in what irregularities and (b) what measures have been taken as a result? B588E

The MINISTER OF PLANNING, PROVINCIAL AFFAIRS AND NATIONAL HOUSING:

(1) No.

(2) Yes.

(a) A member of staff was involved in irregularities in connection with council funds.

(b) Legal steps were taken against the official involved. He was found guilty, convicted and discharged from the service of the Regional Services Council. Stricter control measures were introduced in that auditing of the financial books of the Council is done regularly on a monthly basis.

Military hospitals: bed capacity/occupancy rate

233. Mr R R HULLEY asked the Minister of Defence:

What was the (a) total bed capacity and (b) bed occupancy rate, expressed as a percentage, of military hospitals as at the latest specified date for which figures are available? B551E

The MINISTER OF DEFENCE:

The information, as at 20 March 1991, is as follows:

	(a)	(b)
1. Military Hospital	623	47%
2. Military Hospital	293	46%
3. Military Hospital	173	56%

Afforestation applications

254. Mr M J ELLIS asked the Minister of Water Affairs and Forestry:

(a) How many afforestation applications were received by his Department in each province in 1990, (b) (i) how many of these applications were approved and (ii) for which areas were they approved in each case and (c) (i) how many applications were refused and (ii) for what reason was each application refused? B673E

(c) Indian
(i) 5 (ii) 5
(d) Black
(i) 179 (ii) 179

(bb) LEGAL TRAINING
(a) White
(i) 195 (ii) 175
(b) Coloured
(i) 5 (ii) 3
(c) Indian
(i) 3 (ii) 3
(d) Black
(i) 6 (ii) 5

Sterkfontein Psychiatric Hospital: patients missing

239. Mr P G SOAL asked the Minister of National Health:

(1) Whether any patients went missing from the Sterkfontein Psychiatric Hospital during the latest specified period of five years for which information is available; if so, (a) how many (i) male and (ii) female patients and (b) how many such patients were classified as (i) dangerous and (ii) aggressive;

(2) whether any steps have been taken to ensure that patients do not go missing from the said hospital; if not, why not; if so, what steps;

(3) whether she will make a statement on the matter?

B624E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Yes,
(i) 443 male and
(ii) 70 female
The above include patients who have escaped, broken out, absconded and ones that were allowed to go out on leave, but did not return and

(b) (i) and (ii) the relevant information is not readily available;

(2) yes, dangerous patients are locked up. All others are attended to in open wards and may move about freely. The hospital has no guards patrolling the grounds; neither does it have security fencing or gates. The reason for this is that hospitals must not be looked upon as prisons;

(3) no.

Academic hospitals: bed occupancy rate

251. Mr M J ELLIS asked the Minister of National Health:

What is the annual bed percentage occupancy rate at each academic hospital in South Afria?

B658E

The MINISTER OF NATIONAL HEALTH:

Provincial Administration of the Cape of Good Hope:	*Percentage Bed Occupancy*
Groote Schuur	95,21
Tygerberg	107,93
Provincial Administration of Natal:	
King Edward VIII	91,20
Provinial Administration of the Transvaal:	
Baragwanath	86,40
Coronation	83,50
Ga-Rankuwa	86,40
HF Verwoerd	63,80
Hillbrow	80,10
JG Strijdom	31,70
Johannesburg	80,80
Kalafong	76,00
Provincial Administration of the Orange Free State:	
Pelonomi	91,57
Universitas	65,89
National	60,14

Malaria/typhoid/cholera

255. Mr M J ELLIS asked the Minister of National Health:

(1) Whether there was any increase in the incidence of (a) malaria, (b) typhoid and (c) cholera in the Republic in 1990; if so, (i) to what extent, (ii) in which areas and (iii) how many cases of each disease were diagnosed in each area;

(2) whether any persons died of these diseases during this period; if so, how many

in each race group in respect of each disease;

(3) whether any steps are being taken to combat the spread of these diseases; if so, what steps in each specified area?

B674E

The MINISTER OF NATIONAL HEALTH:

(1) (a), (b) and (c) No;
(i), (ii) and (iii) fall away;

(2) yes,
notified deaths of Malaria in the Republic of South Africa by Population Group, 1990 (as on 20 March 1991)

Population group	*Number of deaths*
Indian	0
Black	27
Coloured	0
White	3
TOTAL	30

Notified Deaths of Typhoid fever in the Republic of South Africa by Population Group, 1990 (as on 20 March 1991)

Population group	*Number of deaths*
Indian	0
Black	28
Coloured	0
White	0
TOTAL	28

(3) yes,
Malaria:
— Disease surveillance.
— Case finding.
— Health Education.
— Encouragement to take prophylactic treatment.
— Vector control.
— Treatment of persons suffering from malaria.
— Notifiable disease.

Typhoid:
— Disease surveillance.
— Case finding: Treatment and isolation of cases to save lives and reduce further excretion of organisms.
— Tracing of carriers and contacts to prevent infections and reduce further excretion of organisms.
— Immunisation is indicated in certain circumstances, examples being exposure to a carrier, outbreaks of typhoid in a community or institution and in the case of groups such as military forces in field conditions.
— Health Education.
— Advice with regard to environmental factors
— Participation in Interdepartmental Committee, providing advice to the authorities responsible for service.
— Notifiable medical condition.

Cholera:
— Disease surveillance.
— Tracing of source.
— Case finding.
— Health Education.
— Treatment of cases.
— Notifiable medical condition.
— Co-ordinated action with all health services to prevent crossborder spread of cholera.

Care of patients by community health workers

259. Miss M SMUTS asked the Minister of National Health:

(1) Whether a senior official of the Department of National Health and Population Development stated in June 1990 that up to 60 per cent of patients treated at hospitals in South Africa could be cared for by community health workers; if so, (a) on what evidence was this statement made and (b) what is the rank of the official concerned;

(2) whether she will make a statement on the matter? B685E

The MINISTER OF NATIONAL HEALTH:

(1) (a) and (b) Dr H J Steyn, Deputy Director-General of the Department of National Health and Population Development, said, during a seminar in June 1990, that the work load of a clinic nurse, could be alleviated by up to 60% by the use of community health workers and voluntary workers. This statement was based on a study carried out at a clinic where community health workers did the follow-up visits at the homes of tuberculosis and family planning clients so that the nurse could carry out her clinic functions;

(2) no.

No. 50, 1991

DECLARATION OF CERTAIN MATTERS TO BE OWN AFFAIRS OF THE WHITE POPULATION GROUP AND ASSIGNMENT OF ADMINISTRATION OF THE MENTAL HEALTH ACT, 1973 (ACT No. 18 OF 1973), TO THE MINISTER OF HEALTH SERVICES: HOUSE OF ASSEMBLY

Under subsection (3) of section 98, read with subsection (4) of that section, and section 16, of the Republic of South Africa Constitution Act, 1983 (Act No. 110 of 1983), I hereby—

(a) declare, after consultation with the Executive Committee of the Province of Transvaal, that the provisions of Part IV of the said Constitution Act, 1983, shall apply to the Mental Health Act, 1973 (Act No. 18 of 1973), which was assigned by Proclamation No. 60 of 31 March 1988 for administration in or in respect of the province of Transvaal to the Administrator of that province, and as amended by the said Proclamation, in so far as the provisions of the Mental Health Act, 1973, relate to the White population group and the Witrand Care and Rehabilitation Centre, Potchefstroom;

(b) assign the administration of the provisions of the Mental Health Act, 1973, mentioned in paragraph (a), to the extent indicated in that paragraph, to the Minister of Health Services: House of Assembly;

(c) determine that the Minister of Health Services: House of Assembly and the Department of Health Services and Welfare, Administration: House of Assembly shall be deemed to be the successor in title to the Administrator and Provincial Administration of the Province of Transvaal, respectively, in respect of all assets, money, liabilities, rights and obligations which immediately prior to the commencement of this Proclamation under, in terms of or by virtue of a provision of the said Mental Health Act, 1973, assigned under paragraph (b), vested in the said Administrator or Administration, as the case may be;

(d) determine that any unexpended moneys appropriated by Parliament in respect of the financial year ending 31 March 1992, in connection with the administration of a provision of the said Mental Health Act, 1973, assigned under paragraph (b) and in respect of a matter mentioned in paragraph (a) shall be deposited in the Revenue Account: House of Assembly, referred to in section 2 (l) (b) (i) of the Exhequer Act, 1975 (Act No. 66 of 1975);

(e) determine that in the application of a provision of the said Mental Health Act, 1973, assigned under paragraph (b), unless clearly inappropriate, any reference in such provision—

(i) to the Administrator, shall be construed as a reference to the Minister of Health Services: House of Assembly;

(ii) to the Executive Director of Hospital Services, shall be construed as a reference to the Head of the Department of Health Services and Welfare, Administration: House of Assembly;

No. 50, 1991

VERKLARING VAN SEKERE AANGELEENTHEDE TOT EIE SAKE VAN DIE BLANKE BEVOLKINGSGROEP EN OPDRA VAN UITVOERING VAN DIE WET OP GEESTESGESONDHEID, 1973 (WET No. 18 VAN 1973), AAN DIE MINISTER VAN GESONDHEIDSDIENSTE: VOLKSRAAD

Kragtens subartikel (3) van artikel 98, saamgelees met subartikel (4) van daardie artikel, en artikel 16, van die Grondwet van die Republiek van Suid-Afrika, 1983 (Wet No. 110 van 1983)—

(a) verklaar ek hierby, na raadpleging van die Uitvoerende Komitee van die provinsie Transvaal, dat die bepalings van Deel IV van vermelde Grondwet, 1983, van toepassing is op die Wet op Geestesgesondheid, 1973 (Wet No. 18 van 1973), wat by Proklamasie No. 60 van 31 Maart 1988 vir uitvoering in of met betrekking tot die provinsie Transvaal aan die Administrateur van dié Provinsie opgedra is, en soos by genoemde Proklamasie gewysig in soverre die bepalings van genoemde Wet op Geestesgesondheid, 1973, betrekking het op die Blanke bevolkingsgroep en die Witrandsorg-en-Rehabilitasiesentrum, Potchefstroom;

(b) dra ek hierby die uitvoering van die bepalings van die Wet op Geestesgesondheid, 1973, in paragraaf (a) vermeld, in die mate in daardie paragraaf aangedui, aan die Minister van Gesondheidsdienste: Volksraad op;

(c) bepaal ek hierby dat die Minister van Gesondheidsdienste: Volksraad en die Departement van Gesondheidsdienste en Welsyn, Administrasie: Volksraad geag word die opvolger-in-regte te wees van, onderskeidelik, die Administrateur en die Provinsiale Administrasie van die Provinsie Transvaal, ten opsigte van alle bates, geld, laste, regte en verpligtinge wat onmiddellik voor die inwerkingtreding van hierdie Proklamasie kragtens, ingevolge of uit hoofde van 'n bepaling van genoemde Wet op Geestesgesondheid, 1973, kragtens paragraaf (b) opgedra, by vermelde Administrateur of Administrasie, na gelang van die geval, berus het;

(d) bepaal ek hierby dat enige onbestede gelde wat deur die Parlement ten opsigte van die boekjaar wat op 31 Maart 1992 eindig, in verband met die uitvoering van 'n bepaling van genoemde Wet op Geestesgesondheid, 1973, kragtens paragraaf (d) opgedra en ten opsigte van 'n aangeleentheid in paragraaf (a) vermeld, bewillig is, in die Inkomsterekening: Volksraad, bedoel in artikel 2 (l) (b) (i) van die Skatkiswet, 1975 (Wet No. 66 van 1975), gestort word;

(e) bepaal ek hierby dat by die toepassing van 'n bepaling van genoemde Wet op Geestesgesondheid, 1973, kragtens paragraaf (b) opgedra, tensy dit klaarblyklik onvanpas is, 'n verwysing in so 'n bepaling—

(i) na die Administrateur, uitgelê word as 'n verwysing na die Minister van Gesondheidsdienste: Volksraad;

(ii) na die Uitvoerende Direkteur van Hospitaaldienste, uitgelê word as 'n verwysing na die Hoof van die Departement van Gesondheidsdienste en Welsyn, Administrasie: Volksraad; en

(iii) to the *Official Gazette*, shall be construed as a reference to the *Gazette;*

(f) determine that this Proclamation shall come into operation on 1 July 1991.

Given under my Hand and the Seal of the Republic of South Africa at Cape Town this Twenty-second day of May, One thousand Nine hundred and Ninety-one.

F. W. DE KLERK,

State President.

In relation to paragraph (a), and (c) to (f), inclusive, of this Proclamation: By Order of the State President-in-Cabinet:

E. H. VENTER,

Minister of the Cabinet.

GOVERMENT NOTICES

DEPARTMENT OF FINANCE

No. 1284 **7 June 1991**

FINANCIAL SERVICES BOARD ACT, 1990
(ACT No. 97 OF 1990)

AMENDMENT OF NOTICE OF LEVIES ON FINANCIAL INSTITUTIONS

I, Barend Jacobus du Plessis, Minister of Finance, hereby make known that I have, under section 16 (1) (b) of the Financial Services Board Act, 1990 (Act No. 97 of 1990), approved the levies imposed by the Board under that section, as set out in the Schedule hereto.

B. J. DU PLESSIS,

Minister of Finance.

SCHEDULE

1. In this schedule "the Levies" means the levies published by Government Notice No. 694 of 28 March 1991.

2. Item 1 of the Levies is hereby amended—

(a) by the insertion in subitem (1) after the words "such fund" of the following expression:

"[excluding a person for whom the entire annuity has been purchased from an insurer registered in terms of the Insurance Act, 1943 (Act No. 27 of 1943)]"; and

(b) by the substitution for subitem (2) of the following subitem:

"(2) The number of members and other persons referred to in subitem (1) shall correspond with the latest statistics in the return furnished or to be furnished to the Registrar of Pension Funds in terms of regulation 12 (h) of the regulations promulgated by Government Notice No. R. 98 of 26 January 1962, or Government Notice No. R. 99 of 26 January 1962 in the case of funds which are exempted, in terms of section 2 (3) (a) (ii) of the Pension Funds Act, 1956, from certain provisions of this Act.".

3. Item 3 of the Levies is hereby amended—

(a) by the insertion after the word "registered" of the words "or provisionally registered"; and

(iii) na die *offisiële koerant*, uitgelê word as 'n verwysing na die *Staatskoerant*;

(f) bepaal ek hierby dat hierdie Proklamasie op 1 Julie 1991 in werking tree.

Gegee onder my Hand en die Seël van die Republiek van Suid-Afrika te Kaapstad, op hede die Twee-en-twintigste dag van Mei Eenduisend Negehonderd Een-en-negentig.

F. W. DE KLERK,

Staatspresident.

Met betrekking tot paragrawe (a), en (c) tot en met (f), van hierdie Proklamasie: Op las van die Staatspresident-in-Kabinet:

E. H. VENTER,

Minister van die Kabinet.

GOEWERMENTSKENNISGEWINGS

DEPARTEMENT VAN FINANSIES

No. 1284 **7 Junie 1991**

WET OP DIE RAAD OP FINANSIËLE DIENSTE, 1990 (WET No. 97 VAN 1990)

WYSIGING VAN KENNISGEWING VAN HEFFINGS OP FINANSIËLE INSTELLINGS

Ek, Barend Jacobus du Plessis, Minister van Finansies, maak hierby bekend dat ek kragtens artikel 16 (1) (b) van die Wet op die Raad op Finansiële Dienste, 1990 (Wet No. 97 van 1990), die heffings opgelê deur die Raad kragtens genoemde artikels soos in die Bylae hierby uiteengesit, goedgekeur het.

B. J. DU PLESSIS,

Minister van Finansies.

BYLAE

1. In hierdie Bylae beteken "die Heffings" die heffings gepubliseer by Goewermentskennisgewing No. 694 van 28 Maart 1991.

2. Item 1 van die Heffings word hierby gewysig—

(a) deur in subitem (1) na die woord "ontvang" die volgende uitdrukking in te voeg:

"[uitgesluit 'n persoon vir wie die volle annuïteit van 'n versekeraar geregistreer ingevolge die bepalings van die Versekeringswet, 1943 (Wet No. 27 van 1943), aangekoop is]"; en

(b) deur subitem (2) deur die volgende subitem te vervang:

"(2) Die getal lede en ander persone in subitem (1) bedoel, moet ooreenstem met die jongste statistiek in die opgawe wat ingedien is of wat ingedien staan te word by die Registrateur van Pensioenfondse ingevolge regulasie 12 (h) van die regulasies afgekondig by Goewermentskennisgewing No. R. 98 van 26 Januarie 1962, of Goewermentskennisgewing No. R. 99 van 26 Januarie 1962 in die geval van fondse wat ingevolge artikel 2 (3) (a) (ii) van die Wet op Pensioenfondse, 1956, vrygestel is van sekere bepalings van dié Wet.".

3. Item 3 van die Heffings word hierby gewysig—

(a) deur na die woord "geregistreer" die woorde "of voorlopig geregistreer" in te voeg; en

BEHIND THE MENTAL HOSPITAL WALLS, A TRAGEDY OF NEGLECT AND UNDERSTAFFING

SA's 6-m mentally ill face a shortage of psychiatrists

w/Mail 7/6 - 13/6/91.

Nearly 6-million South Africans suffer from mental illness, but there are far too few psychiatrists and psychologists to treat them.

By GAVIN EVANS

NEARLY 400 000 South Africans are believed to be suffering from serious mental disorders but there are only 1 131 psychologists and 322 psychiatrists registered to treat them.

According to the World Health Organisation, one percent of any population is likely to be suffering from a seriously incapacitating mental disorder at any time and 10 percent at some time in their lives.

Psychologist Melvyn Freeman, from Wits University's Community Health Department, says that based on conservative estimates, 15 percent of South Africans (nearly 6-million people) are suffering from mental illness, with one percent (up to 400 000) being classified as serious.

This would suggest a ratio of psychiatrists to seriously incapacitated patients of 1:1 250 (compared with 1:190 in Britain and 1:80 in the United States).

This shortage is made even more severe by the fact that most of these specialists are working in the urban, private sector — and many of those registered with the South African Medical and Dental Council have in fact emigrated recently.

"Eighty percent of the population have to rely on state health, yet only about 100 psychologists are employed by the state sector. The situation is even more chronic in the homelands where 20 psychologists serve a population of about seven million people," says Freeman.

According to the Department of National Health, 21 643 patients are currently in state or provincial psychiatric hospitals, state-subsidised hospitals for chronic patients owned by Lifecare and other private psychiatric facilities. This does not include patients receiving treatment in private or provincial general hospitals or those in the "independent homelands".

In addition, there were 556 171 patient visits to 700 psychiatric clinics or outpatient departments during 1989.

A major problem, says Freeman, is the duplication of mental health facilities under apartheid.

"Patients are often transferred from a provincial hospital to 'own affairs' community care on discharge, causing wasteful duplication and bureaucracy with consequent prejudice to patient care.

"For example, a white patient from Krugersdorp who is discharged from the nearby Sterkfontein Hospital will have to travel to Johannesburg to be treated because Sterkfontein, a provincial institution, can't provide community services. Instead these are provided by 'own affairs' structures for whites, Indians and coloureds, and general affairs for blacks — and white own affairs community services don't yet exist in Krugersdorp."

There are currently plans to do away with the 'own affairs' system and introduce a three-tier system of academic, provincial and local mental health care.

The majority of patients resident in mental hospitals are certified in terms of the Mental Health Act.

In addition to patients deemed incapable of consent, and the country's 1 209 State President's prisoners (those committed to a mental hospital on the order of a criminal court) there are several thousand others who are involuntarily confined to mental institutions because they are deemed to be mentally ill.

BEHIND THE MENTAL HOSPITAL WALLS, A TRAGEDY OF NEGLECT AND UNDERSTAFFING

An atmosphere of general neglect

'If a patient dies, his space will soon be filled.' CISKA MATTHES visits a black psychiatric hospital and finds health workers eager to expose what they consider to be unacceptable conditions

IN a ward of the Randfontein Sanatorium a woman missing a leg drags herself across the floor, leading an old blind woman to the toilet.

The blind woman pulls up her dress and squats in the passage but jumps up when a nurse yells at her from the distance. The nurse does not attempt to assist either woman.

Two old women pass slowly, dragging a third by her armpits and knees, as if she were dead. Her old hospital uniform is pulled up, revealing bruises on her bare legs and buttocks. She is wearing no underwear.

"That one can't walk either," a nurse comments, adding "but they care for each other like mothers."

The ward is packed with low iron beds, about 20cm apart. There are no cupboards and no chairs.

This is the ward for the crippled and the blind in Randfontein Sanatorium, a black psychiatric hospital in the Transvaal. It is owned by Lifecare Clinics (Pty) Ltd, a private company hired by the government to provide psychiatric care.

The Weekly Mail visited Randfontein Sanatorium for female patients as well as Millsite Sanatorium for children and males. At both hospitals several healthworkers seemed eager to expose what they felt were unacceptable conditions. Lifecare has strongly denied most of their allegations, including those confirmed by eyewitness accounts of *Weekly Mail* reporters.

For instance, no wheelchairs or crutches appeared to be readily available for crippled patients. But, according to Lifecare, "all crippled patients do get wheelchairs or crutches, except for those who are unable to use them".

The sanatorium buildings are old, brick mine compounds, with low corrugated iron roofs. Outside, patients lie around on the concrete yard.

Staff members said the patient death rate is exacerbated by general negligence, but these cases are seldom properly investigated.

"If a patient dies, who cares," one of the workers commented. "There is a waiting list and his space will be filled again soon enough."

In April this year, for example, a male patient in Millsite was burnt beyond recognition while lying on his bed in the hospital war. Staff only detected the fire when it was too late.

A Lifecare representative confirmed that a male patient died in a fire in April. "The staff immediately notified the police, the fire brigade and Lifecare management and their swift action prevented the fire from spreading. The police are investigating the cause of the fire — thought to have been started by the patient (or patients) smoking in the ward."

The death rate is high in winter, health workers claimed, because of poor conditions in the hospitals.

- There is no hot water, and many sections lack heating.
- The hospital provides no underwear; many patients have no shoes, jerseys or pyjamas.
- The diet is poor, consisting of dry bread and porridge for breakfast, and hot meals that are tasteless and watery.

But according to Lifecare: "All patients are issued with vests, daywear, jerseys and pyjamas. They are given two pairs of shoes per year. Some patients prefer not to wear them or barter them for tuckshop money or cigarettes."

A psychiatrist, who worked for Lifecare until recently and visited Millsite once a week, said that in general conditions were acceptable. "The main complaint I would make is that the medical staff is too small and the nurses know too little about the patients," he said.

Health workers at Millsite and Randfontein said the patients are made to work because of the staff shortage. During night duty, for example, there are only five or six nurses to take care of a ward with up to 300 patients, many of whom are epileptic or incontinent.

"In some areas there are no cleaners at night," one of the health workers said, "and there the better patients must clean up the faeces and urine that others may have dropped on the floor. Patients have been dehumanised totally. The nurses can make them do anything. They work like robots."

Commenting on the work issue, a Lifecare representative said: "The practice of allowing patients to do jobs for money (including occupational therapy) was discontinued years ago. Many patients resented losing their 'jobs' and a few (less than two percent) have been allowed to do voluntary work in the laundry or kitchen, although this places an extra burden on staff in terms of supervision. They are then paid from the occupational therapy budget."

Staff members mentioned the nurses' jargon: patients that are called "good" are the "workers". They are given extra food, or they receive shoes, and some earn a few rand per month. The patients that are too ill to work are called "lazy"; they are neglected.

Patients are also divided into "clean patients" and "wet and dirts", who are seldom washed.

"They smell very bad. They are repulsive, so you shout at them and you push them away when they approach you," said a health worker, who added there were no baths in many sections.

"The nurses have to push them under the cold water. Some patients get a fright and run away. The nurses just leave them. For them, that's minus one problem."

Because there is so little supervision, patients injure themselves or fight with each other, health workers said.

Patients in the two sanatoria are all "certified" and classified as chronic — psychotic, retarded or senile.

Some have been in the care of Lifecare and its predecessors for decades, according to staff members, and have been moved around the country from one institution to another. "Sometimes patients try to escape, because they dream of going back to their families."

With only four psychiatrists (two part-time) and no psychologists for the 3 000 or more patients of Millsite, little therapy is provided other than medication, staff members said: "When a patient is 'difficult', he is simply given extra medication."

They claimed there is no rehabilitation programme.

Lifecare commented: "It is true there are four psychiatrists at Millsite. There are only 200 qualified psychiatrists available in South Africa. In addition, until recent legislation changed this, no private hospital could employ doctors or psychiatrists."

They added that they will soon be getting two more psychiatrists from overseas, and three more have been approached.

But psychologist Melvyn Freeman, from Wits University's Health Policy unit, stated that many of these "chronic" psychiatric patients could be cured: "Perhaps a minority should indeed be under custodial care, but the majority of them are made into custodial patients. They should receive proper treatment, including medical and psychological care."

The psychiatrist who used to work for Lifecare rejected this: "Lifecare's patients are given all help that exists."

Lifecare is the biggest private owner of psychiatric hospitals in South Africa. It accommodates about 9 000 state patients, all of whom are chronic. Millsite and Randfontein sanatoria cater for about 4 000 black patients. Lifecare makes its profit from what the government pays for the care for the patients. according to Lifecare, less than R50 per patient per day.

In 1975 several newspapers exposed conditions at Lifecare hospitals (at the time called Smith, Mitchell and Co), alleging that they were "making millions out of madness". The reports included allegations that patients worked for over 11 hours a day and slept on grass mats on the floor in converted mine compounds. The present-day hospitals are on the same sites.

The government at the time promised to build five new state-run hospitals in order to dispense with the services of Smith, Mitchell and Co. But these hospitals have never been built.

Instead, the Mental Health Act was amended in 1976 to prevent conditions in psychiatric hospitals from being publicly discussed and criticised.

Lifecare said it had "initiated substantial changes in the facilities since the late 1960s when the state asked (us) to take over and manage such facilities". The claim they were making millions was "absolute nonsense".

Barefoot patients meander through a hospital garden. Due to the secrecy which surrounds mental institutions, photographer KEVIN CARTER had to hide on the roof of a nearby building to take this picture

The children who died in care

By GAVIN EVANS

AT least 35 mentally retarded children and youths died at the Millsite Sanatorium between July 1988 and November 1990 — 24 of them as a result of pneumonia, tuberculosis and other respiratory complaints.

This information was provided by a Millsite healthworker, who said the patients were between five and 27 years old. *The Weekly Mail* has obtained independent verification of this claim.

The healthworker said this reflected only about two thirds of the total number of children who died in this period. Many died at the Leratong Hospital, while several others have died at the Millsite Sanatorium over the past six months.

Pneumonia and bronchial pneumonia were the most common causes of death listed. Tuberculosis, asthma, bronchitis and pulmonary oedema were also common. Other causes listed included epilepsy, septicaemia, anaemia, "natural causes" and "sudden death".

The staff member, who asked not to be named, said cold conditions and inadequate food were mainly responsible for the high number of deaths due to respiratory problems.

"First, the heating system is not adequate. There's not enough hot water, and the bathroom and dining room are too cold. What makes it worse is that the patients wear very thin clothes, and most don't wear shoes.

"Second, the food is inadequate and there is a problem with malnutrition, and this lowers their resistance".

■An acute shortage of psychiatric help
■The wards where only the fittest survive
See overleaf

No way out for mentally ill

w/mail 21/6-27/6/91

The plight of a man incarcerated in a mental hospital against his will, raises questions about the committal process, reports GAVIN EVANS

"THIS regards the blindly stupid and illicit incarceration of the writer in a mental hospital, without authority; and the criminal, absolutely unethical behaviour of the so-called medical profession of the Republic of South Africa."

With these words a 49-year-old father of two, former businessman and current mental patient begins an eight-page diatribe about how he was committed against his will to a Transvaal provincial mental hospital and why he has not been able to get out.

After a lengthy exposition on his worldly achievements, intelligence and good character, he gets to the point: He was incarcerated because he had evidence that the KGB had tried to penetrate the National Intelligence Service via MI5, who were also involved in setting up the CCB. As a result, there was "intelligence interference" in his marriage. His late father, also a foreign agent and acting under orders from a British subject, conspired with unethical doctors to have him certified as a paranoid schizophrenic.

Writing about himself he says: "The writer has always enjoyed excellent mental health, evidenced by his *joie de vivre*, energy, activity, efficacy, achievements, irrepressible humour, optimism and active good sincere human relations. He has never suffered from delusions nor halucinations.

"Accusations of such have been unfounded and completely unevidenced and would be completely annihilated by the hard evidence, and many, many witnesses, which the writer could bring to bear if he had the opportunity..."

While his refutation of the doctor's diagnosis is open to question, his account of his committal and the limited channels for appeal make more sense.

He says his father obtained a letter from his doctor recommending "internment and intensive drug therapy". Later, after a fight with his father, he was taken by the police to be examined by the district surgeon.

A Germiston magistrate ordered his committal to the mental hospital, without his having seen the contents of the doctor's letter, his father's recommendation or the magistrate. He was prescribed a drug, Pimozide, and then treated with drugs against his will.

After appealing to the attorney general and hospital superintendent, he was allowed out. But after several attempts to contact the National Intelligence Service and police, his return to Weskoppies was ordered and he spent 29 months in a chronic ward, "with no treatment whatsoever".

"On average the writer saw a doctor for about 10 minutes in two months," he says.

Applications to see the hospital board and its chairman were initially refused. Later he got to see the board, which refused his unconditional discharge but moved him to another ward and allowed him to go out on weekends.

He says he wants to sue for damages, but can't until his original certification order is rescinded.

In a recent article in the *South African Journal of Human Rights*, psychologist Lloyd Vogelman, attorney Nicholas Haysom and academic researcher M Strauss argue that one of the catalysts behind the current certification process was the assassination of Dr Hendrik Verwoerd, which led to a "concern to protect society from the mentally ill, informed in the late sixties by reawakened primal fear of the deranged lunatic".

The committal process, they argue, is essentially an administrative — rather than judicial — procedure, relying on the diagnosis of doctors. "The consequences of a faulty diagnosis are severe, and there is much evidence to suggest that psychiatry has not yet reached a stage where faulty diagnosis is unlikely."

Any adult who believes another person should be committed to a mental institution may apply to a magistrate for an order — and the application may be accompanied by a medical certificate.

The magistrate, who does not need to examine the person himself, calls for the assistance of two doctors, who provide him with a written examination of the person. If no psychiatrists are available, he may rely on the medical certificate supplied by the applicant.

He may then order the committal of the person to a mental institution as a patient — the reception order authorising the detention of the patient for up to 42 days.

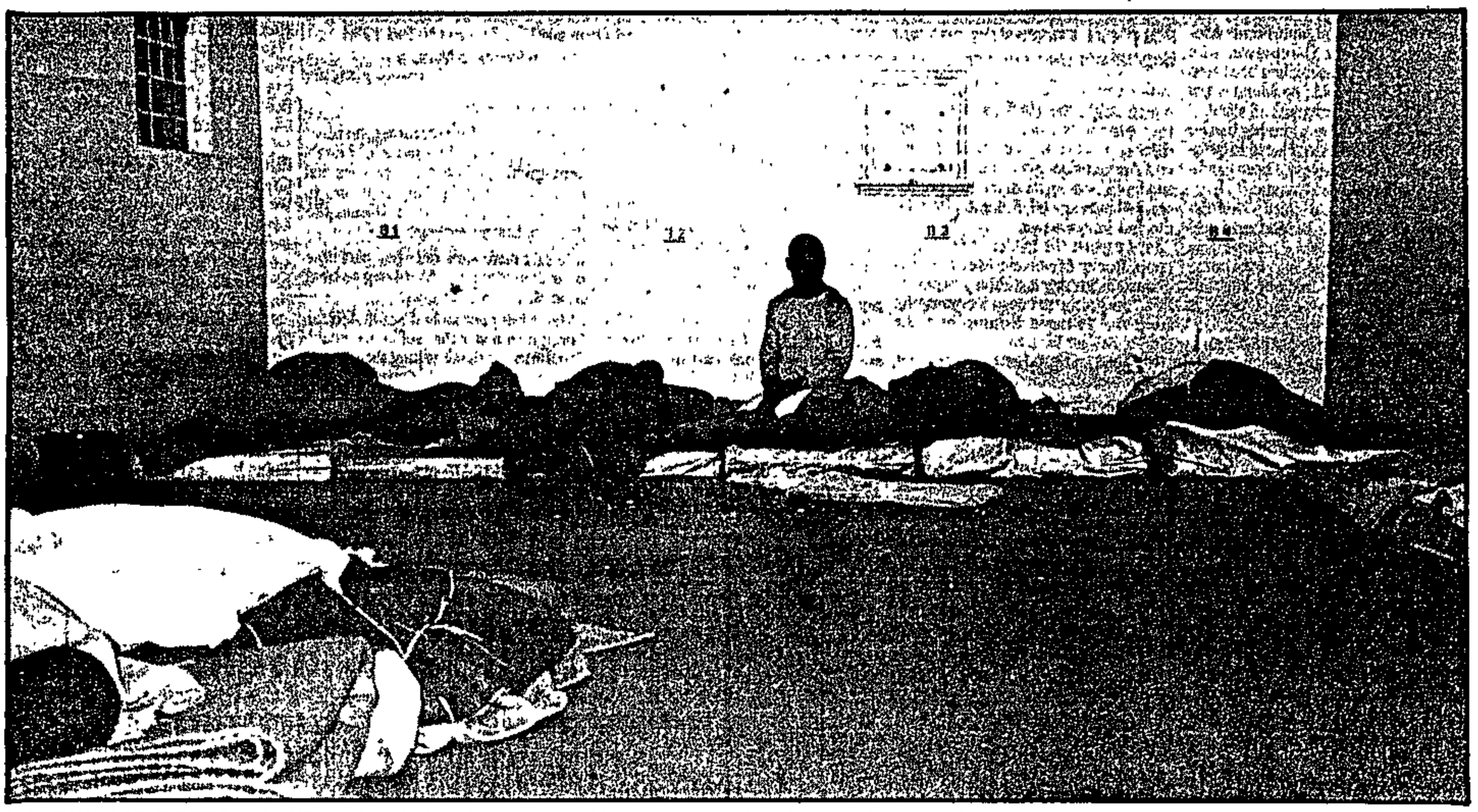
A hospital doctor's report is then sent to the attorney general, after which a judge examines the reports in chambers and may order the further indefinite detention of the patient. After this, discharge is dependent on the doctors, hospital board and superintendent of the hospital.

There is no legal provision for patients to contest their detention and they have no right to refuse treatment — including drugs and shock therapy.

A major problem faced by psychiatric hospitals is the number of certified patients who escape. According to figures released in parliament, at Sterkfontein alone 513 patients "escaped, broke out, absconded or were allowed to go on leave and did not return" between 1986 and 1990.

Inside the bleak cell of despair

w/mail 21/6-27/6/91



DICKENSIAN STARKNESS ... the MB-ward at Weskoppies is home to 20 men, some of whom have lived there for decades Photo: GUY ADAMS

This week The Weekly Mail secretly gained access to another major mental institution in the Transvaal — the state-owned Weskoppies. CISKA MATTHES reports

w/mail 21/6-27/6/91

IN A locked, bare room of Weskoppies psychiatric hospital, about 20 black patients sleep on thin mattresses on a dirty concrete floor.

Above each mattress a number is painted on the dirty yellow walls: "B1, B2, B3..." — short for "Bantu 1", and so on. Paint is flaking off the walls.

Heads and feet stick out from under heaps of old blankets, close together, without sheets or pillows.

The patients get up elatedly when *The Weekly Mail* reporters enter the ward. They all want to shake hands.

"We are hungry, madam," says one. Another begs, "Please, miss, can I go home? I'm OK in my head now."

Staff claim that the patients are given clean blankets only once a month, and change their clothes only once every four days.

Several of the barred windows are broken, letting in the freezing mid-winter air.

Two buckets of water are placed in the middle of the room with three cups — after 3.30 in the afternoon, it is all the patients will have to drink until breakfast the next morning. They have no food during this period.

The room is filled with a rancid smell of urine; in the corner stands a row of old toilets without seats, shielded only by a low wall. In an adjacent enclosure, a blocked urinal is almost overflowing. Wet patches dot the rough concrete floor.

In this "MB-ward" ("Male Bantu") of Weskoppies, some of the patients have lived for years, even decades, health staff said.

They are black State President's Patients (SPD) who were sentenced by the courts to treatment in a mental institution; they were declared not accountable for deeds that range from general aggression to murder.

The Weekly Mail spoke to several of Weskoppies' health workers who felt it was time to expose the problem.

Staff said the only "therapy" black patients receive is medication — none of them receive any individual psychotherapy. Group therapy is given only to those who are about to be discharged.

Few of the black SPD patients are ever discharged; many may stay until they die. "It is a matter of control, not cure," one worker commented.

The health staff claimed that the approximately 100 black SPD patients of Weskoppies were seen by the psychiatrist briefly once every two or three months.

If the hospital staff — and ultimately, the psychiatrist — judges a patient cured, a discharge procedure may be started.

The health staff claim it is a complicated, bureaucratic procedure that is not often started.

For a discharge a "custodian" — preferably a relative — is needed to take responsibility for the patient.

The problem is that relatives are often not willing to be the custodian, as the patients may have assaulted family members. Social workers are continuously discouraged to sign as custodians by management, the health staff claim.

"The management says it is far too dangerous," they say. They acknowledge that it is not certain whether a patient can be rehabilitated to face the outside world. He may not be able to handle the stress.

But the hospital, they add, doesn't even give patients a chance, and seldom are they allowed to go home on leave.

The health workers claim the white SPD patients are given a chance to go home on leave more often; supposedly even for up to one month.

Furthermore, health staff claim some patients can't leave as they live too far away and receive too little travelling money to get there.

White patients always get sufficient resources to go home, the staff said; and are escorted all the way. Black patients though, may be just "dumped" at a station, they said — and may not be able to cope with the stress.

According to a mental health worker Weskoppies was "racially integrated" in January this year. However, this does not relate to accommodation of patients — merely the medical staff is no longer divided into two separate teams.

Some workers claim though, that even this integration has not yet taken place.

Although there are several newly-built black wards that are said to be quite comfortable, the majority of the approximately 1 300 black patients still stay in the overcrowded old wards, with poor facilities.

Meanwhile, the approximately 1 800 white patients are said to enjoy comfortable conditions; and *The Weekly Mail*, visiting the warm white wards — with some private rooms — spotted a white woman patient peacefully playing the piano in the patients' dining hall.

...delighting dry, however, and Red Cross officials made emergency deliveries of food and bedding Photograph: JUSTIN SHOLK, AP

Media Council to look into Mail exposé on mentally ill

wlmail 28/6-4/7/91

By CISKA MATTHES

THE Lifecare psychiatric hospital group has submitted a complaint to the Media Council about *The Weekly Mail's* allegations of maltreatment of black patients at two of its institutions.

And while the Transvaal Provincial Administration has denied some of the allegations about care at Sterkfontein psychiatric hospital, deputy director Jan van Wyk admitted a difference in facilities for white and black patients.

The exposé has had several consequences, including improved facilities, and a new willingness among staff to speak up about their grievances.

Members of the National Education, Health and Allied Workers' Union (Nehawu) at Lifecare last week discussed issues to be negotiated with management, such as racial discrimination among staff, and understaffing, which makes it necessary for patients to be put to work.

And at Sterkfontein, admission forms for the union are "going out like hot cross buns", a Sterkfontein worker commented, "whereas at first people were frightened to join up".

Nehawu members have for the first time been allowed to have a general meeting in the hospital.

Meanwhile, the same day *The Weekly Mail* exposed the extent of apartheid at Sterkfontein — with photographic evidence — management removed signs pointing to the "black kitchen" and the "female black wards".

One worker commented: "They can easily remove those signs but they should improve the situation."

The Weekly Mail had also reported healthworkers' allegations that black patients were kept in cold, overcrowded buildings, worked long hours on the premises and did not receive any treatment other than medication. White patients, on the other hand, were reported to be living in comfortable, warm wards with plenty facilities — and receiving personal therapy.

Van Wyk denied these allegations, saying that all patients were "handled with full empathy". However, he acknowledged that apartheid still existed in the hospital.

"Simply taking practical arrangements as regards the culture, language, eating habits and so on of patients into account, it is clear that the situation that existed before could not be changed overnight," he said.

"As regards the basic facilities in the wards, the matter was investigated... we are busy drawing up a programme to rectify this. This will however depend on the availability of funds."

Healthworkers denied that changes had been started, and claimed there would be enough funds — the problem lay in how the funds were used.

Still, management did make changes overnight, staff reported.

They said four elderly, black patients had last week been admitted to a white ward.

One ward is to become multiracial, as soon as renovations are complete.

Other healthworkers felt, however, that these changes were superficial.

A spokesman at the Nehawu national office said that after Health Minister Rina Venter's announcement last year that hospitals would be integrated, there had not been any circular in any institution to explain to employees what that meant. Neither the TPA nor the minister had taken steps to coordinate and consult staff in integrating the institutions.

● *The Weekly Mail* reported that Sterkfontein contained 700 black patients and 500 white patients. According to the TPA, a patient count following showed there were 426 black patients and 301 whites.

PSYCHOLOGY

Now, a tax on mental health

Psychologists will not be able to play their role in treating the consequences of violence in South Africa once Value Added Tax is imposed on psychological services, says the president of the Psychological Association of South Africa (Pasa).

Dr Theo Veldman says psychological services do not qualify for compulsory benefits in terms of the Medical Schemes Act, but only for benefits which represented between 30 to 40 percent of Pasa's recommended tariffs.

"In practice this means the Representative Association of Medical Schemes (Rams) only pays about R10 of Pasa's recommended tariff of R25 per counselling session," he says.

This has created the situation where psychological services could only be afforded by, predominantly, the white middle class.

"There is an urgent need for across the board group-based services — particularly for black youths who have been severely traumatised by the violence in the townships," he says.

SAPA

Stress in Khayelitsha 'alarming'

Staff Reporter CT 9/7/91

NEWLY urbanised Khayelitsha women are the most depressed — and stressed — group in the country and mental health and treatment programmes should be developed specifically for them.

This was the finding made in a paper by Professor L J Gillis, of the Department of Psychiatry, UCT, delivered at the 10th Epidemiological Conference being held at the University of the Western Cape.

In spite of the general high prevalence of depression, which was "alarming" in Khayelitsha, only five people in Khayelitsha and one in Langa had received psychiatric treatment, said Professor Gillis.

At Langa 195 people were interviewed and in Khayelitsha 170, he said. Two surveys were done, one at the townships and the other countrywide.

The townships were specifically chosen to highlight differences between a largely settled and relatively stable community and one where the majority of people had become urbanised within the past five years.

Variables

It was clear that black women had a more instrumental role, with responsibility for the daily management of the household and children, and the enormous worry where money and resources were limited.

Regarding the marked discrepancy between Khayelitsha and Langa women, it was not possible to define precisely which of the many social circumstances examined were critically relevant because many Langa women, although somewhat better off, were also living in severely strained circumstances, Professor Gillis said.

Depression was related to a number of concomitant variables and four factors — adequacy of housing, length of stay in Cape Town, perceived state of physical health and gender — were found to be significant.

Professor Gillis said depression was much more frequent in elderly black South Africans than in other population groups both here and overseas.

It was also more common among newly settled communities — particularly among women — "alarmingly so" in Khayelitsha, he said.

MENTAL HOSPITALS – THE TPA REPLIES

88

Wmail 12/7-18/9/91

SENIOR Transvaal Provincial Administration officials on Friday met *The Weekly Mail* to give their side to the newspaper's exposé of conditions in the racially segregated psychiatric hospitals, Sterkfontein and Weskoppies.

"I will certainly not say all you have written about the hospitals is untrue," MEC Fanie Ferreira said, "but you must understand that there has been too little time for us to change the apartheid policy."

Management of these hospitals had only been handed over to TPA in 1988 and integration had to be carefully planned, he explained. Ferreira said the TPA was working on a programme for integration but did not elaborate. However, nurses are not involved in the planning.

Another problem, Ferreira said, was the lack of TPA funds for mental health.

The officials denied one of the strongest allegations made by many health workers, that black patients receive no psychotherapy at all.

A three-year investigation into family murders gives tragic insight, writes

Helen Grange

crime

Throwing light on a dark

Star 15/7/91

88

THE real tragedy of family murder is that the suicidal depression of one person results in the death, often by terrible means, of another adult as well as innocent children who have no choice in the matter.

South Africa has seen an increasing number of family murders in recent years, leading to many hypotheses on the phenomenon — one of which was that these tragedies tend to afflict mainly white Afrikaners because of their intense sense of responsibility for the family.

Were it this simple, one could examine and address the factors which lead to such an over-protective attitude. However, further study has revealed that, in fact, family murder affects a wide cross-section of people in South Africa and the causes are very diverse.

After a three-year investigation conducted by the Human Sciences Research Council, commissioned by the Department of National Health and Population Development, and released this week, the phenomenon of family murder has shown itself to be an extremely complex one.

Of course, the problems which lead to the fatal act lie mainly with the murderer himself — and researchers have found some very definite traits which render the murderer incapable of dealing with his situation.

Depression is a strong feature among family murderers, and most of them experience "burnout" and stress some time before the point of no return.

Stress is very predominant in the South African context, as there is much emphasis on achievement.

In most cases, the symptoms of depression and stress become intensified immediately before the murders. A feeling of desperation creeps in — a state of acute isolation where life has lost its meaning.

A host of personality traits usually assist in driving the murderer to his final tragic act — including emotional immaturity, dependency, poor social and self-image, feelings of inadequacy, jealousy, aggression, and the desire to control others — to speak of a few.

But more important are the circumstances of the family itself — the role of the spouse and of the children.

Researchers found that the murderer would be more deeply involved emotionally with the children than the spouse.

In most cases, the children are involved in a power struggle between the couple — and children are used by the parents to manipulate one another or to vent their aggression, and they assume grown-up roles such as taking responsibility for a sibling or being the confidants of the adults.

Most family murderers tend to have a better relationship with the children than with the spouse. It follows then that the structure of such a marriage is shaky.

The murderer's spouse usually has higher educational qualifications, tends to dominate the relationship, suffers from stress and is emotionally ambivalent, confrontational, disapproving, convictive and feels superior.

Surprisingly, alcohol, narcotics, psychological deviations, hours of work, unemployment and financial problems have been found not to play a role in family murders. Nor does the political system, the media or violence in the community have a direct influence.

It is the dynamics of the family, and the inadequate adaptation of the murderer to his or her circumstances, that seems to be most important.

The murderer's motives for finally resorting to killing his family could be the last act of despair and helplessness, an attempt at gaining control, a wish for revenge or a desire not to leave the children without care after the parent has committed suicide.

Apparently autumn is the season for many family murders, with the sleeping hours chosen for the deed — although no reason has been offered for why this is so.

Researchers have made a number of recommendations for preventing family murder — one of them being that professional health workers should be trained not only to recognise the symptoms, but also to intervene successfully.

People should also be taught life skills in order to cope better with the demands of daily life and with stress.

The community should also become actively involved so that people can support and care for one another.

In addition, it is also necessary to determine how to change the attitude of South Africans — too many believe that aggression is the only solution to problems. □

Mentally ill treated badly

LETTERS to the EDITOR

Short letters are preferred and none is considered unless it is signed, with the writer's full address. Pseudonyms may be used but are not encouraged. Write to: The Editor, Sowetan, PO Box 6663 Johannesburg 2000.

SIR - For the past three weeks the *Weekly Mail* newspaper has been exposing horrendous treatment and conditions in various psychiatric hospitals on the Reef.

The Citizens Commission on Human Rights (CCHR), a groups dedicated to the investigation and exposure of psychiatric violations of human rights, has had a steady stream of complaints from patients and relatives alike, not only about the conditions and general treatment at institutions but also concerning mental health treatment received by patients, which sometimes borders on the barbaric.

In most cases CCHR attempts to bring the suspected perpetrators to book by filing suits or complaints with prosecutors and police. However, "proving beyond reasonable doubt" a criminal offence against a patient is a difficult, especially when the patient is a psychiatric one whose allegations can be fobbed off as "delusions".

The amendment to the Metal Health Act in the late '70s resulted in effective self-censorship by the press and the general exercise of caution by human rights bodies in the investigation of treatments and conditions in these institutions.

A further result is that treatment and conditions have deteriorated to a shocking level. The majority of reports made to CCHR bear this out. The institutions and their owners have for too long hidden behind the veil created by this amendment.

What is most startling about *Weekly Mail's* expose is that it shows that nothing has really changed in 15 years since the first exposes in 1976. And if nothing is done to change the conditions or force reform, a similar expose will appear in five, 10 of 15 years from now.

There is a definite need for urgent investigation into the conditions and treatment at these institutions. The institutions themselves will certainly not initiate the investigation, so concerned individuals and groups need to unite if the interests of those who are unable to protect themselves are to be looked after to demand such an investigation, with a view to improving the standard of conditions and treatment of patients and to reforming the law which caters (or should I say hardly caters) for psychiatric patient.

Human rights organisations, reform organisations, lawyers, academics, medical people, nurses and other interested individuals who want to take action should contact CCHR with comments, ideas and suggestions.

Mental patients beaten: SAP called in

(88) CT 6/8/91

JOHANNESBURG. — Unnamed nursing staff at Weskoppies mental institution in Pretoria who allegedly beat up patients last Monday have been sent on two weeks' compulsory leave while police investigate the incident.

"Two of the patients suffered from fractures while the rest received medical treatment," MEC for health services in Transvaal Mr Fanie Ferreira said in a statement last night.

"The Transvaal Provincial Administration might consider taking steps against the possible guilty parties," he said.

"The staff involved will also be reported to the South African Nursing Council."

Mr Ferreira said some of the patients were allegedly assaulted by some members of the nursing staff on the afternoon of July 29.

"Departmental steps were immediately undertaken by the TPA. Statements were taken from the staff involved in this alleged incident before they were sent on compulsory leave for 14 days.

"A criminal charge of alleged assault is currently under investigation by the police."

Mr Ferreira added: "Everything possible will be done to prevent a recurrence of the incident in the future.

"Nursing staff were again informed that anyone guilty of such actions might be prosecuted." — Sapa

Epilepsy under the spotlight

(88)
South 8(8-14/8/91)

ONE OF THE disorders which suffer the worst prejudice in South Africa will be placed under the spotlight at a national conference in Cape Town next month.

Epilepsy, which is commonly believed to be a psychological problem or mental disorder, is often regarded as an uncontrollable disease rather than a controlled disorder.

Many people believe that people with epilepsy convulse on the ground every few minutes and that epileptics will never be able to fulfill meaningful roles in society.

The South African National Epilepsy League's (Sanel) conference on September 5 and 6 will address the medical, psychological, legal, social and community aspects of the condition.

Sanel, established in 1967, is a human service organisation rather than welfare body which works closely with people with epilepsy to overcome their medical, social and economic problems. "Our focus is cooperation rather than service and we rely on epileptics to dictate the direction of our work," said Sanel's national director, Ms Kathryn Pahl.

Sanel offers residential care for people with severe epilepsy who cannot live independently or whose families cannot cope with their condition. They also have a social counselling service where social workers assist families and epileptics to cope with the disorder, initiate appropriate services in the community and offer public education.

Sanel also assists with employment creation as epileptics face tremendous barriers in the marketplace.

"The most disadvantaged are the poor and among them the disabled are the most disadvantaged with epileptics right at the back of the queue," Pahl said.

Sanel train people in vocational and social skills to assist them in surviving the marketplace. It not only prepares people with epilepsy, but prepares the market to accept them as well.

Common myths held by employers are that people with epilepsy tend to be absent from work more often and are likely to have accidents at work.

"We have to convince them that this is not true and when they employ one of our people, provide backup advice and guidance," Pahl said.

There was very little research on epilepsy in South Africa, although some work done in 1986 indicated that one percent of the population had the disorder.

Pahl said epilepsy was definitely not contagious or related in any way to mental retardation.

Epilepsy can be controlled with anti-convulsive medication, Pahl said, just as diabetes could be kept under control with daily medication.

Epileptic employees were just as capable as their colleagues and need not be rushed off to hospital every time they had a seizure.

The Sanel conference, which is open to anyone with an interest in epilepsy, specially people in public positions such as teachers and social workers, will deal with practical problems facing people working with epilepsy.

Highlights of the conference will be papers by two internationally recognised experts in the field, Hanneke de Boer and Joop Lieber of the International Bureau for Epilepsy, and Nicholas George of the Zimbabwe Epilepsy Support Programme.

People who want to attend the conference can contact Sanel at (021) 473014. □

LETTERS

We don't deserve the venom directed at us, says Lifecare

(88)

W/Mail 9/8 – 15/8/91.

The Weekly Mail published a series of articles recently in which, for the first time in years, conditions in psychiatric hospitals were examined. The articles were published to evoke debate, so we are pleased to publish here, unedited and without comment, a response from the owners of two of the hospitals, Lifecare Group

SINCE June 7 *The Weekly Mail* has published several articles allegedly "exposing conditions" in a number of psychiatric hospitals. Two of these facilities, Millsite and Randfontein Sanatoria, belong to the Lifecare Group, the largest private health care group in the country.

Our main complaint is that the tenor of the articles as published conveys a strong impression that Lifecare:

- Severely neglects patients entrusted to its care
- Abuses patients
- Covers up the truth.

These assertions are in no way borne out by reports by responsible medical authorities — some of which material has been made available to both the Media Council and *The Weekly Mail*.

To counter each of *The Weekly Mail's* allegations fully would take a considerable amount of space. We would therefore like to emphasise a few key points.

- Your allegations that this was the "first probe" and that our facilities are "shielded by law from public scrutiny" are unfounded.

In the first place, the law was designed to protect patients and the public, not to provide cover for abuse.

Over past years journalists from *The Star, Business Day, Sowetan, Sunday Times* and other publications have visited our psychiatric facilities. None found abuses that necessitated exposure. On the contrary, they were impressed with the care patients received and the dedication of the staff.

- Your reporters' claim of penetrating the "secretive world of mental homes" is rather ludicrous, since none of them had the slightest problem coming in as one of the many visitors the patients receive. Ciska Matthes had asked for permission to visit as a freelance reporter and had been told that such a visit could be arranged towards the end of June. She chose to go in as a "visitor" to see a specific mental patient whom she then interviewed.
- Your reporters' poor grasp of the nature of medical issues and the rationale for procedures led to very superficial conclusions based on ignorance of the issues they thought they were exposing.

In a comment on *The Weekly Mail's* allegations, Professor AJ Brink (ex-chairman of the Medical Research Council) wrote of people who come from a normal environment, saying "...when coming into contact with ... those who are incapacitated in different physical and mental ways ... it is not unexpected to experience psychological revulsion and to seek a scapegoat and to lay blame all around on society and its structures. I believe therefore that the exaggerated, distorted and untrue interpretation of so-called eyewitness incidents falls into this category of personality inexperience and inadequacy by the observer". He added: "It is not a situation unique to the Lifecare environment. It is unfortunate that the manifestations of the evils of disease are now being projected as being caused by the very persons doing most to alleviate suffering and who serve their fellow human beings."

Linda Rulashe, during her two follow-up visits, seemed unable to grasp that these are chronic care facilities — not ordinary hospitals with ordinary patients that are routinely healed and discharged. The patients in our care are severely psychotic, mentally retarded and often physically handicapped. Some patients refuse to wear shoes and certain items of clothing, repeatedly destroying or throwing away garments issued to them. One patient has the odd but harmless habit of wearing several layers of clothing — up to 17 items.

Your claims that "physically disabled patients have no crutches or wheelchairs" are false. There are dozens of wheelchairs, crutches and walking aids. You, Mr Editor, saw them for yourself. It was also explained to you that each patient is assessed: it is often necessary to encourage a patient to exercise his muscles (and his independence) instead of leaving him with atrophying muscles in a wheelchair. There is therefore a medical reason why some patients do not use wheelchairs. Other patients cannot handle wheelchairs without injuring themselves.

- One of your reports relies on the evidence of an unidentified health worker to explain the deaths of young mentally retarded patients.

No reference is made to the condition of these patients when they were admitted or to the general prognosis of this type of patient. No attempt was made to seek the views of a competent medical authority. No attempt was made by your reporter to ascertain the norms for deaths among these patients anywhere else — locally or abroad.

Instead, sweeping and unsubstantiated allegations of deaths through "negligence or winter cold" are made by your paper.

A large percentage of these patients are highly prone to respiratory ailments because they are immobilised by severe physical handicaps. Many children come to Millsite after waiting three to four years for a bed, usually in a very deteriorated and neglected condition.

We have statistics from abroad which confirm that for this type of patient, the deaths as experienced at our institution are lower than the norm.

Rian Venter, regional nursing manager of Lifecare, explains patient care to Radio 702's Des Latham.

Photo: LIFECARE

It is tendentious and irresponsible to attribute such deaths to negligence, winter cold or malnutrition, or to say that "these deaths are seldom investigated".

Every death is investigated by a committee consisting of the full-time medical officer and senior nursing personnel. Their report goes to the state or local authorities who would order futher investigations if they were not satisfied.

- Rulashe said that she had not spoken to anyone in management on her first visit, but only to two or three staff. Millsite employs more than 700 staff members for approximately 3 000 patients.

The two or three staff members interviewed can, therefore, hardly be regarded as representative.

Had conditions been as bad as *The Weekly Mail* claimed, staff turnover would undoubtedly have been high. In fact, in the period January 1990 to June 1991, the turnover has been under one percent.

Second, their opinions on medical and psychiatric matters were taken as authoritative without any effort to verify this information with the professionals at Millsite.

Lifecare has a wealth of material available for public scrutiny which refutes in detail the allegations contained in the articles.

The challenge to upgrade facilities and to provide proper care for psychiatric patients, beyond the basic accommodation, food and medication, requires the mobilisation of all Lifecare's physical and mental resources.

Your claim of "Sanatorium gets a quick facelift after Mail exposé" is facile. Upgrading and painting is an ongoing process, 300 days a year, not a "hasty paint job". We have 20 full-time maintenance workers painting and fixing on a continual basis.

Our hospitals are regularly inspected and often visited by the Transvaal Provincial Administration Medical and Nursing Personnel. Some of the nurses at Millsite are seconded by the TPA. As they are not employed by us, these people would certainly report on staff shortages or inadequate feeding. On the contrary, their reports have been excellent.

Medical and psychiatric cover is rendered by the TPA. Until a year or so ago private hospitals were prohibited by law from employing doctors. Since these rules have been relaxed Lifecare has substantially increased the medical cover by employing additional full-time doctors.

There is a country-wide shortage of psychiatrists in South Africa. The first two psychiatrists to be employed by Lifecare on a full-time basis are arriving from overseas soon. Others are due to follow.

Lifecare's whole approach to patient care is based on a commitment to improving quality of life and not just custodial care. It has done pioneering work in a number of areas. One of these is rehabilitation.

The approach taken is a multi-disciplinary one. A rehabilitation committee consisting of psychiatrists, medical doctors, occupational and physiotherapists, senior professional nurses and community sisters meets once a week to assess patients' progress.

This multi-disciplinary therapeutic approach has been implemented in Lifecare hospitals since 1977. The statement made by *The Weekly Mail's* reporter that staff "claimed there is no rehabilitation programme" is incorrect or is deliberately misleading.

A spin-off of the therapeutic approach has been the development of a unique training scheme, registered with the South African Medical and Dental Council, to produce physiotherapy and occupational therapy assistants.

To date Lifecare has trained 3 000 nursing, physiotherapy and occupational therapy assistants to help the professionals.

In addition, registered nurses have been able to take a one-year psychiatric training course with Lifecare for the past three years.

Hundreds of students from colleges and universities do their practicals at Millsite annually. It would be very difficult to limit such large numbers to the "special well-kept ward which is the only one shown to visitors" as *The Weekly Mail* claimed.

Overall, Lifecare has developed a model for psychiatric care and rehabilitation that is unique and it could provide a blueprint for institutions in other parts of Africa.

Your paper's articles have caused considerable distress to the hundreds of dedicated staff employed by Lifecare and concern to families of patients. Working with disabled and psychiatric patients day after day, knowing that so few can be rehabilitated is a grinding task. They deserve appreciation, not the venom directed at them by your paper. — **M Malkin, group managing director, Lifecare**

Depression in children is often not recognised

Sowetan 13/8/91

SERIOUS depression in children is often underestimated or not identified because it appears to be a behavioural problem, Mr JL le Roux of the Department of Psychiatry at the University of the Orange Free State, said at a conference on school health in Bloemfontein.

Le Roux said that anti-social behaviour and the use of drugs or alcohol could indicate depression.

The child wanted to leave home because he felt he was not understood or accepted.

These children were often sullen, reluctant to be involved in family activities and withdrew from social activities by staying in their rooms.

Poor self-care and a specific sensitivity to rejection in a love relationship might also appear.

Le Roux said that special features of depression in youth were irritability and inter-personal problems at school.

Alcoholism

Views were expressed that they are "dumb" or "unpopular" and there was an acute reduction in school achievement.

Le Roux said that 46 percent of children with depression also had other disturbances such as alcoholism and anxiety problems.

There was no family history of depression in 31 percent of the children, but 23 percent had a history of depression in the family.

Dr Frieda van Rensburg of Bloemfontein told the delegates that children who suddenly "vanish" and do not respond, are too often diagnosed as epileptics.

Other factors such as health and the lack-of-attention syndrome also caused this condition.

As more demands were placed on the child, its problems increased. 85

The measurement of the electrical waves of the brain (EEG) was not a sifting test and too many children received anti-eplleptic medication after such a test.

Van Rensburg said that other factors should also be considered before medication, which had side-effects, was prescribed.

Dr Pieter Bettings of the UOFS said that the neuro-psychiatric evaluation of pre-school children should receive more attention.

Problems

Of 1 132 pre-schoolers examined in Bloemfontein, more than 400 suffered from neuro-psychiatric illness.

Bettings said that problems found with children examined were with motor co-ordination, perceptual problems, abnormal behaviour, learning problems and minimal brain dysfunction.

It was also found that illnesses such as epilepsy, asthma, allergy and infections had mostly already been diagnosed and that the children were receiving doctors' treatment.

The school health authorities had referred 18,8 percent of the children to, mainly, specialists.

Mrs F Janeke, of the Child Guidance Clinic of the Free State Education Department, suggested that teaching methods should be examined for possible breeding grounds for problems, while classes should be offered to help children from other cultural groups so that children were not unnecessarily referred for remedial teaching. - *Sapa*

Lentegeur: nine people have died of dysentery

HOW DID IT HAPPEN?

South 15|8 – 21|8|91 (88)

By Heather Robertson

AT least four of the dysentery patients at the Lentegeur Psychiatric Hospital in Mitchells Plain died before the various "own affair" health departments linked up to identify and curb the disease.

Allegations were also made this week of a cover-up by the authorities of the outbreak of the disease among patients in the hospital's mental wards.

The disease, caused by the shigella bacteria, claimed its ninth victim on Wednesday.

The hospital's "silence" has drawn strong criticism from community organisations and medical bodies.

According to sources at the hospital, the first signs of the disease were evident in April this year.

The first death from shigella — a highly contagious bacteria which causes stomach cramps and severe diarrhoea — occurred on 23 June. Doctors said the crisis at Lentegeur pointed to the disastrous effects of state fragmentation of the health services.

A source, who cannot be named for professional reasons, claimed that officials at Lentegeur were hamstrung in dealing with the crisis because of the "bumbling" of various medical departments.

Lentegeur is unique in that it is the only hospital that falls under the jurisdiction of the House of Representatives.

A source said one of the patients afflicted with shigella had been turned back from a provincial hospital because Lentegeur was considered an "own affairs" institution.

It was also feared that patients at the provincial hospital would be infected.

Lentegeur, as a psychiatric hospital, did not have the facilities to treat the disease.

When the provincial authorities did not respond promptly, the Medical Research Council (MRC), which is not a service organisation, took the initiative to investigate the epidemic on 1 August.

The symptoms of diarrhoea had already been noticed in mid-May but some members of staff and the public were only informed last week after eight patients had died.

A private general practitioner disclosed that he had attended to a Lentegeur patient who had diarrhoea last week.

He had not known about the epidemic until it was revealed in the press at the end of last week.

"I saw my patient last week and I didn't believe her when she spoke of some unnamed 'mystery disease' at the hospital where seven people had died.

"I feel very angry that the hospital has covered up the epidemic for so long because it's shocking and irresponsible not to notify the general public when so many people had already died."

It was found that his patient did not have shigella."The best way to end an epidemic is to notify the public as soon as possible", he said. But he

● TURN TO PAGE 3

'My night of AWB terror in Ventersdorp'

MACABRE SHOOTING: Ventersdorp victim Tyekeza Myaka this week told of his night of terror after driving into a rightwing mob. **See page 3**

PIC: DYNAMIC IMAGES

FROM PAGE ONE

Lentegeur

added that health workers in the community should have been informed so that they could deal with the disease adequately, he said.

The Lentegeur Hospital authorities had held meetings with the Cape Town City Council, the South African Institute of Medical Research and the Department of Health and Population Development since July 28.

The first meeting, however, to ensure effective co-ordination was convened by Dr Peter Vurgarellis, director of the Western Cape Region of the Department of National Health, only held this week.

The meeting occurred virtually four months after the first cases of dysentery were reported at Lentegeur.

"Very little co-ordination has been necessary because the disease has been contained in the hospital and hasn't spilled into the community," said Dr Vurgerellis when approached for comment

"The main problem is when there are complications and we have to then involve teaching hospitals

"We met on Monday to streamline the referrals from the community hospitals to the teaching hospitals "

Dr Vergarellis claimed that in spite of fragmentation, the various departments of health "worked as a team during crises"

Problem

He conceded, however, in a unitary health system there would be "less treading on toes"

A spokesperson for the National Medical and Dental Association (Namda) said the shigella outbreak was a "public problem" and should not have been "kept under wraps" for so long

"The public should have been informed about what was going on By covering up, the hospital has posed a health risk "

The secretary of the Mitchells Plain Co-ordinating Committee, Mrs Theresa Solomon, has urged that a proper investigation be undertaken.

"We demand to know how, in these days of high-technology medicine, people could have died of shigella, and what conditions in the hospital led to the origin and spread of the disease "

Dr Ahmed Gamieldien, the medical superintendant at Lentegeur, has refuted the allegations against the hospital.

In an interview, he gave the assurance that "everything is under control".

"Shigella has been with us for centuries. It is endemic which means the causative organism (Shigella Flexneri) is always present in the community

Visit to hospital of fear

South 15/8-21/8/91

By Heather Robertson

I VISITED the Lentegeur Hospital and was allowed to enter the clinic where 27 of the most severely hit patients are kept in isolation.

I had to be sprayed with disinfectant and draped in layers of protective clothing as the sister in charge of the clinic led me into each of the rooms

The most severely affected patient appeared to be comatose, struggling to breathe. I heard the next day that he had died in the early hours of the morning.

The sister, who had admitted to fearing for her own safety, was at pains to ensure that "our morale is high"

"Can you hear the music. We're feeling much better now,"she assured me

She said she had been depressed when the death rate increased and the number of patients in the clinic rose from 15 before the weekend to 28 on Monday.

"But we have adapted well with support groups," she assured me.

Another nurse revealed that families who had not contacted patients for years had called to find out if they could take their relatives out of the hospital for good

"This is one of the positive spin-offs of the epidemic. Families hardly keep in touch with these long-term mentally handicapped patients," she said.

There are no hand basins at the entrance to the hospital but antiseptic sprays are situated at the entrance to each ward

Many patients, particularly the severely mentally impaired, do not have control over their bowels which makes combatting the disease even more difficult. Some patients are wearing nappies.

Dr Derek Yach, of the Medical Research Council, says shigella is resistant to existing antibiotics When these failed, the hospital had to use a new drug, Oflaxin.

Since the introduction of Oflaxin, staff report that the condition of most of the patients has improved, although one more death was reported on Wedneday. Three more cases of diarrhoea among staff were reported

Yach explained that shigella is one of the most infectious dyssentry bacteria. "You can catch it from a toilet seat," he said

According to Yach, there are two different forms of the disease

The first is a large mass based food associated outbreak "In the USA, 3 000 women at a pop concert contracted it This was traced to salad which was sold at the concert "

The MRC investigation into the food and stools of kitchen staff at Lentegeur revealed that this was not the cause of the outbreak

Overcrowding

"The second outbreak, which is what occurred at Lentegeur, commonly occurs in conditions of overcrowding and poor sanitation like jails, asylums, ships — basically confined settings, ' said Yach

Speaking about the nine patients that died he said it was probable that they had other diseases and their immune system was weak

A physiotherapist at the hospital revealed that the outbreak has affected more long-term patients because "good care has been given to severely mentally handicapped patients and short-term patients "

The main mode of spreading shigella is through faecal or oral transmission It can be passed on by people who do not properly wash their hands after defaecating and spreads through physical contact and shaking hands

The initial symptoms are stomach cramps, watery stools with traces of pus and blood

"To control the disease you have to focus on very rigorous handwashing and have to make the ward as antiseptic as possible. That is not so easy in a hospital like Lentegeur," said Yach

But the staff at Lentegeur are working around the clock — armed with antiseptic spray guns — staving off panic and paranoia with a good dose of toilet humour Hand washing has become a new form of therapy

HOURS after an ANC commission investigating violence in Crossroads and a police delegation visited the area on Tuesday, renewed clashes occured in the area leaving one person dead, a policeman wounded and four houses petrol-bombed.

The commission, which was established by the national executive committee of the ANC, has alleged that police have not acted fast enough to solve cases where evidence was submitted by residents.

After a two-hour meeting on Tuesday, the commission and the police decided to establish a liaison committee to deal with township violence and assist in solving cases.

Touring Crossroads were, above from left, Mr Andile Sindelo of the Unathi Residents Committee, Colonel Jan Benadie, Athlone district commissioner of police, Mr Sindiso Mfenyana, of the ANC commission, Mr Vincent Diba, ANC, and Mr Patrick Mathanjana

Mental Health Council may rejoin world body

Sowetan 29/8/91 (88)

By PEARL MAJOLA

THE World Federation for Mental Health is considering reinstating the membership of the South African National Council on Mental Health after a six-year ban because of apartheid.

A fact-finding mission is to be sent to South Africa and, after their report, the federation will re-consider renewing the council's full membership.

This follows a meeting in Mexico this month of the federation's board with the council's director, Mr Lage Vitus, to negotiate the council's readmission.

The board decided to start lifting membership restrictions on organisations in South Africa and committed itself on the following:

*The federation will encourage communication between its member organisations, particularly in Africa, with the council;

*Branches of the council which do not practise apartheid and whose affiliates and centres do not practise apartheid will be allowed to affiliate with the federation; and

*A letter will be sent to State President FW de Klerk indicating the federation's support for the work of the council.

The council was a founder member of the federation in 1948.

Clothing costs set to outstrip inflation

Star 12/9/91

Consumer Reporter

The cost of clothing will increase by more than the current rate of inflation if proposed tariff increases on imported clothing and fabrics are accepted, a leading retailer said this week.

The proposals, which appeared recently in the Government Gazette, recommend that tariffs on imported clothing be increased from 30 to 60 percent. There are also proposals that duties on imported fabric be increased from 20 to 40 percent.

Sales House MD Ian Thompson said the increase in tariffs for imported clothing, proposed by the Board of Trade and Industry (BTI), would undoubtedly affect consumers.

"Should BTI's proposal be accepted by the Government, the cost of clothing will increase to a level above the current rate of inflation and customers will suffer," Mr Thompson said.

However, he said it was unlikely that clothing prices would increase by as much as 50 percent as suggested.

The National Clothing Federation of South Africa has issued a hard-hitting statement against the proposed increases.

The NCF, which has a direct membership of 530 clothing manufacturers throughout southern Africa who account for about 80 percent of all clothing manufacturers, said it was gravely perturbed about the "resurgence of a strong and vociferous pro-protection lobby".

Burden

NCF executive-director Hennie van Zyl said increasing South Africa's already high current protection levels would not only be contrary to international trends but would also burden the already embittered consumer — which, in turn, would kill economic growth and create further umemployment.

"To increase import duties at this stage will only benefit a few highly concentrated, capital-intensive industries, and then only in the short term, because domestic inefficiencies and uncompetitiveness cannot be protected indefinitely," Mr van Zyl said.

"One does not have to be a prophet to predict that any further increases in protection will elicit retaliatory action from our trading partners."

The organisation disputed claims that imports of knitwear and spun garments had increased by 131 percent in the first four months of 1991.

Official statistics showed no increase whatsoever, but a decrease in the importation of all knitted fabrics of 17 percent in volume and 13 percent in value in the same period compared to the corresponding period of 1990.

Comparing the same periods, imports of knitted clothing reflected a 65 percent increase in units and 19 percent in value, according to Customs ansd Excise figures, he said.

Mr van Zyl said manufacturers throughout the country were discussing the proposals at present and would comment on them before October 15.

Violence is affecting our mental health

88

Star 12/9/91

Medical Reporter

The impact of the spiral of violence on the mental health of individuals, groups and communities could only be detrimental to a future South Africa, the president of the Psychological Association of South Africa (Pasa), Dr Theo Veldsman, said in the latest issue of the association's newsletter.

Dr Veldsman, the outgoing president of Pasa, said the "continuing and increasing wave of violence sweeping the country is a serious concern for all, including Pasa".

He added that the "daily manisfestation of violence" could in the long term result in an "institutionalised culture of violence".

He appealed to anyone who could play a role in the elimination of violence to support such attempts in their communities.

"Pasa is also more than willing to become actively involved in the planning, co-ordination and initiation of actions directed at preventing and remedying the consequences of violence on the mental health of South Africans," Dr Veldsman said.

(88)

Month-long spotlight on mental health

Star 21/0/91

October has been declared Mental Handicap Awareness Month, when attention will be focused on the 3 percent of South Africa's population which is mentally handicapped. 21/0/91

"The awareness campaign is aimed at educating the public and getting them to meet mentally handicapped people to understand that they are individuals with needs, rights and feelings," said National Council for Mental Health Awareness coordinator S R Pryor.

"The recent Transvaal Special Games, for example, was attended by more than 1 100 mentally handicapped competitors," he added.

A major event during the month will be a "One-to-One Day" on October 27 when members of the public will be invited to adopt mentally handicapped people on a one-to-one partnership basis for a day of fun at the Logwood Ranch near Mulders-drif.

Telephone (011) 646-5149 or 976-5928 for details. — Staff Reporter.

Hospital nurses 'abuse' mental patients

Allegations of abuse of patients by psychiatric hospital staff abound but the state has declined to prosecute two nurses charged with beating inmates, reports

CISKA MATTHES

w|Mail 4/10-10/10/91

TWO male nurses of Weskoppies psychiatric hospital who were accused of severely beating patients will not be prosecuted.

Sixteen patients were allegedly beaten on the soles of their feet with broomsticks by the nurses last month, leaving two patients with broken feet and others needing medical treatment in hospital.

The Transvaal Provincial Administration, which runs Weskoppies, said in a statement that the nurses had been suspended for two weeks. "Statements were taken from the staff involved in this alleged incident before they were sent on compulsory leave for 14 days."

The TPA also expressed its "disbelief", and said that to its knowledge it was "the first time in the history of the hospital that something like this has happened".

Now, the two nurses are back on duty and the attorney general's decision is that the matter should be "resolved internally".

The Weekly Mail has found evidence that abuse of psychiatric patients by hospital staff may be a common occurrence, while patients have little or no chance of protection.

There are two cases of alleged abuse of white patients in Sterkfontein — another TPA psychiatric hospital.

And University of the Witwatersrand psychiatric department head Professor George Hart confirmed there was likely to be patient abuse in Sterkfontein, and, presumably, "in all big psychiatric institutions."

One ex-patient interviewed by *The Weekly Mail* claimed he was beaten up severely last year in Sterkfontein by male nurses; earlier he had been locked outside in the cold half-naked as punishment for escaping shortly after he was forcibly admitted to the hospital.

Little protection ... Patients at Weskopples, where nurses allegedy assault the inmates Photo: GUY ADAMS

The nightmare story, told in an affidavit by the ex-patient, is confirmed by his wife and father, who saw his serious bruises and themselves were confronted with unco-operative hospital staff.

The ex-patient said he was assaulted by a senior male nurse when he refused to throw away the cigarette he was rolling.

"Then he attacked me and three other male nurses joined in. I was beaten, punched and kicked, on the head and in the sides.

"They stripped me naked and then dragged me up and down by my hair, in front of the side rooms, bashing me into walls and doors."

He says he did not fight back until the beating got worse.

According to a psychiatrist who used to work at Sterkfontein: "It is never defensible to assault a patient; at most an aggressive patient should be held down and sedated."

His father and wife say the man was not an aggressive, let alone dangerous patient.

He said he was locked up in a side room and drugged after the assault, until his family came to visit him the following day.

"My son walked with a limp in a stooped position," says his father. "He could hardly sit or stand up, complaining of a pain in his side. His right ear was covered with blood.

"He showed me the bruises on his right side, buttocks and legs. By then he had not even been seen by a doctor."

Later the patient was sent to Paardekraal Hospital for X-rays, where a report was made, saying "assaulted", and mentioning among other injuries bruised ribs, a purple abdomen and a bruised liver.

"The Sterkfontein psychiatrist said it was not the first time that patients had been assaulted," says the ex-patient's father.

A few hours after his father's complaints to the superintendent, the patient was discharged. "All of a sudden he was cured," commented his wife.

The episode started with the man's forced admission to Sterkfontein when he suffered from depression and anxiety: "My general practitioner sedated me heavily and took me to a psychiatrist.

"He certified me — though normally this should be done in consultation with the patient's family — and the police collected me, and two hours later I found myself in Sterkfontein."

As a certified patient he had no legal recourse against his admission. "I was not allowed to speak to my family on the telephone."

Two days after his admission he escaped through a hole he made in a fence. But his father brought him back, under the condition that he would not be locked up again.

That promise was not kept, says the ex-patient: "I woke up from heavy sedation in a small side room in the lock-up ward."

Then, he reports, he was "punished" further: "They locked me outside the building in my pyjamas for two days."

The hospital was never prosecuted: although the suspects admitted to the police they had assaulted the patient, they claimed they had been forced to do so by circumstances, and the only witness to support the accusations was a fellow psychiatric patient.

Says Hart: "Abuse can happen in such a way that injuries are not easily seen — and what the patient says is not believed.

"Staff members may feel threatened by patients and abuse them when no one can see. It is inherent to the psychiatric system. There are too little funds and too few staff for the hospitals.

"Students who went for training to Sterkfontein as registrars have reported cases of abuse to me more than once."

Another psychiatrist who used to work at Sterkfontein mentioned hitting, holding down, and punching.

He explained: "Most of the patients there are severely disturbed.

"At the same time, the staff is not the best. Some have psychopathic needs; they like to show who the boss is."

Other doctors and psychiatrists involved could not comment on the case of the interviewed ex-patient. "But," one of them said quickly, "what he tells you is true."

In a sworn statement, another ex-patient of Sterkfontein also reports abusive treatment, after she was certified and "treated" for anorexia nervosa for seven months at Sterkfontein in 1986.

"I was locked up in a bare cell for three weeks, in a 'reward programme': they took everything away from me — my cigarettes, my clothes.

"They deprived me of water. When I banged on the door and shouted, no one would come.

"My parents were not allowed to phone or visit me.

"I was force-fed through a tube in my nose, or by closing my nose and pouring porridge down my throat. The treatment affected my intestines in such a way that I could not sit still for pain.

"Once, when I had not eaten my soup, the nurse poured it over me and left me like that.

"The psychiatrist kept threatening me with stronger measures."

The TPA this week said it could not yet respond to the allegations, as "the cases are still under investigation".

HEALTH

Mentally ill in S Africa are the socially invisible

Star 16/10/91. (88)

Mental illness is something that "happens to other people". Yet it is estimated that about five million South Africans are suffering from mental illness, of which roughly 330 000 are seriously incapacitated. A social worker in the Johannesburg area examines the problem.

Mental illness can happen to anyone. Mentally ill people in South Africa are socialy invisible.

The severely ill and disturbed are removed from their communities and institutionalised in places such as Sterkfontein, Tara, Weskoppies, Falkenburg, all State hospitals.

Those able to live in spite of their illness are "hidden" — hidden by a silence of fear and the stigma that attaches to mental illness.

Mental illness is a broad concept consisting of two categories: **neurosis** — such as phobias (irrational fears of water, heights, spiders, closed spaces, etc) — or obsessive or compulsive behaviours; **psychosis** — of the "Psycho" movies — refers to severe disturbances such as schizophrenia (loss of touch with reality), manic-depression (mood swings characterised by alternating mania — madness — and profound depression); personality disorders — the stereotypical "psychopath".

In fact, mental illness entails much more — depression, personal problems, suicide, drug abuse, alcoholism, violence and conflict.

The absence of mental illness does not simply imply mental health — mental health means healthy relationships with yourself (self-esteem, a sense of purpose and wellbeing, being in touch with your feelings, coping with stress, the ability to communicate and solve problems); and with others (satisfying, meaningful relationships, ability to empathise with others' feelings).

In the 15th century, people believed mental illness was caused by demonic possession. Hence, witches and people whose behaviour was socially unacceptable were burnt at the stake.

Today, many explanations are given by psychologists and psychiatrists. Some argue that psychoses are genetically inherited, others see them as caused by chemical disturbances of the brain.

The climate of violence is also seen as important; it generates the belief that violence is a socially acceptable way of solving conflict.

To be continued

Neurosis . . . this includes irrational fear of heights. A person with such a phobia will not climb ladders.

Mental hospitals in cash crisis

S|Times 27|10|91 · (88)

By EVELYN HOLTZHAUSEN

SOUTH AFRICA's big mental hospitals are facing a funds crisis which could lead to an increasing number of dangerously disturbed people being refused treatment and left to fend for themselves.

The crisis was disclosed this week by the head of the Department of Psychiatry at the University of Cape Town, Professor Brian Robertson, who is the doctor responsible for the treatment of patients at Valkenberg Hospital in Cape Town.

Professor Robertson has issued an ultimatum to the Cape Provincial Administration which is responsible for funding the hospital which, by the end of this financial year, will be more than R6-million in debt.

In effect, he said. "Give us the funds we need to run the hospital or we will be forced to close!"

Professor Robertson said the staff situation at Valkenberg is already so bad that domestic workers are left in charge of wards at night.

Lack of patient care is leading to an increase in patient stress which is provoking an escalation in assaults on doctors, nurses and domestic staff.

Doors may close to patients who are dangerous

PROFESSOR ROBERTSON
Desperate for funds

Support

This was leading to staff absenteeism which exacerbated the problem by leaving fewer members of staff to cope with even more work.

Medical superintendent of Valkenberg hospital, Dr Geoffrey Garrett has supported Professor Robertson's stand.

If services at the 1 039-bed Valkenberg hospital are cut, other, already overloaded Cape hospitals, not geared for treating mentally ill patients, will have to admit them.

It would also increase the workload on private doctors who have only rudimentary training — if any — in mental illness.

The closure of Valkenberg would also mean that the Department of Justice will have to pay private doctors to assess the bulk of awaiting-trial prisoners ordered, by the courts, to undergo observation.

Admissions

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These include the refusal to accept all but the most serious cases referred for observation by the courts, the "zoning" of the hospital to accept patients who live in the vicinity and closing the hospital's doors to certified patients and "consent patients", including those who are psychotic, homicidal and suicidal and who could pose a danger to society.

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"I would rather cut back on services or close the hospital," he said.

Professor Robertson said from the end of this month, to avert the crisis, the hospital would refuse to accept "voluntary" patients with personality disorders and 30 patients would be transferred to hospitals in the Eastern Cape.

But if the CPA does not

Streets

Professor Robertson predicted that initially these patients would go to other hospitals, but it would not be long before insane people were left in the care of their families or abandoned to fend for themselves.

A spokesman for the Department of National Health and Population Development said budgets for hospitals "are dealt with by provincial administrations to whom funds are allocated by Parliament".

Return to good ol' days as Dealians jam again

By STEPHANIE HULL

LOOK out, here come the Dealians. The local pop group who were top of the charts in the early 70s have banded together again to record an album — 21 years after their first hit, *Look Out, Here Comes Tomorrow.*

"We remained friends and for years we have said we would like to get together again and make an album," said band leader Mike Fuller.

"We decided the time was right and everyone was keen, so we've done it."

It took just a week for the group, comprising Mike, Malcolm Martin, Laurene Evans and Len Cooper to record the album. It consists of their four chart-topping songs, three new numbers and numerous cover versions of popular 60s hits.

"Things have changed a lot since we were a band and this time we will also be making our first compact disc," said Mike.

The group was formed in East London at the end of 1967.

"When we started we were all working at different careers and trying to fit in our music in-between.

"In fact by the time we had won two Sarie awards we were still working in East London and flying to gigs all over the country and eventually we had to come and make Johannesburg our base," said Mike.

In 1974, at the height of their careers, they split up because they had all decided "to pursue different avenues" but they remained friends.

THE DEALIANS: Len Cooper, Laurene Evans and Mike Fuller when they were chart-toppers, left, and Len, Malcolm Martin, Laurene and Mike back in the studio this week

POOR SHOW ... Paula Hamilton who took a taxi-man for a ride this week

TV star Paula wrecks taxi

By CHARMAIN NAIDOO London magaz.nes

Men rate Gunston great

financial year, will be more than R6-million in debt.

In effect, he said: "Give us the funds we need to run the hospital or we will be forced to close!"

Professor Robertson said the staff situation at Valkenberg is already so bad that domestic workers are left in charge of wards at night.

Lack of patient care is leading to an increase in patient stress which is provoking an escalation in assaults on doctors, nurses and domestic staff.

Support

This was leading to staff absenteeism which exacerbated the problem by leaving fewer members of staff to cope with even more work.

Medical superintendent of Valkenberg hospital, Dr Geoffrey Garrett has supported Professor Robertson's stand.

If services at the 1 039-bed Valkenberg hospital are cut, other, already overloaded Cape hospitals, not geared for treating mentally ill patients, will have to admit them.

It would also increase the workload on private doctors who have only rudimentary training — if any — in mental illness.

The closure of Valkenberg would also mean that the Department of Justice will have to pay private doctors to assess the bulk of awaiting-trial prisoners ordered, by the courts, to undergo observation.

Admissions

The "Valkenberg ultimatum" has brought into focus the money crisis faced by other mental hospitals in South Africa, including Weskoppies in Pretoria, Sterkfontein hospital in Krugersdorp and Town Hill and Fort Napier hospitals in Maritzburg.

The 1 350-patient Weskoppies hospital is already R4-million over budget and might soon have to cut back on admissions.

Sterkfontein hospital might also have to consider referring patients to other hospitals.

"We are already R2,5-million over budget," said Mr Rowly le Grange, secretary of Town Hill hospital in Maritzburg. "The situation is chronic."

According to Professor Robertson the "straw which broke the camel's back" at Valkenberg, was the recent news that five posts for registrars, who are doctors training to be psychiatrists, may be frozen at the end of the year.

He said he was not prepared to allow the remaining registrars to severely compromise their training by carrying the extra work-load which would be demanded of them if vacant posts were not filled.

"I would rather cut back on services or close the hospital," he said.

Professor Robertson said from the end of this month, to avert the crisis, the hospital would refuse to accept "voluntary" patients with personality disorders and 30 patients would be transferred to hospitals in the Eastern Cape.

But if the CPA does not respond to his demand for funds by the end of January, when Valkenburg needs to replace the registrars, he will have to take further steps.

These include the refusal to accept all but the most serious cases referred for observation by the courts, the "zoning" of the hospital to accept patients who live in the vicinity and closing the hospital's doors to certified patients and "consent patients", including those who are psychotic, homicidal and suicidal and who could pose a danger to society.

Doors may close to patients who are dangerous

PROFESSOR ROBERTSON
Desperate for funds

Streets

Professor Robertson predicted that initially these patients would go to other hospitals, but it would not be long before insane people were left in the care of their families or abandoned to fend for themselves.

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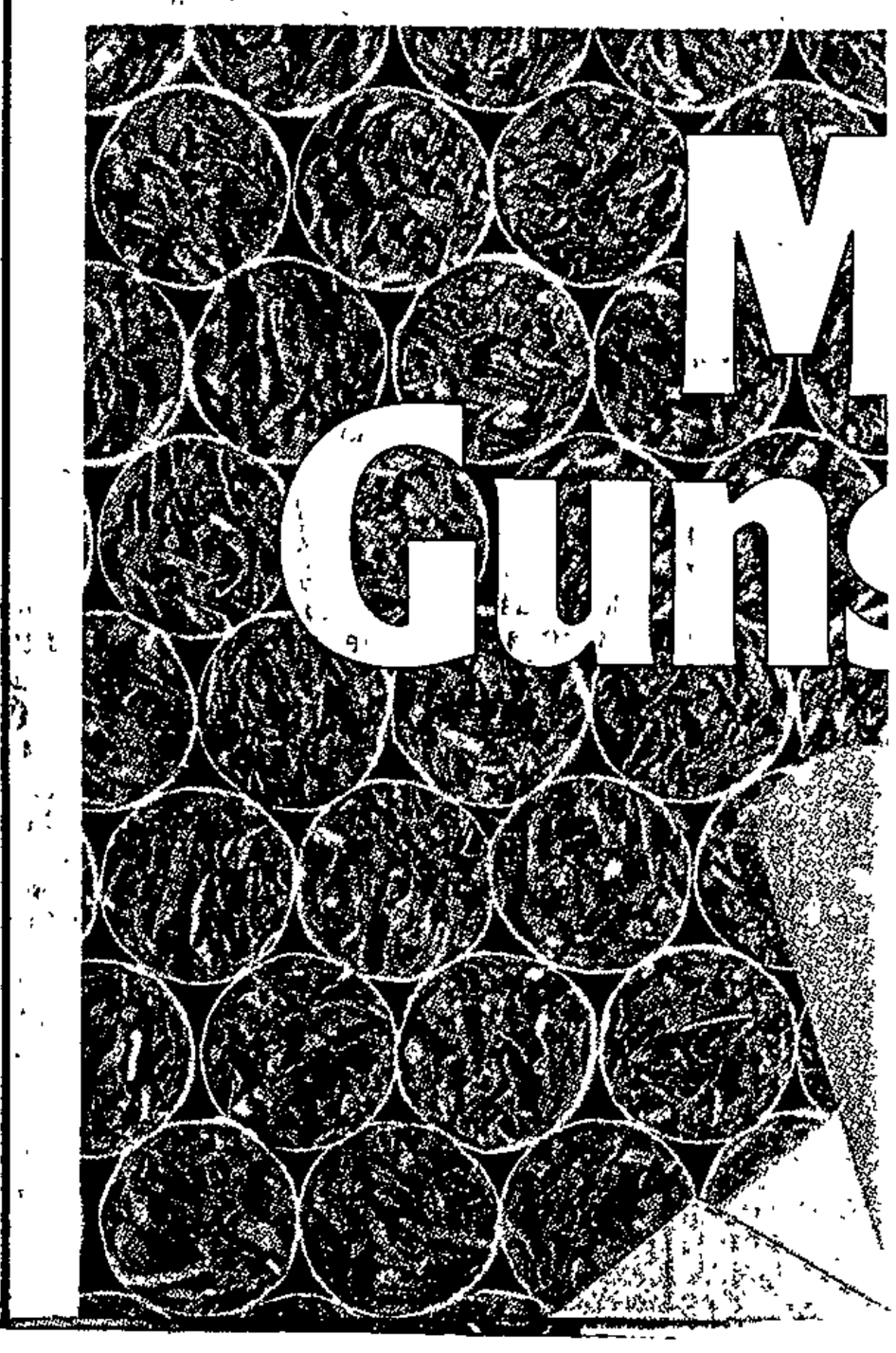


Health cuts would be a catastrophe

WE, the Fountain House community, are deeply concerned about your report (October 27) headlined, "Mental hospitals in cash crisis".

Fountain House is a community-based rehabilitation centre for Capetonians affected by prolonged mental illness. We are a community of 140 men and women of all races who are dependent on services rendered by state psychiatric hospitals. We were therefore greatly concerned when we read about the desperate financial plight in which Valkenberg Hospital and other psychiatric hospitals find themselves.

As a community, we resent the neglect we are being subjected to as a result of budget cuts, compromised standards and staff cutbacks and support Professor Robertson's appeal to the Cape provincial administration for funds.

It would be catastrophic for our community should hospital doors close.

It is, however, unfortunate that this article focussed on the most outdated, sensational stereotypes which reinforces the dehumanising stigma attached to mental illness.

Efforts

We object to the impression created by the article that mentally ill people are dangerous. Mentally ill people are more likely to be the victims than the perpetrators of violence.

You are safer visiting Fountain House or Valkenberg hospital than on the streets of Cape Town.

Mentally ill people make a trivial contribution to violence.

Since Fountain House addresses issues directly related to the community, such as employment, accommodation and rehabilitation, this article, with its reinforcement of stigmatisation, is undoing the efforts we put into the creation of dignified lives for the mentally ill.

Hospital cutbacks and the kind of terminology in your article represent forms of discrimination that we hope will not be part of a changing South Africa. — **Miss E PRINSLOO, project co-ordinator, The Fountain House Community, Cape Town.**

(88) ARG 28/11/91

Home is where the heart is

Residential concept for Fountain House

FUNTS: A Fountain House member sorts the cash used for running the centre. Members are encouraged to get involved in the running of the centre.

Staff Reporter

FOUNTAIN HOUSE, the psycho-social rehabilitation centre in Observatory, has entered a new phase with its first accommodation project — two semi-detached houses bought and renovated with money given by the Schock Foundation and the D G Murray Trust.

The houses are near Observatory station and named after Mr Michael Kimber, a founder member of Fountain House who died last December.

Kimber House has been home, since September 1, to 12 Fountain House members who pay their way according to their pensions.

The house is non-racial, but pension payments aren't, so portions of pensions vary to ensure that all members are left with the same amount of spending money after paying rent. Members are expected to attend nearby Fountain House daily.

Fountain House itself is a rehabilitation centre for people with prolonged mental illness and is not a medical facility or treatment centre.

Modelled on and affiliated to an American concept established in New York in the 1940s, it is a "club house" where members — never called patients — become part of work units of their choice.

Membership is voluntary and members can remain with Fountain House as long as they like.

It's a place, says the Fountain House credo, "to come to, where you can find meaningful relationships and meaningful work, and a place to live," according to Ms Licia Karp, Fountain House employment unit manager.

Members have complete freedom of choice and membership is lifelong, if desired. They choose the nature of the work they do, the jobs being mostly of a household or functional nature. Units take responsibility for the daily running of the club house.

"The staff are not here to look after or supervise people," said Ms Karp. "We take leadership, but the purpose is to hand over leadership."

She is supported by three social workers, an occupational therapist, a Montessori pre-school teacher and a former member who is a full time staffer managing the house's snack bar.

The Fountain House philosophy says people "cannot be expected to make a living in appalling circumstances", hence the establishment of Kimber House.

The clubhouse is also establishing a transitional employment programme, also based on the New York model.

This is a system whereby employers are asked to provide jobs for Fountain House members on the understanding that, being schizophrenic, they are likely to need days off now and then to relieve pressure.

The arrangement is that should that occur, Fountain House guarantees other staff, or members will do the job on such days. The programme fills the gap until the member is ready to move on to fulltime independent employment.

The Observatory centre became affiliated to New York's Fountain House almost by accident.

Ms Mimi Hartley, a founder of the New York clubhouse, was in Cape Town and talked to Cape Mental Health staffers about the concept. It seemed entirely appropriate for local needs and it was decided to adopt the model.

The American model began life in the 1940s when a group of mental patients, discharged after treatment, decided to support one another. They met on the steps of the New York public library, on the streets and in laundromats until they were able to move into a property near Times Square which had a courtyard with a fountain, hence the name.

BREAK-TIME: It's not all hard work. Members chat during a coffee break.

IN THE KITCHEN: Taking their turn . . . members helping to prepare meals.

Law set to act on dangerous psychos

By Helen Grange
Pretoria Bureau

The law governing treatment and sentencing of dangerous psychopaths looks set to become far stricter — a move which would prevent the recurrence of releases such as that of psychopathic killers Freddie Phillips and Keven Brits.

A commission of inquiry investigating the continued inclusion of psychopathy as a certifiable mental illness, and the sentencing and release of sexual and violent offenders, is currently finalising its report.

But proposals have leant strongly towards indeterminate prison sentences for dangerous psychopathic criminals, it was revealed yesterday.

The issue of how to deal with psychopaths has again become a point of angry debate in the wake of the release back into society of Phillips (27) and Brits (26) — who last week left a trail of murder, attempted murder, robbery and abandoned stolen cars, days after being released from prison.

Commission chairman Mr Justice W H Booysen said yesterday that as a result of worldwide acknowledgement by psychiatrists that psychopathy cannot be treated, the commission was considering recommending that psychopaths be excluded from the Mental Disorder Act — which is based on the principle that mental disorders can be treated and patients rehabilitated.

Criminals

It was likely to be recommended, therefore, that criminal psychopaths found by the courts to be dangerous should be sentenced to indeterminate imprisonment — and released only upon another court hearing following a recommendation for release by a statutory body.

The current position is that psychopathic criminals have access to the same prison conditions as ordinary criminals — and can qualify for the one-third remission of sentence as well as another one-third remission for good behaviour.

They need not return to court to be released.

The commission's report is expected to be finalised in March and will then be handed to the state president.

A Department of Correctional Services spokesman said most psychopathic criminals were sent to Zonderwater prison for treatment of up to four years.

This period at Zonderwater may or may not be included in their prison sentence.

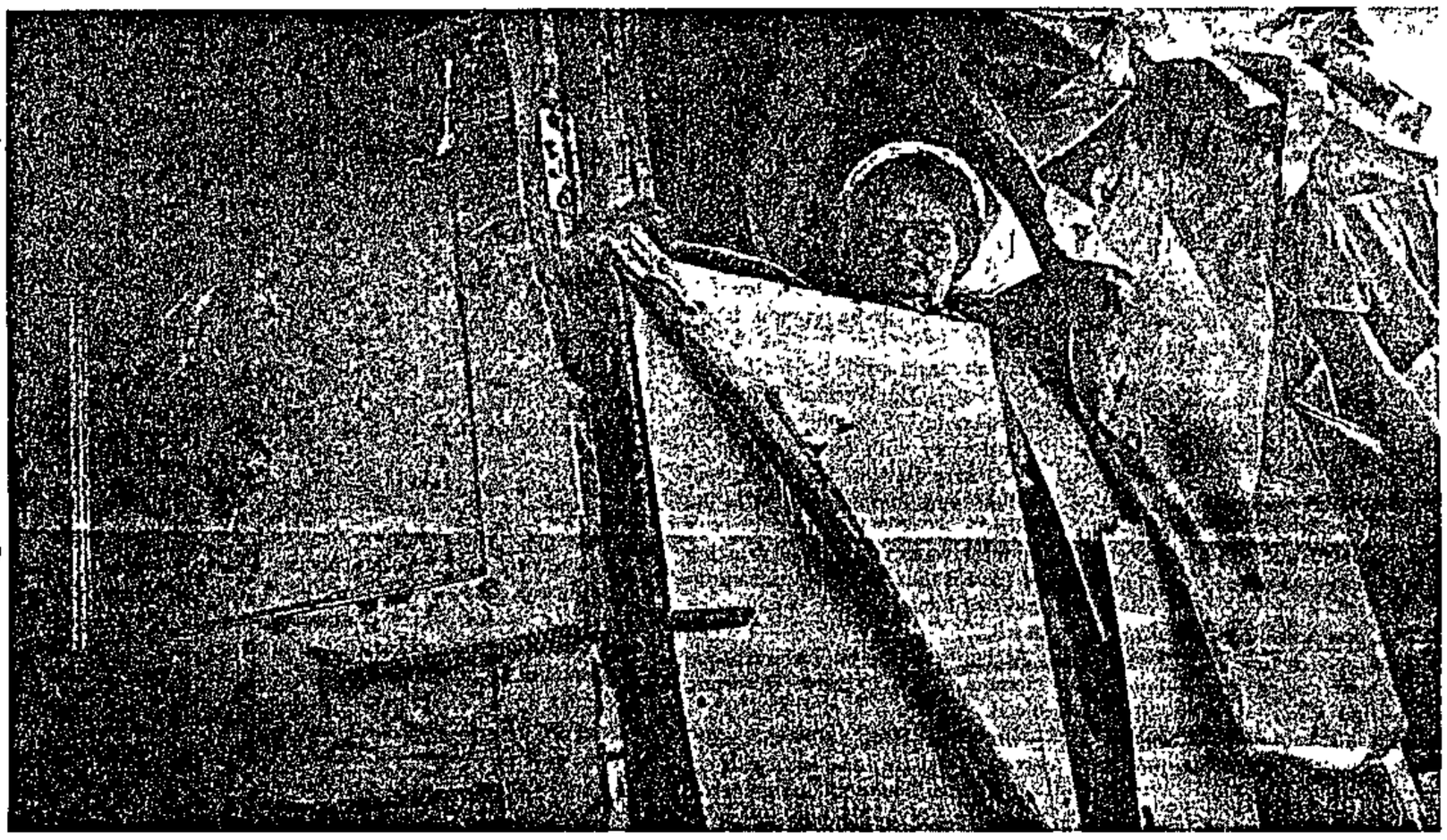
Brits was in Zonderwater for five years before being released last December after being decertified as a psychopath. (He was originally sentenced to 7½ years' jail in 1983.)

Phillips was decertified and released after three years in Zonderwater in February 1988. (He was originally sentenced to four years and four months' jail in 1984.)

They again fell foul of the law this year — on dagga and theft charges respectively.

They were subsequently both briefly in prison before being released days before another crime spree which ended in both committing suicide.

Depression comes at the end of a dream



END OF A DREAM: Depression sets in when there seems little hope of improvements in living standards

A study shows the incidence of depression among the elderly in Langa is the same as in other working-class communities worldwide, but in Khayelitsha it is 44 percent, reports

KATE DE SELINCOURT:

PEOPLE IN KHAYELITSHA have lost their dream. They can no longer dream of going to the city and finding their fortune, because here they are — and there is no fortune to be found. As Ms Lizeun Robbins, nurse at the Philani Nutrition centres, put it: "They have reached the end of the road. There is no way out."

The Philani nutrition centres run a valued service for mothers of malnourished children in Khayelitsha and Crossroads. The centres offer free meals and baby milk supplements. Equally important, they give a chance for penniless women to learn rug-weaving and begin to earn a small income.

But there are some desperately poor women who know about the centres but still don't go, although their babies are starving. These women stay away because they are crippled by depression. They can no longer make the effort to help themselves or their children.

Depression is a scourge in the new townships. It can be identified as an illness — depressed people have disturbed sleeping and eating patterns, they move and talk more slowly than normal. Nothing interests them, and pleasure is forgotten.

Robbins has found depression is a major obstacle keeping people from using the service. "Some of the mothers are so depressed it is difficult to motivate them to come in, even for free food. They can see that their baby is getting thinner and thinner, but they are simply too depressed to do anything about it."

Mrs Erica Langen is director of nursing at Valkenberg psychiatric hospital, in charge of the community clinic at Khayelitsha day hospital. She has also been disturbed by the depression in Khayelitsha patients.

"This clinic in Khayelitsha is the only one where I have seen people so depressed that they start crying as soon as you begin to talk to them."

A study by psychologists and psychiatrists from Groote Schuur hospital has put figures to what these nursing staff have found. Dr Len Gillis and his colleagues devised a questionnaire asking people about their state of mind, how they felt about life, and about their eating and sleeping habits.

The researchers interviewed elderly people in Khayelitsha and Langa. People in Langa showed about the same incidence of depression as other studies have found in working-class communities elsewhere in the world: about 17 percent would have been classified as depressed and needing treatment by a psychiatrist. But in Khayelitsha the figures were far higher. For elderly women in Khayelitsha the figure was a frightening 44 per cent.

Almost half the Khayelitsha women interviewed said they felt life was not worth living. Both men and women said they were slow and had lost energy; the majority had lost interest in what they did. More than half said they enjoyed almost nothing.

Poverty is obviously one of the main reasons people are depressed. People are poor in Langa, but poorer in Khayelitsha. But poverty is not the only factor. Many of the people in Khayelitsha have recently arrived from the rural areas. There, too, people will often have been desperately poor, but in a relatively stable situation, with family, friends and neighbours of long standing near at hand.

When you move to the city, all that changes, as Langen described: "People who come here have to adapt to a totally different lifestyle. In the city there is a lot of anger and aggression, everyone is fighting, there are shootings at night, it's a terrible shock. And then, just as you get to know your neighbours, they move, or the government moves a whole squatter area somewhere else. There is no stability, no support."

Ms Irene Mbanga, the matron who works with Langen, describes the desperate insecurity: "People build themselves a little shack, and there is a fight and it gets burned down, they have to build another one. I don't know how they can bear it, I would not survive one week of that life, not one week."

The other factor adding to people's misery is that their poverty now represents disappointment, the end of a dream.

"People come to the city believing there will be such opportunities for them, and they find unemployment and homelessness instead. It's rather like it must be when there is a gold rush and people find there is no gold," Langen says.

BRITISH PSYCHIATRIST Dr George Brown has worked for many years with working-class women with small children, often confined by poverty to the home, and has documented the importance of the support of friends, neighbours and relatives to mental health.

And he has also observed how often the trigger to depression is not necessarily a disastrous change in circumstances, such as a bereavement or retrenchment, but the loss of a dream.

The psychiatric clinic at Khayelitsha hospital is struggling to help depressed people who find their way there, though resources are stretched. The help offered is at present not much more than drug therapy plus a monthly visit to the sister.

The drugs are better than nothing — unusually for psychiatric patients, those being treated for depression are keen to take the medicine, so some benefit must be felt. Mbanga says they would like to do more.

"We need time for healing. We are going to try to group the patients, so we can work with them together. But it is so hard to find any space. We just have these two tiny rooms. Psychiatry always seems to get the crumbs."

The nurses' work is also hampered by the fact that on the two days a week a psychiatrist visits the clinic, they have to drop their own work to act as interpreters, as none of the psychiatrists at Valkenberg speak Xhosa. The hospital does not have a single trained interpreter.

The Groote Schuur researchers proposed "social, psychiatric and other helpful interventions" were needed. Anyone who can give people in Khayelitsha hope will be a healer indeed. □

Tackling the roots of the problem

COMMUNITY DEVELOPMENT projects such as the Philani nutrition centres in Khayelitsha and Crossroads offer a chance to tackle the roots of depression. Although begun as a project to improve children's nutrition, it quickly became clear that the main obstacle to eating well was poverty and unemployment.

A crucial part of the projects is therefore the training and facilities for rug-weaving. The rugs — the bright patterned mats sometimes seen at craft fairs around the city — have been successful enough for the weaving side of the project to start up with its own purpose-built factory warehouse, to be built next year.

Women coming to the centres have another employment opportunity, too. Many who first attended as worried mothers with sick and healthy babies are now mothers of bouncing tots — and they are now salaried nutrition advisers, educare or administrative workers, at the centres.

Valkenberg saved

ST Times (CM) 29/12/91 (88)

By EVELYN HOLTZHAUSEN

THE threat of mentally disturbed people being refused treatment at a mental hospital and left to fend for themselves in Cape Town has been averted.

Professor Brian Robertson, head of the Department of Psychiatry at the University of Cape Town and responsible for the treatment of patients at Valkenberg, said this week that the hospital would remain open as he had been allowed to recruit three more doctors.

Earlier this year, when budget cuts meant he would not be able to replace doctors who went into private practice, Professor Robertson gave the Cape Provincial Administration an ultimatum.

"Give us the funds we need to run the hospital or we will be forced to close," he said.

After a recent meeting at which the effect of Valkenberg's closure was discussed with provincial health authorities, Professor Robertson said, he was given funds to recruit three psychiatric registrars — qualified doctors who are training to be psychiatrists.

"I had hoped we would get five," he said, "but at least now I will be able to keep the hospital open.

"In the end it was decided to 'unfreeze' three posts with the possibility of a further two being 'unfrozen' next year.

"The possibility of granting Valkenberg a more realistic budget for 1992 was also raised at the meeting."

When he threatened to close the 1 039-bed hospital, Professor Roberstson pointed out that other, already-overloaded Cape hospitals, which were not equipped for mentally ill patients, would have to admit them.

The closure of Valkenberg would also have increased the workload on private doctors who have only the most rudimentary training in treating mental illness. In addition, the Department of Justice would have had to pay private doctors to assess most awaiting-trail prisoners whom the courts required to undergo mental observation.

The "Valkenberg ultimatum" brought into focus the funds crisis at other mental hospitals, including Weskoppies in Pretoria, Sterkfontein in Krugersdorp and the Midlands Mental Hospital in Pietermaritzburg.

Professor Robertson disclosed that because of the lack of funds, domestic workers were being left in charge of wards at night, nurses were used by psychiatrists as interpreters for black patients and the lack of patient care was increasing patient stress, with the result that there were more assaults on doctors and staff.

"We have already cut costs to the core," he said.

"We cannot make any more cuts and still pretend to offer a service to the community."

According to Professor Robertson, the authorities failed to act on his letters, warning of the crisis, in August and September.

It was only after he had threatened to close the hospital that there was a positive response.

Stress sends policemen into clinic

STAR 29/11/92

By Helen Grange
Pretoria Bureau

A soaring crime rate and the difficult role of the police in overseeing the transitional political period have contributed to an increased incidence of stress-related problems among policemen, the SAP said yesterday.

There were 10 policemen in Sandton Clinic being treated for stress, some of whom were receiving sleep therapy.

It has been reported that certain experienced detectives resigned from the force last month after receiving treatment for stress.

Police said in a statement yesterday that statistically there was no indication that stress-related illnesses had become a problem in the force, but it was no exception to other big organisations.

'Mechanism'

Policemen in Sandton Clinic might not all be undergoing treatment for stress, the statement said.

"The reasons why stress has become more of a problem lately may be the increase in the crime rate, as well as the fact that the police have to be the mechanism to see that the transitional period progresses smoothly."

The police were working on the problem continually, and were doing in-depth research projects. Clinical psychologists, social workers and the Institute of Behavioural Sciences had continual contact with members of the force.

A sleep therapist, who could not be named for professional reasons, said policemen would probably suffer from the same stress-related problems as war veterans.

Weskoppies goes 'nuts' over its centenary

STAR 30/1/92

88

Pretoria Correspondent

Staff and patients at Weskoppies Hospital in Pretoria are crazy about the place — and they're not ashamed to show it.

Eye-catching T-shirts with slogans such as "I'm nuts about Weskoppies, "Just be yourself" and "I'm coping ... Just" have been specially printed to mark the psychiatric hospital's centenary this week.

Professor Wilhelm Bodemer, chief psychiatrist, said the T-shirts are aimed at showing the public there is "nothing extraordinary" about Weskoppies Hospital, and at adding "a touch of humour" to the centenary celebrations.

The T-shirts, designed and printed by artist Colombe Ashborn, are on sale at the hospital, along with commemorative coffee mugs and bookmarks stamped with the Weskoppies logo.

Centenary celebrations were officially opened yesterday by Dr W Guldenpfennig, chairman of the hospital board. The programme of festivities includes a special tea for patients, a fun run, sport, a talent competition and a reunion dance for present and former personnel.

An academic day will be held on Friday and speakers will discuss topics ranging from the history of Weskoppies to the future of psychiatry.

Exhibits of Weskoppies memorabilia, such as the padded cell — now a museum piece — will be displayed until Saturday.

When Weskoppies Hospital admitted its first patients in 1892, conditions were extremely primitive. Paraffin lamps were used, bath water had to be fetched by hand, and sick patients were transported in "mule ambulances".

By December that year, there were 29 patients — a fact causing some consternation among the Pretoria public, who were concerned about the "disturbing" rise in patient numbers.

The number of patients reached a high of 5 000 in 1966, and then tailed off to about 2 000 in the '70s. Today, the hospital has about 1 400 beds, and treats up to 30 000 patients a year.

A highlight in the hospital's development was the 1979 opening of a Child and Family Unit, where children up to Standard 5 level are treated for problems such as anxiety, depression, and learning and behavioural disorders.

A young people's unit was established in 1988 for troubled teenagers aged 14 to 18.

Birthday shirts ... Dr Johan Grove (left) and Professor Wilhelm Bodemer model the shirts.

Council cautions on 'over-counter' slimming liquid

By John Miller

The SA National Council on Alcoholism and Drug Dependence has cautioned against the use of over-the-counter slimming solutions containing an appetite suppressant and warned that abuse could lead to psychological dependence.

Manager, professional services, Macelle Christian said no appetite suppressants had a long-term effect.

"There is research to prove that appetite suppressants do not have a long-term effect in controlling obesity.

"The danger with appetite suppressants is that they can cause psychotic disturbances."

She said it has been shown that slimming tablets could, with some people, lead to other drug abuse.

Misuse

The warning follows a report in The Star and subsequent heated debates and comments on radio about the sale of the over-the-counter slimming solution.

Following the reports, the issue is to be raised with Minister of Health Dr Rina Venter during question time in Parliament by DP health spokesman Mike Ellis.

Chris van Niekerk, manager of prices for the South African Pharmacy Council, said all members had been warned in October against the misuse of slimming solutions.

He also said that effects of the appetite suppressant d-norpseudoephedrine had been brought to the attention of pharmacy council members.

"Pharmacists must supply the patient with the correct use of any scheduled medicine," he said.

Mr van Niekerk said new regulations were being written for the Medicines Act.

Dr Rina Venter . . . to be questioned on slimming solution.

A R40 000 fine could be imposed for misuse by anyone who had control of medicines. People with complaints may write to the council, which would then launch an investigation.

He said the present register system, which was seldom used by pharmacists for Schedule 2 drugs, would be made more pragmatic, to enable better control of such substances.

Almost all home-made slimming solutions contained d-norpseudoephedrine, a Schedule 2 drug found in all but two of the slimming tablets available in South Africa.

While these tablets were freely available over the counter in South Africa, they could be obtained only on prescription in the US.

Two pharmacists told The Star they had heard of colleagues who not only used d-norpseudoephedrine in slimming solutions, but also added laxatives, diuretics and a thyroid preparation — both Schedule 3 substances and available only on prescription.

The thyroid preparation affected the metabolism while the d-norpseudo-ephedrine could cause the heart rate to increase and lead to higher blood pressure, aggression, nervousness and sleeplessness.

MLW 2

The amazing tale of Weskoppies

(88)

Sowetan 30/1/92

How the stigma of mental illness was removed

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Sowetan Correspondent

WELL, they certainly didn't mess around with fancy titles or mince words in the early days at Weskoppies Hospital.

The inmates were bluntly called "lunatics'' and the place itself was officially the Pretoria Lunatic Asylum.

It was not until 1911 that the "lunatics'' inmates became the "patients'' and the institution acquired the more innocuous title of the "Pretoria Sielsieke Hospitaal''.

Even so, its soccer, hockey and cricket teams playing against outside teams were burdened with the label "Mentals'' until 1947 when the institution finally came to be called Weskoppies Hospital.

Equally startling was the treatment given patients in the absence of modern-day drugs.

There weren't any sedatives so "agitated'' patients in need of soothing were given piping hot baths (often while strapped into straitjackets).

Incidentally, there were strict "bathing rules'' for patients. They had to bath at least once a week and bath water could not be used by more than one patient. Patients had to bath in the presence of a staff member unless special permission was obtained to bath in private.

Then there was the malaria therapy of 1923 for patients suffering from cerebral syphilis, also known as general paralysis of the insane.

Malaria-carrying mosquitoes were attached to the arms of these patient souls, who were bitten until they contracted malaria.

The idea was that the patient would develop a raging fever, which would then counteract the syphilis. Amazingly, it often worked, so much so that some patients recovered enough to be discharged from hospital.

Another mind-boggling treatment started at Weskoppies in 1937 was for schizophrenic patients.

Known as "insulin shocks'', it involved administering large doses of insulin to patients until they fell into a low-sugar coma lasting about an hour. Patients underwent this treatment for three months, and 60 comas were regarded as a full course.

Drugs are a problem at all psychiatric hospitals in South Africa, but fortunately, 'hard' drugs are very rare here

Again, this treatment apparently "achieved a reasonable'' degree of success - in spite of the risk of brain damage involved.

Happily, The '50s saw the advent of modern medication and treatment, and the padded cell was permanently mothballed.

In the '60s, the fences around wards came down, doors were unlocked, and an "open'' era began at Weskoppies.

But the more relaxed atmosphere and greater freedom for patients had its drawbacks too.

One was alcohol and drugs, notably dagga, smuggled in by visitors, delivery men and patients out on leave.

"Drugs are a problem at all psychiatric hospitals in South Africa, but fortunately, 'hard' drugs are very rare here; we see very little cocaine and heroin,'' said Weskoppies' chief psychiatrist, Professor Wilhelm Bodemer.

Weskoppies enforces a strict anti-dagga and alcohol policy: patients suspected of possessing dagga are given urine tests, police are called in, and offenders can be discharged or prosecuted.

Another by-product of the open-door policy has been so-called "escapes'' by patients, widely reported in the media.

While the hospital's critics say patients "escape'' because conditions there are so ghastly, those who leave without permission don't need to cut through barbed wire or evade armed guards.

As Bodemer points out, few wards are locked, and minimal security (except in closed wards and the maximum security unit) is an international trend at psychiatric hospitals.

Critics have also seized on racial discrimination at Weskoppies, in the form of separate (but not equal) facilities for black and white patients.

By December 1991, though, the colour bar was scrapped and there is now "no such thing'' as a whites-only ward. The hospital, including the maximum security unit, is fully integrated.

And while there were fears that the changes could spark some tension, it's been so far, so good.

As for the "Weskoppies stigma'', it's slowly disappearing.

"We get the impression that our community is becoming more civilised in its attitude towards mental illness. It's no longer such a shame to be admitted to Weskoppies,'' says Bodemer.

Proof of this is that staff and patients will this week wear T-shirts emblazoned with legends like "I'm nuts about Weskoppies'' and "I'm coping . . . just''.

Unusual treatments marked early days

STAR 30/11/92

Pretoria Correspondent

88

They certainly called a spade a spade in the early days at Weskoppies.

The inmates were bluntly called "lunatics", the place itself was officially the Pretoria Lunatic Asylum.

It wasn't until 1911 that the "lunatic" inmates became the "patients", and the asylum institution acquired the more innocuous title of the "Pretoria Sielsieke Hospitaal".

Even so, its sport teams playing against outsiders were labelled "Mentals" right until 1947, when the institution finally came to be called Weskoppies Hospital.

Equally startling was the treatment given to patients in the absence of modern-day drugs.

There weren't any sedatives then, so "agitated" patients in need of soothing were given piping hot baths (often strapped into straitjackets ...)

Then there was the malaria therapy of 1923 for patients suffering from cerebral syphilis, also known as general paralysis of the insane.

Malaria-carrying mosquitoes were attached to the arms of these patients, who were bitten until they contracted malaria.

The idea was that the patient would develop a raging fever, which would then counteract the syphilis.

Amazingly, it often worked. So much so that some patients recovered enough to be discharged from hospital.

Another mind-boggling treatment started at Weskoppies in 1937 was for schizophrenics.

Known as "insulin shocks", it involved administering large doses of insulin to patients until they fell into a low-sugar coma lasting about an hour.

Again, this treatment apparently achieved "a reasonable" degree of success — in spite of the risk of brain damage.

Happily, the '50s saw the advent of modern medication and treatment, and the padded cell was permanently mothballed. In the '60s, the fences around wards came down, doors were unlocked, and an "open" era began.

As for the "Weskoppies stigma", it's slowly disappearing.

"We get the impression that our community is becoming more civilised in its attitudes towards mental illness," says chief psychiatrist Professor Wilhelm Bodemer.

HELP ON THE LINE: A Lifeline counsellor assists a caller

Life Line to open in Gugs

South 6/2-12/2/92

By Sabata Ngcai

GUGULETU residents will soon have access to personal counselling when Life Line opens its newest office at the Uluntu Centre in April.

Previously Cape Town's black residents had not made use of the project's counselling service and no Xhosa-speaking counsellors were trained to assist their communities with their often shattering personal and emotional problems.

But, largely due to the organisation's attempts to reach out to black communities, 18 counsellors have now been trained to assist their community with problems ranging from suicide to murder.

Life Line, established by the Methodist Church in 1963, has 200 centres worldwide and 17 in South Africa. The organisation began its work in the Western Cape in 1968.

"Despite the fact that our training course was open to all, we failed to draw people from the townships due to the inconvenient times and places where we operate, the fees charged and the lack of transport," said Life Line executive director, Mr Andy Laurens.

However, last year Life Line's office was inundated with calls from township residents with problems. There were no Xhosa-speaking counsellors to assist them.

Life Line's training course equips counsellors to assist callers with — among other problems — rape, suicide and murder.

Normally trainees are expected to pay R180 for each of the first two courses, but the first batch of township counsellors have been offered the course free of charge.

"They hadn't known about the course until we made contact with them and we are trying to make it acceptable to their community," Laurens said.

"In future we will charge a minimal fee, depending on the trainees' financial circumstances."

The 18 township trainees from Langa, Guguletu, Nyanga and Khayelitsha attend classes at the Uluntu Centre once a week in the evenings and weekends to allow employed people to attend.

The newly-graduated counsellors will work from April, initially under the guidance of an experienced counsellor.

Laurens said training would be ongoing and aspirant counsellors need not wait until April before applying to do the course.

A Guguletu trainee counsellor said it was important for people to learn how to behave in their family and community life.

"Counselling teaches people to cope with problems they encounter in life and not to think about committing suicide when confronted by such problems."

Comprising 350 trained volunteer counsellors and six paid administrative staff members, Life Line operates for 24 hours every day at its Cape Town centre.

Mental patients return to hospital

THREE of the 11 Valkenberg mental patients on the run after their break-out this week have returned to the hospital. Cipen 16/2/92

Police said yesterday that Johannes Simon, 40 – a State President's Discretion (SPD) patient who murdered his wife – gave himself up, saying he was "very hungry". 88

Sipho Dlamini, 27, facing charges of attempted housebreaking and assault, and Simon Mothlaping, 26, a SPD patient, returned to Valkenberg on their own.

Police are searching for the other eight.

Security staff were switched to clerical duties due to budget cuts

S/Times 16/2/92

DOCTORS at a mental hospital predicted over a year ago, when security staff were moved into clerical posts because of budget cuts, that maximum security prisoners would attempt to escape. (88) (93)

Now, as police comb through the Western Cape for eight dangerous, mentally-ill prisoners who are on the run, the doctors have the grim satisfaction of knowing they were right.

By EVELYN HOLTZHAUSEN

The eight were among 34 patients held in a maximum security building at the Valkenberg Hospital in Pinelands, Cape Town, who broke out of the hospital on Thursday afternoon.

Ten escapees were caught by "pure chance" by two policemen driving past the hospital.

A police spokesman said: "They saw the men pouring over the wall, some in their blue hospital pyjamas and others in their underwear, and arrested them without too much trouble."

Afterwards, one of the escapees, still in hospital pyjamas, tried to attack commuters on a Cape suburban train before he was arrested. One was re-arrested in Paarl after boarding a train, another was arrested in Philippi and two in Manenberg.

JOHNNY SCHOLZ
Behind escapes?

Police suspect one patient is trying to make his way to Kimberley, while another is probably heading for Citrusdal in the Western Cape. Escapee Johannes Simon, 40, was caught "hungry and tired" in Steenberg near Cape Town early yesterday.

Late yesterday two others, Simon Mothlaping, 26, and Sipho Dlamini, 27, returned to Valkenberg Hospital.

Scary

Yesterday, Valkenberg trainee psychiatrists (registrars) said they were not surprised by the escape.

One said: "We take our lives into our hands every time we go into the maximum security wing. It's very scary, especially since the security staff were given clerical jobs over a year ago."

Last October, Professor Brian Robertson, head of the Department of Psychiatry at the University of Cape Town and the doctor responsible for the treatment of patients at Valkenberg, threatened to close down the hospital unless funds were provided to replace registrars.

He said domestic staff were left in charge of wards at night and that registrars and nursing staff had been assaulted by patients.

Early this year additional, but limited, funds were provided to replace registrars, but not for the employment of security staff.

Said one intern: "Patient frustration caused by overcrowding, the lack of staff to administer proper care and red tape causing long, frustrating delays before patients can be released, have escalated tension at the hospital."

Thursday's escape was apparently led by long-term patient, Johnny Scholz, 28, who has been described as extremely dangerous.

He overpowered a medical orderly who was dispensing medicines.

Professor Robertson warned that the patients were dangerous. He could not predict how they would react once their daily medication, an anti-psychotic drug, wears off.

A team of Cape Provincial administration heads, officers from the Department of Correctional Services and clinical psychiatrists have met to discuss the escape.

Valkenberg Hospital Medical superintendent Dr Geoffrey Garrett confirmed that doctors at the hospital had been "scared" to go into the maximum security wing since the reassignment of security staff.

"I am scared myself. I never turn my back on a patient in there," he said. "Sometimes I ask a male nurse to accompany me."

One of the men on the run, Rashaad Solomon, 22, was spotted in Cape Town's Lavender Hill area early last night, according to a police spokesman.

Apart from Solomon and Scholz, the men at large are: Bernard du Plessis, 41, Rodney van Eeden, 29, Marius Scheffers, 30, Anthony Benjamin, 28, Marthinus Swartz, 39, and Thomas Tieties, 24.

We warned of escape, say doctors

Breakout shows all was not well at Valkenberg

STAR 17/2/92

88

In the light of last week's escape by 34 patients who are criminally insane, GRAHAM LIZAMORE takes a look at Valkenberg Psychiatric Hospital near Cape Town.

BEFORE 1890, mentally ill patients, then termed lunatics, were kept on Robben Island alongside lepers and political prisoners, where they remained out of sight and there was little chance of escape.

Conditions on the island were appalling and the erection of a hospital on the mainland was recommended. Valkenberg was established in Observatory in 1891, in the shadow of Devil's Peak, with the greenery of the suburbs creating a sylvan backdrop to what was then a "modern" institution.

But things do change, and almost 10 years ago the medical superintendent, Dr G M Garrett, said the old idea of a mental hospital — to crowd mentally ill patients together in big wards — had given way to the philosophy of treatment in a more home-like environment, in small wards with a village-like atmosphere.

Then, about two years ago, the hospital began to "rationalise" along nonracial lines and a spokesman for Valkenberg wrote that the hospital had become in a sense a "microcosm of the new unfolding South Africa".

But like the new cash-strapped South Africa, Valkenberg has also had to face smaller budgets with more mouths to feed and more disturbed souls to care for.

Since then there have been a number of reports that the institution, particularly the maximum security wing, had started sliding back to the dark Victorian age of Robben Island where overcrowding and lack of proper care were again evident.

Last year, the head of the Department of Psychiatry at UCT, Dr Brian Robertson, issued an ultimatum to the Cape Provincial Administration that unless more funds were made available to the hospital it would have to close.

He warned that the staff situation at the hospital was so bad that domestic workers were left in charge of wards at night.

He also pointed out that lack of care was leading to an increase in patient stress which was provoking an escalation in assaults on doctors, nurses and domestic staff.

Less than six months later, 34 criminally-insane patients broke out of the maximum security wing.

Within 48 hours 22 had been rearrested, but 10 potentially violent men have the communities that spawned and nurtured them in a stranglehold of fear.

As their powerful medication wears off, these criminally insane patients are hidden, lethal time-bombs in the back streets of Cape Town.

Police are scouring the streets and questioning friends and families in a desperate search to find the men before some innocent becomes the victim of a twisted, violent mind.

The mass breakout has at last forced the CPA to admit that they knew all along that all was not well at Valkenberg.

Dr G S Watermeyer, chief director of hospitals and health services, said in a statement:

"We want to stress that the Cape Provincial Administration has, for some time, been concerned about the fact that considerably more patients have had to be accommodated in this unit than provided for by the facilities.

"Although this maximum security unit only makes provision for 65 patients, the hospital has had to accommodate up to 120 patients (90 at present)."

While authorities sort out their priorities, there will be many who might be thinking that old-timers did know something: after all, dangerous "lunatics" could not escape from Robben Island. □

Snakes, animals and naked women . . .

88 (66) ARG 20/2/92

Staff Reporter

THERE are metal grilles over the tiny windows, peepholes in the doors and no taps on the basins.

"They put them in socks and use them as weapons," explains senior nursing service manager Mr Jan Witbooi.

The atmosphere in Ward 20 is prison-like, although the hospital authorities have made obvious efforts to relieve the starkness — for example, in the dining area there are colourful posters on the wall and cloths on the tables.

The patients have their own ideas about decoration. Pin-ups and magazine illustrations are stuck on the walls and several dormitories have been adorned with murals.

Snakes, naked women and odd animal-like figures dominate.

"You look at these drawings and you can see the dark, evil side — it's Satanism," a male nurse suggests.

The beds in the eight-man dormitories are mostly made up neatly, with towels hanging over the ends. The steel bedside cabinets are unattractive but functional.

There's a strong smell of stale smoke; in some places also that of sweat and urine.

There are single cells for observation patients — gloomy rooms with just a covered mattress and blankets.

In the occupational therapy block, patients work on various sub-contracts: they assemble electrical extension leads, punch holes in medical tags, glue and fold, pierce and pack for small printing orders.

"We urgently need more work," says occupational therapist Mrs Diane Fairhead, who has spent 13 years working in Ward 20.

Patients are paid weekly for their work, earning up to R9 which they spend at the tuckshop or save to buy radios or clothing.

"If we don't get enough work to keep them occupied and help with rehabilitation, we reach the stage where there's no money and then we're really in trouble," she said.

Mrs Fairhead has also noticed a rise in the level of tension and frustration in the ward.

"Our biggest problem is our lack of facilities for sport. Any sport where they can get rid of their frustrations is good — I'm on my third punch bag."

● Anyone who can help with offers of work or by giving television sets and radios can contact Mrs Fairhead at ☎ 470050.

The View from Valkenberg's security wing

More prison than hospital

JOHN YELD
Staff Reporter

THE yellow brick walls are seven metres high and topped with razor wire.

From inside the bare, paved exercise yard, there's a tantalising view of Devil's Peak, but there are at least five locked doors — one a solid metal grille — to negotiate before you're out in the open.

This is Valkenberg Hospital's maximum security section — Ward 20 — from which 34 mental patients escaped last week, including 11 described as "highly dangerous".

Nearly all are now back behind bars, either in the hospital or in Pollsmoor Prison, and life in Ward 20 is slowly returning to normal after the break-out.

Senior medical superintendent Dr Geoffrey Garrett acknowledges that Ward 20 is "grim and forbidding".

"It is like a prison and not a hospital ward, but the nature of the clientele demands it," he said.

Ward 20 accommodates all the hospital's male forensic (anything to do with law) patients. There are few female forensic patients — often only two or three — and they are all housed separately in the hospital's general section.

There are two main categories of patient in the ward:

● Observation cases — people who have appeared in court where there is some doubt about their mental condition, and who are sent for 30 days' observation; and

● State patients (previously known as State President's patients) — those who have been found to be mentally ill after having committed a crime and are sent for treatment as a forensic case.

Dr Garrett said at times individual patients from the general section of the hospital were transferred to Ward 20 for an indefinite period after being declared dangerous by two psychiatrists.

"And occasionally we have a criminal patient, a committed prisoner, who becomes mentally ill.

"We prefer the majority of them to be kept in a prison hospital to be treated there, but sometimes their behaviour is such that they have to be sent to a mental hospital."

Ward 20 had been built about 14 years ago, he said.

"It was handed over to us to house 80 patients, but after taking over we found the living accommodation was only really suitable for 65 and the number was officially reduced.

"Since then, we've had on occasions anything up to 120 patients. On the day of the break-out, there were 90 patients."

Over-crowding was tackled quickly by opening another ward and shuffling patients, so that maximum over-crowding had usually been limited to between seven and 10 days, Dr Garrett added.

"But there are seldom fewer than 80 patients and the demand for this accommodation is never-ending. On some days we have up to seven or eight admissions."

The hospital management had warned that security staff were needed, Dr Garrett said.

"We expect psychiatric nurses to be responsible for the security of their patients but it is different in Ward 20 — it's not just security of mentally ill patients but of criminally mentally ill patients. And that is the big factor — you're dealing with criminality."

There were two types of patient — the criminally insane, and the insane criminal, Dr Garrett pointed out.

"When the insane criminal recovers from his illness, you are still left with the basic criminal personality and he's the difficult guy.

"Otherwise (the criminally insane) you can be left with a normal personality and they don't give us anything like that trouble."

Dr Garrett said that in spite of its prison-like nature, they had attempted to make Ward 20 as much like a hospital as possible.

"For example, there are television sets, video recorders, a tuckshop, a very active occupational therapy section and musical instruments.

"When staff are available and the demand is not too great on them, they do physical exercises with the patients in the yard.

"Unfortunately the nature of the building precludes any ball games, although an area of land between the ward and the Black River was recently ceded to the hospital and there are plans to fence this for a games area for this ward."

Dr Garrett said Ward 20 did not usually look as bad and dirty as it did at present. "Cleanliness is an important part of nursing and usually it is much nicer than it is now."

The ward had been painted six months ago but there were already drawings on the wall.

"It is simply impossible to keep it clean — we would have to paint every week," he said.

The Star
20/2/92
Page 20

'Education will remain segregated'

By Carina le Grange

For the next 50 years, most children in South Africa would continue to be educated on a racially segregated basis due to the fact that they lived in segregated areas, educationist Dr Franz Auerbach said in Pretoria yesterday.

Dr Auerbach said one of the ways in which the education process could promote mutual respect and tolerance would be integration at school level.
whether the education system could teach children to live meaningfully.

He was one of the speakers on the first day of the national conference of the National Council for Mental Health.

The aim of the conference is to prepare a strategy for the formulation of a child mental health policy to be presented to Minister of National Health and Population Development Dr Rina Venter.

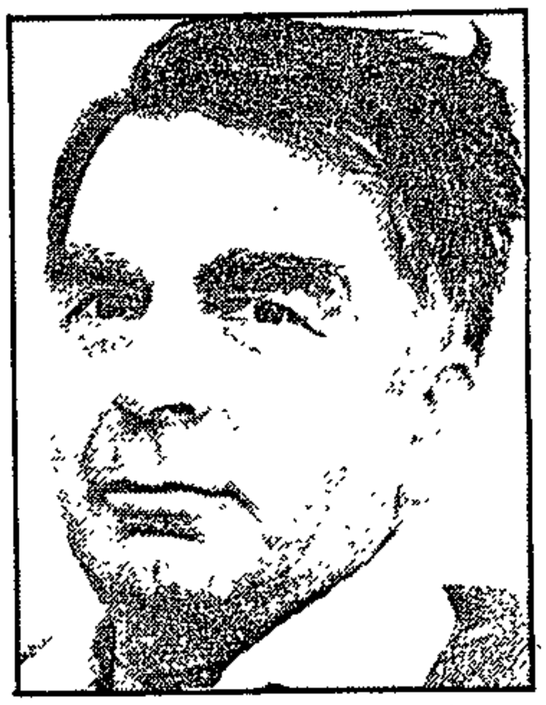
But Melvyn Freeman of the Centre for Health Policy at the University of the Witwatersrand questioned whether it was appropriate to present Dr Venter with the strategy "as if she should restructure (child mental) policy at this time".

"We must think of where we want to be going with a representative strategy — not only to this constituency (the conference) but also to a wider one.

"It is not enough to have representatives from (progressive) organisations like the National Education Co-ordinating Committee and the Organisation for Appropriate Social Sciences to say that this is a representative meeting," Mr Freeman said.

Earlier, he had said it was not necessary to be too pessimistic on the outlook for child mental health, since SA would get a new government that would care for people's needs.

He said the best way to improve mental health was to effect changes in educational, political and economic structures.



Franz Auerbach . . . need to promote mutual respect.

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Valkenberg hospital

117. Miss M SMUTS asked the Minister of National Health:

(1) (a) How many psychiatric patients escaped from the maximum security unit at the Valkenberg Hospital during February 1992, (b) for how long was each of them at large, (c) how many patients (i) is this unit intended to accommodate and (ii) were accommodated there at the time and (d) how many (i) medical and (ii) nursing posts at this hospital were vacant at the time of the escape;

(2) whether any patients escaped from this hospital during the preceding 12-month period; if so, (a) how many, (b) when and (c) for how long was each of them at large;

(3) whether, during the 12-month period preceding this incident, there was any increase in the number of persons referred by the courts to this hospital for observation; if so, to what extent?

B303E

The MINISTER OF NATIONAL HEALTH:

(1) (a) 32 escaped on 17 February 1992,

(b) by 18 February 1992, 30 patients were recaptured while two awaiting trial are still at large,

(c) (i) 65 and (ii) 90 and

(d) (i) 4 and (ii) 22;

(2) yes, (a) 1, (b) middle 1991 and (c) less than 24 hours;

(3) yes, from an average of 33 to 43 per month.

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Number of persons without legal representation

44. Mr L FUCHS asked the Minister of Justice:

How many persons appeared in (a) (i) district and (ii) regional courts and (b) the Supreme Court in each province in 1991 without legal representation?

B77E

The MINISTER OF JUSTICE:

The statistics hereunder are only with regard to more serious criminal offences. Statistics with regard to minor offences, for example stationary traffic offences, are not included in the data. The required information regarding the Supreme Court is not readily available. To obtain the information all court records will have to be scrutinized which is not economically feasible.

Transvaal:

(a) (i) District Courts—215 135 persons

(ii) Regional Courts—11 130 persons

Orange Free State:

(a) (i) District Courts—61 148 persons

(ii) Regional Courts—5 110 persons

Natal:

(a) (i) District Courts—120 031 persons

(ii) Regional Courts—7 152 persons

Cape Province:

(a) (i) District Courts—242 217 persons

(ii) Regional Courts—21 718 persons

It is important to take cognizance of the fact that our system of adjudication of criminal matters provides for various intrinsic safeguards to prevent miscarriages of justice and this means that accused appearing in courts are not necessarily prejudiced by a lack of legal representation. Consequently only approximately 20 percent of the large number of accused which appeared in the courts without legal representation were convicted and committed to prison.

Assault complaints: prisoners against prison warders

100. Mr L FUCHS asked the Minister of Correctional Services:

(1) (a) How many complaints relating to assault were made by prisoners against prison warders in 1989, 1990 and 1991, respectively, and (b) how many prison warders were (i) charged with and (ii) convicted of assault on a prisoner in each of these years;

(2) in respect of 1989, 1990 and 1991, respectively, (a) how many prison warders faced disciplinary hearings arising out of an assault on a prisoner, (b) how many prison warders were dismissed for assaulting prisoners and (c) what other forms of disciplinary action was taken against such prison warders?

B260E

The MINISTER OF CORRECTIONAL SERVICES:

With reference to the information for 1989 and 1990 respectively, I refer the hon member to my written reply of 9 April 1991 to question number 180 in the House of Assembly (Hansard col 902-904). Regarding 1991, the information is as follows:

(1) (a) A total of 1 426 complaints of alleged assault were received and registered.

The Department of Correctional Services regards every complaint of alleged assault on a prisoner by a member of the Service, no matter how petty, in a very serious light. In terms of the Departmental Orders, every complaint of alleged assault is registered in the appropriate register and properly investigated by the Commanding Officer.

Likewise, assaults on personnel by

Cont ... p

the deceased is Mr Malatudi Lebatha alias Lawaai.

(2) (a), (b) and (c)

No, Mr K Findlay and Mrs F Findlay were summonsed and appeared in the Vereeniging court on 11 March 1992 on a charge of murder. The case was remanded until 10 April 1992.

Repealing of legislation iro the Press

*7. Mr P G SOAL asked the Minister of Home Affairs:

(1) Whether, with reference to each of the 11 Acts particulars of which have been furnished to the Minister's Department for the purpose of his reply, it is the Government's intention to repeal legislation which detracts from the free flow of information and restricts the Press from reporting; if not, why not; if so, what are the relevant details;

(2) whether he will make a statement on the matter?

B294E

The MINISTER OF HOME AFFAIRS:

(1) and (2)

Of the 11 Acts referred to by the hon member, the Department of Home Affairs administers only the Electoral Act, 1979 (Act 45 of 1979). Since section 143 of the Electoral Act, which is at issue here, has it in view to prevent unjustifiable influencing of voters, it is not this Department's intention to repeal it at this stage.

However, in view of more recent developments, such as, *inter alia* discussions at Codesa, renewed discussions regarding the respective acts are now the proper course which will be formulated in more concrete form in due course and hopefully progress could be reported in course of time.

Mr P G SOAL: Mr Chairman, arising out of the reply of the hon the Minister, I want to say that I originally formulated this question to be addressed to the hon the State President, but it was obviously felt that this hon Minister had great influence with his colleagues in the Cabinet, and that he would be able to influence them to have these pieces of legislation repealed. May I ask if he would please undertake to talk to his colleagues in the Cabinet who are responsible for the 11 pieces of legislation that I outlined in my question with a view to having them repealed as soon as possible in order that there may be a free flow of information before we get to the situation at Codesa in which that is required?

The MINISTER: Mr Chairman, the hon member will have concluded from my reply that discussions were in fact taking place in this regard. Naturally I cannot give any undertaking on behalf of my colleagues as to whether they will repeal the legislation of not, but this is the process and I think my reply has been very clear in this regard.

Pretoria Regional Services Council: personal loans

*8. Mr F J LE ROUX asked the Minister of Local Government and National Housing:†

Whether the Pretoria Regional Services Council has granted any personal loans of money to any person or body in the year ending 31 March 1992; if so, (a) to whom or what body, (b) how much money was lent to this person or body, (c) at what rate of interest was it lent and (d) when does the loan have to be paid back? B295E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

No.

(a)-(d) Fall away.

Proposed structure: single education authority

*9. Mr R M BURROWS asked the Minister of National Education:

(1) Whether a proposed structure for a single education authority, together with non-racial, geographic departments of education, has been devised by or for his Department; if not, why not; if so, (a) (i) by whom and (ii) when was this structure devised and (b) to whom has it been propagated;

(2) whether he will make a statement on the matter?

B299E

The MINISTER OF NATIONAL EDUCATION:

(1) No. In the Education Renewal Strategy (ERS) developed by the Committee of Heads of Education Departments (CHED), and not by the Department of National Education, broad proposals in this regard were made. Comments on these broad proposals have been sought nationally and final recommendations on a future educational structure could be submitted by the CHED, as part of the ERS, to the Education Ministers. Devising an acceptable future education structure is, however, a process which is closely linked to future constitutional structures at present being negotiated.

(a) (i) Falls away.

(ii) Falls away.

(b) Falls away.

(2) No.

Archival material: restrictions

*10. Mr R M BURROWS asked the Minister of National Education:

(1) Whether any restrictions are imposed on the public scrutiny of archival material derived from South African State Departments; if so, (a) what are these restrictions and (b) by whom were they imposed;

(2) whether the Government proposes to relax the current restrictions on the scrutiny of State archival material; if not, why not; if so, to what extent;

(3) whether he will make a statement on the matter?

B300E

The MINISTER OF NATIONAL EDUCATION:

(1) Yes.

(a) The making available of archives from Government departments to members of the public for research purposes is controlled by section 9 of the Archives Act (Act 6 of 1962). According to this section a so-called "closed period" of about 30-years is maintained as a general principle and documents dating from the period before 1961 are at present available. Individual applications to consult documents in archives depots which still fall in the closed period are considered on merit.

(b) The Archives Act, 1962 (Act 6 of 1962).

(2) No. The present arrangments are in accordance with international standards and no problems are experienced with these in practice.

(3) No.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Valkenberg Hospital: security staff

*11. Miss M SMUTS asked the Minister of National Health:

(1) Whether, at the time of the escape of a number of psychiatric patients from the maximum security unit at the Valkenberg Hospital during February 1992, there were any security staff in the employ of this hospital; if so, where were they at the time; if not, why not;

(2) whether security staff have been introduced since; if so, (a) what staff and (b) for how long;

(3) whether any further steps are being contemplated in respect of improving security; if not, why not; if so, what steps?

B301E

The MINISTER OF NATIONAL HEALTH:

(1) No, the hospital does not have posts for security personnel on its establishment;

(2) yes,

(a) security personnel of the Department of Corrective Services and

(b) from 17 February 1992 till 1 March 1992.

(3) yes,

(i) the obtaining of quotations from private security companies with a view to the implementation of a security service from 2 March 1992;

(ii) the limiting of patients to 65 for which the maximum security unit makes provision;

(iii) the filling of vacant nursing posts;

cont ...→

(iv) the implementation of a direct radio link between the Medical Emergency Service Unit and the Valkenberg Hospital;

(v) the launching of an investigation into the effective safeguarding of the Hospital.

Maximum security psychiatric facilities

*12. Miss M SMUTS asked the Minister of National Health:

(1) Whether there are any maximum security psychiatric facilities available in the Cape Peninsula at institutions other than the Valkenberg Hospital; if so, what are the relevant details; if not, why not;

(2) whether any funds have been allocated to any administration for the erection of maximum security facilities; if so, (a) to which administration, (b) how much and (c) when?

B302E

The MINISTER OF NATIONAL HEALTH:

(1) No, planning was undertaken and completed in January 1991 for the building of a maximum security unit on the grounds of Lentegeur Hospital, Mitchells Plain, Cape Town. No funds were specifically allocated to the Administration: House of Representatives, Department of Health Services and Welfare for the building of a maximum security unit and secondly, since the total budget for the financial years 1990/1991 and 1991/1992 were significantly reduced, the project could not be proceeded with;

(2) no, (a), (b) and (c) fall away.

Codesa: assistance of public servants

*13. Mr D J DALLING asked the Minister of Constitutional Development:

Whether any public servants have been released temporarily or permanently from their normal duties to assist any political parties in their work at Codesa; if so, (a) what are their names, (b) what positions do they hold, (c) which political parties are they assisting and (d) what is the cost to the State of this assistance?

B304E

The MINISTER OF CONSTITUTIONAL DEVELOPMENT:

(a), (b), (c) and (d)

No, no officials of the Constitutional Development Service have been relieved of their normal duties to assist any political party involved in Codesa.

Commuters killed/injured: two persons

*14. Mr D J DALLING asked the Minister of Law and Order:

(1) Whether, with reference to an incident in which two persons allegedly killed three commuters and injured ten others on a train between Kathlehong and Wadeville on the East Rand on or about 9 October 1991, the two persons in question were overpowered by passengers and handed over to the Police; if so, what are their names;

(2) whether these persons were arrested; if not, why not; if so,

(3) whether they have been charged; if not, why not; if so, (a) with what offences and (b) what stage has their trial reached?

B305E

The MINISTER OF LAW AND ORDER:

(1) Yes, one of the assailants, Albert Dlamini, was arrested at the Natalspruit Hospital after being pointed out to the South African Police by witnesses. A second assailant was arrested at the Wadeville railway station after he too had been pointed out to the South African Police.

(2) Yes.

(3) (a) Only Albert Dlamini was charged on 2 counts of murder and 9 counts of attempted murder. The case against the second assailant was withdrawn by the State Prosecutor because of insufficient evidence.

(b) On 19 December 1991 Albert Dlamini pleaded not guilty to all the charges. The case remanded to 8 April 1992.

State funds for political parties: Namibia

*15. Mr F J LE ROUX asked the Minister of Foreign Affairs:†

Arising from his reply to Interpellation No 1 on 19 February 1992, (a) to which political parties or groupings of political parties in South West Africa did the South African Government make funds available with a view to the election of members of the Constituent Assembly in South West Africa/Namibia in November 1989 and (b) what amounts were made available to these parties or groupings of parties?

B306E

The MINISTER OF FOREIGN AFFAIRS:

(a) and (b)

This matter was conclusively dealt with in my reply to Question No 29 of 27 March 1990 as well as in my reply to Interpellation No 1 of 19 February 1992.

Black local authorities: quorums

*16. Mr J CHIOLÉ asked the Minister of Local Government and National Housing:†

How many Black local authorities in the (a) Transvaal and (b) Orange Free State still had quorums as at 31 January 1992?

B307E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(a) Transvaal
36 out of 85.

(b) Orange Free State
19 out of 73.

Questions standing over from Wednesday, 11 March 1992:

SAP: examination fees

*1. Mr A J LEON asked the Minister of Law and Order:

(1) Whether the South African Police will no longer be required to pay the examination fees for policemen studying for the National Diploma in Police Administration; if so, why; if not, what is the position in this regard;

(2) whether he will make a statement on the matter

B288E

The MINISTER OF LAW AND ORDER:

(1) and (2)

It was never required from the South African Police to pay the examination fees for policemen studying for the National Diploma (Police Administration) nor was it a condition of service.

The amount was approved by the Treasury on condition that funds were available. As a result of the reduction in state expenditure, funds have been withdrawn and expenses that were paid to members for obtaining the National Diploma (Police Administration) were recently suspended.

Since January 1992 a new dispensation has come into effect, whereby a cash amount of R3 740,00 for the three year study course is allocated to students after successful completion of the course.

Theft of medicines

*2. Mr M J ELLIS asked the Minister of National Health:

(1) Whether any instances of theft of medicines from the State hospitals and clinics occurred during the course of 1991; if so, (a) from which hospitals and clinics and (b) what is the value of the medicines stolen;

(2) whether her Department is investigating these thefts; if not, why not; if so, with what result;

(3) whether she will make a statement on the matter?

B313E

The MINISTER OF NATIONAL HEALTH:

Provincial Administration of the Cape of Good Hope (CPA)

(1) Yes,

(a) Eben Dönges Hospital, Worcester and

(b) R15 000,00;

(2) yes, in accordance with regulations all investigations by the CPA are undertaken in conjunction with the South African Police and the Department of Justice. The above-mentioned case is still to be finalized; the accused has been brought to trial;

(3) no.

cont --->

We handle life's stress 'quite well'

(88)

AMG 21/3/92

LINDA GALLOWAY
Weekend Argus Reporter

SOUTH Africans are not a model of psychological health, but they aren't doing too badly coping with the stresses of a violent and divided society, says a leading psychologist.

South Africans should be in really bad shape with mental stress fatigue. Black South Africans, in particular, coping with township violence, poverty and political conditions should be past the point of collapse. But we aren't, says University of Cape Town industrial psychologist Professor Deo Strümpfer.

Like other nations coping with economic crises, internal conflict and external pressure, the South African psyche is troubled.

Rising death tolls, unemployment, poverty and a society clearly divided on racial grounds is the cause of tension and distress.

But South Africans are resilient, and recent positive developments have given us a "breathing space" to recover from an intensely traumatic time much in the same way soldiers with war fatigue have rest and recreation breaks before returning to the front.

This will stand us in good stead for coping with the difficult times which lie ahead.

Professor Strümpfer is positive about the psychological health of South Africans.

Political strife could be a factor in causing, or precipitating, mental illness, he said.

"Studies on economic upswings and downturns have shown a small but significant correlation between downturns and an increase in hospitalisation for mental illness.

"A correlation between economic patterns and drinking behaviour also exists — it's vague and not very large but it's there."

It was possible to generalise from there that political factors could have the same effect.

"One could argue that tense political situations make some people drink more, or smoke more, but this is difficult to prove empirically," he said.

Professor Strümpfer said one way people dealt with stresss was denial — like whistling in the dark.

"A good example is the 'it could never happen to me' syndrome which allows people to drive from Cape Town to Johannesburg knowing that, given South Africa's accident statistics, the odds are stacked against them.

"Like the right wing saying 'to hell with the world, sanctions don't matter'. It makes them feel better.

"Left-leaning people are more aware of the tremendous external pressures and their effect on society. Like taking away international sport. We feel it. It hurts!

"Sanctions have had a discernible effect through the economic crisis which was artificially brought on by political factors in the country," he said.

Hostilities, divisions and clear-cut distance between groups based on race, cause tension and distress.

"We are living with the reality of racial and cultural differences and we are vulnerable to it.

"The violence is so overwhelmingly terrible — the number of people dying every day is comparable to a war situation — that we cannot possibly absorb the horror of it."

People use the self-preservation technique to "switch off" the reality because it is no longer possible to deal with. This defence mechanism results in a deadening of feeling which is morally problematic but which contributes to survival.

Professor Strümpfer said he was a great believer in resilience and there was reason to believe that changes in the country since February 1990 had had a positive effect on health and productivity.

"People are strong, they keep going even under war conditions. We develop mechanisms of coping starting as a child, building self-esteem and the inner knowledge that we can cope.

"These are resources we use as we get older to overcome really difficult situations, providing that there is some relief along the way.

"South Africa is in a period of relief. It's not always comfortable, but we're breathing again, and building up resources of strength so that if anything happens we will be able to cope."

mental health

48

REPUBLIEK VAN SUID-AFRIKA

STAATSKOERANT

GOVERNMENT GAZETTE

FOR THE REPUBLIC OF SOUTH AFRICA

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VOL. 321

KAAPSTAD, 13 MAART 1992
CAPE TOWN, 13 MARCH 1992

No. 13836

KANTOOR VAN DIE STAATSPRESIDENT

No. 788. 13 Maart 1992

Hierby word bekend gemaak dat die Staatspresident sy goedkeuring geheg het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:—

No. 19 van 1992: Wysigingswet op Geestesgesondheid, 1992.

STATE PRESIDENT'S OFFICE

No. 788. 13 March 1992

It is hereby notified that the State President has assented to the following Act which is hereby published for general information:—

No. 19 of 1992: Mental Health Amendment Act, 1992.

GENERAL EXPLANATORY NOTE:

Words underlined with a solid line indicate insertions in existing enactments.

ACT

To amend the Mental Health Act, 1973, so as to delete certain obsolete definitions; to provide for entering into agreements with other States relating to the detention, reception and treatment of patients and persons from such other States in institutions in the Republic, and their discharge from such institutions; and to exclude the territory of South West Africa from the application of the Act; and to provide for matters connected therewith.

(Afrikaans text signed by the State President.)
(Assented to 3 March 1992.)

BE IT ENACTED by the State President and the Parliament of the Republic of South Africa, as follows:—

Amendment of section 1 of Act 18 of 1973, as amended by section 1 of Act 10 of 1978, section 1 of Act 38 of 1981, section 1 of Act 3 of 1984, section 2 of Act 34 of 1986, section 1 of Act 55 of 1987 and section 6 of Act 51 of 1991

1. Section 1 of the Mental Health Act, 1973 (hereinafter referred to as the principal Act), is hereby amended by the deletion of the definitions of "province" and "Republic".

Substitution of heading to Chapter 5 of Act 18 of 1973

2. The following heading is hereby substituted for the heading to Chapter 5 of the principal Act:

"PATIENTS AND PERSONS FROM OTHER STATES"

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

3. The following section is hereby substituted for section 42A of the principal Act:

"Minister may enter into agreements relating to detention, reception, treatment and discharge of patients and persons from other States

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

(a) the detention in an institution in the Republic of any person who is charged in such a State of an offence specified in such agreement, for the purposes of examination of and report on the mental condition of such person;

ALGEMENE VERDUIDELIKENDE NOTA:

Woorde met 'n volstreep daaronder, dui invoegings in bestaande verordenings aan..

WET

Tot wysiging van die Wet op Geestesgesondheid, 1973, ten einde sekere verouderde omskrywings te skrap; voorsiening te maak vir die aangaan van ooreenkomste met ander State met betrekking tot die aanhouding, opneming en behandeling van pasiënte en persone uit sodanige ander state in inrigtings in die Republiek, en hul ontslag uit sodanige inrigtings; en die gebied Suidwes-Afrika van die toepassing van die Wet uit te sluit; en om voorsiening te maak vir aangeleenthede wat daarmee in verband staan.

(Afrikaanse teks deur die Staatspresident geteken.)
(Goedgekeur op 3 Maart 1992.)

DAAR WORD BEPAAL deur die Staatspresident en die Parlement van die Republiek van Suid-Afrika, soos volg:—

Wysiging van artikel 1 van Wet 18 van 1973, soos gewysig deur artikel 1 van Wet 10 van 1978, artikel 1 van Wet 38 van 1981, artikel 1 van Wet 3 van 1984, artikel 2 van Wet 34 van 1986, artikel 1 van Wet 55 van 1987 en artikel 6 van Wet 51 van 1991

1. Artikel 1 van die Wet op Geestesgesondheid, 1973 (hieronder die Hoofwet genoem), word hierby gewysig deur die omskrywings van "provinsie" en "Republiek" te skrap.

Vervanging van opskrif by Hoofstuk 5 van Wet 18 van 1973

2. Die opskrif by Hoofstuk 5 van die Hoofwet word hierby deur die volgende opskrif vervang:

"PASIËNTE EN PERSONE UIT ANDER STATE"

Vervanging van artikel 42A van Wet 18 van 1973, soos ingevoeg deur artikel 4 van Wet 38 van 1981

3. Artikel 42A van die Hoofwet word hierby deur die volgende artikel vervang:

"Minister kan ooreenkomste aangaan met betrekking tot aanhouding, opneming, behandeling en ontslag van pasiënte en persone uit ander State

42A. (1) Die Minister kan, op die voorwaardes wat hy goed ag, maar behoudens die bepalings van hierdie Wet en enige ander wet, en in oorleg met die Minister van Finansies, met 'n ander Staat 'n ooreenkoms aangaan wat voorsiening maak vir—

(a) die aanhouding in 'n inrigting in die Republiek van 'n persoon wat in so 'n Staat aangekla is van 'n misdryf in die ooreenkoms bepaal, vir die doeleindes van ondersoek van en verslag oor die geestestoestand van so 'n persoon;

(b) die voortgesette aanhouding in 'n inrigting in die Republiek en ontslag uit so 'n inrigting van 'n persoon wat na 'n ondersoek bedoel in paragraaf *(a)* bevind word geestesongesteld te wees;

(c) die opneming en behandeling van 'n pasiënt van so 'n Staat in 'n inrigting in die Republiek en sy ontslag uit so 'n inrigting.

(2) Geen sodanige ooreenkoms of wysiging daarvan is van krag nie—

(a) tot tyd en wyl dit deur die Staatspresident by proklamasie in die *Staatskoerant* afgekondig is; of

(b) tensy deur die wette van die ander Staat of deur die ooreenkoms voorsiening gemaak word vir die uitreiking van 'n bevelskrif deur 'n hof of ander bevoegde instansie of persoon in daardie Staat vir die aanhouding of opneming soos bedoel in subartikel (1).

(3) Behoudens die bepalings van subartikel (1) is die tersaaklike bepalings van hierdie Wet en van die Strafproseswet, 1977 (Wet No. 51 van 1977), van toepassing op iemand wat kragtens hierdie artikel in 'n inrigting in die Republiek aangehou of behandel word, asof hy ingevolge hierdie Wet of die Strafproseswet, 1977, na so 'n inrigting verwys is.".

Herroeping van artikel 78 van Wet 18 van 1973

4. Artikel 78 van die Hoofwet word hierby herroep.

Voorbehoud

5. Ondanks die wysiging van artikel 42A van die Hoofwet deur artikel 3 van hierdie Wet word met 'n persoon uit 'n staat wat voorheen deel van die Republiek uitgemaak het en wat op die datum van inwerkingtreding van hierdie Wet in 'n inrigting bedoel in die Hoofwet in die Republiek aangehou word, gehandel asof hierdie Wet nie aangeneem is nie.

Kort titel en inwerkingtreding

6. Hierdie Wet heet die Wysigingswet op Geestesgesondheid, 1992, en tree in werking op 'n datum wat die Staatspresident by proklamasie in die *Staatskoerant* bepaal.

(b) the continued detention in an institution in the Republic and discharge from such an institution of a person who, after an examination referred to in paragraph *(a)*, is found to be mentally ill;

(c) the reception and treatment of a patient from such a State in an institution in the Republic and his discharge from such an institution.

(2) No such agreement or amendment thereof shall be of force or effect—

(a) until it has been published by the State President by proclamation in the *Gazette*; or

(b) unless provision is made, by the laws of the other State or by the agreement, for the issue of a warrant by a court or other competent authority or person in that State for the detention or reception as referred to in subsection (1).

(3) Subject to the provisions of subsection (1), the relevant provisions of this Act and of the Criminal Procedure Act, 1977 (Act No. 51 of 1977), shall apply to any person detained or treated in an institution in the Republic under this section, as if he had been referred to such institution in terms of this Act or the Criminal Procedure Act, 1977.".

Repeal of section 78 of Act 18 of 1973

4. Section 78 of the principal Act is hereby repealed.

Saving

5. Notwithstanding the amendment of section 42A of the principal Act by section 3 of this Act, any person from a state which previously formed part of the Republic who is detained in an institution referred to in the principal Act in the Republic on the date of commencement of this Act, shall be dealt with as if this Act had not been passed.

Short title and commencement

6. This Act shall be called the Mental Health Amendment Act, 1992, and shall come into operation on a date fixed by the State President by proclamation in the *Gazette*.

Venter damned on Valkenberg breakout

By Justin Pearce South 28/3-2/4/92

THE minister of national health, Dr Rina Venter, has confirmed in parliament that Valkenberg Hospital was understaffed when a group of patients broke out of the maximum security unit on February 13.

But her failure to acknowledge nursing posts at Valkenberg had been frozen has drawn sharp criticism in psychiatric circles.

At the time of the escape, 22 nursing posts at Valkenberg had been frozen owing to a shortage of state funding.

One of the consequences of the incident was the unfreezing of these posts to redress the critical shortage of nurses.

But in a reply to a question posed in parliament by Miss Dene Smuts, Venter referred to "the filling of vacant nursing posts".

"The posts were not vacant," said an angry trainee psychiatrist who was working at Valkenberg when the patients broke out, adding that he knew of nurses who had applied for posts at Valkenberg and been turned down as the posts were frozen.

He said that Venter's statement amounted to a direct admission of responsibility for the events at Valkenberg, but that it had been made in a way that was deliberately misleading. **See page 12**

The hospital has no interpreters, and there are no Xhosa-speaking psychiatrists

Valkenberg patients feel blows as cutbacks strike health care

Mental health care has been dubbed the 'Cinderella of the health services'. **Justin Pearce** reports on the effects of financial neglect :

South 28/3 - 2/4/92

JAILBREAK — Valkenberg prisoners on run, screamed the headline of a Cape Town daily. It was followed by a story about Valkenberg Hospital that read like a cross between a crime novel and a horror movie.

Few readers would have connected it to the previous day's headline, "Hospital shake-up", above a story on a reshuffle in medical services owing to a shortage of funding. The tone of the Valkenberg story was such that readers would sooner have connected it with the gruesome reports about American serial killer Jeffrey Dahmer that were appearing at the same time.

Yet the hospital plans and the events at Valkenberg are symptomatic of the profound crisis faced by all health care services. In a time of recession and inflation, hospital budgets have become tighter and tighter over the past few years.

One psychiatrist points out that the state has chosen to invest most of its inadequate health budget in primary health care, as this will reduce the strain on more expensive hospital care. Mental health care and the other hospitals try to get by on the leftovers Furthermore, Professor Francois Daubenton, head of Community Psychiatric Services at Valkenberg, describes mental health care as the "Cinderella of the health services".

"Even before the cutbacks, our funding was insufficient" Daubenton says.

It was a lack of funds for expansion which lead to a situation where 90 patients were accommodated in a ward designed for 65, which in turn caused the frustation that prompted patients to force their way out of the ward.

"In any overcrowded place you get problems," says Dr Geoffrey Garrett, Chief Medical Superintendent at Valkenberg. "And in this case it was complicated by the financial difficulties which led to the freezing of posts."

He says the ward has at certain times accommodated 120 patients, nearly twice the number for which it was intended.

For the newspapers, the funding crisis was of interest only in that it unleashed a supposed public menace on the sane citizens of Cape Town. This interpretation was misleading on two counts.

First of all, the patients in Ward 20 constitute a minority of the inmates of Valkenberg. And psychiatrists are unanimous that of those in Ward 20, very few could in any way be considered a public danger.

Secondly, the cash shortage is harming nobody more than it harms Valkenberg's patients.

Daubenton admits that staff shortages lead to patients having less individual contact with staff than they would in an ideal situation. Therapeutic activities such as occupational therapy are also diminished.

It is not only clinical care that affects the morale of patients. Several of the wards are gloomy and in need of paint. The food at Valkenberg, while nutritious, is unexciting owing to efforts to keep costs down.

Far more serious are reports of patient abuse that emerge from Valkenberg from time to time. Garrett has stated that "we do not tolerate any mishandling of patients".

Illustration: Grant Schrieber

But individual psychiatrists can tell of abuse that has occurred out of sight of the authorities.

Dr Frances Ames, part-time senior specialist at Valkenberg, has heard reports of nursing staff who physically abuse patients. "That is hearsay — but it is heard too often not to have some basis of truth.

"People ask why nursing staff, who are supposed to be caring, behave like this. The reason is that they are tired, underpaid and get no extra money for extra work — they're only human," says Ames.

Hospital staff are bound by oath not to publicise these incidents. And patients, says Ames, have little chance of being heard. "Once you are stigmatised as mad, there is no one who can help you."

One positive result of the escape is that Valkenberg has taken on 22 nurses to fill previously frozen posts.

"The filling of the 22 nursing posts was the most important as it will lead to better care," Garrett says. But staff are short in other areas too: Occupational therapists are 30 percent short, psychologists 50 percent short and social workers 30 to 40 percent short.

Valkenberg employs no interpreters, and there are no Xhosa-speaking psychiatrists. This means that a Xhosa-speaking nurse has to be removed from nursing duties for an hour or more to act as interpreter when a Xhosa patient needs to speak to a psychiatrist.

Funding has also been granted for a private security firm to provide five security officers day and night to Ward 20.

Garrett says the additional beds have been removed from the ward, and gave an undertaking that the ward would never accommodate more than the prescribed maximum of 65 patients.

However, he says no patient will be turned away from Valkenberg "under normal circumstances".

Wards at the hospital are graded according to levels of security: most of them open, others fenced, others locked. Only Ward 20 has high security facilities. A patient who is not considered dangerous may be moved out of Ward 20 into an ordinary locked ward.

Garrett believes that if all posts at Valkenberg were unfrozen, there would be no staff shortage. He hopes that the deficiencies in last year's funding allocation will be rectified by more generous funding in the coming financial year.

But faced with both a new Budget which has not been particularly kind to health services, and with the reality that primary health care is a necessary priority for the state, people working in mental hospitals are far from optimistic.

Next week, the second article in this two-part series looks at alternative ways of caring for the mentally ill.

Southliving12

March 28 to April 2 1992

health

'Mentally ill and criminal divide has become blurred'

South 28/3 - 2/4/92 (88)

Mental hospital or prison? That was the question left in many people's minds by press reports of the "escape" from Ward 20, the maximum security unit at Valkenberg Hospital last month.

Readers could be forgiven for not knowing whether the Valkenberg escapees were convicted criminals or disturbed souls who had been locked away for their own safety, or whether they were typical of all Valkenberg's patients.

Anyone who has been treated in Valkenberg or who has had a friend or relative treated there will know that the average Valkenberg patient is anything but a criminal. Most of them are in full control of their own behaviour, but suffering disturbances to their emotional or perceptual functioning that are traumatic to themselves, yet which pose no threat to others.

So why should a hospital, intended for the treatment of ill people, include on its premises a unit with a small number of criminals?

The answer lies in the law. The Criminal Procedure Act states that a person charged with a crime may only be convicted if he or she can be held responsible for his or her actions at the time of the crime. An accused may enter a plea of insanity, upon which he or she is sent to the forensic unit of a mental hospital for a 30-day observation period.

Of the 65 patients now in Ward 20, between 40 and 50 have been remanded for observation. Most of the rest are state patients, with a small number, particularly new admissions, who are not criminals but are considered dangerous.

While it is generally accepted that some kind of screening is in the interests of justice, controversy surrounds the way this principle is put into practice.

Some psychiatrists question the necessity of keeping a patient within the hospital system for a whole month, when a diagnosis can often be made within a matter of days. Someone may commit a crime while under the influence of drugs and be referred for observation, but be in full control of his or her mental faculties within hours.

Though it is possible in these cases for the patient to be discharged before the end of the 30 days, this is a bureaucratic process that may take days or weeks.

Psychiatrist Dr Frances Ames believes it was "an appalling mistake" to situate a maximum security unit such as Ward 20 within the grounds of Valkenberg. She pointed out that the building had been designed to be part of Pollsmoor Prison and staffed by psychiatric nurses from Valkenberg.

"The distinction between the mentally ill and the criminal has become blurred," Ames said. "As soon as you have a prisoner remanded by the court you introduce a criminal element into the hospital. The forensic unit should go back to Pollsmoor."

Professor Francois Daubenton, head of Community Psychiatric Services at Valkenberg, disagrees. When a psychiatric unit is attached to a prison, "it is tacitly criminalising mental illness", he said.

"In South Africa the primary responsibility is to look after mentally ill people who are seen by the judicial and psychiatric communities not to be responsible for their actions. It is therefore appropriate that these people should be in a hospital."

Daubenton admits that this has the potential to cause confusion among the public about the role of a mental hospital but believes this can be rectified by means of greater public awareness.

Public ignorance remains, and affects nobody more than patients themselves. Ames tells of the distress experienced by mentally ill people in the community on hearing reports implying that mental patients are murderous.

"Most of the mentally ill are not violent," says Ames.

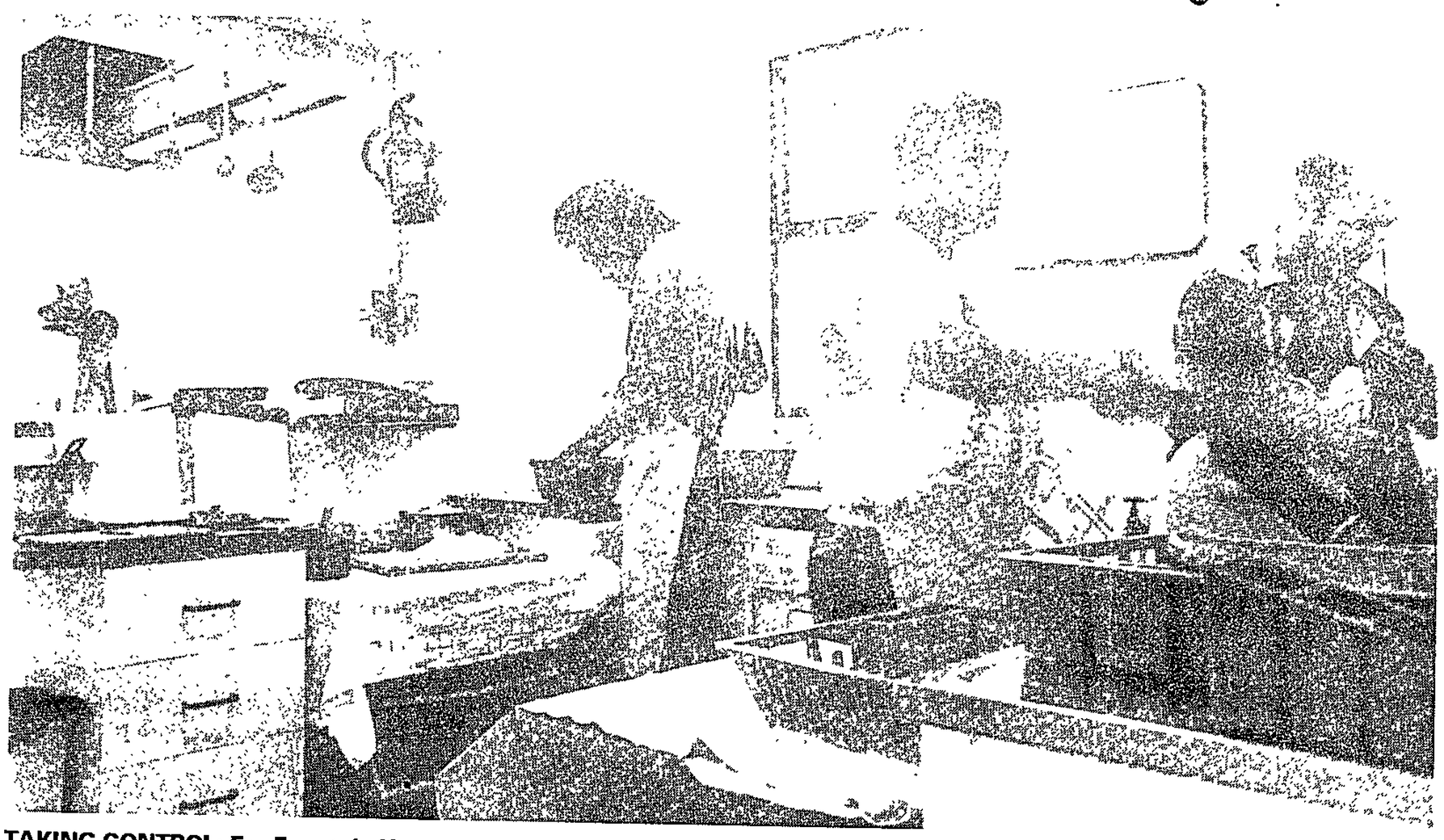
Anyone who has been in contact with a mentally ill person could only agree.

April 4 to April 9 1992

Supporting the mentally ill

Justin Pearce looks at an alternative (88) method of rehabilitating the mentally ill:

South 4/4-9/4/92



TAKING CONTROL: For Fountain House members, running their activities is a step towards taking control over their own lives

ACTIVITY is the first impression greeting a visitor to Fountain House. People work at computers, prepare food for the fully-fledged restaurant and sit in animated conversation in the garden of the renovated Victorian house in Observatory.

As a social centre for people with chronic mental illness, Fountain House is a world away from the notion that gloomy, silent hospital wards are the only place for mentally ill people.

Fountain House is based on a concept that started 45 years ago with a house in New York, with which the Cape Town house maintains formal links.

There is a network of 270 houses worldwide, all working on the same principles that give mentally ill people maximum control over their own lives.

"People idealistically think being in the community is a better alternative to being in an institution, but the community cannot always offer the right kind of support," says project co-ordinator Ms Erna Prinsloo.

Hence the need for a place like Fountain House, which functions as a club with 160 members who come to the house regularly, but with only six staff members. The bulk of the work around the house, whether administrative or domestic, is done by the members themselves. Nowhere in Fountain House will you find a door with a "staff only" notice. All space is communal, all decisions are made collectively by the members and staff, who interact on an equal basis.

"That is the main difference between us and the more traditional care schemes," says Prinsloo.

"The membership concept is central to how we are placed in the community. We never refer to members as patients or clients."

Membership of the club is free, and attracts people from all races and classes: at the centre professional people mix with former vagrants.

Members' medical needs are looked after by the outpatient unit at Valkenberg Hospital or by one of a number of satellite clinics. This prevents Fountain House from having to operate along medical lines.

"Membership is a far more enabling designation, as it enables people to get away from the patient identity," Prinsloo says.

Members of Fountain House have organised a consumer group which voices their needs as consumers of mental health care facilities. Following the sensational newspaper reports about people who escaped from Valkenberg's maximum security ward, the Fountain House group wrote to the press protesting the demeaning and insulting stereotypes propogated.

"Fountain House makes you feel good about yourself," says member Mr John Levendal.

"When I came here I was depressed and felt I couldn't do a job. Nowadays I look at newspapers and see plenty of jobs I could do."

Fountain House members now employed independently include a dentist, a librarian, an electrician and several voluntary workers. One has joined the permanent staff at the house.

For those who feel they are not yet ready to take this step, Fountain House runs a transitional employment project to help members refine their work skills. Companies are asked to give an entry-level employment post to the club, which undertakes to place two Fountain House members, each working half a day. If one worker goes off sick, the club ensures that another worker is there as a replacement. Fountain House trains the candidates so that they arrive at the company ready and able to do the job.

Each placement lasts six months. A worker who feels pressured by the placement may choose to leave it at any time. In this way members are rehabilitated into working life without the stress that can be dangerous to a person who has recently been mentally ill.

"Companies are positive about the scheme in the long run," says Ms Licia Karp, manager of the employment unit, "but in the current economic climate they are reluctant to take people on."

Fountain House, operating under the auspices of the Cape Mental Health Society, receives state funding, additional funding coming from the Community Chest and private donors. So far the club's facilities reach only a tiny percentage of mentally ill people: one in 100 people is estimated to suffer from schizophrenia at some point, which means around 20 000 people in the Cape Town area alone.

"Slowly things are happening but they need to gain an awful lot of momentum," Prinsloo says. "If they don't, we will end up with a situation like in New York where a sizable proportion of mentally ill people are homeless and untreated."

Fountain House is a world away from the notion that gloomy, silent hospital wards are the only place for mentally ill people.

'They need their own space'

South 4/4 - 9/4/92

More and more mentally ill people are becoming homeless and being turned onto the streets, says Ms Erna Prinsloo, project co-ordinator at Fountain House.

With disability grants ranging from R293 for Africans to R345 for whites, paying rent for conventional accommodation is way beyond the means of most mentally ill people.

While most people who suffer a mental illness are hospitalised for a period of weeks or months, most of these reach a stage where all medical needs can be met by visits to an outpatients clinic. Yet employers are wary of hiring people with chronic mental illness, and most former patients find themselves destitute upon leaving hospital.

Those who have families may live with them. Some live alone in flats rented by their families if they have sufficient income, or in seedy boarding houses. The less fortunate end up on the pavements.

Bureaucratic bungling means people may wait for five months after diagnosis before receiving their first disability payment. People with no other means of support end up staying in hospital longer than necessary simply because they have nowhere else to go.

This situation has prompted people like Mrs Kim Elias to take an independent initiative in providing homes for mentally ill people. Eight years ago Elias, who has two relatives with chronic mental illness, became involved in setting up a social group for schizophrenia sufferers. Three years later the project set up a house to accommodate some members.

"We started with a resident who had been totally abandoned by his family," Elias says. "He was living in a graveyard — though he assured me there were no bodies in it!"

From there the project grew gradually into Cape Town's first home for schizophrenia sufferers, residents being accommodated in a house in Observatory purchased by Elias. (88)

"We take anyone," Elias says, "and we have proved that the scheme works. Little houses are the answer — they form a little body of people who support one another."

The house is organised to grant privacy to each resident. "People with schizophrenia collapse under stress," says Elias. "They must all have their own space."

For this reason she believes living with a family is not the ideal situation, since relatives' ignorance about schizophrenia can lead to a stressful environment.

The houses are run collectively, decisions being taken by the residents. Recently a resident decided to give up medication and leave the house. Fellow residents refused to accept his notice and persuaded him to continue with his medication.

"Five years' work was worth it just for that incident," says Elias. One of the biggest challenges posed by schizophrenia is that some patients have no insight into the nature of their illness or even into the fact that they are ill. Here was a case of schizophrenia sufferers taking it on themselves to see to a fellow patient's care, rather than leaving it to the medical establishment.

The concept Elias pioneered in Cape Town is spreading, albeit slowly, with the establishment of homes along similar lines.

Last year the Fountain House organisation, which functions primarily as a social and rehabilitation centre, started a residential home at Kimber House in Observatory. Thirty-six people applied for the 12 places in the house, places being granted on the basis of emotional and financial needs.

The existing homes supply only a tiny percentage of the accommodation needed by the mentally ill. But in proving to a sceptical public that mentally ill people can take control of their own lives, the existence of the homes defies the prejudices of a world that remains ignorantly hostile towards mentally ill people. **Justin Pearce**

Alcohol linked to poor black health

Sowetan 8/4/92 88

MORE than 60 percent of black psychiatric patients were treated for alcohol-related conditions, the MEC for social welfare and liaison services, Mr Temba Nyati, said yesterday.

Thirty percent of black patients hospitalised for medical reasons were treated for alcohol-related problems, he said during the Provincial Budget debate in Cape Town.

The Cape Province's first frail care facility was being erected in Cape Town this year. There were 18 service centres for aged blacks and three old-age homes for blacks in the province.

There were four special day-care centres for severely mentally retarded blacks, and 11 workshops for the disabled.

Nyati said an estimated 21 000 social workers were needed by the turn of the century, but there were only 1 089 registered black social workers, and no more than 4 000 social workers in the country.

The CPA was appointing social auxiliary workers to support social workers. - *Sapa*

Absa won't talk about retrenchments

Sowetan 8/4/92

AMALGAMATED Banks of South Africa yesterday declined comment on a report in the *Sunday Star* that it plans to retrench at least 4 000 workers in a sweeping rationalisation programme.

The finance section of the *Sunday Star* reported the casualty toll could reach as high as 6 000 by mid-year.

However, Absa human resources director Dr Petrus Claassen this morning declined to confirm or deny the extent of staff cutbacks with a terse "No comment."

He added: "There is a retrenchment programme and full agreement has been reached with the trade unions about the procedures to be followed."

Violence: massacre of mental health

CHILDREN AND FEAR
Spiralling violence has led to an increasing number of children as young as 10 dropping out of school. A small number of people is trying to focus on these children to forestall problems. MPINE QAKISA reports.

THE Boipatong dust has settled, the dead are buried, the injured are recovering, even a two-month old baby who lost his mother during the massacre has stopped crying for her breast. STAR 13/7/92

But the atrocities of the night of June 17 live on in the minds of hundreds of children who watched with horror rampaging attackers shooting, stabbing and hacking to death their relatives and friends.

For them, witnessing such violent acts is the beginning of a life-long nightmare that may lead to depression, says Dr Solly Rataemane of the child psychiatry unit at Baragwanath Hospital.

This depression breeds defence mechanisms which take the form of violent behaviour in most cases, Dr Rataemane said at a conference organised by the National Council of Mental Health in Johannesburg last week.

Dr Rataemane treats children from Thokoza squatter camps who witnessed members of their families killed.

"These children have seen their homes invaded. They were asked not to shout or scream. And now, they fear everything around them.

Scared

"Many are so scared that they don't even go to school because they think that the attackers may come back again for the little that they've got."

Most of the time children's problems are not resolved and their only outlet becomes depression, which leads to poor perfomance in schools.

Dr Rataemane says: "I was treating a 10-year-old boy who is brain-damaged because of substance abuse. He breaks into people's homes, steals and lies — and that's a child who is supposed to be at school."

When treating such children, he says, the socio-economic and political situation needs to be considered.

The drop-out rate among children aged 10 is "unbelievably" high in black communities, while in white schools the average drop-out rate is 16 as in other civilised countries, he says.

In South Africa, violence is one of the biggest causes of death among the youth. This includes young people who are actively involved in violent behaviour as well as those who are victims.

People who are not directly affected by violence experience tension because "you have to choose where you walk, where you drive and what you say".

Violence is also experienced through the media and through parents talking about it.

Dr Rataemane treated a young girl who was constantly scared when her parents did not come back from work at the expected time.

"This child didn't think that her parents may be stuck in traffic or had gone grocery shopping, but what she saw was death," he says.

Driekie Moutinho of the National Council for Mental Health says if children witness violence often, they become emotionally numb or they break down.

Resorting to violent behaviour is often a plea for help, she says, and ironically it is viewed as a way of solving problems that plague our society.

Depending on the make-up of a child, she says, children who are subjected to traumatic events may break down emotionally and hurt themselves in the process, while others laugh about the atrocities.

This is often nothing more than a reaction to extreme frustration and in South Africa it is often directed towards the education system.

And while the focus is on the killings in the country, violence in the family should not be overlooked.

The security of a child depends on the family that should provide it. But in the black communities, says Ms Moutinho, it is difficult for parents to provide security and stability for their children because the basics such as housing, learning opportunities, recreational and health facilities are not there.

Also, there is a need to de-stigmatise mental health problems. People need to learn that a person who is mentally ill is not necessarily "crazy".

Also, there is a need to de-stigmatise mental health problems. People need to learn that a person who is mentally ill is not necessarily "crazy".

Shattered lives . . . children are bearing the scars of the fractured communities in which they live.

Danger signals in the young

Early signs of emotional distress in very young children are:

- Depression may be present if a child loses pleasure in almost all daily activities, is tearful, moody and irritable.
- Overanxiousness and fearfulness may occur when a child is separated from loved ones and worries about future situations.
- The extremely "good child" becomes a perfectionist, compliant and overeager to please.
- Disruptive and uncontrollable behaviour occur where the child is constantly angry, resentful, spiteful and vindictive.
- Low self esteem and poor self image, where adoloscents are severely confused about their own identity, the meaning of life and the future.

If a relative or a friend notices these common danger signals they should contact the National Council for Mental Health in Johannesburg, telephone (011) 725-5800.

TOMORROW
In the year 2002 you may decide to ignore the previous decade's puritan health warnings and indulge yourself in a traditional breakfast. Chances are your breakfast will be anything but traditional.

Helping a 'society in crisis'

STAR 25/8/92

By Monica Oosterbroek

A young Sowetan, Pat Mosiane, stood by helplessly while a man was necklaced in front of him.

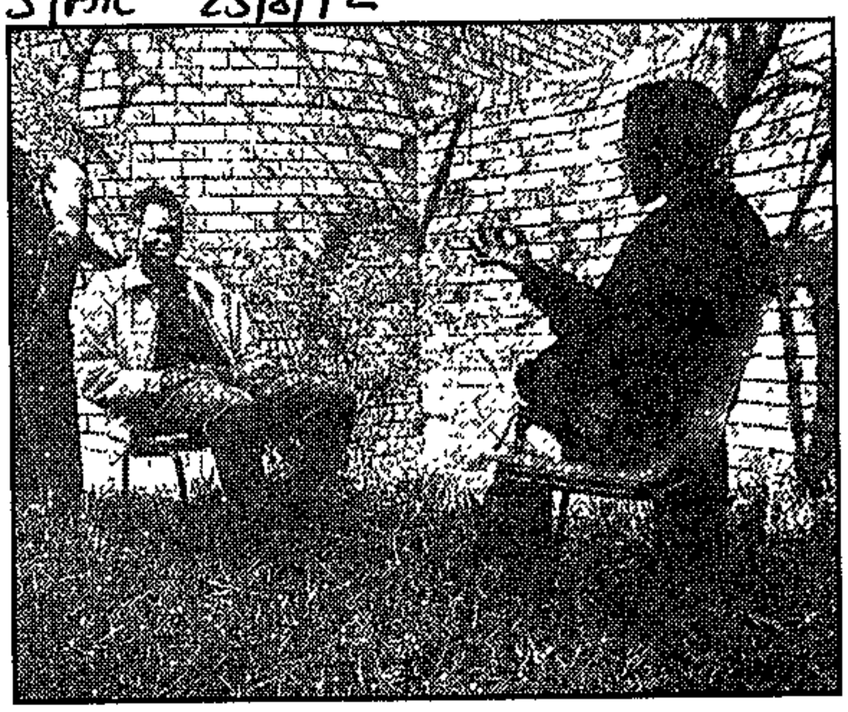
And a close friend of 25-year-old Lebo Maphologe was gunned down and his house was set alight.

With nobody to speak to about their horrifying experiences, they bottled up feelings of fear and distress until both became ill.

Fortunately, they were referred to The Family Institute where they received couselling, comfort and care.

They went on to become community lay counsellors in a course run by the institute and will share their experience and insight with others who have also been traumatised by violence.

Because the institute is unable to cope with the increasing number of people needing counselling, they have begun training youths to go out and work in the community.



Helping others . . . counsellors Pat Mosiane and Lebo Maphologela. Picture: Gary Bernard

Psychologist Lindi Maseko said the intensive three-day programme recruited people like Pat and Lebo who have suffered, and who could understand emotions evoked by violence.

With role-playing, they learned to cope with their confused feelings, to understand and control them. They then found it easier to deal with their hurt, anger and fear, Miss Maseko said.

Once Miss Maseko was satisfied the cousellors would be warm, open, mature and objective, they began working in the community under the supervision of the institute.

Pat Mosiane said the scope for their help was enormous as the township residents were a "society in crisis".

"People are very poor, there are no jobs, schooling or housing. And this leads to crime and violence like rape, child abuse and mindless killings," the youngster said.

"Family structures have broken down and there are no support groups. Our culture dictates we do not reveal our feelings so they ferment inside our heads and we become very depressed and sad."

When he saw the man being necklaced, he was sick with guilt.

"It was frustrating because there was no one to talk to who would understand," he said.

Pat has found that by helping others work through their terrible experiences, it has helped him cope with his problem.

Anyone wanting further information can contact Lindi Maseko at The Family Insitute on (011) 838-4541.

results in heart disease ● Supplement in four big newspapers

Hidden pain causes stress

Sowetan 26/8/92

BURIED PROBLEMS People who deny they have problems end up sick: (88)

THE price of hiding psychological troubles can be a heart that overreacts to stress, and that might mean a higher risk of heart disease, a new study suggests.

Researchers found that people who were hiding psychological distress even from themselves showed an unusual jump in heartbeat and blood pressure when doing stressful tasks.

Other studies have linked such overreaction to an elevated risk of heart disease, said researcher Jonathan Shedler. Heart disease sets the stage for heart attacks.

"We know that being emotionally distressed, being constantly anxious or constantly depressed isn't so healthy. But the new work suggests that suppressing distress may be even worse.

It is not known what percentage of people who consider themselves psychologically healthy have hidden distress, although it was common in the non-random samples he studied, he said. Such hidden problems are hard to detect in oneself, but they may appear in indirect ways such as unexplained headaches or stomach aches, or friends might notice that a person appears anxious or unhappy, Shedler said.

Shedler is a professor of clinical psychology at the Institute of Advanced Psychological Studies at Adelphi University in Garden City, NY. He spoke in an interview before presenting his work last Saturday at the annual meeting of the American Psychological Association.

Dr Redford Williams, a behavioural medicine researcher at Duke University Medical Centre in Durham, NC, said he found the proposed link to heart disease "quite plausible". He said it follows previous research linking heart disease risk to lack of social support, hostility and "job strain," which is the experience of having little control over a demanding job.

The new study adds more credibility to the idea that psychological factors can promote heart disease, he said.

Williams also said that the link between heart disease and cardiac overreaction to stress has not yet been proven, although he considers it a strong hypothesis. Shedler said he considers the evidence convincing.

One experiment Shedler reported involved 58 University of Michigan students and staff, with an average age of 21.5 and no known history of heart disease. They filled out assessments of their psychological health as well as a test that probed their earliest memories.

Researchers identified nine participants who appeared truly healthy, 18 as having "illusory mental health" as defined by hidden distress, and 11 who reported themselves distressed. The other participants were not classified, often because their responses to the early-memory test were too sparse for analysis.

All participants were hooked up to devices to check their blood pressure and pulse rates in response to stress. Their stressful tasks were to do mental arithmetic while being timed with a stopwatch, make up stories about ambiguous drawings and to say the first thing that came to mind when they heard certain phrases.

The drawings and phrases were designed to raise themes that some people find psychologically threatening, Shedler said.

People with hidden distress were found to be twice as reactive to stress as genuinely healthy people, and also more reactive than people who said they were distressed, Shedler said. - *Sapa.*

...Sunday. Simon is a soccer fanatic and dreams of going to the World Cup. ...courtesy of The Star, to the South Africa versus Zambia game at
Picture: Jacoob Rykliff

Tara staff holds open day fete

88

STAR 28/8/92

Staff members at the Tara Hospital for the mentally handicapped in Hurlingham, Sandton, will hold an open day fete at the hospital on Saturday.

Tara hospital spokesman Lara Boss said the purpose of the fete was to generate public awareness about mental illness.

Ms Boss appealed to the public to donate any items, from canned or bottled foods to old books, which will be used in the fun and prizewinning activities.

Donors can hand in their donations to ward staff at the hospital or phone Lara Boss or Pos Yudelowitz on (011) 783-2010.

Guitarist Steve Newman of Tananas will give a solo performance at the fete.

Rubber bullets and teargas fired at teachers

STAR 28/8/92

By Phil Molefe
Education Reporter

The looming teachers' strike took an ugly turn yesterday when riot police broke up a peaceful demonstration and arrested protesting teachers.

More than 20 teachers were arrested and several others said they were assaulted on Wednesday when the police broke up a demonstration by teachers at a school in White City Jabavu.

About 500 teachers were demonstrating outside a school in White City Jabavu to back the teachers' demands for the reinstatement of two dismissed teachers and the withdrawal of suspension notices against 127 colleagues.

The Star saw policemen indiscriminately fire rubber bullets to disperse the demonstrators, seriously injuring an elderly teacher in the foot and hitting another in the eye.

A one-month-old baby was overcome by teargas fumes when police fired the gas into a house where the baby was sleeping.

A Star journalist, Joe Louw, was among those arrested. His camera was confiscated.

Louw was charged for allegedly taking pictures of "people under arrest". He was released after three hours.

A spokesman for the teachers, Oupa Mpetha, said yesterday that police intervention boded ill.

"If the authorities think education issues can be addressed by the police, they are in for a real shock because teachers will not allow a police state, which South Africa has come to be," said Mr Mpetha.

Soweto police spokesman Captain Joseph Ngobeni said last night that 22 teachers were arrested in White City for embarking on an unlawful march and confirmed that police used rubber bullets and teargas on the protesters.

He added: "As far as I know the police warned the protesters that the march was illegal and asked them to disperse. Apparently they refused, and police had to use rubber bullets and teargas on them.

"Twenty-two people were arrested and charged at the Moroka police station for taking part in an unlawful march. They were given an option to plead guilty to the charges or appear in court on September 30," said Captain Ngobeni.

He said he was "not aware of any injuries sustained by protesters" and urged those "who allege they were unlawfully dealt with to report the matter to their nearest police station".

Teachers criticised police involvement in dealing with the problem and dismissed charges against their colleagues as "frivolous".

"Once police get involved in education matters, then there must be problems," they said.

Licence warning

Big prizes offered to young

...himself

ART OF HOPE . . . this large canvas was painted by Abri Day Centre members supervisor Nophumzile Zihlangu, Mike Walliss, Trevor Castleman, John Koukoullis, Hennie Muller, Carel Kruger and Bobby Diderick

Pictures: JACK LESTRADE

Centre brings hope to the mentally ill

S/Time [Cape Metro] 6/9/92 88

By DIANA STREAK

A PAINT-splashed room has become the focus of a recreation centre for people with chronic mental illness which opened in Observatory yesterday, providing much-needed companionship and support.

The Abri art, craft and recreation centre is part of a move to accommodate and give meaningful occupation to people suffering from mental illness, like schizophrenia and bipolar dysfunction, who might otherwise be on the streets.

Mrs Kim Elias of Abri Foundation, which provides accommodation for 12 people in two houses, said the centre was open to anybody with a mental illness. "People who come here have nowhere else to go."

So far the day centre has about 30 members and provides classes in art, pottery, stained glass and music. Badminton, table tennis and snooker are available.

Mrs Elias said she was positive and excited about the centre, where the activities provided therapy for members. "In the study of psychiatry no art or music therapy is included. I would love our centre to be the place where they could come to learn."

She said the medical profession had shown a keen interest in progress at Abri, which means shelter in French, but funding was needed for materials.

Art teacher Mimmie Pienaar said classes increased the members' confidence, particularly in their creative ability. "They have very few things with which to build their confidence so it's very important."

Hennie, ~~44~~, who has been in and out of Stikland Hospital 16 times, has lived at the Abri house for five years and said it was the happiest place he has ever lived in. He had been on the streets for several years, jobless and rejected by his family who did not understand his illness.

Callie, 59, said he had been a president's patient for 20 years, always in an institution without a home to go to.

Love

In 1987 he met Mrs Elias and joined Abri. "I get the feeling my family don't want to see me and I don't want to go where I'm not welcome."

Callie said he felt part of a family at Abri. "I'm so happy here. Ive even got a girlfriend."

Abri is looking for a drama teacher to take classes once a week.

Minah, 34, would also love to do drama and while she is waiting for a disability grant she works as a domestic.

Ros, 52, a qualified librarian, lives alone in a flat in Rondebosch. "Abri has meant such a lot to me. It's the highlight of my week."

● The Abri Day Centre is at the Methodist Church Hall, corner Wesley and Milton Roads, Observatory.

Athlone mentally handicapped children facing a hungry time

VENNESSA SCHOLTZ
Staff Reporter

PUPILS at the Mary Harding Training Centre for the Mentally Handicapped in Athlone may have to go hungry soon, after the school's food budget was cut by R30 000.

"Last year we were given R51 000 for food, but this year only R21 000. We initially asked for R67 000 because food prices are surging all the time," said the chairman of the school's management board, Mr Ebrahim Hendricks.

He said the school had already overspent their R21 000 food budget by more than R12 000.

"Our pupils depend on the fully balanced therapeutic meal they get here. Sometimes it's the only meal they get for the whole day as most of them come from disadvantaged backgrounds. At the moment we are giving them soup, because It's all we can afford," said Mr Hendricks.

The training centre caters for 208 pupils, of which 85 stay in the hostels at the centre.

Mr Hendricks said the school was expected to make up for any shortfalls from school fees.

A PLACE OF LEARNING: The Mary Harding Training Centre.

"The fees are R15 a month for day pupils and R45 a month for those in the hostels. Most of the parents cannot even afford to pay that as most parents are unemployed. When a child enrols we also apply for a grant in aid from the government, but the amount depends on the income of the parents. Sometimes we get R45 a year for a pupil," said Mr Hendricks.

The principal of the centre, Mr George Africa, said special education, specialised teachers and equipment were expensive.

He said the Department of Education and Culture "can cut everything else, but just not our food budget".

According to Mr Africa some of the teachers bring food for the children.

Mr Henry Jansen, the Director: Communication Services of the Department of Education and Culture, said the amounts of R51 000 and R21 000 were not allocated for the feeding of the pupils, but for therapeutic purposes.

"The Mary Harding Centre is State-subsidised and not a State institution. State-subsidised institutions are subsidised according to prescribed formulae," said Mr Jansen.

Athough subsidies are allocated to the Centre from available funds, the actual responsibility for providing for the pupils' maintenance rests with the Board of Management and the parents concerned, Mr Jansen said.

●The Mary Harding Training Centre aims to teach mentally handicapped children to be as self-sufficient and independent as possible.

The hostel premises offers accommodation for 44 girls and 44 boys mainly from country areas and the total professional staff consists of 35 members and includes teachers and therapists.

ART IS FUN: These pupils are threading wool through holes in the masks. It teaches the children hand-eye co-ordination and helps them to concentrate.

Drip test results

JOHANNESBURG. — Tests on products supplied to a company which provided contaminated drips have been instituted by medical supply company Sabax — and results should be known by Wednesday.

According to a statement issued yesterday by Sabax, the company was told on Thursday by Johannesburg's Park Lane Clinic, that a baby had died and another was seriously ill. — Sapa.

THE ART OF SPEECH: Speech therapist Mrs Sharon Burger tells a story to some of the junior pupils at the Mary Harding Training Centre in Athlone.

Pictures: OBED ZILWA, The Argus

Judge urges better mental health for all

JOHN VILJOEN
Staff Reporter

(88) ARGS 5/10/92

ALL South Africans must have access to psychology if the profession is to be relevant and legitimate, said Mr Justice P J J Olivier, chairman of the South African Law Commission.

He told the 10th annual congress of Psychological Association of South Africa (Pasa) in Stellenbosch that legitimacy had become a central concept in the country's constitutional transformation.

South Africa would have a new constitution about two years from now, based on a Bill of Rights, he said.

In spite of all the apparent differences between the major role players, there were more areas of convergence than divergence.

"On the whole, I take the view that the new order will be a better one — perhaps not in materialistic terms, but certainly in securing a greater degree of justice, legitimacy, and eventually, peace in our country."

However, if the science and practise of psychology did not succeed in becoming accessible to all South Africans, irrespective of money or means, it would become irrelevant and illigitimate.

He asked psychologists whether the cost of their service was not so prohibitive that it could only be provided in a small minority of towns.

If this happened, South Africa would lose an important segment of its health care, and justice in health would become the victim.

Psychology had to become functionally efficient in South African terms, not those of Manhattan or Beverley Hills.

South Africa was the country in the world with the largest disparity between rich and poor.

A new approach to psychology had to be developed in this country. It had to be low in cost, easily understood by ordinary people and should use local facilities wherever possible.

South African psychologists had an awesome responsibility to ensure the accessibility and legitimacy of their discipline, he said.

Alarm over mental health

STAR 13/10/92. (88)

South Africa faces a shortage of psychologists at a time when they are most needed, reports SHIRLEY WOODGATE.

ABOUT 47 percent of patients who consult their general practitioners actually suffer from emotional, not medical, problems, the Human Sciences Research Council reports.

The anomaly is that while nearly half the waiting rooms in the country are filled with people who should not be queueing to consult medical doctors, only 15 percent of trained psychologists are actually practising, said Psychological Association of South Africa president Anne-Marie Wentzel.

To make matters worse, many South Africans of all races were experiencing their darkest hours, struggling to combat mental stress at a level seldom encountered before.

"Problems include dealing with the aftermath of violence, the breakdown of families, the general insecurity sweeping the country, the loss of jobs, situations arising due to the increasing divorce rate, and changes in society at various levels.

"At the same time, services are changing in general. For instance, psychological services are disappearing in schools and teachers are not adequately trained to deal with children's problems," she said.

Another shortcoming in the mental health field was the shortage of black trained psychologists to deal directly with the largest sector of the population suffering the after-effects of increased violence.

"Mental health deterioration inevitably manifests in physical health problems and the breakdown in interpersonal relationships essential for normal life," she warned.

Wentzel's claims were backed by Dr Coen Slabber, director-general of the Department of National Health and Population Development, who said ahead of World Mental Health Day: "In South Africa only 1 percent (372) of the medical profession is registered as psychiatrists compared with 5 to 10 percent in Western countries.

"This means there are only 8,6 psychiatrists per 100 000 people in this country."

Dr Ian Fraser, the department's director of mental health, added that between 10 and 20 percent of the total population of about 38 million was in need of some form of mental treatment. A great deal of the necessary treatment was at primary level, he said.

Wentzel singled out medical aid societies for part of the blame.

"Even if there were enough practitioners, the truth is that patients cannot afford the treatment. The general rule is that medical aid societies pay a total of R35 for a three-hour procedure. This is totally inadequate. While psychologists are entitled to charge an hourly tariff of R134, patients could only expect reimbursement of R47. At the end of the day, some medical aids limit total payment to R200 per family a year."

Ideally, the focus should be on preventive programmes which meant psychological services should be available at grassroots level, Wentzel said.

He added: "If we cannot succeed in getting the community involved to mobilise the unexploited voluntary labour potential within the community, then there are serious doubts whether the professionals alone can deal with the mental problems now surfacing in the country". □

news in brief

6 die in unrest

SIX people died and at least 10 were wounded in unrest-related incidents on Monday and early yesterday, police reported. Sowetan

At Tokoza in Alberton gunmen firing from a vehicle killed four people and wounded seven. 14/10/92.

In Alexandra on the Witwatersrand police found the bodies of a man and a woman. Both had been shot.

Gunmen opened fire on a man at Wembezi, Estcourt, seriously wounding him.

Explosives were detonated at homes in Ratanda, Heidelberg, and at Khuma, Stilfontein. There were no injuries in the Ratanda explosion but the blast at Khuma early yesterday injured two people.

2 Durban suicides

A POLICE constable shot and killed himself in his flat in Overport, Durban, on Monday night. Police said Constable TM Shangase (30) was found with a bullet wound to his head in a flat in South Road. Foul play is not suspected.

In another incident, Mr J Govender of Chatsworth was found hanging from a tree.

Cop shot four times

AN off-duty municipal policeman, Sergeant Robert Khatshelo (39), was shot and wounded on Monday night.

Soweto police liaison officer Lieutenant Eugene Henning said Khatshelo went to investigate a noise at a neighbour's house in Generator Street, Power Park, at about 7.40pm when he was confronted by three men, one with a firearm.

During an ensuing argument four shots were fired, wounding the policeman twice in the right arm and twice in the left leg.

The suspects fled on foot.

Khatshelo was admitted to the Garden City Clinic. His condition is stable.

Mental health care

Sowetan 14/10/92 88

THE South African Federation for Mental Health launched its public awareness campaign for October at a two-day conference in Johannesburg last week (Oct 6 and 7).

The conference, which focused on mentally handicapped children, resolved to reduce the incidence of mental handicap in children.

Driver dies in hijack

A TRUCK driver has been shot dead near Dundee in what police believe to be an attempted robbery and hijacking, SABC radio news reported yesterday.

Church discriminates against blacks, claim

Sowetan 14/10/92

■ **BLACKS EXPELLED**: 300 members bring accusations against church:

By Mandla Zibi

A GROUP of 300 people who were allegedly expelled from the Old Apostolic Church of Africa's Transvaal region have accused the church of discriminating against black members.

This was said at a Press briefing in Carletonville at which representatives of the fired members expressed their dissatisfaction about the church administration headed by Apostle JJ Boshoff.

The group's spokesman, Mr Theophilus Mahlatshana, said the church had promised to build creches, old people's homes, schools and other projects but only white members's needs had been met so far.

Mahlatshana claimed about 300 members had been expelled.

"For example, we have long been asking for an old people's home but only white church members have one in Johannesburg, and yet everyone of us contributes 10 percent of their monthly salary to the church," Mahlatshana said.

Another major grievance was that blacks were denied top positions in the church.

Measles attacks older kids

Sowetan 14/10/92.

■ **Outbreak in Johannesburg also emphasises need for immunisation:**

By Mokgadi Pela

THE Department of Health has reiterated the importance of early immunisation against measles in the wake of recent outbreaks of the disease in Greater Johannesburg.

Dr Coen Slabber, director general of the department, said 40 cases were reported to the Johannesburg City Health Department in one week. This indicated a sharp increase in the incidence of the disease compared to the same period last year.

The Johannesburg outbreak came largely from high school pupils who were not immunised as children. According to Slabber, such outbreaks can only be prevented by the early immunisation of children and by maintaining vaccination levels.

Most children in South Africa received the measles vaccine but a small proportion did not develop immunity.

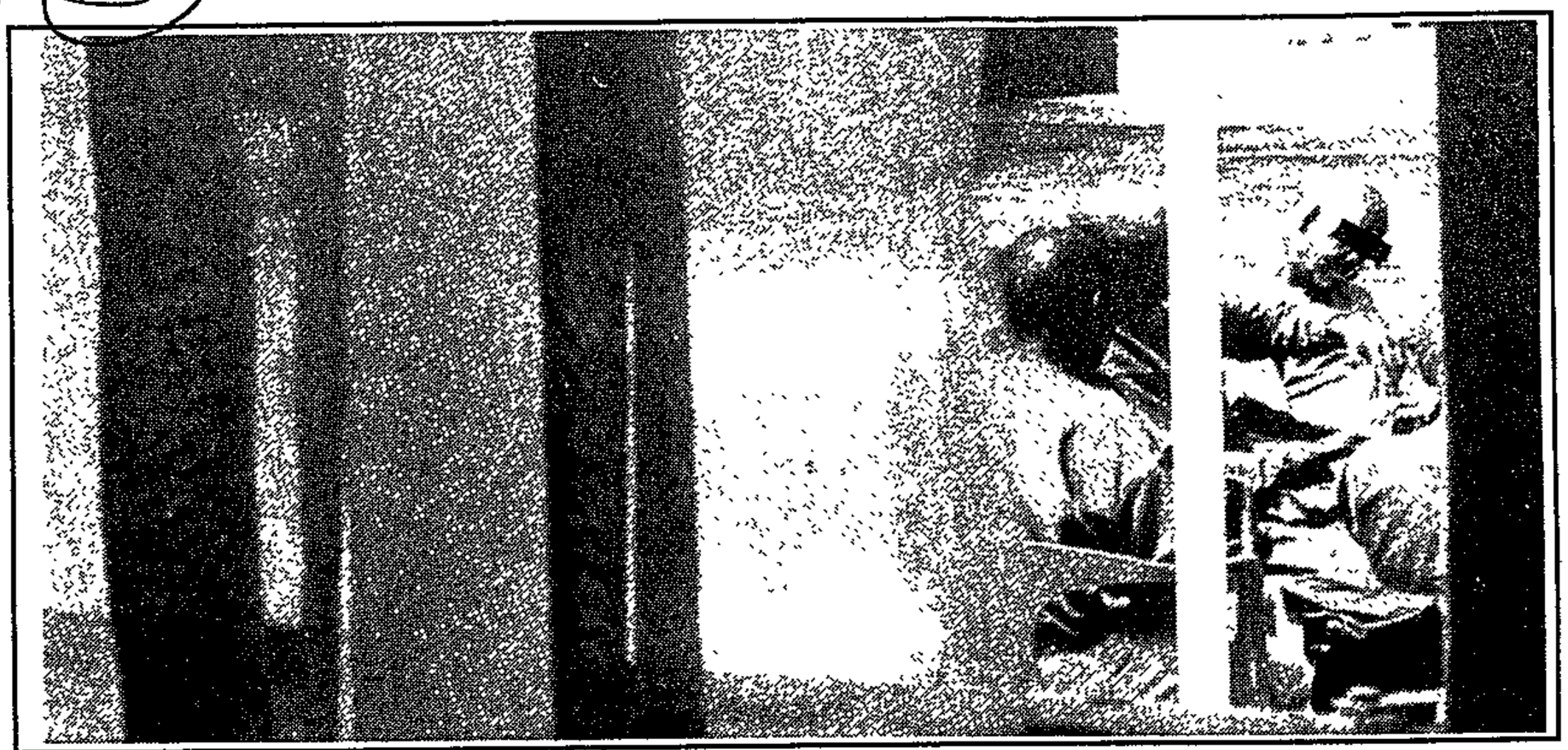
One flew over the cuckoo's nest

Sowetan 15/10/92.

88

■ SHOCK TREATMENT *The appalling conditions under which mental patients live:*

Exclusive by Investigations Reporter RUTH BHENGU



Room with a view ... a sneak picture taken of patients at the Millsite Sanatorium. Pic: SELLO MOTSEPE

WE ARE SITTING ON a bench in the grounds of Millsite Sanatorium: my sister, a family friend and I.

A tall, gaunt, barefooted man in a dirty brown uniform shuffles towards us.

Next to him walks a shorter man in a snow-white uniform.

The man in white uniform walks with confidence. He smiles as we exchange greetings. He is a nurse.

The man in the brown uniform - who barely looks up as we inquire after his health - is a patient.

The patient does not smile. His feet are calloused and he looks as if he has not had a bath for months. His hair is unkempt.

The dried-up grime on his legs and arms falls off in flakes as he walks.

We struggle to hold back the tears as we watch him wolf down the food we have brought for him. This is our younger brother, Vusi Elijah Bhengu. He is 35 years old.

He has been in and out of mental institutions since 1976. The doctors describe him as a chronic schizophrenic.

We notice there is something wrong with his right hand. It looks as if it has been scalded with water. The skin has bunched up into a grotesque pattern. The fingers are bandaged with plaster and two of them are welded together.

My composure is beginning to desert me. My sister has this perturbed look on her face. I ask my brother what happened. Without lifting his eyes from the ground he says it happened long ago and that he cannot remember the details.

I ask the nurse. He says he does not know what happened. He refers me to the sister in charge of Vusi's ward.

A week later I am back at the hospital, this time accompanied by colleagues. I request to see the sister in charge.

> **"We struggle to hold back the tears as we watch him wolf down the food"**

The sister in charge, who refuses to tell me her name, is defensive. She cannot understand why I am asking questions.

The fact that I also want to see the psychiatrist who attends to my brother unsettles her.

The matron who mans the front office assures me my request is reasonable. She says I can also see the physician if I am not satisfied with the sister's report.

Eventually the sister in charge promises to set up an appointment with the psychiatrist. She says she does not know what happened to my brother's hand because she was transferred to Ward Six only two days ago. She can check the medical records and see what happened. She asks me to phone her the next day.

When I phone the following day we are back to square one.

I have to explain who I am and what I want. Reluctantly she tells me the psychiatrist, Dr Hammer, will see me between 10.30 and 11am the next day.

> **"The patient does not smile. His feet are calloused and he looks as if he has not had a bath for months. His hair is unkempt"**

She tells me that maybe my brother was injured during a fight among patients. The physician who attended to him is Dr Gilles. He is on leave.

The following day I am there to see Hammer at the appointed time. This time I am accompanied by a photographer.

Hammer asks us to wait for him at section six of Ward Six.

We walk through the hospital grounds to the ward. Along the way we sneak pictures.

The sister in charge to whom I spoke the previous day is off. There is another sister in charge. She says my brother suffered a fracture while fighting with another patient. The skin on his hand looked as if it had been scalded because it had been bandaged.

I decide to shut my mouth and concentrate on the psychiatrist. After a chat with Hammer - who tells me he has only been at the sanatorium for two months - we leave.

A week later I meet the physician, Gilles. He shows me X-ray plates that show my brother's fingers were fractured. Gilles also does not know how it happened.

I still have no idea how my brother's hand was injured.

UP NEXT

TOMORROW we will take a look at conditions inside Millsite Sanatorium

This is how they should be treated

Human rights charter for hospitalised mental patients

Sowetan 15/10/92

88

The bill of rights provides that within five days of admission every patient shall receive written notice of the rights to which the patient is entitled.
If a patient has a crisis the period shall be extended to fifteen days. A signed copy of the receipt of this notice of patient's human rights is to be placed in the patient's medical record folder.
A mental patient has the right:

- **To a safe**, sanitary and humane living environment; three meals every day; water for a regular bath; a mattress and blanket; appropriate medication and professional attention; suitable clothing.
- **To be free** of unnecessary or excessive medication.
- **To be free** of physical repression.
- **To be free** from isolation, except if necessary - in that case it will be limited to 24 hours.
- **To receive** prompt and adequate treatment for any physical ailment.
- **To have** the opportunity to meet with physicians and other members of the treatment team.
- **To sue** for physical, moral or psychological abuse against the person who commits it.
- **To wear** own clothes.
- **To go** outdoors at regular and frequent intervals with authorisation.
- **To have** suitable opportunities for interaction with members of the opposite sex.
- **To practice** the religion of own choice.
- **To mail** and receive unopened correspondence. To have ready access to letter writing materials, including postage.
- **To have** access to a telephone, to make and receive confidential calls (long distance calls will be made at the patient's expense).
- **To education** if minor or illiterate.
- **To participate** in a rehabilitation programme.
- **To ask for** a review and /or revision of treatment plan if you don't agree with it.

UNDERCOVER *The second article in a three-part probe into condition at Millsite Sanatorium*

Life in Stalag Millsite

Sowetan 16/10/92. (88) (89)

Exclusive by Investigations Reporter Ruth Bhengu

DOUBLE IDENTITY *Some say Millsite is caring, some say that it is grossly negligent:*

HEALTH WORKERS AT the Millsite Sanatorium describe it as a concentration camp.

Management talks about it as a caring and efficient private institution.

It is tempting to believe management, especially after a guided tour of the hospital. The authorities sound rational.

The problem is there are things that simply do not add up.

For instance, it is not only the professional nurses, the nursing assistants and social workers who claim that patients are subjected to gross negligence and abuse at Millsite.

The World Health Organisation (WHO) and the American Psychiatric Association (APA), after visiting the hospitals, published reports claiming that black patients at psychiatric facilities were abused.

"Making millions out of madness"

Comment in an 1975 newspaper expose of the Life Care Group

The surveys were aimed specifically at hospitals owned by Smith Mitchell and Company, which has since been changed to the Life Care Group.

Life Care is the largest private health care group in South Africa and is the only one that caters for black psychiatric patients.

In 1975 several newspapers exposed conditions at Life Care hospitals alleging that they were "making millions out of madness". The reports included allegations that patients worked for over 11 hours a day and slept on grass mats on the floor in converted mine compounds.

Staff at Millsite claim that the hospital is chronically understaffed with sometimes as few as six nurses looking after 300 patients.

The authorities say the nurse-patient ratio is 1 to 8. But during the tour we counted six nurses to about three hundred patients in most wards.

In April last year a male patient at Millsite was burnt beyond recognition while lying in his bed in the hospital ward. The staff only noticed the fire when it was too late. If the number of nurses had been evenly spread, would it have been possible for a patient to be burnt beyond recognition before someone noticed?

Another patient fractured his hand and none of the staff could tell how it had happened.

Staff also make the following claims:

- A high death rate during winter months because patients are exposed to cold. According to the staff most windows are broken and the heating system is poor.
- Inadequate clothing, with only a few patients supplied with jerseys, pyjamas and shoes. None of the patients have underwear.
- Poor food which led to malnutrition and diarrhoea. Patients ate from rubbish bins because there was not enough food.

"Patients at Millsite always suffer from diarrhoea. The toilets are few and overcrowded and diarrhoea and any other infectious disease spread quickly.

"Patients at Millsite always suffer from diarrhoea. The toilets are overcrowded and diarrhoea and other diseases spread quickly"

"So if one patient has diarrhoea soon every patient has it," said a staff member. This was confirmed by several other health workers we spoke to.

- There was often no hot water and patients had to share bath water.
- Most wards had broken windows and it was easy for patients to escape. Some patients were found dead after they had escaped from the hospital.
- The patients' beds were very close to one another and this promoted sodomy.
- Shortage of staff included a shortage of security and this led to patients escaping easily. Also psychiatric patients had easy access to the retarded children's ward and sometimes raped them.
- There was not enough protection for female nurses working in male psychiatric wards. In some wards there were no male nurses. One nurse said she had been attacked by a violent patient.
- Management of Millsite was quick to bury patients as paupers and they did not bother to trace relatives.
- As a result of Millsite being able to admit patients directly from communities from 1990, staff have been increasingly subjected to violence.
- The hospital often ran out of medical supplies and patients were affected.
- Staff worked for up to 15 hours a day.
- There was only one social worker in a hospital with at least 3 000 patients.

UP NEXT

Not home from home

Sowetan 19/10/92. (88)

Exclusive by Investigations reporter Ruth Bhengu

■ IN DEFENCE *Management of Millsite*

Sanatorium responds to Sowetan allegations:

MILLSITE SANATORIUM, the black mental health centre, is no home from home.

Besides the appalling lack of facilities listed in our Friday story, the hospital has also been found to have no hot water. Many sections lack heating.

The hospital provides no underwear and many patients have no shoes, jerseys or pyjamas.

There are not enough blankets. Patients do not have their own regular beds and lockers. A patient can change beds every night.

We put all the allegations and our observations to the hospital authorities and this is how Manager Mr Abie Masiela responded to the charges:

"There are three large boilers constantly heating water. Additional electric geysers are also operating in certain ablution areas.

All windows on exterior walls are burglar-proofed. All broken windows are replaced on an ongoing basis. Only one patient was found dead after escaping last year.

Millsite supplies five blankets a patient during winter. In winter all wards have heating systems. The minimum temperature in a ward, recorded last winter, was 15 degrees Celsius. The temperature varies between 15 and 21 degrees Celsius.

A large percentage of the patients (especially children) at Millsite are highly prone to respiratory ailments because they are immobilised by severe physical handicaps.

Many come to Millsite with a history of respiratory problems. The number of deaths occuring, however is well within the US rate for chronic mental retards.

Patients have three jerseys and three T-shirts at any given time. The supply of shoes is done via the ward sisters. The records show an issue of 2 278 pairs of shoes for the period October 4 1991 to September 30 1992..

Because of their mental condition, patients have varied attitudes to clothes. Some take off as much as possible, others will wear a dozen layers. Many throw their shoes away The grading and grouping system helps to keep patients in groups but they are not forced to participate in group activities. Loitering patients sometimes scavenge but this is stopped when noticed.

Special diets and dietary requirements (also required quantities) are worked out and monitored by a qualified dietician.

Patient labour has long been done away with. However, work-related activities (washing dishes, cleaning) are included in the rehabilitation programme of the A and B group, as part of their preparation for leaving Millsite.

The closeness of beds cannot in any way contribute to homosexuality.

Nurses work the 40 hours a week prescribed by SANC. No case of assault has been reported in the past year. If an assault has taken place, it is the nurse's responsibility to report the matter. (This would be regarded as an injury on duty case, and handled by Workman's Compensation.)

Thorough screening is done before any patient is admitted. Millsite accommodates only chronic, long-term patients. Violent patients would be referred back to Sterkfontein.

Only one case of rape between patients has been reported in a five-year period. On investigation it was found to have been an attempted rape. If nurses are aware of such occurrences, and do not report them, they would be guilty of negligence and could be reported to the Nursing Council.

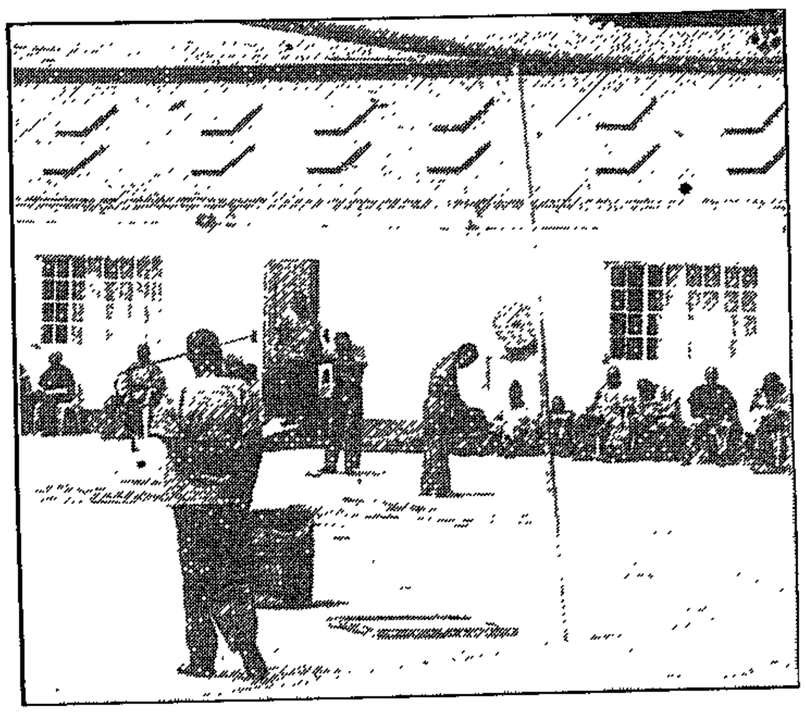
All attempts are made to locate the family of a deceased. Relatives pay for such burials. Pauper burials are arranged after a minimum of 14 days (sometimes as long as 21 days) if the family cannot be traced. Millsite pays for burials and certainly does not benefit financially.

Diarrhoea has many causes, not only unsuitable food. Special committees dealing with infection control and hygiene assess and correct situations if and when they occur. An average of one patient per month escapes. Three patients are known to have died while being an escapee. An average of five patients a month die.

All our doctors belong to the SA Medical and Dental Council. Allegations of abuse are serious and should be reported. If these are untrue it would be construed as libel."

'Because of their mental condition, patients have varied attitudes to clothes. Some take off as much as possible, others will wear a dozen layers'

'An average of one patient a month escapes. Five patients a month die'



Battle field ... Millsite, scene of the controversy.

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UNDERCOVER *The final article in our probe into conditions at the Millsite Sanatorium*

What the eye doesn't see ...

■ NO CHANGE *A 14-year-old report by American psychiatrists underlines the message:*

Exclusive by Investigations Reporter Ruth Bhengu

THE ABUSE OF BLACK patients in private psychiatric hospitals in South Africa can only be described as a gangrenous sore.

Instead of the authorities improving conditions in these institutions, they improve their methods of hiding things from the public.

Over the years different groups and individuals have exposed the unbearable conditions that mental patients have to endure but very little has changed according to those who work in some of these institutions.

In fact, health workers who spoke to *Sowetan* are beginning to despair.

Said one health professional who would not be named for fear of reprisals: "Even as I tell you about the horror we witness daily, I have a feeling that nothing is going to change.

"The hospital authorities do not want to get rid of the rot, they just dress it up nicely and spray it with perfume.

"When the public comes to investigate they are taken on a guided tour. There are certain wards which are meant for showing to the public.

"When the Press exposed these institutions a year ago, all that happened was that security was tightened."

Fourteen years ago a team of American psychiatrists visited South Africa's mental health institutions after reports by the World Health Organisation (WHO) of gross abuse of black patients.

The State was also accused of placing blacks in such facilities for political reasons.

These members of the American Psychiatric Association (APA), led by their president, Dr Jack Weinberg, were invited by the South African Government to do an independent survey and prove WHO wrong.

South African officials denied the WHO allegations.

Ironically the APA found that most charges made by WHO were factual. The criticism was directed mainly at the Government-funded private psychiatric facility of Smith, Mitchell and Company, which has since been renamed Life Care.

Life Care, among other hospitals, runs Millsite which is notorious for its alleged abuse of patients.

Smith, Mitchell and Company, under contract to the South African Government, provided racially segregated daily care for chronic psychiatric patients transferred from State institutions.

"Our investigation convinced us that there is good reason for international concern about black psychiatric patients in South Africa. We found unacceptable medical practices that resulted in needless deaths of black South Africans.

Medical and psychiatric care for blacks were grossly inferior to that of whites.

"We believe that these findings substantiate the allegations of social and political abuse of psychiatry in South Africa.

"Some of the charges of abuse were misleading. We found no evidence that black dissidents were confined in Smith, Mitchell and Company facilities. However, what we did find is sufficiently disturbing to warrant criticism and continued scrutiny by objective international observers.

We were heartened to discover concern about and criticism of these abusive apartheid practices among psychiatrists, physicians, medical students and nurses in South Africa," wrote the APA in their report.

The charges involving Smith, Mitchell and Company facilities for blacks were:

● High death rate - the committee found evidence of needless deaths among black patients.

● Sub-standard care - the committee found substantial grounds for this charge at most Smith Mitchell facilities.

● Abusive practices - the committee found this was true in some cases.

● Grossly inadequate professional staff - the committee found the evidence was unequivocal.

● Inappropriate use of drugs and electro-shock treatment - the committee concluded that there was no substance to this charge in the facilities it was allowed to investigate.

● Exploitation of patient labour - there was no evidence that Smith and Mitchell had made significant profits from patient labour but there were unresolved questions about the use of patient labour.

The APA also found the following:

● Black patients were provided neither toilet paper nor wash basins. The Department of Health suggested that "when toilet paper is provided the patients misuse it, causing sewerage blockages and inconvenience to fellow-patients".

> **"Many patients at Millsite, in our view, could benefit from more lively psychiatric care"**

● Many black patients by policy were not provided with sheets although a significant number are incontinent.

● In many instances the beds were crowded together without adequate ventilation.

● Most black patients had no lockers, no bedsteads and no personal possessions.

● Black patients had unnecessarily crowded dining rooms.

● Black patients were bathed in group showers.

● Smith Mitchell provided two-piece pyjama-like clothing for black male patients and sack type dresses. Many were without shoes.

● The food met minimum standards but there was a drastic discrepancy between what whites and blacks had.

Following the visit of the APA delegation that investigated Life Care (formerly Smith, Mitchell and Company) and State psychiatric hospitals and residential facilities for the chronically ill and mentally retarded, Life Care conducted its own investigation of facilities and has made many changes, according to a report by the American Psychiatric Association.

This report was made after two psychiatrists from the APA had visited South Africa in 1989. They were part of a delegation of the American Association for the Advancement of Science.

An American psychiatrist has also visited and reviewed the Life Care facilities regularly since 1981 at their request, the report shows.

"In our own estimation and according to several knowledgeable South African psychiatrists, the Life Care facilities have improved over the past 10 years and they are probably better run than the Government-sponsored mental health centres.

"Certainly there is less red tape. Yet the severe shortage of psychiatrists in the country creates a burden on those working for both private and Government facilities, and allows many gaps in the supervision and quality of care," a spokesman for the APA said.

Unlike the 1987 APA visit this one lasted about two hours and did not include a review of patient records, or more than brief talks with staff and patients.

The report shows there are 4 000 beds at Millsite. Patients usually stay five years or longer. Some of the patients arrive without names and are given names by the Millsite staff.

"We asked for, but were not given, the amount of money spent by Life Care on each patient a day for black compared to white patients. We were told that the black-white gap has narrowed over ten years, but it is not clear by how much."

The psychiatrists visited the children's unit and several adult wards.

"Many patients at Millsite, in our view, could benefit from more lively psychiatric care," the APA said.

> **"We believe that these findings substantiate the allegations of social and political abuse of psychiatry in South Africa"**

Payout to parents of disabled

(88) ANC 28/10/92

Health Reporter

THE Cape Provincial Administration has promised to pay out R500 000 it owes to the parents of mentally disabled children after a six-month delay.

The money is owed by the CPA after it failed to pay out an increased amount of R278 to 580 parents from April 1.

On Monday, parents marched with their disabled children to hand a petition to the CPA pointing out that the "single care grants", as they are termed, had created problems for black children with disabilities.

Racial disparities and stringent demands by the Act for the testing of children made it difficult for parents who frequently did not have the means to get their children to hospitals.

The memorandum said children had been burnt to death in shacks while their parents were trying to find a way of providing food. Others had been exposed to physical and sexual abuse as there were no adequate facilities or financial support for them.

A CPA spokesman confirmed that 580 parents were owed backpay for six months after the Department of National Health and Population Development upped the grants in April.

The CPA has also promised to take up other problems hampering the care of the children.

Demand for rights

■ Plight of mentally handicapped:

CAMPAIGNS to press for a charter of rights for the mentally handicapped take place on Saturday with petitions being signed at major shopping centres in the country.

South African Federation for Mental Health spokeswoman Mrs Thelma Mahlobo, announcing this, said that the campaigns would reinforce previous activities aimed at highlighting the plight of the mentally-handicapped.

Earlier this week, relatives of the handicapped and mental health workers staged a march as part of the campaign.Mahlobo said Health Minister Dr Rina Venter would talk about her position on the subject on Saturday.

88

28/10/92.

SO Wafer

Aid controls affect 50 kids

Staff Reporter

ABOUT 50 out of 2 670 severely mentally handicapped children will be affected by a more stringent application of regulations for state subsidies, the Department of Health Services and Welfare in the House of Assembly said yesterday.

This follows reports that the state's single-care allowance of R314 a month and its day-care centre subsidy of R121 a person a month are to fall away on January 1 for children whose parents earn more than R1 333 a month. (88) CT 23/10/92

Mr Paul Meyer, a management committee member at the Friends Day Centre in Pinelands, said yesterday that R1 333 a month for a means test was too low.

Miss Gaén Boucher, a spokesman for the Department of Health Services and Welfare, said criteria in effect since 1988 were merely being more stringently applied because of the unfavourable financial climate. No more than 50 cases already receiving allowances would be affected.

(1) Whether the Government is responsible for paying the costs of representatives of the (a) United Nations and (b) Organization for African Unity who recently visited or are currently visiting the Republic as observers; if so, (i) to what extent, and (ii)(aa) what are these costs to date and (bb) in respect of what period is this information furnished; if not,

(2) whether he will make a statement on the financing of the above-mentioned visits?

B859E

The MINISTER OF FOREIGN AFFAIRS:

(1) (a) As far as the UN and other observers are concerned the Department of Foreign Affairs did not pay any expenditure to date.

(b) (i) and (ii)

Only certain transport costs in accordance with international practice. From 14 September 1992 to 4 October 1992 and amount of R9 550 has been paid.

(2) The general worldwide practice in the case of such missions is that the host country where a team is being deployed, provides financial assistance with regard to office accommodation and related expenditure. It could thus be expected that certain costs will indeed be paid. The amount cannot be provided at this point in time because there still have to be discussions about the extent of the services.

Special representative of Secretary-General of UN: costs of visit

362. Mr F J LE ROUX asked the Minister of Foreign Affairs:†

(1) Whether the Government is responsible for paying the costs involved in the visit to the Republic in August this year of Mr Cyrus Vance, Special Representative of the Secretary-General of the United Nations; if so, (a) to what extent and (b) what were the costs involved; if not,

(2) whether he will make a statement on the financing of this visit?

B860E

The MINISTER OF FOREIGN AFFAIRS:

(1) No.

(a) and (b) Fall away.

(2) Not applicable given the answer under (1).

Imizamo Yethu settlement at Hout Bay: site

364. Mr C W EGLIN asked the Minister of Local Government and National Housing:

(1) Whether the Imizamo Yethu settlement at Hout Bay is situated on a site of approximately 18 hectares agreed to in the second phase of the development in this regard; if not, what are the relevant details; if so,

(2) whether his Department has any plans for extending the above settlement; if so, what are these plans;

(3) whether these plans have been discussed with the liaison committee representing the Hout Bay communities; if so, when; if not, why not?

B862E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(1) Yes.

(2) No; the activities of the Western Cape Regional Services Council on the relevant site of approximately 34 ha have been influenced to such an extent that they have to acquire an alternative site. Consequently the Cape Provincial Administration is obliged to purchase the whole area of approximately 34 ha.

(3) Although no formal plans for the development of the additional approximately 16 ha have been discussed, the Hout Bay Liaison Committee has agreed that the residential component will be confined to approximately 18 ha. The future utilisation of the additional approximately 16 ha is thus still to be decided upon in consultation with the local communities. This land could possibly be utilised for community facilities.

Pine forest area in Hout Bay: cutting down of trees

365. Mr C W EGLIN asked the Minister of Local Government and National Housing:

(1) Whether his Department has any plans to cut down any trees in the existing pine forest area near the Imizamo Yuethu settlement at Hout Bay; if so, (a) what trees and (b) why;

(2) whether an independent environmental impact study has been made regarding the possible effect of the cutting down of these trees; if not, why not; if so, (a) when and (b) by whom;

(3) whether he will make public the findings resulting from such a study?

B863E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(1) Yes;

(a) only those trees that have been identified during a scientific investigation to be dead, or are in the process of dying, as well as a limited number of trees which will hamper the alignment of roads or services in the development;

(b) the retention of the dead trees is a risk to the lives of people and property. It would also not be cost effective to re-align roads and trunk services for purposes of retaining a small number of trees.

(2) Yes;

(a) in June 1992;

(b) by Ms E L van and Honert, M.Sc. (Botany) employed by Messrs Hill, Kaplan and Scott, consulting engineers;

(3) Yes.

Single care grants: children of each race group

367. Mr K M ANDREW asked the Minister of National Health:

How many children of each race group were receiving single care grants in terms of the Mental Health Act, No 18 of 1973, in respect of each province as at 30 September 1992 or the latest specified date for which information is available?

B865E

The MINISTER OF NATIONAL HEALTH:

Province	White	Coloured	Indian	Black
Orange Free State	7	0	0	18
Cape	98	0	0	580
Natal	44	0	101	307
Transvaal	141	0	19	459
Total	290	580*	120	1 364

*Figures are not kept per province.

SA citizenship: independent Black states

368. Mr P G SOAL asked the Minister of Home Affairs:

Whether any Blacks in the independent Black states have applied to regain their South African citizenship in terms of the provisions of the National States Citizenship Act, No 26 of 1970, as amended by the National States Citizenship Amendment Act, No 13 of 1978; if so, in respect of each such state, (a) how many applied, (b) how many applications were approved and (c) for what specified period is this information furnished?

B866E

The MINISTER OF HOME AFFAIRS:

Owing to the provisions of the Restoration of South African Citizenship Act, 1986 (Act 73 of 1986), which came into effect on 1 July 1986, no Black of any of the independent states applied in terms of section 3 of the National States Citizenship Act, 1970 (Act 26 of 1970), as amended by the National States Citizenship Amendment Act, 1978 (Act 13 of 1978), for South African citizenship since that date.

Particulars of applications prior to the commencement of the above-mentioned Restoration of South African Citizenship Act are not readily available.

Telephone installations: North Rand

369. Mr P G SOAL asked the Minister of Posts and Telecommunications:

Whether any applications for telephone installations for (a) residential, (b) facsimile and (c) business purposes were outstanding at the North Rand office of Telkom as at 1 October 1992; if so, (i) how many in each case and (ii) when is it anticipated that these backlogs will be eliminated?

B867E

NEWS FEATURE *Lifecare replies to allegations in four articles by Ruth Bhengu*

The Millsite story

Sowetan 20/11/92 88

In October Sowetan published four articles by Ruth Bhengu of our investigations team alleging major abuse of patients at Millsite, a psychiatric hospital managed by the Lifecare Group. Lifecare disputed the allegations and after mediation by the Media Council, Sowetan has agreed to give Lifecare space to reply to the allegations, and this is their side of the story:

THE FOUR Millsite articles that appeared in October contained such totally inaccurate statements as: "a high death rate", "most windows are broken", "staff work up to 15 hours a day" and many others. Space does not allow us to address every allegation but a comprehensive refutation was given to the Media Council.

To reply briefly to these:

- the Millsite death rate (3,6%) is well within the US figure for chronic psychiatric patients;
- during Ms Bhengu's visit it was obvious that the windows were not broken. Patients do break windows - sometimes up to 30 in one day - but these are repaired on an on-going basis;
- nurses work according to strict hours laid down by the SA Nursing Council.

The use of unsubstantiated and misleading headlines such as "Stalag Millsite" - associating the hospital with the infamous German prisoner of war camps - or captions using words such as "concentration camp" and "battlefield" were also particularly damaging to the reputations of professional staff who care for the patients at Millsite.

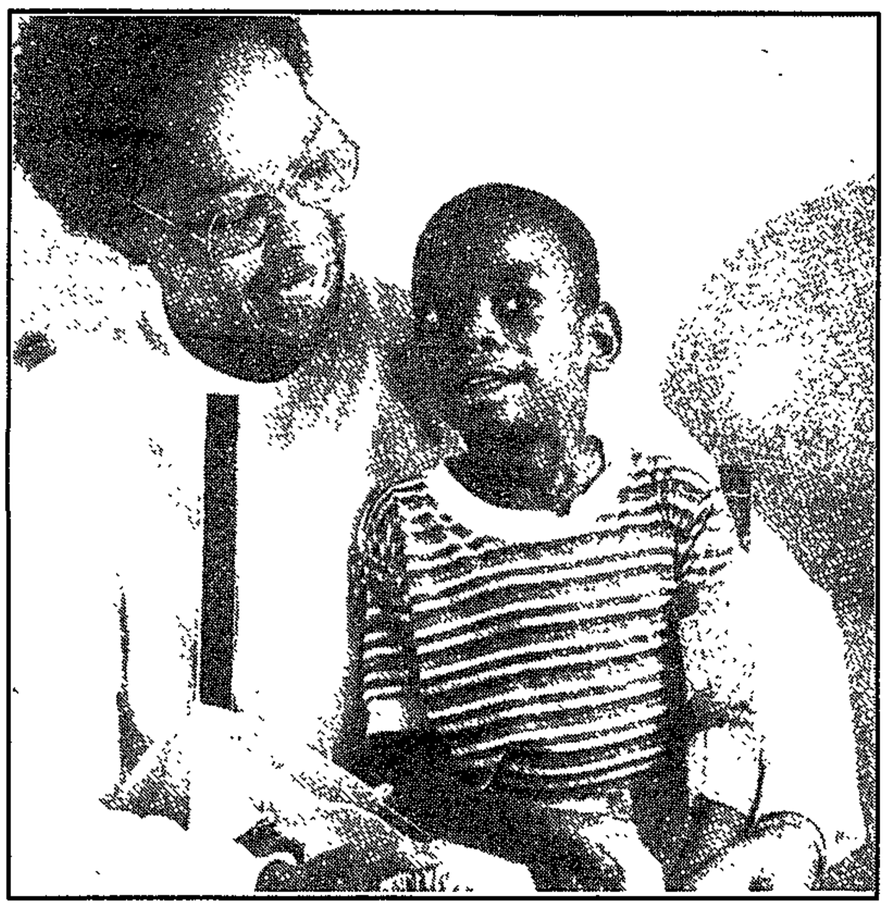
This type of journalism reinforces the stigma attached to psychiatry and it infringes on the rights of the patients and the community.

Most people do not understand the world of the mentally ill. The average person is put into emotional turmoil when coming into contact with persons who are mentally and physically incapacitated. For this reason conditions and situations are often totally misinterpreted and labelled as "abuse".

Treatment at Millsite

Patients at Millsite typically receive the following:

- medical treatment in the sick bay when they fall ill. A 24-hour dispensary stocks a vast variety of medicines and full-time doctors are on duty. Acute cases are transferred to nearby hospitals such as Leratong;
- psychiatric observation and care from full-time psychiatrists;
- 24-hour nursing care;
- physiotherapy to maintain and sometimes improve the physical condition of the patient;
- occupational therapy programmes to stimulate them physically and mentally;
- wholesome food, planned by a qualified dietician;
- comfortable accommodation, with ablution facilities in the wards, adequate blankets and heating in winter;
- clothes, jerseys and shoes as needed;
- relaxation - TV, games, singing, concerts;
- spiritual support, from ministers who regularly hold church services;
- the opportunity to visit their relatives for periods, if this is feasible;
- the opportunity to receive visitors as often as the visitors want to come.



Physiotherapy department: a nurse works with a young cerebral palsied patient, using equipment designed specially at Millsite.

Patient profile

- Millsite cares for 2 600 patients (2 200 males and 400 mentally handicapped children). They are long-term psychiatric patients, referred to Millsite mainly by the state hospitals, Sterkfontein and Weskoppies. Many have no relatives that can be traced.
- Many people expect that patients will be treated and cured, as in ordinary hospitals, but "long-term" means that the great majority of these patients have very little chance of recovery and discharge. The best that can be done for them is to improve their quality of life.
- Because of their mental state, a large number of patients do not know who they are, what they are wearing or how to look after themselves. Thirty percent of the adults are incontinent and have to be changed up to three times daily by the nursing staff.
- Some of the children in Millsite are so deformed that it is difficult to dress and wash them. Their brain function is so limited that they need constant, close observation and care to maintain their basic life systems.

Millsite is providing an essential service to society and to hundreds of families who would otherwise have to try and cope with such disabled relatives. Before lifecare started providing this service, many such people landed in jail because of a lack of facilities.

Looking after mentally and physically defective patients day after day calls for extraordinary commitment, stamina and special training. The Millsite staff have these qualities. They are well-trained and dedicated and they give an invaluable contribution to the community, who would otherwise have to look after such patients.

The colourful garden of Baneng - the children's section of Millsite.

A Millsite sister explaining aspects of patient-care to a student nurse from Baragwanath. Thousands of students have done the practical part of their psychiatric nursing training at Millsite.

the Millsite mangement team includes top professionals with considerable expertise. The manager has 21 years of experience in psychiatric nursing and hospital management. one of the nursing sister managers trained at Harvard University in the USA and is presently studying for a Masters Degree in Psychiatric Nursing. Others are also involved in post-graduate studies.

The physiotherapy co-ordinator is an adviser to the Professional Board of Physiotherapy and several occupational therapists have represented South Africa at overseas conferences. Some of them lecture at Medunsa and the University of Witwatersrand and one is chairman of the South African Institute of Sensory Integration.

Millsite has the full-time services of a qualified dietician, pharmacists and dentist. Several psychiatrists, medical doctors, a paediatrician and social workers work at Millsite.

The Millsite staff in general have given years of dedicated service. Staff turnover is low (2,4%) and over 40% of employees have worked at Millsite for 10 years or longer.

A large percentage of Millsite employees are formally represented by Nehawu with whom Lifecare has recently concluded a wage agreement.

Training

Because of the difficult nature of this work, there is a serious shortage of psychiatric personnel in South Africa. To alleviate the problem, Lifecare has initiated training schemes, approved by the Medical and Dental Council and the SA Nursing Council. Several thousand nursing auxiliaries have already been trained, as well as dozens of physiotherapy- and occupational therapy assistants.

Registered nurses can take a one-year post-basic psychiatric nursing course with Lifecare and thousands of students from the University of the Witwatersrand, RAU, Medunsa, Baragwanath and other hospitals regularly do their psychiatric practical training with Lifecare, in particular at Millsite. It would be very difficult to hide the alleged "appalling conditions" from so many people.

Not all students or trained health professionals can handle the stress of being confronted with severely mentally and physically disabled patients. It is not surprising that members of the public, including reporters, find the situation too stressful, jump to the wrong conclusions and claim "abuse".

Running Millsite

Millsite was never intended to be a five-star hotel, but the care give to patients does improve the quality of their lives. However, as in any home or institution, things can and do go wrong: the electricity fails or a boiler breaks down, leaving a section without hot water for a time; patients throw their shoes in the garden shrubs or on the roof; they leave taps open or break windows.

Problems are handled as they come up. Eighteen full-time maintenance staff provide ongoing repair and upgrading services: installing larger pipes for hot water, fixing broken windows, painting one ward after the other, building new ablution blocks - a never-ending list.

Although patients are closely supervised, they do get ill and they do occasionally injure themselves. Treatment is given accordingly. Regular multi-disciplinary meetings are held to assess patients and to evaluate treatment These teams include the psychiatrists, medical doctors, a paediatrician, a clinical psychologist, the nursing staff, the occupational and physiotherapists, social workers and the dietician.

To improve supervision, patients are divided into four categories: A, B, C and D. Most patients are severely disabled and fall in the C and D categories. These need the most supervision. A small percentage of "A" patients are capable of rehabilitation and discharge. Special programmes, activities and outings are planned to help them cope with normal life when they are discharged. The tragedy of some of these is that they have no place to go back to because their families are unable to care for them.

Lifecare continually attempts to involve the community where possible at all its facilities. Millsite arranges an annual Open Day for families and interested persons. The next one takes place at the end of this month.

Lifecare has developed a model for psychiatric care and rehabilitation that is unique and it could provide a blueprint for institutions in other parts of Africa.

The *Sowetan* articles have caused considerable hurt to the hundreds of dedicated staff employed by Lifecare and concern to families of patients. They deserve appreciation and support, not attack.

No threats against Bhengu

Lifecare Group's reply to columnist's claim:

Ruth Bhengu, in her column Heartbeat on October 20 1992, said she had been receiving "slightly threatening letters from the company that owns Millsite, the Lifecare Group. Their beef is that I am making them look bad".

Sowetan acknowledges that the correspondence it received were not threats against Bhengu, physical or otherwise, but threats to take the newspaper to the Media Council or to court.

Doctors shocked by violence in country

Psychologists threatened by own clients:

By Mokgadi Pela Sowetan 21/12/92

TWO visiting British clinical psychologists have expressed shock at the amount of violence in families and the threats faced by their South African counterparts in mediating in such disputes.

Drs Elsa Jones and Renos Papadopoulos made this remark at the end of a five-day workshop organised by the Family Institute in Mayfair, Johannesburg, on Friday.

"How can we still expect therapists to be of help when they are scared of their clients?" Jones asked.

She, however, paid tribute to South African therapists for continuing to counsel families despite difficult circumstances.

Jones said due to the multiple levels of violence in South Africa, the therapist was unsure how to counsel his client.

She said violence came from individuals, families, society and government.

HEALTH & DISEASE - MENTAL HEALTH

1993 — 1997

Psychopaths face long terms

STAR 18/1/93

By Brendan Templeton 88

Psychopaths found guilty of violent crimes may get indeterminate sentences if Parliament accepts drastic changes to the Mental Health Act, proposing to differentiate psychopathy from other types of mental illness.

At present, psychopaths are regarded as being mentally ill and are sentenced accordingly. This means they get defined sentences, and may get parole and time off for good behaviour.

If a draft Bill published for comment on Friday by the Justice Department is accepted, only a Regional Court magistrate or a Supreme Court judge will be able to release a psychopath early.

The Bill is the result of proposals made by the Booysens Commission which spent almost two years investigating how the law should apply to psychopaths.

The proposed changes were welcomed by psychiatrists who agreed that psychopathy was not a treatable illness.

Dr David Norris of the University of the Witwatersrand said: "If you are going to jail a person suffering from an anti-social personality disorder who commits a violent crime, he should be put away for life.

"These people are born with their disorder — not like others who acquire their mental illnesses through accidents, drugs or what they are forced to experience.

"Their illness permeates their whole personality, and you cannot change a person's personality."

Professor Gerald Doyle agreed: "When a person is psychotic he has a lack of awareness of the consequences or seriousness of his actions and simply acts impulsively."

The need for an indeterminate sentence was highlighted horrifically in 1987 by screwdriver-rapist William van der Merwe, a certified psychopath.

He was released after serving only six years of a 20-year sentence, despite warnings from family members that he would kill again.

Their fears were confirmed when he raped two women in the Cape, killing one of them.

Change in psychopath law

SOUTH 23/1 - 27/1/93 (88)

By Justin Pearce

PSYCHIATRISTS have welcomed draft legislation which aims to put psychopaths in jail rather than in mental hospitals.

In terms of the draft Criminal Matters Amendent Bill, due to go before Parliament, psychopathy will no longer be a classifiable mental disorder in the eyes of the law.

Psychopaths, more properly called people with antisocial personality disorder, are people whose personality is disposed towards destructive or criminal behaviour.

The disorder may manifest itself in the person committing murder, rape, assault or other violent crimes.

Last year, when a number of allegedly dangerous patients escaped from the maximum security ward at Valkenberg, observers commented that it was inappropriate for the over-extended resources of a mental hospital to accommodate patients who had no chance of rehabilitation.

The draft bill recommends a new sentence option for "dangerous offenders", which it defines as persons who, because of a mental illness or disability or otherwise, are a danger to other people and to society. Supreme and Regional Courts will now be able to impose a sentence of indeterminate length on these offenders, and to determine a fixed minimum sentence.

The draft bill recommends that only the court which imposed the sentence be authorised to consider an application for the offender's release.

Before sentencing, an offender will be subjected to an enquiry by a panel of experts which will determine whether or not the new sentence option is appropriate.

One psychiatrist, who for professional reasons may not be named, said psychopathy could not be regarded as a medical disorder, but rather as a condition arising out of an individual's personality development.

Law 'threat to patient rights'

CT 25/11/93,

JOHANNESBURG. — The Patients Rights Organisation of SA (Prosa) has strongly condemned any legislation that gives medical service suppliers the right to make decisions for patients.

Their protest follows moves to allow big business and medical aids to run health maintenance organisations which would enter into contracts with hospitals and pharmacies and employ their own practitioners.

The Medical Schemes Amendment Act is expected to be approved by Parliament in February or early March this year. — Sapa

Mental care probe

A COMMITTEE of inquiry into single care grants, in terms of the Mental Health Act, had been appointed, Health Minister Rina Venter said yesterday.

She said the committee, which is to be chaired by Johannesburg's Chief Magistrate O de Meyer, should submit its report on the inquiry within six months.

Mental health campaign

Sowetan 5/2/93

88

■ Emphasis will be on children and psychiatric services:

By Mokgadi Pela

THE South African Federation for Mental Health is to embark on a vigorous campaign to create public awareness about the plight of thousands.

Spokeswoman for the movement Mrs Thelma Mahlobo said 1993 was significant as it marked 80 years of the body's existence. Formerly called the National Council for Mental Health, the body will organise around three campaigns:

- Mental Health — relating to mental fitness or being able to cope with life's demands, being productive and entering into meaningful relationships;
- Mental Illness — relating to certain ailments of the mind, the best known being depression; and
- Mental Handicap — relating simply to brain damage.

Mahlobo said there were "trainable patients" and the profoundly mentally handicapped.

Mahlobo said the emphasis would be on children.

"We feel they are the most neglected. Children are also likely to suffer as they can't handle frustrations like adults. Our campaigns will also highlight the need for psychiatric services in black communities."

Accept stress as a challenge

B/DAY 26/2/93. (88)

DIANE FINE

EVERYONE experiences stress at some time, whether from situations of their own making or from other sources. Common causes of stress are physical illness, financial worries, problems with children, marital strife, work overload, moving house, marriage, new job, personal injury, new baby, change of financial state, going on holiday, death of a family member; the list is endless. All change produces stress, but what is important is how the individual deals with it.

Stress produces physical symptoms with which most people are familiar — feeling sick, butterflies, jelly-like legs, aching muscles, headaches, palpitations, indigestion, and so on. Stress affects behaviour — you say more provocative things than usual, become argumentative or clumsy. Your mood is also affected as you feel depressed, fearful, angry, hopeless and helpless.

Stress can be perceived as either challenging and motivating or it can be experienced as overwhelming and anxiety-provoking. It is when the latter is experienced that a problem develops. What one person experiences as challenging, another may find overwhelming. Each person possesses his or her own level of tolerance. The greater the intensity and duration of stress, the more severe the anxiety.

Dr Paul Hauck, an American psychologist, believes we create stress by believing irrational thoughts. He says if we change our irrational beliefs we can reduce our stress levels significantly. Some of the beliefs outlined by him as irrational are:

☐ The idea that one should be thoroughly competent, adequate and achieving in all possible respects if one is to consider oneself worthwhile. This belief may make you fearful of beginning any new task or completing a task, and assume that you are not entitled to make mistakes or admit to difficulty in handling a situation;

☐ The idea that one should be dependent on others and need someone stronger than oneself on whom to rely. If you believe this it is stressful to function independently or to allow others to be dependent on you;

☐ The idea that one should become quite upset over other people's problems and disturbances. This allows you to take on the world's problems, being unable to say no to others;

☐ The idea that there is invariably a correct, precise, and perfect solution to human problems and that it is catastrophic if this perfect solution is not found. This common belief can result in delaying decisions, worrying constantly if you have made the right decision and being unable to let the problem go in case a better solution might arise. It is, in fact, naive and/or arrogant to suggest that there might be perfect and certain solutions. Only death is certain;

☐ The idea that it is catastrophic when things are not the way one would like them to be. Rather than become devastated when things are not as you would like them to be, try to change them. What cannot be changed needs to be accepted philosophically;

☐ The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrows and disturbances. This suggests that you have no ability to control your feelings;

☐ The idea that if something is or may be dangerous one should be terribly concerned about it and keep dwelling on the possibility of it occurring; and

☐ The idea that it is easier to avoid than to face certain difficulties and responsibilities. This is a common reason for procrastination and compounding stress.

To reduce one's stress level it is necessary to look at what beliefs are causing stress and then to change these. For example, if you believe it should take 20 minutes to get to work in rush-hour traffic and it takes much longer you are likely to become agitated. But if you accept that the drive will take 45 minutes, by the time 20 minutes have passed you will still be calm and relaxed.

A further useful technique is to divide and accord priorities to the tasks facing you. Visualise yourself succeeding at these parts and set realistic goals in terms of completing these small segments.

Self-affirmation is vital to convince yourself you are able to manage. Other important skills in handling stress are not to blame others for your problems — this only causes frustration; to maintain a daily routine whose structure provides order and security; not to save problems for bedtime; to learn to accept the inevitable daily crises which occur; to build a support network; to laugh; to exercise regularly to reduce muscular tension build-up and to maintain a healthy diet.

It is essential to begin to look at pressure as a challenge and as an opportunity for growth and progress. Our lives will never be totally stress-free so it is vital to find ways to handle stress more effectively.

☐ The author is a counsellor at the Family Life Centre.

Where handicapped and normal children fit in

Getting to know you . . .

88

ARG 3/3/93

GERMAN VISITOR: A visiting volunteer, German student Stefan Schönweiss, gets to know some of the children on his first day at the centre.

CONTAINER CLASSROOMS: Pupils and teachers from the Peter Pan Down Syndrome Centre, a pre-school for handicapped and "normal" children, outside their new container classrooms in Salt River. Pictures. OBED ZILWA, The Argus.

ANDREA WEISS
Health Reporter

IF you thought handicapped children needed to be separated from others, it's time you had a rethink.

Integrating handicapped with non-handicapped children is one of the chief aims of the Peter Pan Down Syndrome Centre — a pre-school in Woodstock.

At the Methodist Church in Roodebloem Road, about 30 children — a quarter of whom have handicaps ranging from Down's Syndrome to physical disabilities — play happily side by side.

The casual visitor would probably have to look twice before noticing differences among the lively pre-schoolers.

Mrs Almarie Williams, vice-principal and fund-raiser, explained: "From the handicapped children's point of view, they are not seen as different from other children and because of this they develop at a greater rate than they would otherwise.

"On the other hand, the 'normal' children come to realise that there are others who are handicapped and spontaneously learn to help."

For a shy child, for instance, the contact with a characteristically sweet and loving Down's syndrome child could help to break the ice.

Conversely, the handicapped children constantly surprised their teachers by doing things they may not have been expected to manage.

The school, with its four dedicated teachers, principal, vice-principal and driver, is soon to move to new premises in Salt River to occupy eight shipping containers given by Safmarine.

While, for many, container classrooms may seem like making do with very little, the school is delighted with the move.

For a while the school was housed in premises owned by the Roman Catholic Church in Hope Street. But these were sold and it moved to Woodstock.

It is hoped the latest move will give it a permanent home and there are plans for a community centre on a vacant site next to the containers.

The containers are insulated, have linoleum floors and windows, making them quite comfortable classrooms.

Outside, a stretch of gravel awaits roll-on lawn and the concrete walls are just begging for bright murals.

The children follow a programme called Get Set, devised in the United States and adapted for South African use. Its emphasis is on developing the individual potential of each child.

Classrooms are divided into a variety of areas, from art to a quiet area. The day starts with planning time when each child chooses what he or she wants to do. The sessions are rounded off with call time when they get together to talk about their activities.

Now that the school's space problem has been solved temporarily, salaries remain the biggest headache. It has some funding from Germany and visiting German students help out.

Parents pay a nominal R70 a month but because two meals a day and higher levels of staffing are needed, salaries are low.

It is perhaps a mark of the staff's dedication that they are prepared to stay when more lucrative appointments may be obtained elsewhere.

The school also has immediate needs: wood for shelving, trees and plants for improving the surroundings, child-size tables, curtains and even a paddling pool would all be gratefully accepted. Even the services of a builder to touch up walls would come in handy.

Anybody able to lend a hand should contact the principal, Mrs Jean Kench, or Mrs Williams at the school at ☎ 47 5554 or Mrs Williams at home (☎ 794 6856).

N Friday March 5 1993

Help for suicide attempt patients

Sowetan 88

■ 20 people counselled each week 5/3/93

By Mokgadi Pela

BARAGWANATH Hospital psychologists counsel about 20 suicide attempt patients per week, *Sowetan* has learnt.

The psychologists believe, however, that the unit is under-utilised and suspect that many cases are not being reported.

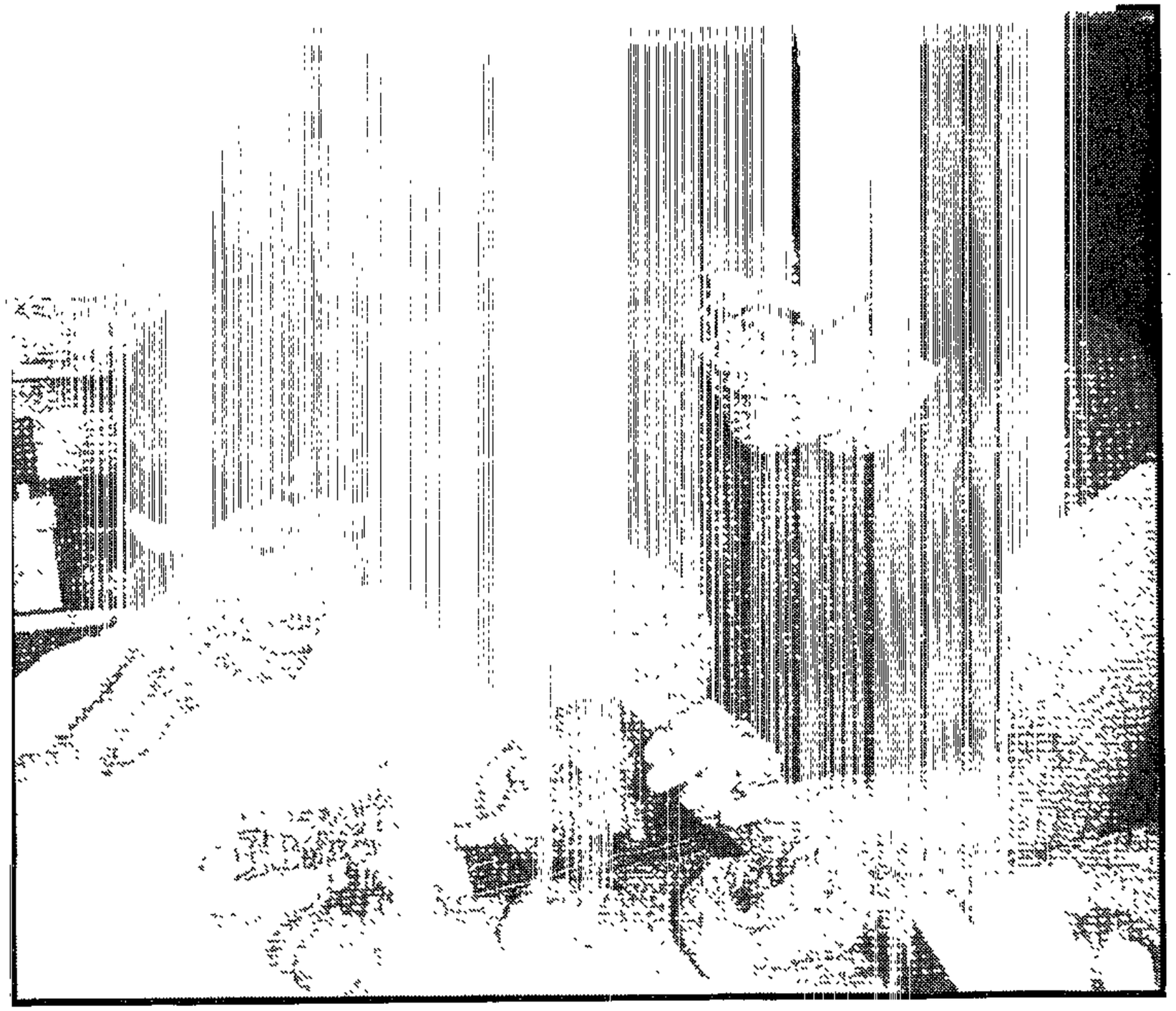
The reasons cited for the suicide attempts include breakdown in relationships, parent-child relationships, economic hardships, collapse of the traditional support systems in the black community and increasing social problems.

In an interview with Mercy Lebakeng of Bara's psychology department, it became apparent that the reasons counsellors often received from patients were not always the sole ones that trigger the process.

Lebakeng said since the beginning of the year, the unit had counselled four pupils who failed their matric examinations and attempted suicide.

She said the ages of patients they counselled ranged from 16 to 70.

She said the community could assist in alleviating this problem in Soweto and other areas by offering the necessary support in times of need.



Pictures: DALE KNEEN, The Argus.

SPECIALISED TEACHING: Mrs Annalies van Rijswijk, a teacher at the Vera School for Autistic Children, gives Enrico some help in the classroom.

BUSY WEAVERS: Showing principal Dr Marinus van Rooyen their handiwork are, from left, Melissa, Melanie and Cathy. Jessi is seated.

One organisation for all with autism is the aim

88
ARG 8/3/93

DALE KNEEN
Staff Reporter

SOCIETIES for autistic people have formed a national organisation to pool medical knowledge and give autists a voice when a bill of rights is formulated.

The Western Cape Society for Autistic Children, the Southern Transvaal Society for Children and Adults with Autism and the Society for Autism in Pretoria formed Autism SA at a meeting in Cape Town recently.

Chairman Mr Bill Holland said the organisation's aim was to co-ordinate the research, treatment and care of autists and to develop and enhance the facilities for them throughout the country.

The move was prompted by the possibility of government funding drying up and to co-ordinate autistic care which had been divided during the years of apartheid.

Autism SA also would enable South African delegations to represent autists at international conferences and to pressure politicians into enshrining the rights of people with autism in a bill of rights.

Four in every 10 000 people have autism, a developmental disability that results in limited language development and bonding as well as obsessive behaviour. It usually is accompanied by some degree of mental retardation.

Dr Marinus van Rooyen, principal of Cape Town's Vera School for Autistic Children, the world's first purpose-built school for autists, said the syndrome first was identified 50 years ago by German Professor Leo Kanner.

"Autism affects language in a general sense — speech, body language, humour and being able to pick up ethical cues and innuendo. Autists' perception of language is very concrete," he said.

"On a socio-emotional level, they usually have a problem forming relationships and showing affection. Because of that, their social interaction is severely hampered."

The cause of autism is not known, but research indicates it is of organic, rather than emotional, origin. More boys tend to be autists than girls, but girls with autism tend to be more severely affected.

The best treatment for autism at the moment is a structured educational environment. Each autist is unique and thus requires individual attention, which makes education very costly.

I therefore agree with the speakers who preceded me that the control of the welfare funds should be improved, and so should the control of the funds that are approved for the express purpose of protecting the poor and people who are being cared for by the welfare organisations. It is clear that many donations are not used for the purpose for which they were intended. The National Tourism Forum is not the only case. We are also dealing with cases in which foreign funds did not reach the welfare organisation or the poor, for whom it was intended. The department is at present locked in discussions with the welfare people. We are negotiating with them and a White Paper will be composed. The deficiencies that exist at present will be dealt with in that way.

However, it is also the right of the members of the public, if they are aware of such irregularities, to lay a charge with the police, who are the people who will eventually have to take the matter in hand if a crime has been committed. [Time expired.]

*Dr W A ODENDAAL: Mr Speaker, on a point of order: I would like to know whether you would allow other members of this House to ask follow-up questions after the completion of such an interpellation.

*The DEPUTY SPEAKER: Order! No, This may not be done during interpellations.

Human rights abuses in mental hospitals: commission

(88) (88)

3. Dr Z B JIYANE asked the Minister for Health: Hansard 29/3/95

(1) Whether she intends responding to the call by the Secretary-General of the Inkatha Freedom Party for the immediate appointment of a commission of enquiry to investigate allegations of continued human rights abuses in mental health hospitals; if not, why not; if so, when;

(2) whether it has come to her attention that human rights activists from other countries have expressed their concern about this issue; if so, what are the relevant details?

N274E.INT

The MINISTER FOR HEALTH: Mr Deputy Speaker and hon members, before I answer the hon member's question, it may be appropriate to explain the background history of mental institutions in this country.

Prior to the Union in 1910 all four provinces had legislation covering the care for their mentally ill patients. In the Cape Province they had the Lunacy Act of 1877, and in Natal they had the Custody of Lunacy Law. The Acts were combined in 1914 in an Act on Lunacy and Leprosy. This Act was repealed in 1916 and replaced by the Act on Mental Illness. We must remember that at this stage there was no effective treatment available. The Act only provided for custody of such patients.

Institutions were there for the safe physical care of patients in places situated away from the community. These institutions resorted under the jurisdiction of the Department of Internal Affairs until 1943. There were very rigid and unbending administrative procedures, including those regarding staff. For instance, staff needed permission to get married if they worked in any of these institutions.

In 1944 the management of psychiatric hospitals was placed under the Department of Health for the first time. In 1966, after the murder of Dr H F Verwoerd, a commission of enquiry under the chairmanship of Judge Frans Raath was set in place.

This revised the Act of 1916. In 1970 another commission under the chairmanship of J T van Wyk was appointed, which put forward the Act of 1973. Although this Act has been amended many times, it is still in force today. This Act does provide for the outward movement of treatment to communities, through which isolation and stigma has decreased. The separation of mental hospitals from mainstream health is thus a historical one and is also emphasised . . . [Time expired.]

Dr Z B JIYANE: Mr Speaker, I regret the fact that the hon the Minister did not have time enough to answer directly as to what is happening now in mental health hospitals.

The IFP called on the hon the Minister to immediately appoint a commission of inquiry into the allegations of gross violations of human rights in South African psychiatric institutions generally and in private psychiatric institutions specifically.

As partners in the Government of National Unity we made this call not as an indictment against the ANC, but as a genuine attempt to expedite the resolution of this problem. The IFP

feels that there are many other human rights issues needing attention, but the urgency of this particular matter lies in the fact that many thousands of mentally handicapped South African citizens constitute a class of forgotten, helpless beings who have suffered severely under apartheid and who should not find that in this new South Africa their pain and suffering remain unaddressed.

Credible international organisations continue to observe that in the new South Africa the Government has not done much to change the situation. In the 1983 report of the WHO Organisation, for example, it was reported that—

> . . . between 8 000 and 9 000 Africans suffering from mental disorders are detained against their will in mental institutions in the Republic of South Africa. These Africans are the object of a business deal between the State and profit-making White companies which receive Government subsidies on a per capita basis against the provision of custodial care for mental patients.

The report also states that the private companies made a profit of about R10 million in one year. This profit is achieved by providing subsistence at lower cost than at Government facilities and by the use of patient labour.

The report notes that this situation has no parallel in history or in the present state of psychiatric care worldwide. It certainly does have a parallel in the ownership and trading of slaves, the report concludes.

In addition to the WHO Report of 1983 there was also a report by the American Psychiatric Association. I quote:

> Our investigation convinced us that there is good reason for international concern about psychiatric patients in South Africa. We found medical practices which were unacceptable and which resulted in the needless deaths of Black South Africans. We found that medical and psychiatric care provided for Blacks was grossly inferior to that provided for Whites. We found that apartheid has a destructive impact on Blacks—their families, their social institutions and their mental health. We believe that these findings taken individually and as a whole substantiate allegations of social and political abuse of psychiatry.

The SA Federation for Mental Health, in correspondence recently with us in September 1994, confirms these allegations contained in both the WHO Report and in the American Psychiatric Association Report. The situation has not changed up to now. That is why we should like the hon the Minister to tell the House whether this very necessary step has been taken.

I did not mention the fact that so many of these helpless and forgotten citizens of South Africa die in these mental hospitals, particularly in the private mental hospitals, in which profits are being made at the cost of these people's human rights. [Time expired.]

*Mr P W GROBBELAAR: Mr Speaker, the conditions in the psychiatric hospitals are a cause of great concern. Twenty three percent of the patients occupying beds in Western Cape hospitals are psychiatric patients. The State must also take into account that these patients may not be neglected under any circumstances, and that there is no alternative for them. They are patients of the State. The Government will have to ensure that the conditions in these hospitals are improved, as they create a very bad impression abroad.

The single greatest factor that places pressure on the care of these patients is the lack of the necessary facilities. This results in acute psychotic patients being admitted to ordinary wards. This again has an effect on the safety of personnel. As a result of the lack of safety and the bad pay there is a personnel shortage.

Urgent attention will have to be given to the necessary facilities and the safety of personnel. The Minister for Health will have to consult with the Minister for Safety and Security to see if a way out cannot be found, in that the SAPS will train people to see to the safety of personnel at these hospitals on a standby basis.

As has already been mentioned, these patients are the responsibility of the State, and there is no reason why the necessary facilities and a high quality of care cannot be provided. We in the Republic of South Africa cannot entertain heads of state at great cost if these patients are not cared for.

The MINISTER FOR HEALTH: Mr Speaker, the intention of giving the background was to show that this service joined the Department of Health very late, and for many years it has been

treated as a Cinderella service with very little of the Budget and limited personnel going to it.

However, it is also important to note that, yes, some of these hospitals are run by the Government, and some by private institutions. These private institutions managed them before. They managed them for the KwaZulu government; and some of them are still being run by the KwaZulu government, even now. Having said that, it is clear that there is a backlog of 10 to 20 years, both in terms of facilities and health resources. Therefore there will be no magic wand to change the status of the facilities. What I have done is the following. I have not instituted a commission of inquiry, as the IFP requested, to look at human rights. I have instead appointed a committee to look at mental health services as a whole, and not just the human rights aspect of it, because we cannot solve the human rights aspect until we have dealt with the question of personnel, facilities and everything else that goes with it.

That committee has started its work; I have the names and everything if the hon member is interested in the identities of the people who are looking into this. My answer therefore is, no, the committee is not a commission of inquiry, but is rather a committee that is looking at mental health services as a whole, including human rights. [Time expired.]

Dr Z B JIYANE: Mr Speaker, I would have appreciated it if the other Government institutions that are responsible for running mental health services were not meant to be an excuse that nothing should be done to address this grave situation. We note that several years into the nineties top executives of mental health institutions in South Africa confirm that what happened during the apartheid era has not changed.

It is therefore incumbent upon us in the GNU and here in Parliament to see to it that steps are taken, particularly to look into the matter of people who are profiteering from the conditions of these unfortunate persons who are in mental hospitals.

I do not see where the difference is when the Minister talks about a commission of enquiry into human rights violations and distinguishes it from the investigation into the state of mental health generally.

As far as we are concerned if that comprised investigations into the issue of these gross violations of human rights, that would suffice. However, we would also appreciate it if, in the spirit of co-operation, we look at this matter thoroughly. As the organisation that raised the issue, we should be in contact with the Minister as she tries to look into the subject. We would be interested to know who the people on that committee or commission—I think she chooses to call it a committee—who are going to look into the matter are, because the issue is of public concern.

We should not forget that during the days when we were under the apartheid regime, the world looked at us, and watched things that were happening which should not have happened. There is no reason, when we are now in Government, for the world to forget that those things should be addressed simply because there is a Black government, and the mental institutions are a case in point. By now we should have addressed this problem. There is no reason for the head of the South African Federation for Mental Health to have said in September 1994 that nothing had changed in the condition of these forgotten citizens of South Africa.

I would also like the Minister to address the issue of the 1976 amendment to the Act of 1973 which restricted access to these institutions. As hon members may know, whenever there were people who wanted to visit these institutions, what happened was that they window dressed and freshly painted the buildings as if things were continuing normally there. In reality, however, if people went there without notice, they would find that terrible things happened there. According to the WHO, these things were comparable to a situation of slave trading, because profit was involved. [Time expired.]

The MINISTER FOR HEALTH: Mr Speaker, obviously the hon member has no clue of what he is talking about, because if he thinks that we could change what is going on there in these few months, in less than a year, then he does not understand.

Clearly something is being done, but nothing is going to change overnight. One cannot change centuries of neglect in nine months with a budget that is still what it is. So if he is realistic and not living in some cloud-cuckoo-land, it is very clear that it is going to take time. We are taking steps

to change things, but they are not going to change overnight. It is not fair for the hon member to say everything should have changed by now. [Interjections.]

Illegal aliens: legislation

4. Ms M SMUTS asked the Minister of Home Affairs:

Whether the proposed legislative measures in respect of illegal aliens are in line with the policy of the Government of National Unity; if not, what is the position in this regard; if so, what are the relevant details?

Hansard 29/6/95 N275E.INT

The MINISTER OF HOME AFFAIRS: Mr Speaker, hon members, in my response to this question of the hon member Ms Smuts, I think it was put because I recently, during a briefing of the press, among other things gave an overview of the legislative proposals which are being envisaged for 1995.

The media reports which followed the briefing highlighted the proposals with regard to the amendment of the Aliens Control Act, 1991. I presume that the hon member is referring, in her interpellation, to those particular proposals.

During June 1994 the Cabinet requested the Cabinet Committee for Security and Intelligence Affairs to investigate whether the provisions of the Aliens Control Act, 1991, were adequate to address this thorny problem of illegal aliens in the Republic.

After a very thorough investigation it became evident that the Aliens Control Act of 1991 in its present form could be improved to ensure more effective control of aliens under the present circumstances, and that the provisions regulating the entrance into, sojourn in and departure from the Republic of aliens did indeed require changes.

The draft Aliens Control Amendment Bill must still be considered by the Cabinet and although I do not want to pre-empt the decision of the Cabinet in this regard, I can nevertheless at this stage state that the Government of National Unity will most certainly welcome measures which will ensure more effective control over illegal persons in this country.

South Africa has become the country of survival for many people from countries within Africa and also other parts of the world, where internal strife, underdeveloped economies and over-population are forcing them to leave their countries and to look for a better future elsewhere.

However, with whatever sympathy and understanding one may judge those people, the interests of our own citizens and legal residents must still be the first and foremost consideration. The Government of National Unity cannot allow its immigration and aliens control policies to be rendered meaningless by foreigners who are leaving no stone unturned to settle here.

The Government can also not allow illegal and "back-door" immigrants to continue to flood the local labour market with devastating effects on both our own people and the RDP to which we have committed ourselves. I am convinced that I will have the entire Government's support in the introduction of stricter measures to curb the present influx of illegal immigrants who enter this country either by means of forged documentation or under false pretences.

A matter of grave concern is that the Department of Home Affairs has lately increasingly been confronted with aliens proceeding to South Africa under false pretences as visitors. [Time expired].

Ms M SMUTS: Mr Speaker, yes, the question was indeed initially prompted by the hon the Minister's briefing, but it was also prompted by a deeper concern about the subject of illegal aliens. The real question is whether the Government of National Unity does have a unified policy on illegal aliens at all. We know that the hon the Minister has a policy on aliens. He wants aliens to come and mediate autonomy for Natal.

The deeper question, however, is: Does the Government of National Unity have a policy on illegal aliens at all? One can put it crisply by putting it like this: What is the use of tightening up the temporary permit requirements when the ANC warns everybody against xenophobia? Now to us it seems that a multipronged approach looks like the only answer to what is a very difficult problem.

Strengthening the subcontinental economy, especially that of Mozambique, especially now that the UNHCR is giving up effectively; plugging our porous borders, not only for alien control, but also to stop gun and drug-running, car theft rackets, health risks, and so that illegal trade does not ruin legal trade; as well as closing the loopholes in legislation and in documentation so

I therefore agree wit' 'e speakers who preceded me that the co. : l of the welfare funds should be improved, and so should the control of the funds that are approved for the express purpose of protecting t'e poor and people who are being cared for by the welfare organisations. It is clear that many donations are not used for the purpose for which they were intended. The National Tourism Forum is not the only case. We are also dealing with cases in which foreign funds did not reach the welfare organisation or the poor, for whom it was intended. The department is at present locked in discussions with the welfare people. We are negotiating with them and a White Paper will be composed. The deficiencies that exist at present will be dealt with in that way.

However, it is also the right of the members of the public, if they are aware of such irregularities, to lay a charge with the police, who are the people who will eventually have to take the matter in hand if a crime has been committed. [Time expired.]

*Dr W A ODENDAAL: Mr Speaker, on a point of order: I would like to know whether you would allow other members of this House to ask follow-up questions after the completion of such an interpellation.

*The DEPUTY SPEAKER: Order! No, This may not be done during i: erpellations.

Human rights abuses i- nental hospitals: commiss'on

3. Dr Z B JIYANE asked the Minister for Health:

(1) Whether she intenc: esponding to the call by the Secretary-General of the Inkatha Freedom Party for the immediate appointment of a commission of enquiry to investigate allegations of continued human rights abuses in mental health hospitals; if not, why not; if so, when;

(2) whether it has come to her attention that human rights activists from other countries have expressed their concern about this issue; if so, what are the relevant details?

N274E.INT

The MINISTER FOR HEALTH: Mr Deputy Speaker and hon members, before I answer the hon member's question, it may be appropriate to explain the background history of mental institutions in this country.

Prior to the Union in 1910 all four provinces had legislation covering the care for their mentally ill patients. In the Cape Province they had the Lunacy Act of 1877, and in Natal they had the Custody of Lunacy Law. The Acts were combined in 1914 in an Act on Lunacy and Leprosy. This Act was repealed in 1916 and replaced by the Act on Mental Illness. We must remember that at this stage there was no effective treatment available. The Act only provided for custody of such patients.

Institutions were there for the safe physical care of patients in places situated away from the community. These institutions resorted under the jurisdiction of the Department of Internal Affairs until 1943. There were very rigid and unbending administrative procedures, including those regarding staff. For instance, staff needed permission to get married if they worked in any of these institutions.

In 1944 the management of psychiatric hospitals was placed under the Department of Health for the first time. In 1966, after the murder of Dr H F Verwoerd, a commission of enquiry under the chairmanship of Judge Frans Raath was set in place.

This revised the Act of 1916. In 1970 another commission under the chairmanship of J T van Wyk was appointed, which put forward the Act of 1973. Although this Act has been amended many times, it is still in force today. This Act does provide for the outward movement of treatment to communities, through which isolation and stigma has decreased. The separation of mental hospitals from mainstream health is thus a historical one and is also emphasised . . . [Time expired.]

Dr Z B JIYANE: Mr Speaker, I regret the fact that the hon the Minister did not have time enough to answer directly as to what is happening now in mental health hospitals.

The IFP called on the hon the Minister to immediately appoint a commission of inquiry into the allegations of gross violations of human rights in South African psychiatric institutions generally and in private psychiatric institutions specifically.

As partners in the Government of National Unity we made this call not as an indictment against the ANC, but as a genuine attempt to expedite the resolution of this problem. The IFP

feels that there are many other human rights issues needing attention, but the urgency of this particular matter lies in the fact that many thousands of mentally handicapped South African citizens constitute a class of forgotten, helpless beings who have suffered severely under apartheid and who should not find that in this new South Africa their pain and suffering remain unaddressed.

Credible international organisations continue to observe that in the new South Africa the Government has not done much to change the situation. In the 1983 report of the WHO Organisation, for example, it was reported that—

> . . . between 8 000 and 9 000 Africans suffering from mental disorders are detained against their will in mental institutions in the Republic of South Africa. These Africans are the object of a business deal between the State and profit-making White companies which receive Government subsidies on a per capita basis against the provision of custodial care for mental patients.

The report also states that the private companies made a profit of about R10 million in one year. This profit is achieved by providing subsistence at lower cost than at Government facilities and by the use of patient labour.

The report notes that this situation has no parallel in history or in the present state of psychiatric care worldwide. It certainly does have a parallel in the ownership and trading of slaves, the report concludes.

In addition to the WHO Report of 1983 there was also a report by the American Psychiatric Association. I quote:

> Our investigation convinced us that there is good reason for international concern about psychiatric patients in South Africa. We found medical practices which were unacceptable and which resulted in the needless deaths of Black South Africans. We found that medical and psychiatric care provided for Blacks was grossly inferior to that provided for Whites. We found that apartheid has a destructive impact on Blacks—their families, their social institutions and their mental health. We believe that these findings taken individually and as a whole substantiate allegations of social and political abuse of psychiatry.

The SA Federation for Mental Health, in correspondence recently with us in September 1994, confirms these allegations contained in both the WHO Report and in the American Psychiatric Association Report. The situation has not changed up to now. That is why we should like the hon the Minister to tell the House whether this very necessary step has been taken.

I did not mention the fact that so many of these helpless and forgotten citizens of South Africa die in these mental hospitals, particularly in the private mental hospitals, in which profits are being made at the cost of these people's human rights. [Time expired.]

*Mr P W GROBBELAAR: Mr Speaker, the conditions in the psychiatric hospitals are a cause of great concern. Twenty three percent of the patients occupying beds in Western Cape hospitals are psychiatric patients. The State must also take into account that these patients may not be neglected under any circumstances, and that there is no alternative for them. They are patients of the State. The Government will have to ensure that the conditions in these hospitals are improved, as they create a very bad impression abroad.

The single greatest factor that places pressure on the care of these patients is the lack of the necessary facilities. This results in acute psychotic patients being admitted to ordinary wards. This again has an effect on the safety of personnel. As a result of the lack of safety and the bad pay there is a personnel shortage.

Urgent attention will have to be given to the necessary facilities and the safety of personnel. The Minister for Health will have to consult with the Minister for Safety and Security to see if a way out cannot be found, in that the SAPS will train people to see to the safety of personnel at these hospitals on a standby basis.

As has already been mentioned, these patients are the responsibility of the State, and there is no reason why the necessary facilities and a high quality of care cannot be provided. We in the Republic of South Africa cannot entertain heads of state at great cost if these patients are not cared for.

The MINISTER FOR HEALTH: Mr Speaker, the intention of giving the background was to show that this service joined the Department of Health very late, and for many years it has been

treated as a Cinderella service with very little of the Budget and limited personnel going to it.

However, it is also important to note that, yes, some of these hospitals are run by the Government, and some by private institutions. These private institutions managed them before. They managed them for the KwaZulu government; and some of them are still being run by the KwaZulu government, even now. Having said that, it is clear that there is a backlog of 10 to 20 years, both in terms of facilities and health resources. Therefore there will be no magic wand to change the status of the facilities What I have done is the following. I have not instituted a commission of inquiry, as the IFP requested, to look at human rights I have instead appointed a committee to look at mental health services as a whole, and not just the human rights aspect of it, because we cannot solve the human rights aspect until we have dealt with the question of personnel, facilities and everything else that goes with it.

That committee has started its work; I have the names and everything if the hon member is interested in the identities of the people who are looking into this. My answer therefore is, no, the committee is not a commission of inquiry, but is rather a committee that is looking at mental health services as a whole, including human rights. [Time expired.]

Dr Z B JIYANE: Mr Speaker, I would have appreciated it if the other Government institutions that are responsible for running mental health services were not meant to be an excuse that nothing should be done to address this grave situation. We note that several years into the nineties top executives of mental health institutions in South Africa confirm that what happened during the apartheid era has not changed.

It is therefore incumbent upon us in the GNU and here in Parliament to see to it that steps are taken, particularly to look into the matter of people who are profiteering from the conditions of these unfortunate persons who are in mental hospitals.

I do not see where the difference is when the Minister talks about a commission of enquiry into human rights violations and distinguishes it from the investigation into the state of mental health generally.

As far as we are concerned if that comprised investigations into the issue of these gross violations of human rights, that would suffice. However, we would also appreciate it if, in the spirit of co-operation, we look at this matter thoroughly. As the organisation that raised the issue, we should be in contact with the Minister as she tries to look into the subject. We would be interested to know who the people on that committee or commission—I think she chooses to call it a committee—who are going to look into the matter are, because the issue is of public concern.

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I would also like the Minister to address the issue of the 1976 amendment to the Act of 1973 which restricted access to these institutions. As hon members may know, whenever there were people who wanted to visit these institutions, what happened was that they window dressed and freshly painted the buildings as if things were continuing normally there. In reality, however, if people went there without notice, they would find that terrible things happened there. According to the WHO, these things were comparable to a situation of slave trading, because profit was involved. [Time expired.]

The MINISTER FOR HEALTH: Mr Speaker, obviously the hon member has no clue of what he is talking about, because if he thinks that we could change what is going on there in these few months, in less than a year, then he does not understand.

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Illegal aliens: legislation

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Hansard 29/6/95 N275E.INT

The MINISTER OF HOME AFFAIRS: Mr Speaker, hon members, in my response to this question of the hon member Ms Smuts, I think it was put because I recently, during a briefing of the press, among other things gave an overview of the legislative proposals which are being envisaged for 1995.

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However, with whatever sympathy and understanding one may judge those people, the interests of our own citizens and legal residents must still be the first and foremost consideration. The Government of National Unity cannot allow its immigration and aliens control policies to be rendered meaningless by foreigners who are leaving no stone unturned to settle here.

The Government can also not allow illegal and "back-door" immigrants to continue to flood the local labour market with devastating effects on both our own people and the RDP to which we have committed ourselves. I am convinced that I will have the entire Government's support in the introduction of stricter measures to curb the present influx of illegal immigrants who enter this country either by means of forged documentation or under false pretences.

A matter of grave concern is that the Department of Home Affairs has lately increasingly been confronted with aliens proceeding to South Africa under false pretences as visitors. [Time expired].

Ms M SMUTS: Mr Speaker, yes, the question was indeed initially prompted by the hon the Minister's briefing, but it was also prompted by a deeper concern about the subject of illegal aliens. The real question is whether the Government of National Unity does have a unified policy on illegal aliens at all. We know that the hon the Minister has a policy on aliens. He wants aliens to come and mediate autonomy for Natal.

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Medical

Mental illness rife

MENTAL illnesses accounted for about 80 percent of all diseases in South Africa, a meeting organised by the South African Federation for Mental Health heard. (88)

Company director Mr Gordon Wright told a meeting marking the 80th anniversary of SAFMH in Johannesburg that at least 30 per cent of the population suffered from a mental disability.

He said South Africans had been subjected to a value system that did not harmonise with good mental health. Government and business corruption were the latest forms of mental illness, he said.

He said it was not surprising that there was growing unrest in South Africa's cities, Aids, drugs and crime, as this emanated from mental disorders. Sowetan 31/3/93

How to assist violence victims

The Witwatersrand Mental Health society is running a training course for those interested in counselling victims of violence.

The focus is on domestic violence, but is also aimed at people who have been victims of robberies.

Carol Koffman, project co-ordinator, said the society had been inundated with requests for such a course.

The course will run until May 19. A course in stress management and assertiveness will run from May 24-28. For more information telephone 624-2500/8.

Star 18/5/93 -

Three-part programme to help victims of violence

Star 21/5/93

By Helen Grange

A three-pronged violence intervention programme — aimed at addressing the most immediate needs of the victims of violence — is to be launched by The Family Institute (TFI) in July or August.

The programme's first component, a toll-free telephone counselling service and follow-up direct counselling service, is already in operation as a pilot service which has proved highly successful, says TFI executive director Dr Saths Cooper.

The second component will be a mobile community crisis response and recovery unit. This unit will provide swift support for and entry into a community afflicted by violence, back-up for organised mediators and a multidisciplinary team of trained "neutrals" to provide trauma counselling, emergency medical services and legal advice.

The third component is humanitarian assistance and development. This entails setting in motion processes whereby the survivors of violence can assume greater control over their lives and communities.

More specifically, the emphasis is on reducing people's vulnerability to violence and their focus on their victimology while increasing their receptivity to community consolidation and cohesiveness.

In accomplishing this, TFI will be linking with all organisations involved in the peace initiatives and humanitarian aid or relief.

It will also be establishing teams of "rehabilitated" survivors of violence to assist and counsel others who are experiencing adaptational problems arising from constant exposure to public violence.

● The toll-free telephone counselling service number is 0800-113399.

Credit agency fights poachers

MARIANNE MERTEN

CORPORATE and consumer credit information is being used to trace illegal rhino horn and ivory traders.

Kreditinform financial director Peter Sullivan said yesterday the company had given conservation agencies "unlimited access" via modem to a network which contained about 160 000 corporate and directors' names in its corporate database and more than 9-million names in its consumer database.

The donation — worth about R20 000 — was made because "as individuals and as a company we are interested in conservation", Sullivan said.

Although the arrangement was planned initially for only one year, the company would like to repeat it, he said.

A conservation agency source said yesterday it was a sensitive operation which "has already helped conservation agencies in tracking poachers".

"SA was an outlet for illegal trade in both ivory and rhino horns because of its ports and international trade relations."

The databases did not contain any confidential information, but provided contact names used to trace illegal dealers.

Wits unveils plan to redirect youth skills

JOHN DLUDLU

THE WITS Mental Health Unit will soon launch an intervention programme to rechannel township youth skills into social reconstruction, according to programme coordinator Melvin Freeman.

He says the programme's main objective is to equip the youth in violence-torn townships with the skills of coping with the current transitional period and the future SA, which demands more than just militancy.

The youth, he says, have to be credited for having contributed significantly to the current political negotiations through their militant struggles in the 1980s.

"Over the years skills such as leadership and militancy were built. But in the New SA militancy will have to be reharnessed to reconstruct the country," he adds.

He says youth energy and initiative developed in the 1980s will have to be rechannelled to "more progressive and constructive" programmes of rebuilding the country.

The intervention programme will consist of two parts. One part will be a pilot study that will evaluate a more effective way of training the youth in developing the coping skills.

"We want to involve the communities as volunteers.

"So the study will determine if it's a good idea to use volunteers or social workers as trainers."

The other part will be the training of the youth in what Freeman terms "life skills", which will include negotiating skills, conflict resolution skills, and skills that will help them understand themselves and other people better.

Freeman says the programme will also try to build trust among adults and the youth to normalise the relationship between the two groups. "Adults have so much to learn from the youth and the youth in turn has much to learn from adults," he adds.

Several youth wings of political organisations have already been consulted and some have expressed support for the project.

The project will be financed by a private local foundation and non-governmental bodies will be approached.

While the programme will have psychological aspects to address the after-effects of the current violence in the townships on the youth, more emphasis will be placed on practical intervention, Freeman says.

"In our intervention we have to acknowledge the traumatic past and deal with it, as well as equip people for the future," he adds.

Call on non-governmental organisations

GAVIN DU VENAGE

THE local business sector should take over from foreign donors in supporting non-governmental organisations (NGOs), Gerald Kraak of the Interfund aid agency said in the latest Corporate Social Investment newsletter.

Kraak said NGOs, traditionally dependent on overseas support, were facing a reduction of resources as western governments cut their aid budgets and revised their policies towards SA.

If organisations were forced to shut down it would mean a loss of valuable expertise, experience and "the vision of a democratic social order which the NGO sector came to embody", said Kraak.

A "burgeoning movement" of NGOs had sprung up in SA over the past 15 years, active in education, health, education, welfare and local government, he said.

They had developed innovative strategies to confront social needs and forged close ties with communities.

NGOs also had a keen understanding of conditions on the ground, and were also able to operate where government bodies were viewed with suspicion, he said.

Apart from their role in providing services service, NGOs formed the core of civil society in SA he said, and could play an important role in building a stable democracy.

Donor countries had actively promoted the developmental role of NGOs, but their support was no longer certain: "There can be no doubt that this aid contributed substantially to the building of a strong NGO sector in SA," said Kraak.

The local corporate sector had only recently begun looking at these organisations as conduits to help disadvantaged communities.

A few large corporations had set up funds to help NGOs, but these needed to be extended into a broader partnership between business and organisations.

This would make it possible for the corporate sector to respond directly to community needs, said Kraak.

Hospital aims to minimise trauma of rape

ST Times [Cape metro] 73/6/93.

By MICHAEL O'REILLY

A NEW programme designed to make it less traumatic for women to report rape, is being introduced at Victoria Hospital in Wynberg.

Its aim is to eliminate the "second ordeal" which many victims say they are forced to undergo by having to report to police stations and district surgeons for a medical examination.

A special "comfort room" has been set up at Victoria Hospital, where women are examined, treated, and counselled in a friendly and reassuring environment.

"Our mission is the proper care and long-term follow-up of women and children who have been sexually assaulted," said Dr J S Rossouw, District Surgeon for Wynberg and Athlone.

In the new system, rape survivors who report to police stations are taken directly to Victoria Hospital by specially trained police officers, who then call the district surgeon.

Counselling

The room is curtained and carpeted and has comfortable seating. There are trained medical and counselling staff who can assess the patient's condition and administer preliminary medication if necessary.

The room has a separate entrance, so that the hospital's general reception area is avoided.

When the district surgeon arrives, and a police statement has been taken, the assaulted person is given a medical and legal examination.

On leaving the hospital, the rape victim is put in touch with support groups and social workers.

This procedure is a radical change from the old system, in which women were interviewed at the police station by officers with no special training, and would sometimes wait an hour or more for the district surgeon to arrive.

"They had to wait in cold, locked police station offices," said Dr Rossouw.

It is hoped that the new process will make it easier for people who have been sexually assaulted to seek help, report the crime, and help the state to arrest, prosecute and convict the offenders.

"We're devising a team approach," said Dr Rossouw, "so we can co-ordinate the input of legal, medical and social workers, as well as non-public groups like Rape Crisis."

"A similar system is already being devised in Paarl," said Dr John Moodie, Regional Director of Hospitals and Health for the CPA.

Claim for mental anguish

SOUTH African courts have accepted emotional shock as a damage, but have so far confined it to situations where the victim has been in sight of a traumatic event.

There is the view, however, that a person should be able to claim for general damages arising out of mental suffering, distress and grief caused by the death of a close relative.

Since our courts regularly assess emotional injuries sustained in personal injury, adultery and other cases, there cannot be any rational basis for continuing to deny compensation to bereaved close relatives for their very real and acute mental anguish in wrongful and malicious death cases.

In the case of Thulani Chistopher Cele, who was shot by the Kwazulu Police, such a claim on behalf of the deceased's motherhas been made.

The original claim for damages related solely to funeral expenses, but was subsequently amended to include a sum for mental suffering and grief, depression, emotional shock, injuria and contumelia.

Twenty-year-old Cele was shot twice in the back with an R1 rifle by members of the KZP.

Although he was clearly severely wounded, the policemen intentionally delayed taking him to hospital, a mere 10-minute drive away, for almost two hours.

Evidence from police statements and presented in court consisted of a crudely spun web of inconsistencies, half-truths and contradicitons.

The inquest magistrate concluded that he had no alternative but to recommend that murder charges be brought against the four policemen involved.

KOLOM A	KOLOM B
Streek 5.....	Amersfoort, Balfour (Tvl.), Barberton, Belfast, Bethal, Bochum, Bolobedu, Carolina, Eeste Hoek, Ellisras, Ermelo, Giyani, Groblersdal, Hoëveldrif (Secunda), Letaba 1 (Tzaneen), Letaba 2, Lydenburg, Malamulele, Mapulaneng, Messina, Mhala, Middelburg (Tvl), Mokerong 1, Mokerong 2, Mokerong 3, Namakgale 1, Namakgale 2, Naphuno 1, Naphuno 2, Nebo, Nelspruit, Nkomazi (Kamhlushwa), Nsikazi, Phalaborwa, Pietersburg, Piet Retief, Pelgrimsrus 1, Pelgrimsrus 2, Potgitersrus, Rivati 1, Rivati 2, Sekgusese 1, Sekhukhune, Seshego, Soutpansberg (Louis Trichardt), Standerton, Thabamoopo, Thabazimbi, Volksrust, Wakkerstroom, Warmbad, Waterberg (Nylstroom), Waterval-Boven, Witbank, Witrivier.
Streek 6.....	Alberton, Benoni, Boksburg, Brakpan, Brits, Bronkhorstspruit, Cullinan, Delmas, Germiston, Heidelberg (Tvl.), Johannesburg, Kempton Park, Krugersdorp, Mdutjana 1, Mkobola, Moutse 1, Moutse 2, Nigel, Oberholzer (Carletonville), Pretoria, Randburg, Randfontein, Roodepoort, Sasolburg, Soshanguve 1, Soshanguve 2, Springs, Vanderbijlpark, Vereeniging, Westonaria, Wonderboom.

(25 June 1993)/(25 Junie 1993)

BOARD NOTICE 61 OF 1993

TRANSVAAL PROVINCIAL ADMINISTRATION

HEALTH SERVICES BRANCH

MENTAL HEALTH ACT, 1973 (ACT No. 18 OF 1973)

APPOINTMENT: HOSPITAL BOARD: WESTFORT HOSPITAL, PRETORIA

Under section 47 of the Mental Health Act, 1973 (Act No. 18 of 1973), the Administrator of the Province of the Transvaal has appointed the following persons as members of the Hospital Board, Westfort Hospital, Pretoria, for a period of three years with effect from 15 March 1993 until 14 March 1996:

Mr J. H. Tshungu (Chairman).

Col G. J. P. Pretorius.

Rev. M. A. Masipa.

Rev. M. D. Robbertze.

Mrs A. Venter.

(25 June 1993)

RAADSKENNISGEWING 61 VAN 1993

TRANSVAALSE PROVINSIALE ADMINISTRASIE

TAK GESONDHEIDSDIENSTE

WET OP GEESTESGESONDHEID, 1973 (WET No. 18 VAN 1973)

AANSTELLING: HOSPITAALRAAD: WESTFORT HOSPITAAL, PRETORIA

Kragtens artikel 47 van die Wet op Geestesgesondheid, 1973 (Wet No. 18 van 1973), het die Administrateur van die provinsie Transvaal die volgende persone as lede van die Hospitaalraad, Westfort Hospitaal, Pretoria, vir 'n tydperk van drie jaar met ingang van 15 Maart 1993 tot 14 Maart 1996 aangestel:

Mnr. J. H. Tshungu (Voorsitter).

Kol. G. J. P. Pretorius.

Ds. M. A. Masipa.

Ds. M. D. Robbertze.

Mev. A. Venter.

(25 Junie 1993)

BOARD NOTICE 62 OF 1993

CANNON ISLAND SETTLEMENT MANAGEMENT BOARD

Notice is hereby given in terms of subsection (1) of section 4 of Act No. 15 of 1939, that the time service of the members of the Cannon Island Settlement Management Board lapses on 31 July 1993 and that a public meeting of the owners will be held on Saturday, 31 July 1993, in the public hall from 09:00 to 11:00 for the purpose of nominating and election of a new board.

By Order.

L. C. KRUGER,
Secretary.

Kanoneiland.

7 June 1993.

(25 June 1993)

RAADSKENNISGEWING 62 VAN 1993

KANONEILANDNEDERSETTINGSBESTUURSRAAD

Kennisgewing geskied hiermee, ooreenkomstig subartikel (1) van artikel 4 van Wet No. 15 van 1939, dat die dienstyd van die lede van die Kanoneilandnedersettingsbestuursraad op 31 Julie 1993 verstryk en dat daar op Saterdag, 31 Julie 1993, vanaf 09:00 tot 11:00 'n openbare vergadering van tuinperseeleienare in die saal gehou word vir die benoeming en verkiesing van 'n nuwe raad.

Op las.

L. C. KRUGER,
Sekretaresse.

Kanoneiland.

7 Junie 1993.

(25 Junie 1993)

Cape pupils involved in sex, drugs, violence

ARG 3/7/92

DI CAELERS
Weekend Argus Reporter

TEENAGERS in the Western Cape smoke, drink alcohol, use drugs, have unprotected sex and are responsible for, and victims of, violence.

That is the harsh reality revealed in an extensive study of risk-taking behaviour of Cape Peninsula high-school pupils, published in this month's South African Medical Journal, which demands urgent action from health and educational authorities and enhances the need for sex education at the primary school level.

The study was conducted by Dr A J Flisher (principal investigator), Dr C F Ziervogel, Mr P H Leger and Professor B A Robertson, all of UCT's department of psychiatry, as well as Dr D O Chalton of the SA Medical Research Council's Institute for Biostatistics.

Canvassing 7 340 pupils from 16 schools in all the education departments, the study found that most youngsters were having sex for the first time at about 15 years of age.

A substantial number of the heterosexual encounters recorded, especially those of Xhosa-speaking as well as male pupils generally, were not safe in terms of unwanted pregnancy and sexually transmitted diseases, including the HIV virus.

About a quarter of those pupils having sex had not known their partner for longer than seven days and just more than half had done anything to avoid pregnancy.

The study said: "Our finding that a considerable proportion of adolescents are commencing sexual activity at a relatively early age and, furthermore, that many of these younger students have not known their partner for more than seven days and are not taking adequate precautions against pregnancy and sexually transmitted diseases, implies that education regarding sexuality should commence in primary school."

In an editorial discussing the findings, Dr Derek Yach, leader of the medical council's essential health research group, said it was crucial that adolescent health and well-being be treated as high-priority during transition.

It was clear the volatile, uncertain socio-political process had had a profound impact on South African teenagers.

family Advocates. The purpose of these offices for the children with each one of them," said

While some cases are "cut and dried" and can

sations of sexual molestation.

Trauma centre helps victims of violence

ST Tues (CC Metro) 4/7/93

By BILL BLUMENFELD

THE Trauma Centre for Victims of Violence and Torture in Cape Town, which opened this week, has received a boost with a R1,18-million contribution from the Danish government.

The Centre will help people traumatised by imprisonment, torture, detention, combat, exile, civil unrest, and other political violence.

More than 13 900 people are believed to have died in political violence in South Africa since 1984, according to background information supplied to the centre. Last year alone 3 499 people died and 5 685 were injured.

The centre is based at Cowley Centre — which until recently was used to accommodate returning exiles — a 19th century monastery in District Six leased by the Anglican Church.

It operates on a non-sectarian and non-party political basis and will be manned by members of the South African Health and Social Services Organisation.

Present at this week's official opening were Danish Minister of Development Co-operation and head of European Community Aid, Mrs Helle Degn; Danish Ambassador to South Africa, Mr Peter Bruchner; Prof Ole Esperson, president of the International Council for the Rehabilitation of Torture Victims in Copenhagen and Cheryl Carolus, a member of the ANC's national executive committee.

The head of the centre's management committee, Glenda Wildschut, said that as South Africa entered the fourth year in its transition to democracy, "unprecedented levels of violence grip our divided nation".

"Our country desperately needs peace, but we also need healing. The Trauma Centre is a place for healing the wounds of the past, mending the social fabric torn by years of endemic violence, and preparing our people for a hopeful future," Ms Wildschut said.

She said Centre aimed to:

● Offer counselling, medical advice, and social services to victims of politically motivated violence. They are multi-disciplinary, holistic and aimed at empowering "victims" to gain control of their lives so that they become "survivors".

● Train health care professions and non-professionals in helping people cope with the psychological trauma resulting from acts of political violence, and

● Monitor violations of human rights in relation to its effect on physical and mental health.

The centre can be telephoned at ☎ (021) 45-7373. — Sapa

Psychology body plans to relaunch

Ballot to replace 'white' image

Staff Reporter

OVER 2 000 psychologists voted to close down their apartheid-tainted organisation — the Psychologists' Association of South Africa (PASA).

The move was decided by a ballot of the 2 400-strong organisation and will result in an "absolutely new beginning", University of Stellenbosch psychology lecturer and executive member of the Committee for the Reconstruction of Psychology (CRP) Professor Bodley van der Westhuizen said yesterday.

A new organisation will emerge after an international conference at the University of the Western Cape early next year, he said.

The South African Psychologists Association (SAPA) in the '50s had an unwritten policy not to admit black psychologists into its ranks and when it did in the '60s, caused the formation of a splinter group, the Psychologists Institute of the Republic of South Africa, Professor Van der Westhuizen said.

The two organisations united in the 1980s as PASA, which was "coloured by its political history", Professor Van der Westhuizen said.

CRP chairman and UWC lecturer Dr Lionel Nicholas said PASA was "a white-dominated status quo supporting body, with little concern for the havoc apartheid reaped on the mental health of South Africa".

CRP executive member Ms Rachel Prinsloo, also of UWC, said psychology clearly had a role — for instance, to prepare mentally soldiers of liberation movements and the SADF to work together in a new national force.

Psychology students to practising psychologists may become members of the new organisation, whereas PASA had limited its membership to SA Medical and Dental Council-registered psychologists, a CRP spokeswoman said.

A meeting to discuss the future of South African psychology will be held at 7pm tonight at the University of Cape Town. The meeting will be confined to psychology students, psychologists and interns.

Khayelitsha's place of healing

UCT psychiatry department aims to address psycho-social problems

ARGT 28/9/94 (88)

LIBBY PEACOCK
Health Reporter

A WOMAN who was forced to leave her small children in the care of a 12-year-old while she worked long hours, earning low wages, is one of many benefiting from a new project by the University of Cape Town's Psychiatry Department.

When Nikiwe Mabaxa, 31, was left without an income or grant after her husband's death from TB earlier this year, she had no choice but to go out and work on a farm outside Stellenbosch — for R40 a week.

By the time she called on the Empilweni (Place of Healing) project in Site C, Khayelitsha, for help, her nine-month-old baby was near death from malnutrition.

Community workers (also known as case managers) at the project arranged within a week for a parent support grant for Mrs Mabaxa.

Her baby is in hospital now and her 12-year-old daughter and extremely bright 10-year-old son are back at school.

The Empilweni project was set up in response to a grave need for effective and affordable psycho-social help for people like Mrs Mabaxa, living in extremely poor communities.

Although counselling is done at the project office, trained case managers working with social worker Esmé Kleinveld, do the bulk of their work in the community itself — visiting families on foot and by taxi.

Karin Ensink, a psychologist at the UCT Department of Psychiatry, co-developed the project with Professor Brian Robertson of the same department.

She said screening in the initial pilot project showed that 76 percent of the children questioned manifested "some suggestion" of psychological disorder ("tested positive").

In a similiar study done in Zimbabwe, only 46 percent of children tested positive. This indicated how serious the situation was in Khayelitsha.

During a further psychiatric epidemiological study, 115 of the 500 children interviewed needed referral or intervention for a wide range of problems, including depression, post-traumatic stress disorder, sexual and physical abuse and behavioural problems.

The case managers received six months' training and started seeing patients at the beginning of the year.

Ms Ensink said there were many small community projects in Khayelitsha, but Empilweni was the first to specifically address psycho-social problems in this way.

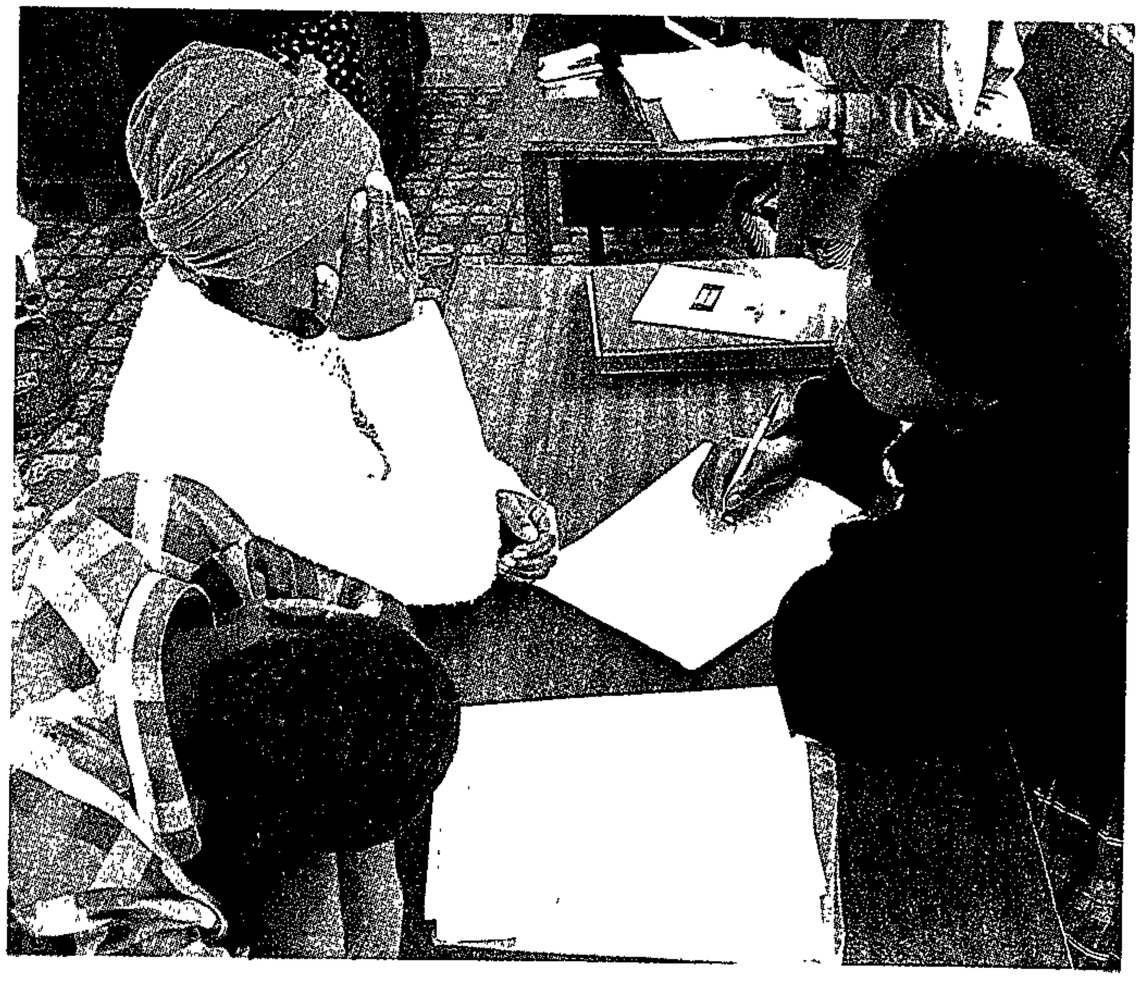
The case managers at the project had developed enough skills to counsel as well as professionals, she said.

"In the past if a child was lucky enough to get to a psychiatrist once, he would not be able to get back."

Now the case managers will follow up each individual.

The project has been set up with support from UCT extension services, De Beers and the Independent Development Trust and will be funded for the next three years by the Overseas Development Agency.

TEAMWORK: Case manager Priscilla Baleni, social worker Esmé Kleinveld and case managers Pretty Mabumbulu and Zanyiwe Maneli, outside Empilweni, Site C, Khayelitsha.



Pictures: HANNES THIART, The Argus.

HELP AT EMPILWENI: Priscilla Baleni counsels an unidentified Khayelitsha mother and her child as part of a new service by the University of Cape Town's psychiatry department.

NEWS FEATURE *'Staff shortages and poor facilities cause deaths and human right's abuses'*

A bitter cure for mentally ill

By Glenn McKenzie

■ PATIENTS' LIVES *Disturbing scenes at local psychiatric hospitals:*

A HEAVILY DRUGGED psychiatric patient rocks back and forth on his heels, knocking his head against a freshly painted wall. Outside, another man begs visitors for small change while his friends run frantically in circles around a hospital compound.

Disturbing scenarios like this prompted the World Health Organisation to call on governments to phase out psychiatric institutions more than 20 years ago.

But in South Africa these scenes are still common in places like Millsite Sanatorium, the country's largest and most controversial mental hospital.

Case study

With almost 3 000 black mentally ill and handicapped patients, Millsite has become a case study in the debate over the continued existence of psychiatric institutions.

Whether patients at Millsite lead an acceptable standard of life is open to debate. Last year alone, 147 patients at Millsite died.

Lifecare spokeswoman Helen Duigan says this is not unusual. The hospital takes care of frail, "defective" children and elderly adults who die of natural causes.

But some workers at Millsite complain that chronic staff shortages and poor facilities cause deaths and human rights abuses.

Cover up

The workers say hospital management ignores problems and forces employees to cover up embarrassing incidents.

"We need independent assessors, legislated by the Government to make sure that management, myself or any of the other staff do not do something wrong," says a nurse at Millsite who asked not to be named.

Louis Moolman, director of Lifecare Group, the private company that runs Millsite, blames many problems on a shortage of funds. Currently only 1,5 percent of the national health budget is spent on mental health care. A fraction of that goes to Lifecare.

> *"We need independent assessors, legislated by the Government to make sure that management, myself or any of the other staff do not do something wrong"*

Another hurdle is a lack of community involvement. Most people don't know what to do with people who are mentally ill and would rather shy away from them.

Public inquiry

"The public needs to take responsibility for mental illness and not point fingers," says Moolman.

Lifecare is so desperate to prove they are doing a good job that the organisation has called for a public inquiry into both government and private psychiatric institutions.

Dr Ralph Mgijima, chairman of the PWV government's new strategic management team for health, is one person that Lifecare will have to convince.

Among other things, Mgijima is concerned over apparent "disparities" in funding given to traditionally white and black institutions.

While a contract negotiated by the Government and Lifecare funds black "chronic, adult" patients at Millsite and Randfontein sanatoriums with a daily tariff of approximately R35 a bed, similar patients at the all-white Witpoort Sanatorium receive R75 a bed.

Meanwhile, Millsite and other black institutions continue to exist because, for most of patients, there is no alternative.

Few capable

There are few community structures capable of dealing with the mental health problem and until there is, hospitals will continue to be a bitter solution.

WHO medical officer Mr Jules Bertolote says community care can be cheaper than institutional care, but it must be done properly and carefully.

Many countries have made the mistake of closing sanatoriums before developing proper clinics, halfway houses and support services.

When Italy began closing mental hospitals in the 1970s, patients in the northern part of the country were easily absorbed into the community and treatment continued with few interruptions. In contrast, many patients in southern Italy ended up on the streets, and received inferior treatment after being released, says Bertolote.

Slow process

Dr Alan Haworth, a psychiatrist with the University of Zambia, says the process of turning mental patients into the community is often a slow one.

When Haworth first began working in Lusaka in 1966, all 400 beds in the local mental hospital were occupied and many patients were sleeping on the floor.

Now that same hospital stands almost empty.

"If communities are to deal with the mentally ill, families have to be involved, counsellors have to be trained and people have to be educated.

Otherwise these so-called delinquent sons can tear their communities apart," says Haworth.

Not saying

Back in South Africa, neither the national nor provincial government is saying what they plan to do about the country's mental health problem.

While PWV's new administration is not expected to begin work until early next year, budget plans for the province's mental hospitals have already begun.

Acting director-general of health Dr Pieter van der Berg said next year's budget for mental institutions would probably resemble the current one.

> *"Many countries have made the mistake of closing sanatoriums before developing proper clinics, halfway houses and support services."*

"We don't have the funds. There is really no other option for us," says Van der Berg.

Disgruntled nurse

A disgruntled Millsite nurse disagrees: "Lifecare and the Government don't care about the mentally ill. They should not be allowed to decide their future.

"We have to do what is right and bring these people back into our townships."

Tied up like a dog all day

☐ *Donald's plight highlights need for mental care*

ARG 30/5/95 (88)

SABATA NGCAI
Staff Reporter

DONALD Mabhanga, 15, spends his days alone in a shack tied to a pole by a length of wool round his left thigh.

He shivers in his torn, light clothes as cold winds gust through the large space between the door and the ground.

He sits forlornly on a block of wood that is his chair and eats only first thing in the morning and again late in the afternoon ... unless a kindly neighbour drops in with food.

That's because Donald is mentally handicapped, and because there are no facilities in Imizamo Yethu squatter camp in Hout Bay to offer him a better life, his mother has no choice but to tie him up while she goes out to work.

And Ruth Mabhanga has been tying him up each day for the past three years.

Cape Mental Health says there "is almost nothing we can do" because the squatter camp has no facilities.

They say they are in touch with the family but refuse to discuss details claiming they are bound by "ethics of confidentiality". But Mrs Mabhanga denies the contact.

To see Donald alone, looking sad and abandoned is a touching experience. He sits forlornly on his block of wood — which smells of urine — resting his cheek on the pole, as if agonising about his plight. He cannot speak and only stares. Occasionally he bursts into hysterical laughter.

At one stage during The Argus' visit Donald tried to lie down on the floor but his firmly tied leg kept him sitting upright.

Mrs Mabhanga says her son wanders about if he's not tied up, and she's concerned that he may wander into a road and get knocked down.

When Donald was untied, he immediately left home and didn't know how to return. When she returned from work she then had to search for him each night throughout the squatter camp.

"It hurts me. I don't tie him up because I enjoy it," Mrs Mabhanga said in a sad and shaking voice.

"I have to go to work because the R300 a month disability grant he gets is not enough. I also have three other children to support.

"I am working as a char to help the family get food."

She said Donald had been sick since he was four, and "it is the agony of my life".

"I am looking for any help I can get for my child."

Donald also suffers from epileptic fits and he is deaf and dumb.

The Child Welfare Society in Wynberg said they were aware of the case and that it had been referred to Cape Mental Health (CMH) in January this year. CMH confirmed that the case was in their hands.

Supervisor Trish Leaver said there was "almost nothing we could do" because the squatter camp has no facilities. She said CMH was "lobbying" with the state to provide facilities.

Mrs Leaver said the only nearby facilities to help the child were in Ocean View, but "transport is a big problem".

She could not say specifically what they were doing about Donald because she was forbidden by "ethics of confidentiality".

She said the office was in touch with the family, but Mrs Mabhanga denied this.

Mrs Mabhanga previously lived in Langa while working as a char in Hout Bay. There, Donald was fetched every day by a minibus sent by a school for the handicapped.

But Mrs Mabhanga was forced to leave Langa because she could not afford the high daily taxi fares to Hout Bay.

Mrs Mabhanga leaves for work at 7 am and returns after 2 pm.

She tried to employ someone to look after Donald, but the person "got impatient and left".

TETHERED: Mentally handicapped Donald Mabhanga on his block of wood and tied to a pole while his mother goes out to work.

Chaos of the mental kind

cl 7/5/95

(88)

Tower Hospital services collapse

By SHADLEY NASH

THE PATIENTS are neat and orderly as they go about their work under the careful eye of the nurses.

The last doctor at Tower Hospital for the mentally ill is now himself a patient at a mental institution.

Tower Hospital lies on the outskirts of Fort Beaufort and is the setting for both heroes and victims of the process of transition.

A stoic group of 104 nurses and assistants, under the capable leadership of matron Nomalungelo Ruxwana, keeps the hospital's 428 patients in comfort and security.

When Ecna paid a surprise visit to the hospital, staff were supervising a team of workers in the hospital's workshops, where some patients busy themselves repairing furniture and making boxes, mats and photo frames.

In the 35-bed children's ward, the television set blares and the stench of an uncleaned nappy wafts through the room.

All of the children are mentally retarded.

"The children have no future. They will grow up here and die here," said Ruxwana.

Behind this scene lies a tale of woefully inadequate staffing which affects the delivery of psychiatric services to a multitude of patients.

"There is a critical shortage of professional staff and there is no doubt that patient care is suffering," said one professional source.

Tower Hospital is but a microcosm of a regional crisis that authorities are currently grappling with.

As services begin to collapse in rural areas, particularly the former homelands, the only fully functioning institutions are now experiencing a patient overload.

According to the source, there are "little or no services" in the whole of the former Transkei. "Patients are starting to trickle to institutions here and soon we can expect a flood of patients," one doctor admitted.

There is no resident doctor and no full-time psychiatrist in the case of Tower Hospital and for "some time" the institution has been operating without a superintendent.

The source said there "was no-one there to see to the psychiatric needs of the patients."

Ruxwana said that the "hospital has vacancies for two full-time doctors, a superintendent, three senior nursing positions and 44 nursing posts."

But posts cannot be filled until rationalisation of the region's psychiatric services takes place.

Tower Hospital is presently serviced by two doctors who perform daily shifts of one hour each at the hospital, not nearly enough hours to treat patients effectively.

"In terms of the Mental Health Act all acute patients need to have daily psychiatric evaluations, but this is not done," said another professional source.

Institutions catering for the psychiatric needs of the Eastern Cape are confined to a handful in urban areas, and with rationalisation some institutions may still close their doors.

In Queenstown, authorities met this week to close the 100 bed Ezibeleni Hospital described by one administrator as "not fit for human habitation".

Grahamstown's Fort England hospital is also facing a crunch with superintendent Dr Athol Schultz warning that the hospital administrators were "seriously considering closing a ward".

One of the workers at Tower puts the finishing touches to a wooden coffin. It will be used to bury the next patient who does not make it to the outside. – Ecna

WHAT HOPE FOR DIGNITY? . . . At Tower Hospital, patients are kept busy while their future hangs in the balance

■ Pic: TARYN CASS

Coping with handicaps

(88) Star 23/3/95

SOCIAL STIGMA

March is Mental Health Month. Despite information campaigns over the years, there is still a social stigma associated with mental illness.

MARIKA SBOROS reports.

When children come into your life, they usually change it dramatically, and for good.

But when one of those children is mentally handicapped, the changes can be traumatic and it may be hard to see the changes as good.

The Government has declared March Mental Health Month, to focus on the problems and opportunities facing people with mental handicaps, as well as their families and communities.

A mentally handicapped person is one whose learning and intellectual abilities are limited, says psychiatric social worker Glenn de Swardt, assistant director of the Witwatersrand Mental Health organisation.

Degree

The degree and type of mental handicap varies considerably. No reliable statistics are available on the incidence of mental handicap in South Africa, but it is generally accepted that it occurs in between 1 and 3% of the population.

The prevalence of mental handicap is higher in undeveloped and developing communities than in developed communities. The incidence is directly associated with poverty and illiteracy, De Swardt says.

About one in 100 children is born with some degree of mental handicap. When the diagnosis is made, parents experience shock, denial and depression. They may also feel guilty (wrongly), believing that they have "caused" the handicap, he says.

Common syndromes and spotting them

Common syndromes usually associated with mental handicap:

■ Downs Syndrome: this chromosomal abnormality affects about one in 700 babies. The risk of having such a baby increases significantly with the mother's age. Pregnant women in their late 30s and older can choose to have a pre-natal test.

■ Fragile X syndrome: this inherited condition affects mostly males. Females can also be affected, usually less severely, but in most instances they are carriers, and can pass the genetic condition on to their sons. Tests are available for detecting carrier females and for accurately diagnosing affected males early during pregnancy or after birth.

■ Foetal alcohol syndrome: this pattern of abnormalities, seen in children, is caused by alcohol consumption by the mother during pregnancy. There are no safe levels of alcohol intake, and for this reason it is advisable not to drink any alcohol at all during pregnancy.

■ Neural tube defects: this complex condition is due to a genetic susceptibility, but also in many cases by a deficiency of the vitamin folic acid during the very early stages of pregnancy. A large proportion of neural tube defects, and the often associated mental handicap, can be prevented by folic acid supplementation, before and during early pregnancy. Ultrasound investigations and screening tests on maternal serum are available for detection of defects during pregnancy.

Information from the Department of Health, Pretoria.

Parents often try to blame each other, and may accuse each other of passing on a genetic predisposition for illness.

The marital and family conflict that ensues often sets up rigid barriers, isolating the family system from the outside world. The special care and medical expenses that mentally handicapped children may need put strain on the family nucleus and on parenting skills as well, De Swardt says.

The problem is further exacerbated by a lack of community resources; and where there are resources, these are frequently inaccessible due to transport or economic constraints.

And despite information campaigns over the years, there is still a social stigma associated with mental illness which places yet further stress on the family system.

There is also a consistent incidence of sexual abuse of mentally handicapped people.

Parents continue to make desperate and fruitless attempts to find a "cure" for their mentally handicapped children, through traditional healers and other forms of alternative healing therapies.

Yet there are opportunities and facilities for the education and care of mental handicapped children. There is help available for their families as well, De Swardt says.

Communities need to accept responsibility for mentally handicapped individuals and ensure a steady, reliable provision of necessary resources such as training centres, day-care facilities and protected employment workshops to maximise functioning, De Swardt says.

Every family is at risk of having a child with a mental handicap, although some families are at greater risk than others. Risk factors will include a pregnant woman being in her late 30s or older, a history of mental handicap in either of the parents' family, one or two unexplained miscarriages and spouses who are closely related.

Environmental factors include German measles, syphilis, pre- and post-natal infections, brain injury, lack of oxygen at birth, premature birth, drug abuse or misuse, inadvertent exposure radiation and socio-cultural factors which include malnutrition, sensory deprivation and child abuse.

But while genetic factors may predispose a person towards mental handicap, or the development of a mental illness, this can frequently be overcome through positive environmental dynamics, says De Swardt.

These will include seeking genetic counselling if you believe you are in a risk group before becoming pregnant, pre-natal screening and eating a healthy diet during pregnancy, ensuring an adequate intake of vitamins (especially folic acid, a vitamin found in green, leafy vegetables).

If a serious abnormality is detected in the foetus before birth, you can choose to terminate your pregnancy legally.

Genetics

The Department of Health has a sub-directorate of genetic services which includes the services of genetics and psychiatric nurses. For telephone numbers of provincial offices, you can telephone the Department of Health at (012) 312-0316.

Witwatersrand Mental Health has branches in Johannesburg, Soweto, Katlehong, Tembisa and Eldorado Park. For more information, or if you are interested in joining the Association for Mental Handicap, telephone (011) 337-1922.

TOMORROW:

A nowhere man: World famous classical music giant Lord Yehudi Menuhin wants to be free from boundaries and nationalities.

Psychiatric hospitals probe

PRETORIA: The mental health and substance abuse committee has been instructed by Minister of Health Dr Nkosazana Zuma to investigate and report on any malpractice in psychiatric hospitals and make recommendations to improve the standard of care, the Department of Health said yesterday. Members of the public and organisations should make written submissions on the matter before June 15.

CT 31/5/95

Political Staff, Sapa-Reuter

Epilepsy: The disease that can cost you your job...

ARG 26/6/95

(296) (88)

SABATA NGCAI
Staff Reporter

MYTHS and negative perceptions about epilepsy have reduced its sufferers to social outcasts whose enjoyment of life is limited and whose ability to find jobs hamstrung, regardless of their qualifications.

That's the opinion of the SA National Epilepsy League which says that while epilepsy may be incurable, it can treated symptomatically with drugs.

All that's needed is more understanding on the part of employers and the public, they say.

South Africa's favourite cricketer, Jonty Rhodes, an epileptic, has gone a long way to raising awareness of the disease, but for Jane Vinsen, who graduated with a BA degree in 1985 — her majors were industrial psychology and public administration — the picture is not so rosy.

She has been employed several times and in some cases was fired because she was an epileptic.

Between 1992 and 1993 Miss Vinsen worked for a private company in Cape Town and her employment was terminated with no reasons being given after serving for one year.

Subsequently, she was employed as a marketing co-ordinator, but had a major seizure one day while taking a client around.

Six months later, she had another seizure in her office in the presence of a colleague. A few months later she was called in by the personnel manager and handed two letters, one terminating her employment and the other demanding her resignation.

She chose to resign: "I believe my forced resignation was because I had seizures at work."

Later in 1993 she worked for a hospital in Cape Town as a public relations officer and fundraiser. She had seizures several times and was asked to leave, apparently because they could no longer afford her.

Now she works at a centre for the disabled in Bridgetown and survives on a meagre R45 paid to her each week.

The Cape Town Chamber of Commerce and Industry says it is against denying job opportunities to epileptics.

The organisation's deputy director, Colin Boyes, says epilepsy is controllable. The organisation also has an epileptic on its staff.

The Epilepsy League (Sanel) says the problem is that employers often do not understand epileptics. They think that when someone has a seizure at work he or she could hurt themselves and the employer would be held responsible.

SOCIAL OUTCAST.. Jane Vinsen.

The employers also think if an epileptic has a seizure in front of customers, they may chase the customers away.

They also believe an epileptic would affect their production.

However, Sanel believes that an epileptic can do any job for which they are qualified.

The Employment Commission of the Internal Bureau for Epilepsy says in its publicity information that interviews should focus on the capabilities of an individual with epilepsy, and not on his or her real or assumed limitations.

"Suitability for a particular job should be decided by the employer before any implications arising from the job applicant's epilepsy are considered," the commission says.

"When seizures occur for the first time, the employer should respond fairly by giving the employee adequate opportunity to get proper medical treatment before making any decisions about job suitability.

"If seizures are likely to occur at work, the employer should help the employee with epilepsy to disclose the disease to work mates.

"Some first-aid training or other information should be provided for those who might be involved should a seizure occur."

Sanel, a non-governmental organisation helping epileptics in the Western Cape, says, a survey conducted a few years ago found that one in 200 people in all population groups in South Africa suffered from epilepsy.

They believe that number had probably risen to two in every 200 people.

Sanel says epilepsy is predominant in poverty stricken areas, where there are high levels of crime and violence, and motor car accidents.

If a certain part of the brain gets injured or damaged in an accident or in an act of violence, an individual is likely to contract epilepsy.

The disease is also caused by drug and alcohol abuse, although some people are born with it. If a child gets encephalitis or meningitis — inflamation of the brain — it leaves a child seriously handicapped and in danger of contracting the disease.

Sanel is involved in public awareness programmes, parent support groups, care groups and teen groups to raise awareness and change perceptions about epilepsy.

Sanel regional director Ingrid Daniels says the programmes help allay fears and concerns that epileptics cannot get married or fall in love because of the disease.

"Youths and elderly people are also given skills on how to handle an epileptic and someone who has siezures."

Mrs Daniels says epileptics have a right to lead a normal life and be given the same opportunities as others.

The high rate of unemployment among the epileptics has forced Sanel to help and encourage job-creation projects.

This has helped some epileptics to start home-based projects and earn a meagre income to augment their monthly disability grants.

Those who do not get a grant live on the income from the projects.

The Sanel projects operate in Mitchell's Plain, Guguletu, Lansdowne and Khayelitsha.

They cater mainly for unskilled epileptics to teach them skills so they can become self-reliant.

Among other things, the people do weaving using waste material and make African art products which are sold in the markets.

The workers get 80 percent of the income while 20 percent goes towards sustaining the project. Sanel says that in the past year about 80 percent of epileptics seen by the organisation were unemployed. And while unemployment iss a national problem, the epileptics are certainly at the back of the line when it comes to unemployment.

■ HOUT BAY

11 mentally disabled children identified in squatter camp (88)

ARG 4/7/95

Southern Reporter

ELEVEN mentally disabled children have been identified so far in the sprawling Imizamo Yethu squatter camp in Hout Bay and several adults in the community feel something should be done to help them.

There are also many starving dogs running around the shacks in the camp which is home to about 4 000 people.

Cape Mental Health officials say they know of these children but don't have the resources to assist all the people needing help in the squatter camps around the Peninsula. They say they face closure if they do not get more money.

The children, who are between six and seven years old, have been traced and identified since The Argus told the story of another mentally handicapped young man in the camp, 15-year-old Donald Mabhanga who is now being cared for in the Alexandra Care and Rehabilitation Centre in Maitland.

One six-year-old girl, with a head much smaller than she should have at her age, is causing concern to some community members because she is one of the children wandering around the camp while parents are away at work.

Concerned Hout Bay domestic worker Virginia Yapi — who found out the names and addresses of the 11 children — said there were probably more children like them in the camp that no-one knew about.

"There is a group of Christian people who come to the camp on one Saturday every month to help feed and play with the children. But that's all the attention they seem to get from the outside world," said Mrs Yapi.

She said she believed three of the children go to school.

Mrs Yapi said if anyone knew of others in the camp that had not yet been identified she would like to hear from them in order to compile a list.

Telephone her on ☎ 794-4001 (between 9 am and 3 pm weekdays).

● Shaun Bodington, chief inspector for the SPCA, said an anonymous animal lover had given the organisation over R100 000 and with the money they were planning a mobile animal clinic for the Imizamo Yethu camp.

Mr Bodington said another R30 000 from Round Table No 9 would buy medicines for clinics in all squatter camps.

A new group Project for Upliftment of Pets and People (PUPP) has been formed to support the SPCA's projects. Contact the SPCA on ☎ 705-3757 for more information and if you want to be a volunteer.

IN BRIEF

88

Mental health facilities racist

AN international mental health activist has urged South Africa to investigate apartheid psychiatric abuses and "scientific racism" taking place in the country.

Ms Jan Eastgate, president of the Los Angeles group Citizens Commission on Human Rights (CCHR) told a Health Ministry committee this week that South African laws prevented people from learning about alleged human rights abuses in mental institutions.

The South African Mental Health Act makes it a criminal offense to report on, photograph or sketch psychiatric facilities.

Sowetan 27/7/95

Abuse in mental hospitals exposed

BD 28/7/95 (88)

Kathryn Strachan

DOCTORS and lawyers yesterday spoke out against the abuse of human rights in SA mental institutions with patients being denied legal representation when they were involuntarily committed, with many patients being wrongly diagnosed as being mentally ill.

A doctor, who cannot be named for ethical reasons, said yesterday patients with physical problems were often misdiagnosed as mentally ill because doctors failed to carry out thorough examinations.

He said there was a tendency for psychiatrists to prescribe powerful psychiatric drugs for such things as learning problems in children.

Attorney Mark Turnbull said that in SA it was easier than in many other countries to commit a person to an institution against their will. Although there were legal clauses which protected patients, in most cases these patients did not know their legal rights and did not have access to legal representation.

There were many cases where people were committed involuntarily without being allowed to put their side to the district surgeon or to the magistrate's court.

Patients also lost their rights once they were institutionalised. He said in the case of a teenage boy who was allegedly drugged and raped by a male nurse in a Randfontein private psychiatric hospital, police could not investigate because they needed psychiatrists to say the boy's testimony was valid.

SA institutions also carried out contraversial practices which were banned in most other countries, such as electric shock therapy and deep sleep therapy.

These allegations emerged at the release yesterday of an international investigative report, called Creating Racism: Psychiatry's Betrayal, which states how SA has been "gripped by scientific racism" since the start of the century.

Because of the lack of mental health resources in SA, the profession depended to a large extent on simply drugging patients, rather than curing them through psychological counselling.

The report has been submitted to the recently established committee looking into mental health and psychiatric abuse. However, international president of the commission Jan Eastgate said the abuses of the past had to be aired before a new mental health system was set up. Unless this was done, the same people who carried out these abusive practices would be setting up a new mental health structure.

Brandon Hamber, of the Wits centre for the study of violence and reconciliation, said the centre was concerned at what was happening in psychiatric hospitals and the violation of human rights. Many of the problems lay in the fact that there were not enough facilities to deal with people outside of institutions.

It was also necessary to change the Mental Health Act which was concerned more with how to go about institutionalising a person rather than with safeguarding human rights.

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'The madness of apartheid'

ET 29/7/95 (88)

JOHANNESBURG: Blacks did not have access to regular medical examinations and so were often misdiagnosed as paranoid schizophrenics, a psychiatrist said yesterday at the release of a report on abuses in mental health care.

This was a remnant of apartheid, he said.

The report, Psychiatry's betrayal: creating racism, was compiled by the Citizens' Committee for Human Rights.

Banned

The psychiatrist said if blacks were given thorough medical examinations doctors would realise many of those thought to suffer mental disorders suffered from misdiagnosed medical conditions.

Mental health practitioners still used therapies banned in other countries, such as electric shock treatment and deep-sleep therapy, he added.

He said that more than 10 000 blacks had been put in psychiatric hospitals without their consent. — Sapa

CP 30/7/95 (88)

Shrinks fed racism — claim

By PEARL RANTSEKENG

MUSICIAN Isaac Hayes has welcomed the exposure of human rights abuses in South African mental health institutions.

The award winning singer wrote a letter to the Citizens' Commission on Human Rights, congratulating them on their recent report which disclosed the apalling conditions in the country's psychiatric hospitals.

The commission's international president, Jan Eastgate, said the report was released after comprehensive research was carried out in South Africa and America.

She said the report, called *Creating Racism: Psychiatry's Betrayal In The Guise Of Help*, was a 'no-holds barred' look at the psychiatric and psychological programmes that spawned racism in South Africa".

The South African Health Ministry recently set up a committee of six people to look into the allegations of malpractice in pyschiatric institutions.

The report shows that apartheid was bolstered by intelligence (IQ) and other psychological tests which fraudulently found that blacks had "lower IQs".

Speaking at a press conference at the Carlton Hotel in Johannesburg this week, Eastgate said, "Whites were conditioned through education that this was fact. Unless this is addressed, there will always be an underlying, although probably unspoken, feeling that blacks are somehow inferior."

She said when she visited operational camps in the country last November she also encountered vastly different conditions between the black and white psychiatric institutions.

According to Eastgate, the death rate in private psychiatric hospitals in South Africa is more than double that of American state psychiatric institutions.

"Unless those individuals who were responsible for the psychiatric and psychological abuse of blacks in this country are brought to account they will continue to practise, unchallenged," said Eastgate.

Recommendations put forward by the commission to the committee investigating conditions and violations of human rights abuses in psychiatric institutions include:

- Ensuring that those people diagnosed as mentally ill are protected under the Bill of Rights and also have their own patients' rights code embodied in law;
- A full investigation into the deaths, sexual abuse and other abuse of patients in private and state psychiatric hospitals;
- Repeal of the Sterilisation Act of 1975;
- Reforming the 1976 Mental Health Act to ensure full physical examinations before admission.

Helping to raise and educate the mentally retarded

(8s) Sowetan 8/8/95

OLD MUTUAL 150 1845-1995

By Russel Molefe

WHEN MRS Nora Lebotse was told in 1993 that her son, then a Sub-Standard A pupil, was mentally retarded, she felt like the whole world had fallen on her.

At the time, there were no special schools at Haartebeesfontein in the North-West and surrounding areas. She had to send her young son to school more than 800km away.

A block away from her home lived another 16-year-old boy who was mentally retarded and epileptic. The boy did not attend school and begged for food around the area before he died.

These two pathetic cases dramatically changed the life of Lebotse.

"I did not want to send my son far away. But at the same time I wanted him to receive education. It was very painful and I decided to do something," Lebotse said.

She started by going around homes and schools to find if there were other children who were not coping because of their condition.

"I was surprised by the number of children in the township who were mentally retarded.

"I spoke to their parents with a view of starting special school for them.

"But some people took it as if I was not serious. We held a mass meeting to discuss plans and ideas to provide a school," Lebotse said.

However, plans to start a special school did not materialise. But Lebotse did not rest and enrolled at the Mental Care and Rehabilitation Centre.

> **"I did not want to send my son far away. But at the same time I wanted him to receive education. It was very painful and I decided to do something"**

Lebotse, who is also a co-ordinator for the Rural Women's Project, now cares for 38 mentally retarded children. She uses two rooms at her shack in Hartebeesfontein.

The children are taught, among others things, life skills and personal hygiene.

Most parents told *Sowetan* their children improved soon after joining Lebotse.

And when a creche in the area closed after the sponsors withdrew, Lebotse took up this plight as well.

She worked towards re-establishing the creche and it is today running smoothly.

Watch Cosmo-Life on CCV-TV tonight at 7.30pm.

Mrs Nora Lebotse started a special school for mentally retarded children.

Racism blamed on psychiatry

Psychiatric racism exists, mainly in SA, the US, Canada and Australia

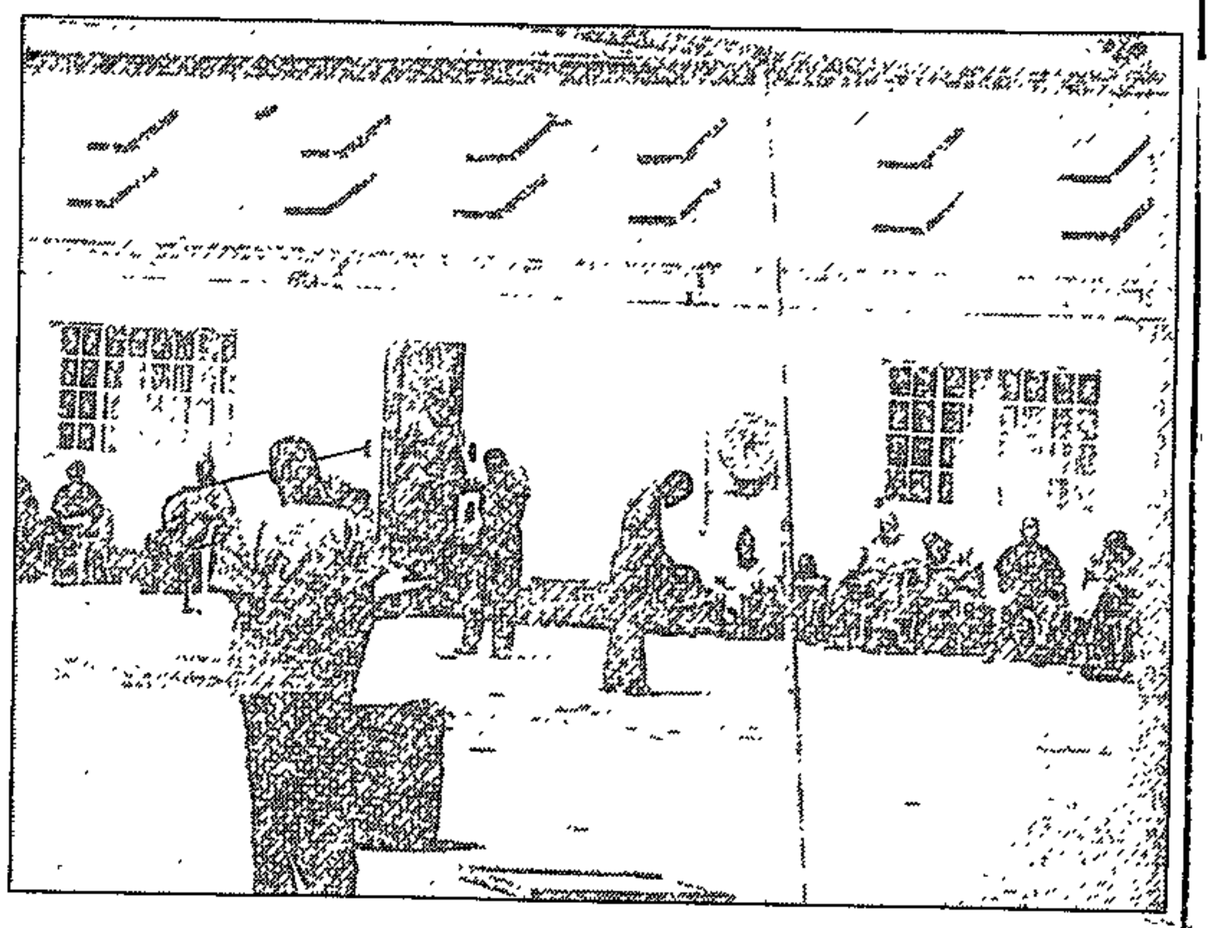
By Glenn McKenzie

APARTHEID WAS BORN in a science laboratory... Racism is perpetrated by psychiatrists These statements may sound like wild fiction but are they true?

According to a new report published by the international organisation Citizens Commission on Human Rights (CCHR), psychiatry played a big part in creating apartheid, and is still maintaining racial inequality in South Africa.

In their report, titled *Creating racism: Psychiatry's betrayal*, CCHR supports its unusual claims with a surprising body of evidence. According to CCHR:

- The architect of apartheid, Dr Hendrik Verwoerd, trained in German universities that "energetically forwarded psychiatric genetics"; and
- The science of "eugenics" – which was used by Germany's Nazis to justify eliminating millions of Jews, blacks, homosexuals and other "defective students" – was coined by Francis Galton, who in 1869 studied black "races" in South Africa.



Imprisoned by psychiatry ... A new international report makes astounding claims about the treatment of black patients in South African mental hospitals.

Follow a master

Galton wrote about the Damara tribe in Namibia: "These savages court slavery... You engage one of them as a servant, and you find that he considers himself as your property, so that you become the owner of a slave. They have no independence about them, generally speaking, but follow a master as a spaniel would."

CCHR quotes Verwoerd as saying: "Racial relations cannot improve if the result of native education is the creation of frustrated people who, as a result of the education they received, have expectations in life which circumstances in South Africa do not allow to be fulfiled immediately, when it creates people trained for professions not open to them."

Little credibility

Some say CCHR – which was formed by the Church of Scientology – has little credibility. The organisation is often accused of exaggerating the problems of psychiatry and of holding a vendetta against the profession. Scientology has also been widely labelled in the United States as a cult.

But other world bodies seem to back some of the claims of psychiatric racism raised by CCHR. In 1983, the World Health Organisation wrote about South African psychiatry: "Although psychiatry is expected to be a discipline which deals with the human being as a whole, in no other medical field in South Africa is the contempt of the person cultivated by racism more precisely portrayed than in psychiatry."

Independent research also seems to support arguments that some South African psychiatric institutions have operated on a racially biased manner.

As recently as early this year, black private mental hospitals run by the Lifecare Group on the Government's behalf received about half of the funding given to white institutions.

The death rate in Millsite Sanitorium, one of South Africa's most infamous "black" mental institutions, reached 147 cases in 1993.

CCHR says racism continues to be perpetrated by some psychiatrists and psychologists. While the country has been transformed into a democracy, South African mental institutions still administer painful and unethical treatments on black patients, the organisation says. For example, electric shock therapy is administered to patients without using antibiotics, the group says. Deep sleep treatments are also given to black patients, sometimes with permanent side-effects. Tranquillisers are used frequently and indiscriminately.

CCHR international president Ms Jan Eastgate has called on mental institutions to begin "curing patients", not "drugging them for their entire lives".

"We're not saying that all psychiatrists are bad people. But there is significant evidence that some people in the profession are harming a lot of people," she says.

Eastgate recently called on the Government to repeal the Mental Health Act, which prevents anyone from photographing, writing about or otherwise portraying conditions in local mental institutions. "Nowhere else in the world does such legislation exist," she says.

Psychiatric racism

Psychiatric racism is not unique to South Africa, according to the CCHR. They claim that the problem also exists in countries like the US, Australia and Canada. Here are some of their claims:

- In the US in the 1950s, black prisoners were used for psychosurgery experiments which involved electrodes being implanted into the brain;
- As recently as 1983, Duke University Medical Centre in the US was given almost R2,5 million to research the aggressive "behaviour patterns" of African-American children living in high crime-risk areas; and
- And in the 1990s, the National Institute of Mental Health, an American funding agency for psychiatric and psychological research, attempted to launch a "National Violence Initiative".

This programme allegedly targeted black and Hispanic children, and used "biological markers" in an effort to determine who would become criminals.

Saturday Star
August 26 1995

Star 26/8/95

Deduction made available to the mentally ill

(320) (88)

A recent amendment has removed an anomaly from the Income Tax Act.

Previously, only a physically handicapped person (and not a mentally handicapped person) was entitled to the benefit of a greater medical expenses deduction.

Now, the definition of handicapped has been amended to include a peron who suffers from a mental illness, as defined in Section 1 of the Mental Health Act of 1973.

Handicapped people are allowed to deduct from their taxable incomes so much of their medical expenses as exceeds R500 a year.

This deduction applies even if the taxpayer himself is not handicapped, but his spouse, child or stepchild is handicapped.

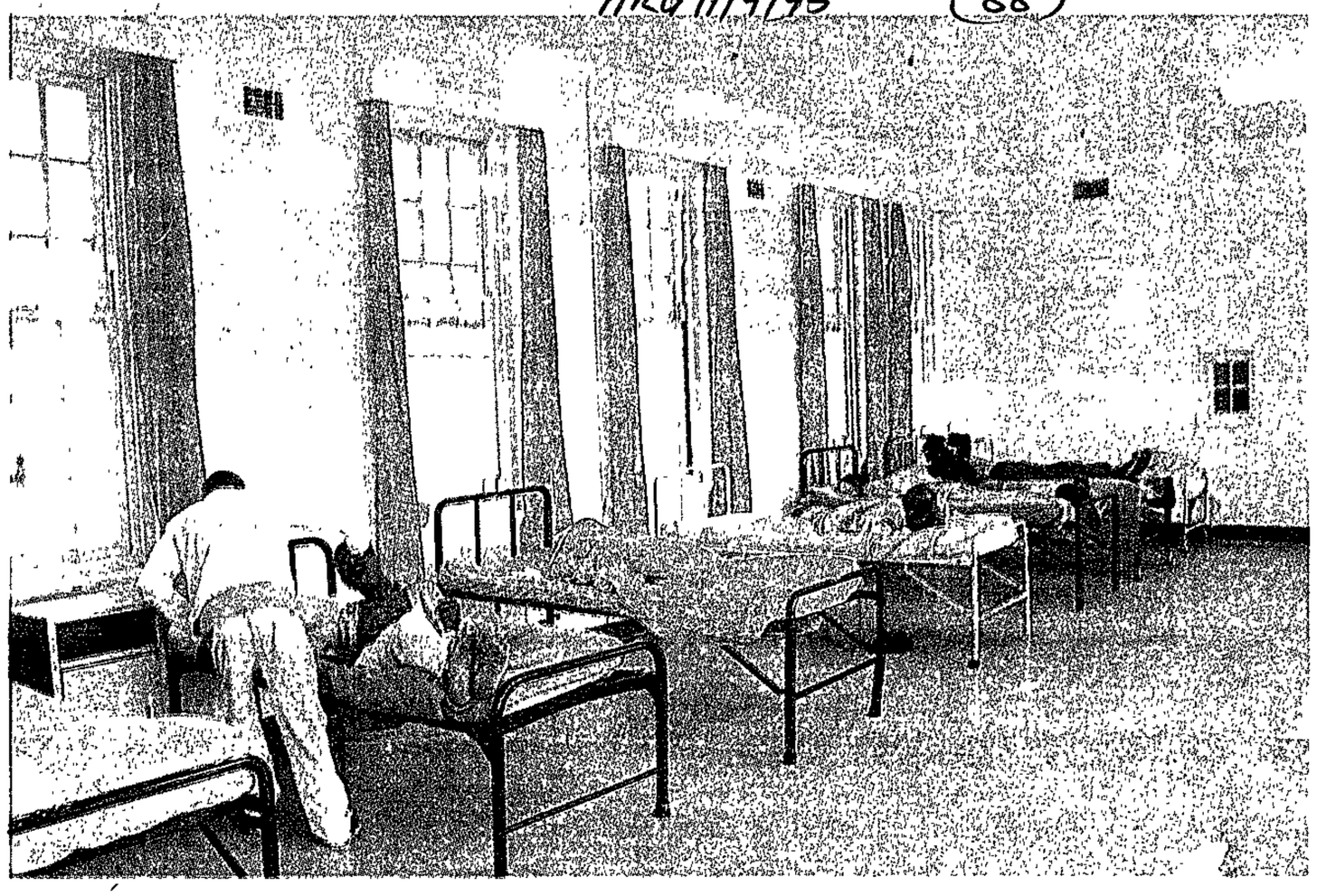
The Income Tax Act also defines the criteria for determining a physically handicapped person.

The bleak world of seclusion

□ *Concerned group fights for better conditions at Valkenberg*

ARG 11/9/95 (88)

JENNY VIALL
Health Reporter



BARE ESSENTIALS: Only the red curtains and blankets bring life to the sleeping area in the male lock-up ward at Valkenberg Hospital. Pictures: ROY WIGLEY, The Argus.

THE small room is bare, with dirty cream walls. There's a strong smell of urine, and the light in the windowless room is covered with a wire cage. It's a cold and uneasy room, and you can only wonder at what it must feel like to have the door close on you, and to be left alone.

This grim room is not, unfortunately, a relic of yesteryear. Neither is it a place of punishment. It's the seclusion room at Ward 15, Valkenberg Hospital, for patients who are unmanageable and need to be calmed down. It's the place you or a relative would go should you become psychotic and need to be contained.

Built in the 1910s, when the management of mental illness was custodial, and the treatment of patients very different to what it is now, the room is only one of the sections of Ward 15 that needs to be changed.

The whole ward, which is a closed ward, is bleak. To get in you have to walk through a series of locked doors. The only brightness breaking the monotony of the cream walls and cream linoleum floors are the red curtains and blankets of the dormitory, where men are lying on thin mattresses, some sleeping, some staring.

The dining area is a large, empty room, the yellow-checked tablecloths doing little to cheer things up.

The recreation room has a television set and a broken table tennis table.

Sean Bauman, psychiatrist in charge of the wards, believes the wards are totally unacceptable and completely inadequate.

"When people are disturbed, this is where they go. They're already frightened, and this feels like a prison. The seclusion ward, where people are taken to calm down, need not be like a punishment cell. It needs to be therapeutic, a private and secluded place, with natural lighting and colour."

Dr Bauman said research had shown that the worse the environment, the worse patients behaved. The worse they behaved, the more staff were needed. "We need custom-built wards. Renovation isn't an option, as the changes necessary are so complete."

The only light on this bleak scenario is that there are people who want to do something about conditions in this and the equivalent ward for women. They're concerned people who are forming themselves into a group called the Friends of Valkenberg.

One of the first projects of the Friends of Valkenberg, which will be launched tomorrow, is to build new wards, says chairperson Francoise Robertson. These would cost about R3 million.

But the Friends know that new improved buildings at Valkenberg are not enough.

Without adequate staff, patient care cannot be up to standard. Valkenberg Hospital has a chronic shortage of staff; and nurses are stretched way beyond their capacity. Many nurses have left because of the poor conditions, and posts have not been filled. The hospital is finding it difficult to attract new staff, especially male psychiatric nurses, because no-one wants to work in those comditions.

Staff ratios in high-care wards, of which Ward 15 is one, should be one nurse to every patient, says Francois Daubenton, a psychiatrist at Valkenberg. At Valkenberg there's one nurse for every six to eight patients during the day, and one nurse for 15 patients at night. Doctors are looking after 45 to 50 patients at a time.

That's an impossible load, says Dr Daubenton, who believes that the attention given to mental health services is sadly lacking.

While there's little prospect of more staff being allocated to Valkenberg, the Friends of Valkenberg intend improving conditions to make it more attractive to staff.

Other plans include opening Valkenberg Hospital to the public and laying a jogging track around it. Organically grown vegetables, grown by those patients who are interested, will be sold to the Observatory community.

The Cape Town community must become involved in what is their hospital, says Dr Daubenton. "About 100 long-stay patients need less than an hour of nursing once a week. They are here because society has no other suitable place for them to live.

"My vision is to bring the Cape Town community closer to the hospital," says Dr Daubenton. "There must be dialogue to reduce the stigma and develop understanding, so that mental illness is not a total mystery."

● Contact Friends of Valkenberg at ☎ 47 9130 (mornings only).

NO FRILLS: The bleak dining area of Ward 15 is a sterile, unfriendly place, not a place likely to promote healing. Francoise Robertson of the Friends of Valkenberg discusses future plans with psychiatrist Sean Bauman.

SECLUSION CELL: The seclusion room at the ward is grim, and more like a place of punishment than a therapeutic environment to calm down patients, explains psychiatrist Sean Bauman.

Mental health services undergo revamp

BD 31/10/95 (88)

Kathryn Strachan

NORTHWEST is one of the first provinces to bring in a new plan to restructure its weak and fragmented mental health services.

Provincial health MEC Dr Paul Sefularo said the plan, which was being implemented immediately, would transform the services into a comprehensive provincial arrangement able to respond to the community's needs with more expertise and accessibility.

The plan was developed by a task team of senior professional members, in consultation with the staff of the hospitals involved and with the families of the patients.

All mentally ill patients at the regional hospitals would be transferred to Witrand Hospital, which would be the only facility in the province to admit, treat and discharge patients.

Bophelong Hospital would become the central referral hospital for patients with chronic mental illness. Bophelong's psychiatric section would be run as an independent unit.

"The Herberg" at Gelukspan would be renovated to become the only state hospital for the admission, care and rehabilitation of the physically disabled.

Forensic psychiatry would no longer be practised in the province.

Saturday Star
November 18 1995

South Africans up there with shakiest in high-stress stakes

(88)

Star 18/11/95

By KURT SWART

Stress is as much a feature of 90s urban lifestyle as microwave ovens, the Internet and cellular phones, according to a consumer health researcher.

Johannesburg researcher Sherene Cuthbert, employed by the giant Roche pharmaceutical group, has been conducting tests on the levels of stress endured by employees and management personnel in various professions and occupations.

Results have indicated that South Africa has one of the world's most highly stressed populations, she told the *Saturday Star* this week.

Negative effects

Everyday stress, which all individuals experience, can be beneficial and healthy. It is only when stress levels become excessive that problems set in.

"Interestingly, as more people become aware of the negative effects of unhealthy stress levels in their professional and personal lives, sectors that could be termed 'stress management related' – like health and exercise clubs, aromatherapists, medication classes and health spas – are experiencing boom times.

"It's for good reason that thousands of people patronise these services – a healthy diet, regular exercise, and sufficient rest and relaxation are all acknowledged de-stressors," Cuthbert said.

Studies on stress levels are being conducted internationally by Roche.

"As soon as enough research data is available, a comparative study of South Africa and other countries will be made. I reckon that, apart from Bosnia and Croatia, South Africa has one of the most highly stressed populations in the world."

The mental health of South Africans of all walks of life is under severe strain.Therapists are experiencing a boom, and doctors are prescribing tranquillisers by the thousands.

The causes were job uncertainty and violence, Cuthbert said, adding that Roche research had indicated that black people were generally able to cope slightly better with stress than whites.

"The number of armed robberies and the fear of that happening really causes stress among white South Africans. In the black community, the main stresses are caused by breakdowns in relationships, and not having peer acceptance and respect within the community. White stress levels are affected by change – especially in work, financial status and living conditions."

Other stress factors affecting the entire population included worry about education, Aids, personal violence or being witness to violence. Prolonged exposure to violence and witnessing violence, psychologists argue, can cause permanent psychological damage.

SHERENE CUTHBERT: Stress signals include constant fatigue

"In the workplace, stressors often identified are heavy workloads leading to overwork, unpleasant office politics, badly defined professional roles and having to juggle family and work demands."

Cuthbert conducts stress tests using the Berocca Stress Barometer – a standardised question-and-answer form. Test results below 30 and especially below 20 indicate that the test subjects are in the clear. But their work performance might suffer through being distracted by other matters.

Work performance is likely to peak with scores in the upper 30s and lower 40s, with only a small decline at a score of 50.

Average scores of below 40 in tests conducted include directors and upper management (37,0), middle management (38,9), sales managers or representatives (32,7), professionals and specialists (35,0), self-employed people and small business managers or owners (35,7), blue-collar skilled and semi-skilled workers (37,9), white collar workers (37,7), state employees and civil servants (39,4) and housewives (39,9).

A test score of about 40 gives the point where positive and negative symptoms of stress are in balance.

"At this point, the respondent is exhibiting signs of stress but is able to cope with it. Such a person will be operating at, or near, his peak although it will be important that he or she takes an occasional break to maintain the balance."

Cuthbert said people who score 40 or more are less likely to say they felt healthy, alive and cheerful, than people with scores below 30. This was especially true among black respondents.

"South African nurses and teachers are very stressed because of long hours and low salaries.

"Among teachers, there is a lack of teaching aids and a lot of teachers do not have the skills to adapt to intermeshing cultures in new South African classrooms," said Cuthbert.

"Once a score exceeds 40, people will begin to complain of feeling stressed and agitated and will become increasingly negative."

In this category were unskilled workers (average test score 48,4) and the unemployed (44,0). Unskilled workers suffered high stress because their jobs tended to be insecure.

"At a score of 50, negative symptoms dominate. Performance will certainly have reached a plateau and may have even declined. Black respondents show more negative physical symptoms after this point, like loss of energy, neck and backache, coughs, colds and minor infections; whereas white respondents feel more down emotionally and experience sleeping problems."

At scores over 50 the respondent's condition deteriorates quickly, as does performance.

She said she was shocked at the stress test scores achieved by an admittedly small sample group of the *Saturday Star*'s reporters, photographers and editors.

"This is the highest I have ever seen. I have never come across levels this high in any group of people tested."

Only 2 to 5% of respondents in worldwide tests scored over 70. In South Africa, considered highly stressed, 8% scored over 70. By comparison, more than 65% of the journalist sample group scored way over 70, with scores including 119, 118, 116, 99, 83 and 79.

Stress levels over 70 indicate the respondent is abnormally, even clinically, stressed, with anxiety levels considered beyond normal.

Physical symptoms

They suffer neck and backache, headaches, feel tension in their muscles, and suffer cramps and spasms.

"They are likely to be using more alcohol, tobacco, drugs or tranquillisers. Tea or coffee consumption may also increase. Stomach and digestive problems may occur," said Cuthbert.

"I am glad I'm in marketing and not a journalist. Immediate action to reduce stress has to be taken. At these levels, physical symptoms should already be obvious and psychological symptoms will follow shortly," she warned.

Besides exercise and a healthy diet, stress can be eliminated or reduced by techniques such as time management skills, learning to delegate, and being assertive by not accepting excessive amounts of work.

Another way to counteract stress is the use of visualisation techniques: taking a moment to relax and picture a positive scene, like a beach, when a work situation becomes intolerable.

Mental torture

Racism, rape and malpractice claims at hospital

(88) Sowetan 24/11/95

By Glenn McKenzie

ALLEGATIONS OF RACISM and malpractice have surfaced at a major mental hospital in Bloemfontein amid reports that rape and other forms of abuse are rife among staff and patients.

In four separate interviews with nurses at Oranje Hospital, *Sowetan* has learnt that authorities had allowed male and female psychiatric patients to be housed in the same units for several years until September this year. This continued in spite of the fact that female patients were frequent victims of rape and sexual abuse.

Nurses said that Free State chief of community mental health services Professor Carlo Gagiano had established male-female units because they were "important for socialisation and building of patients' self-esteem".

Staff members have also claimed that:

● An internal inquiry into abuses at the hospital was launched only recently after a white family complained that their relative (who is a patient) had been sexually abused. Rapes and assaults against black patients had not resulted in official action being taken;

● At least two male staff members who have been accused of sexually molesting patients at the hospital are still on duty. *Sowetan* is in possession of their names;

● In September an 80-year-old woman was raped by a young male patient. No action was taken besides the filing of a police report;

● The hospital regularly gave patients HIV tests without their consent, and without the benefit of pre-test and post-test counselling. This continued until August of this year; and

● Sexual activity involving psychologically unstable HIV-positive patients was a "regular occurrence" as a result of a low staff complement in most wards.

Asked about the allegations of rape and sexual assault, Gagiano told *Sowetan:* "It is possible that these incidents occurred but we do not know for sure."

He added that in his opinion, "patient abuse shouldn't happen (when male and female patients are housed together) if they are given optimal care".

Gagiano said he knew that an internal inquiry existed but preferred to reserve his comment about it.

Last month an Afrikaans daily newspaper reported that authorities were investigating two cases of rape against psychiatric patients and three cases of alleged sexual molestation of patients by staff members at the hospital.

The Citizen's Commission on Human Rights said it had been made aware of incidents at the hospital in which "sexual harassment and rape became a daily terror for some of the weaker patients, particularly women".

The CCHR, an organisation that has been accused of fomenting ill-will towards psychiatry, said it was investigating further allegations of abuse at the hospital.

The Free State department of health responded to the allegations yesterday, saying a committee of management personnel, nursing staff, clinical personnel and a human rights lawyer had been appointed to investigate the situation at the hospital.

The department emphasised that while "it would be opportunistic" to presume that the mixed wards resulted in rapes, molestation and assaults, "this was probably conducive to the abuse of human rights".

It further emphasised that no members of staff had been implicated in allegations of rape.

● See Page 2

Mental patients raped, assaulted

Sowetan 24/11/95 (88)

By Glenn McKenzie

A DEPARTMENT of Health committee of inquiry has uncovered human rights abuse at several mental hospitals, and is likely to recommend "significant" changes to the laws governing these institutions, informed sources have told *Sowetan*.

The committee, whose mandate includes probing alleged malpractice and human rights violations in 33 psychiatric hospitals, recently completed a six-month investigation.

Recommendations to "enhance the standard of care in our institutions" will be given to Minister of Health Dr Nkosazana Zuma in December. A full report could be made public by the end of the year.

Most of the human rights violations uncovered occurred before 1994, *Sowetan* has been told. Further details regarding instances of abuse have not been divulged.

Some of the recommendations that are likely to be made by the committee include:

- Repealing a portion of the Mental Health Act which prohibits journalists taking photographs or sketches of mental institutions; and
- Changing the laws by which patients can be involuntarily "certified" and committed to mental institutions.

Nurses witnessed abuse

Meanwhile, the committee itself has come under attack from psychiatric nurses at two hospitals for allegedly failing to consult them about human rights conditions there.

In interviews this week, four nurses from Oranje Hospital in Bloemfontein told *Sowetan* that they had witnessed gross abuses such as rape, assault and racist treatment that went unchecked. The nurses said the committee of inquiry had not approached them to give testimony.

Several outspoken nurses from Millsite Hospital, which has been accused of having an inordinately high death rate and poor patient care, also said they had not been consulted.

Committee members have defended their actions, saying they spoke to unions, workers and patients during the inquiry.

Yesterday, the Citizens Commission on Human Rights said it was concerned that the Department of Health committee did not have "the teeth or manpower" to fully investigate problems in South Africa's mental hospitals.

'IT DRIVES US CRAZY

CP 26/11/95

Black mental patients suffer abuse in mental hospital, claim 'frustrated' staff

By BENISON MAKELE

BLACK MENTAL patients at the Oranje Hospital in Bloemfontein are subjected to gross human rights abuses, black staff members claim.

Staff sources allege the white management shows a "racist indifference" to the plight of black patients – leaving black staff frustrated at seeing them suffer.

The sources claim no disciplinary action was taken against a white patient who allegedly raped a black woman – but that a black male patient who allegedly raped a white woman is now in the Grootvlei prison, awaiting trial on a charge of rape.

City Press has the man's name.

Staff claim these incidents occurred as a result of the mixing of female and male patients in an experimental measure by Professor Carllo Gagiano, head of psychiatry at the University of the Free State, and head of the hospital.

Gagiano felt the integration of male and female patients would be good for "socialisation and the raising of patients' self-esteem", hospital sources said.

Last year Gagiano tried a process of "de-institutionalisation" – ordering that patients who wanted to be discharged be released, sources say.

However, this allegedly backfired when 30 minutes later all the patients were back in their wards at the hospital.

■ Gagiano could not be found for comment by the time of going to press – but weekend media reports quote him as preferring to reserve his comments on alleged abuses and on the forthcoming report of a Health Department committee of inquiry into alleged abuses at mental institutions.

■ Hospital sources also claim they fear that the bodies of deceased black patients whose relatives cannot be traced by the hospital are used for "anatomical research".

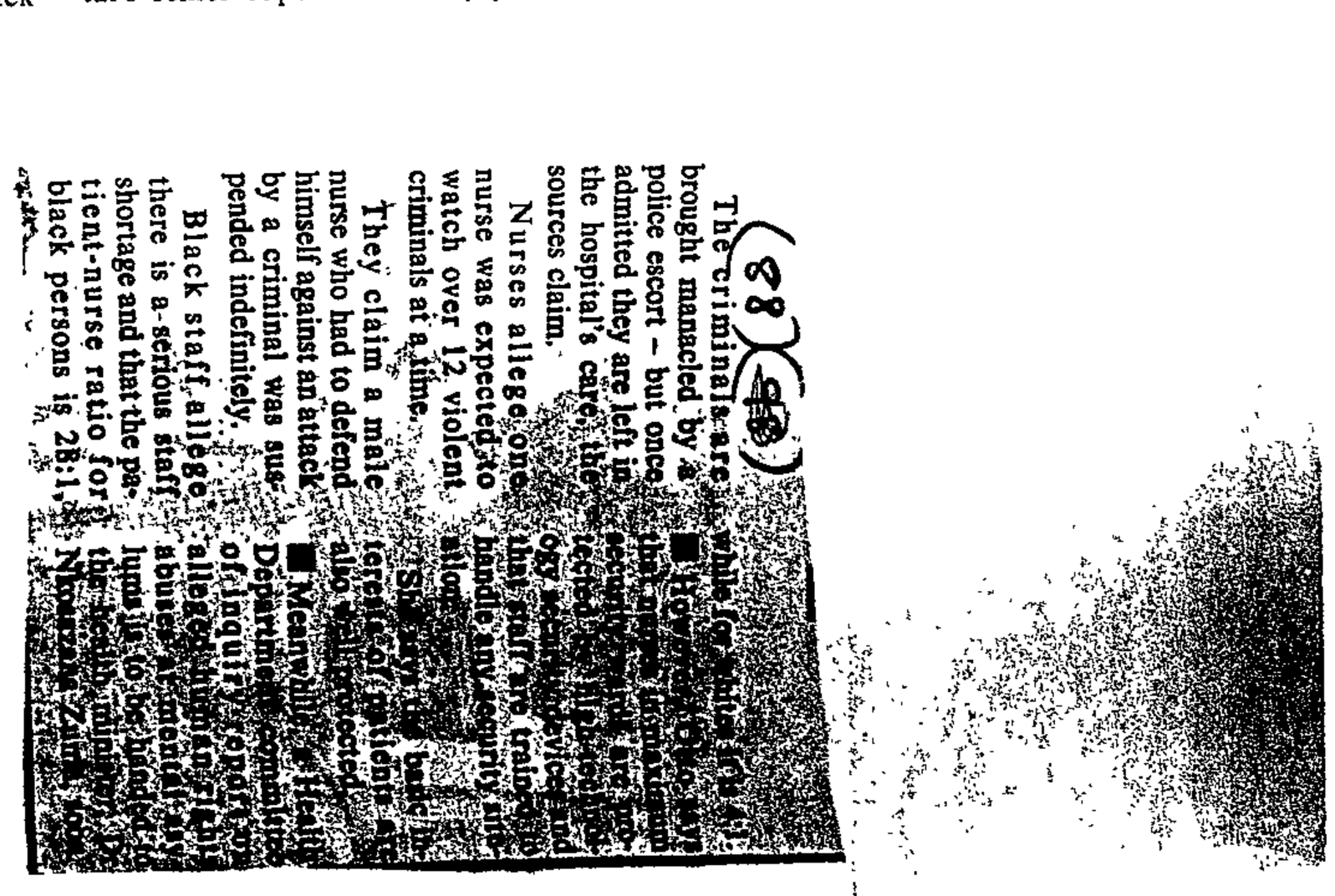
They claim no funeral rites are conducted for deceased black patients.

When white patients die a funeral service is held at the hospital, after which the service proceeds to the cemetery, the sources claim.

■ However, the hospital's senior superintendent, Dr Susan Otto, says the hospital does its best to trace the relatives of deceased patients – both black and white – and that funeral services are the same for both races.

The State pays all funeral expenses, she says.

■ Staff claim they fear for their safety in the maximum security wards which house violent criminals sent for psychiatric observation.



Empty wards ... Free State chief of mental health services Dr Carlo Gagiano has been lauded for discharging many mental patients from hospitals into community care facilities. But now he is taking heat for alleged rapes and other forms of abuse at Oranje Hospital in Bloemfontein.

Concern at abuse of mental patients

Sowetan 27/11/95 38

Too few underpaid nurses and mixed wards lead to rapes

By Glenn McKenzie

IN A SMALL house in Mangaung, Bloemfontein, a nurse divulges the "secrets" of her job. The psychiatric institution where she works at Oranje Hospital is fraught with racism, rape and other forms of abuse, she says.

These problems have existed for many years but now the morale of nurses has fallen to a point where "we (nurses) are becoming as sick as our patients".

The reason she is speaking to the Press, the nurse says, is desperation.

"For a long time we thought we could sort out our problems internally," she says. "We thought that if we kept communicating with management, we could change the hospital. But we have given up now."

The nurse, one of four Oranje Hospital health workers who spoke candidly to *Sowetan*, said the hospital housed male and female patients in the same wards for several years until September.

This was in spite of the fact that female patients were frequent victims of rape and sexual abuse at the hands of male patients and staff members.

The hospital allegedly launched an internal inquiry into abuses only after a white family complained that a relative of theirs (who is a patient) had been sexually abused. Rapes and assaults on black patients went "unnoticed", the nurse says.

All four nurses recount tales of staff members being allowed to remain on duty after they had been accused of sexually molesting patients. They also claimed that:

- An 80-year-old woman was raped by a young male patient. No action was taken other than the filing of a police report. (The Free State Department of Health and Welfare said the accused was immediately arrested.)
- The hospital regularly gave patients HIV tests without their consent and without offering counselling – until at least August this year.
- Sexual activity involving psychologically unstable HIV-positive patients was a "regular occurrence" as a result of a low staff complement in most wards.

Professor Carlo Gagiano, head of community mental health services in the Free State, says: "It is possible these incidents occurred but we do not know for sure."

Patient abuse

He adds that, in his opinion, "patient abuse shouldn't happen (when male and female patients are housed together) if they are given optimal care".

Even more telling is the statement by the Free State Department of Health and Welfare: "It would be opportunistic to presume the living arrangements of the patients did directly result in the allegations of rape, molestation and assault. However, this was probably conducive to the abuse of human rights."

The department says that, according to management, patients are never given HIV tests without their consent or the consent of their families.

It further emphasised that keeping patients of the opposite sex in the same ward (a policy begun under previous hospital management) had been stopped. Patients never slept in the same rooms, they say.

In addition, all male personnel, who were previously responsible for female patients, had been moved to other wards.

Still, the nurses who spoke to *Sowetan* expressed concern over the fact that they had not been asked to give testimony to either the Oranje Hospital internal inquiry or to a national committee of inquiry commissioned by Health Minister Dr Nkosazana Zuma to investigate conditions in 33 mental institutions.

"How are we going to stop these rapes if we are not even allowed to talk about them?" a nurse asks.

Another nurse has more practical concerns: "When you have only two people to take care of 28 psychiatrically ill patients, abuse is inevitable. What we need is more nurses and security to back us up."

He says scuffles often ensue and "sometimes people get hurt".

Recommendations

Sources close to a national committee of inquiry charged with investigating conditions in mental institutions say it is likely to recommend substantial changes to the Mental Health Act, which legally governs psychiatric hospitals.

Some of the recommendations could include:

- Repealing a section of the Act which prohibits journalists from taking photographs or sketches of mental institutions.
- Changing laws by which patients can be involuntarily "certified" and committed to mental institutions.

One committee member says it was difficult to prove many of the abuse claims brought to the group's attention. Another says the committee had successfully uncovered various abuses which occurred "prior to 1994".

The committee will give its findings to Health Minister Dr Nkosazana Zuma in December. A report could be made public by the end of the year.

PSYCHIATRY (88)

On trial

FM 19/1/96

Allegations that the apartheid government sponsored secret mental hospitals in old mining compounds where black inmates suffered human rights abuses at the hands of psychiatrists, are to be submitted to the Truth & Reconciliation Commission.

Details of these compounds are revealed in the latest edition of *Freedom,* a magazine of the Church of Scientology, which it seems, opposes psychiatry in principle.

The article forms the basis of the Scientologists' submission to the Truth Commission in which it aims to catalogue the systematic denial of black mental patients' human rights under apartheid.

Much of the information was unearthed in the Seventies when Scientologists uncovered what they term a "network of psychiatric oppression" in SA that ultimately drew the attention of the international media, the United Nations and other authorities.

The article says that between 1963 and 1972 the Department of Health transferred the care of black mental patients to a private psychiatric hospital consortium. The hospitals were guaranteed a 90% occupancy rate and payment on a per-capita basis, but were not listed in annual health reports or the department's lists of hospitals.

In 1976, *Freedom* published a series of articles alleging that thousands of black mental patients were suffering "appalling conditions and wanton abuse" in the Smith Mitchell hospitals that operated in old mining compounds:

Jan Eastgate, international president of the Citizens Commission on Human Rights (CCHR), a Scientology watchdog group, says: "Scientologists' efforts to bring the psychiatric racist abuse of blacks into the public and political eye were met with utter defiance and a sledgehammer mentality."

The Church of Scientology not only blames psychiatry as a whole for the horrors some psychiatrists allegedly committed under apartheid, but also holds the profession responsible for providing the "ideological twist" which enabled racism to become institutionalised in the first place.

It wants the profession to publicly apologise for "their racist studies, their false ideology that blacks were intrinsically inferior and for the abuses committed under apartheid."

A different picture is presented by Daniel Ncayiyana, editor of *The SA Medical Journal*, in a paper entitled "Human Rights in Psychiatry" which he delivered at a Bloemfontein psychiatric conference last September.

Ncayiyana said: "I have been unable to find examples of politically motivated professional malpractice in psychiatry in our country even during the darkest days of apartheid, which is extremely surprising and should speak well of SA psychiatrists."

However, though gross psychiatric abuses perpetrated on a large scale by countries like Nazi Germany and the Soviet Union had become "quite uncommon," other forms of abuse — such as those manifest in filthy conditions and a lack of privacy — continued to exist in mental institutions around the world.

"In this country I can tell you from personal experience of the absolutely disgraceful conditions in mental hospitals in the Transkei. And everyone will recall the death of a patient in the Cape from the use of a straitjacket," Ncayiyana said.

The Society of Psychiatrists acknowledges that conditions were "less than ideal" in the Smith Mitchell hospitals under apartheid.

But society vice-president Dr Clifford Allwood of Wits University says that from the mid-Eighties the society frequently visited these hospitals and found that in some cases patients were actually better kept than in general hospitals.

"State mental hospitals were no different from ordinary hospitals. At that time all hospitals were racially segregated and across all medical facilities there were places that were less than ideal.

"We can't say that nothing ever happened anywhere. In the Smith Mitchell hospitals conditions were less than ideal, but they kept chronically ill people off the streets and gave three meals and a roof to people who may otherwise have lived in holes in the ground or in streets and sewers."

Six months ago the society investigated Durban's Ekhlengeni Hospital and found that fresh allegations of human rights abuses were also unfounded.

Allwood completely rejects the allegation that psychiatry provided the scientific justification for apartheid.

The society, together with a ministerial committee that is investigating mental health-care delivery, has recommended to Health Minister Nkosazana Zuma that the prohibition contained in the Mental Health Amendment Act be scrapped.

Backing the move is Free State psychiatry professor Carllo Gagiano, who says: "An open and transparent system is always a healthy one and this is what we would like to see. It is one way of protecting the human rights of your patients."

Until the prohibition is scrapped, SA will never know the true story of life inside our mental institutions, past and present. The Truth Commission could be the first opportunity to cast a bright light on institutions which the State has protected from public scrutiny for 20 years. ■

Mental health to get a face-lift

By Glenn McKenzie

GAUTENG could see a dramatic increase in community health services for mentally ill people and victims of abuse, drugs and violence in 1996 and 1997, a senior health official said this week.

Dr Ruth Zwi, Gauteng's director of mental health, said her department had budgeted for a 50 percent increase in day care and "workshop" facilities for mentally handicapped people in the coming financial year.

The provincial government also hoped to create posts for 50 social workers, 50 psychologists and 50 occupational therapists. The positions would be equally distributed among the five regions.

The new staff will be involved in counselling drug abusers, survivors of violence and people who have been involved in or been victims of child abuse.

Zwi hoped to gradually make Gauteng's mental health services more accessible to black people this year. Many blacks are still deprived of quality mental health services that are available to white people.

"It is an extremely complex process, but we are hoping to bring about change that will benefit the majority." The capacity of Gauteng's day care facilities will more than double this year to serve more than 800 patients, from 390 last year.

Most day care facilities are provided by non-government organisations, but are funded by the government.

In addition, the number of beds for mentally ill patients in psychiatric institutions could gradually decrease in future, said Zwi.

The government hoped to put some institutionalised patients in community programmes this year or in 1997.

In addition, the Government is likely to review its contract with Lifecare Group, which administered a number of mental health facilities.

"We are also committed to building community health facilities," said Zwi.

Valkenberg 'a disgrace'

CT 16/2/96 (88) (98)

ANEEZ SALIE
HEALTH WRITER

VALKENBERG Psychiatric Hospital is a "disgusting dungeon" where apartheid is alive and well, an official investigation has found.

The probe also found that Valkenberg staff members were being booked off as they were on "unacceptable amounts of anti-depressants".

Countrywide, many psychiatric patients are grossly abused — both physically and sexually — and some have received shock treatment without sedation or guidelines.

This is according to the Mental Health and Substance Abuse Committee, chaired by Professor T B Pretorius of the University of the Western Cape. The committee includes many prominent people in the field of mental health..

The report on the state of mental health institutions was commissioned by the government health department, and was presented to Health Minister Dr Nkosazana Zuma in Parliament yesterday.

Zuma said she was "deeply concerned" by the findings, and would implement corrective measures urgently.

Western Cape Health MEC Ebrahim Rasool said task teams would be appointed immediately to correct the situation.

The committee found unacceptable health standards, inefficient management of patients and staff, a lack of safety measures, neglect of buildings, allegations of human rights violations, overcrowding and staff shortages, among many others.

❑ Turn to Page 3

Valkenberg 'disgusting'

(88) (98)

CT 16/2/96

r From Page 1

Of Cape Town's three institutions, the 1 352-bed Lentegeur Hospital in Mitchells Plain met basic requirements because the facility was relatively new. Programmes in Afrikaans only are a problem, and the quality of the food is unsatisfactory.

Stikland, with 925 beds, was found to be still 99% white. It was one of the best facilities the committee investigated. They said the buildings and wards were in a "splendid" condition.

At Valkenberg, with 900 beds, the wards were in a shambles, the committee found.

"The ablution facilities are totally disgusting" and "most of the old ward dormitories are dungeons", with 60 beds crammed in each, affording no privacy.

Black patients are mostly kept in the worst buildings and white patients in new and better equipped wards.

Some of its buildings have become so dilapidated that patients have had to be evacuated, and others are far below the minimum health and safety standards.

There is an acute staff shortage, and food is a major complaint.

"In essence, there is a gradual disintegration at this hospital," the committee reported, "and we urge that urgent steps be taken to remedy the situation".

In a footnote, the committee says that after its report was concluded, allegations were reported of drug trials and experiments on patients without their consent.

Some mental hospitals unsuitable for patients

BD 16/2/96 (88)

CAPE TOWN — Several psychiatric hospitals are unsuitable for patients and Umzimkulu Hospital in Eastern Cape is "a dungeon", a government investigation of mental institutions has found.

This hospital and the Westfort facility near Pretoria should be closed, while other decaying facilities needed upgrading urgently, the mental health committee probing human rights violations and alleged malpractice in psychiatric institutions found.

Health Minister Nkosazana Zuma said yesterday her department would be taking steps to address the situation. Further investigations, possibly by police, would have to be carried out, she said.

"We are deeply concerned about the findings of this committee."

Among the human rights violations listed in the report were assaults on patients by staff in the guise of self-defence, sexual abuse, denial of proper medical treatment and improper medication. Often hospital managements failed to investigate assaults and at no hospital had criminal charges been preferred against the perpetrators, the report said.

It described filthy conditions at several hospitals.

The stench in wards at Valkenberg, Weskoppies, Groothoek and Westfort was "such that one fails to understand how doctors and nurses cope".

At the Hayani and Umzimkulu hospitals the colour of the blankets could not be determined.

Although comprehensive in its report, the committee could not give detailed information on malpractice and abuses by staff.

However, details of incidents were reported by individuals — in submissions to the committee — at the Millsite, Ekuhlengeni, Weskoppies, Oranje, Fort England and Valkenberg hospitals. Lack of details on the extent of the problem was attributable to the "code of silence" in these institutions, Zuma said.

The report said: "At a majority of institutions staff members were bent on protecting each other and this made it difficult for the committee to ascertain whether certain abuses did occur."

Some patients' deaths could be attributed to the "conditions under which patients are being kept".

Lack of human resources at black institutions in particular was critical.

Zuma said it was not clear how much the upgrading and rebuilding of these facilities would cost, and whether the health department could carry the financial burden.

This would be known only once the general audit of hospitals had been completed, she said. This report was expected at the end of March. — Sapa.

SA 'may ruin its markets'

BD 16/2/96

Michael Hartnack

VICTORIA FALLS — SA's pursuit of short-term gains endangered its own interests, leading Zimbabwean businessman and former Southern African Development Community (SADC) executive secretary Simba Makoni warned yesterday.

Makoni told delegates at a conference on regional integration SA risked impoverishing its neighbours and ruining its markets.

Current aggressive policies pursued by SA businessmen and SA's unequal tariff regime against imports could drive neighbouring states' industries into bankruptcy, Makoni predicted.

"This attitude, apparently to fulfil short-term gains, is ultimately to the detriment of SA itself," Makoni said in an address punctuated by applause from the 140 delegates from all 12 SADC states. Zimbabwe, which has dropped export incentive payments under pressure from the IMF, claims SA exporters retain an unfair advantage through Pretoria's continuing subsidy system and the punitive tariff barriers affecting Zimbabwe's exports to SA of textiles, clothing, footwear and electrical goods.

Makoni, currently head of Zimbabwe's state-controlled media, said "two cancers" were devouring the SADC and the 30-nation Comesa (formerly the South, Central and East African Preferential Trade area).

"The first is the bad blood between the two secretariats. This undermines their ability to work together in a spirit of co-operation."

The second, he said, were the inconsistencies implicit in states such as Zimbabwe being members of both the SADC and Comesa. Within days of SADC meetings, "heads of state routinely adopted conflicting resolutions" at Comesa summits.

Southern Africa needed to harmonise its economic and political paradigms to achieve real unity, he said.

(98) (88)

Absurd doctor: patient ratio

22/2/96 Sowetan

By Bronwen Roberts

THREE state psychiatrists in the Eastern Cape were struggling to treat up to 2 200 mental patients, a top psychiatrist said today.

Head of the Eastern Cape Psychiatric Services Dr Charles Lowe, told *Ecna*: "They (the three psychiatrists) can only stop people from going berserk."

Meanwhile, the mental health of people in East London – the second largest city in the region – was "not very good". This was according to the director of the East London-based Mental Health Society, Beth Burton, who told *Ecna* that depression and stress was rife in the city.

She said this was heavily influenced by an unstable economy, unemployment and a lack of resources.

Burton said: "In this environment people often use dagga and alcohol to escape. This compounds depression and forms a vicious circle of poor mental health."

Dr Lowe said that proper treatment of mental patients was being hampered by huge staff and resource shortages at the four mental hospitals in the region – all in formerly white areas.

These hospitals were absorbing the overflow from three collapsing mental hospitals in former Transkei and Ciskei.

However, Lowe believed the region's mental health service was "good compared to Third World conditions, but not so good compared to First World conditions".

Lowe said one of the Eastern Cape psychiatrists was seeing up to 100 patients a day.

This meant only severely depressed or psychotic people were being treated: "mildly depressed" patients were not being treated adequately.

Lowe firmly denied that patients were being maltreated.

He was commenting on a government report which stated that mental hospitals were in a worse state than the South African prisons.

Rejected report

He rejected a report today which claimed that patients at Grahamstown's Fort England hospital were placed in solitary confinement, or heavily sedated as a form of punishment.

However, he said: "Our hospitals are few and far between and if we need to transport difficult patients, we may drug them for the journey.

Sedation helped to calm patients and to prevent exposure to outside influences which might disturb them.

BRIEFS

Stikland Hospital 'not 99% white'

THE superintendent at Stikland Psychiatric Hospital, Dr Miles Booker, has denied his institution is 99% white, as alleged in a report by the Mental Health and Substance Abuse Committee presented to Health Minister Dr Nkosazana Zuma last week.

Originally a white facility, Stikland now had 68% whites in its general wards and 37% in the acute wards, he said.

88 88

ST 20/2/96

Report paints a grim picture of abuse in SA's psychiatric institutions

(88) (48)

Kathryn Strachan

A REPORT commissioned by the health ministry has lifted the lid on SA's psychiatric institutions, disclosing a grim picture of widespread abuse and malpractice.

The report concluded that conditions in most prisons around the country were better than those existing in some psychiatric hospitals.

"Patients are being treated as subhuman for no valid reason — simply for being ill.... While our Bill of Rights protects even juveniles who are in prisons and detention centres, innocent children whose only offence is merely being ill are made to bear conditions from which we protect even the worst criminals in society," the report says.

Health Minister Nkoszana Zuma hassaid criminal prosecutions were being considered, arising from the report.

The report — compiled over two months by 10 mental health experts from medical schools, the health department, the Medical Association of SA and Lawyers for Human Rights — detailed claims of sexual abuse, assault and neglect.

Patients' right to dignity was violated by hospital conditions and the lack of privacy in toilets and showers.

At Millsite Hospital, near Johannesburg, nurses said believed that death certificates were falsified to hide neglect by psychiatrists and doctors.

The committee was told potentially dangerous tranquilisers were prescribed indiscriminately. Although a child lost his sight and another went almost blind after being given the tranquiliser Largactil, psychiatrists continued to prescribe it.

There had been many deaths at Millsite in the past few years. Nurses believed these were a result of inadequate heating in winter and of psychiatrists' neglect of sick patients. Patients were also frequently assaulted by staff, the report said.

Random and frequent use of electroconvulsive therapy at some institutions indicated it was being abused as a treatment. Sexual abuse was common at many institutions because male patients were allowed into female sections, the report said.

Staff at many hospitals disclosed that during strikes, when some wards were unattended, male staff had raped female patients. Nursing staff at Millsite were said to have taken female patients out at night to serve as prostitutes at a brothel and to have taken young girls out at night to have sex with them.

At Ekuhlengeni Hospital in Kwa-

BD 21/2/96

Continued on Page 2

Abuse

Continued from Page 1

(88) (48)

Zulu-Natal, girls as young as 12 were sexually abused by male patients.

At Weskoppies a patient who was admitted for depression was allegedly sodomised by a psychiatrist. When the patient complained to hospital authorities, they insisted that he was hallucinating.

The standard response to investigation of sexual abuse at hospitals was that the patients were hallucinating.

At Groothoek and Pololo hospitals in the Free State, staff connived with members of the public to use the institutions as disciplinary centres. One girl was admitted at the behest of her stepfather as a way of disciplining her. Kept there for five months, she said patients were assaulted when they refused to take medicine.

At Fort England in Eastern Cape, patients were sometimes put in solitary confinement and drugged so severely they could hardly move. This was done as punishment, the committee was told.

One Fort England patient said she was certified by a psychiatrist a year in advance so that she could not leave the institution, the report said.

At many hospitals there was a "no-discharge" system. Patients were committed indefinitely even if they did not deserve to be kept in an institution. The report said patients who left Millsite, run by the private Lifecare Group, were discharged only because their families had demanded it.

While some patients had been at Millsite nearly 60 years, their files were vague about the reason for their continued committal.

The report said it was in the interest of the Lifecare Group to keep as many patients as possible as government subsidised it for every patient.

Millsite patients, more than a quarter of whom were children, lived under appalling conditions and were given a substandard diet. Many died as the cold, combined with poor nutrition and indiscriminate prescription of drugs, weakened their resistance to disease.

A physician at Millsite was said to assault patients whom he accused of being too slow or of irritating him.

Most of the flagrant abuse in psychiatric hospitals apparently took place at night.

"At the majority of institutions, staff members were bent on protecting each other and this made it difficult for the committee to ascertain whether certain abuses did occur," the report said. The responses to the committee's inquiries were mostly: "I have heard about that but I cannot recall who said it; personally, I know nothing about that." Pursuit of specific allegations garnered similar responses.

Most of the people who could have given vital information chose not to do so for fear of victimisation.

BD 21/2/96

See Page 4

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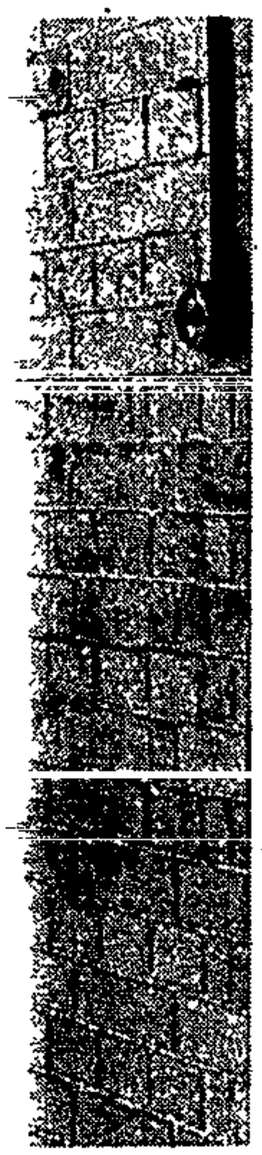
See Page 4



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Shortage of funds results in poor mental health services

BD 21/2/96

(88)

Kathryn Strachan

IN THE locked forensic ward of Sterkfontein psychiatric hospital — to which state patients who have committed crimes are admitted — there are only four nurses for the 60 acutely disturbed patients.

With so many psychotic men kept enclosed in one space with hardly any supervision, the reports of violence in wards are given some perspective.

But Sterkfontein — situated on the outskirts of Roodepoort — is one of the better resourced institutions, and as other mental hospitals across the country are even more underfunded so their standards keep plummeting.

Out of these hidden health institutions emerge many reports of abuse and maltreatment.

In her research into patient's experiences of mental health services, Prof Leana Uys, head of the department of nursing at the University of Natal, encountered countless reports of abuse and is now trying to investigate the extent of maltreatment.

In group discussions, patients say they have been threatened by nurses. Some say they have been stripped naked, and there are many complaints that police steal their belongings when they are picked up.

"The way in which police pick up patients at their homes is so traumatic that everyone in the street knows about it, and it makes going back into the community when they have recovered all the more difficult," says Uys.

"When patients are psychotic, they are totally defenceless. Only a small proportion are paranoid so these accounts would not be made up."

Gauteng health department mental health services director Dr Ruth Zwi says lack of humane treatment in the justice system adds to the trauma of being interned.

She relates a recent experience of a psychotic woman who was lucid enough to ask for legal assistance when she was picked up by police and taken to a magistrate's court.

The magistrate then threw a telephone directory at her and told her to find herself a lawyer.

The justice system also works in a way that means that if a person who committed a crime is ruled by the courts to be mentally ill, they may end up being incarcerated in psychiatric institutions for a far longer period than they would have been if they were simply sent to jail.

Patients are also often kept in police cells after having been picked up.

National health department director of mental health services Hlengiwe Mkhize says psychiatric institutions are the most neglected part of the health sector and are in a poor condition country-wide.

"The question of patients' rights is going to emerge as a major issue for mental health if the Bill of Rights goes through," she says. Psychiatry and its institutions are a very old established section, and it will need a careful process to change them.

"But we need to move very fast to ensure that mental health and the care and rights of patients are in line with the Bill of Rights."

Pat Skea, the matron at Sterkfontein Hospital, says the institution is held back from providing better care because it is underfunded, understaffed and overcrowded. There are only five psychiatrists for 800 patients, but Sterkfontein is still a lot better off than most institutions.

Relapses

One factor that would alleviate the burden on the hospital is an adequate community-based service. Patients are sent home once they have received treatment, but without an adequate community-based service to do follow-ups, to pick up relapses at an early stage, and to check that patients are taking their medication, many of the patients are soon readmitted.

More patients could be sent home to their families but without the community-based service to offer support to those who give care at home, families are reluctant to take patients home and they have to remain in the hospital for an indefinite period.

Health professionals are amazed that the mental health system could ever have been designed in such a destructive way, and the system is hampered by relics of the past; the huge institutions hidden away from society's view, and the way in which mental health has been divided at every level of care from the rest of the system.

Community-based care does not only make sense from an economic perspective, but from a treatment perspective as well.

Prof Carlo Gagiano of Free State University's department of psychiatry is one of the leading architects of a fundamentally new mental health system for the country.

The old system of institutionalisation, with very little community-based care, has resulted in stigmatisation and an inaccessible service for most of the people needing care, he says.

A strong community-based service will remove the stigma from patients and render a service for mild and uncomplicated mental illness that comprises more than 80% of the total work load, he says.

With training and back-up from specialists at hospitals, primary care workers are capable of delivering the service, and more complicated cases could be referred on.

Hospital-based care would be available for the treatment of the severely mentally ill but this would not be institutionalised care for the mentally ill in its present form.

Hospital-based care will consist mainly of short-terms admissions with highly specialised therapeutic programmes. A very small component should be long-stay patients. These units should preferably be small 20-bed units linked to a sheltered employment facility, he says.

Karen Ensink, a researcher at the University of Cape Town's psychiatry department, said that when the UCT medical school set out to do an epidemiological survey of Khayelitsha, it was surprised to find that the community placed mental illness near the top of its list of most pressing health problems.

The community requested urgent assistance, particularly with child and adolescent psychological problems, as the psychiatric services in the area were too thinly spread to absorb the high level of mental illness.

A survey showed that 64% of children and adolescents between six and 16 years presented one or more symptoms frequently associated with psychiatric disorders.

Even if primary care mental health services were developed, it was likely that only the most severe psychiatric disorders would be identified and treated at clinics. A great many "at risk" or "marginalised" children would still be overlooked and not receive appropriate interventions, she said.

Mental Health Act changes sought

BD 22/2/96

Kathryn Strachan

MENTAL health experts are pressing for the abolition of legislation that prevents public scrutiny of psychiatric hospitals following horrifying reports of widespread abuse, assault and neglect at the institutions.

A clause of the Mental Health Act of 1973 has been used to prohibit journalists from reporting on conditions in psychiatric hospitals and a committee of experts believes that, without public scrutiny, these abuses have been allowed to continue "unabated and unchallenged". A report by the committee said: "Culprits have committed gross abuses of patients with impunity and in the certainty that they will get away with it."

A meeting scheduled with the Parliamentary standing committee on health will discuss changes to the Act.

Another concern was about people being certified mentally ill when they were not. The absence of accountability on the part of people who certified patients led to abuse of certification, said the report.

Cheap psychotropic drugs, which had a variety of side-effects, were continuously administered and their persistent use did more harm than good.

The investigation — carried out by the committee which was made up of experts from medical schools, the health department, and Lawyers for Human Rights — detailed claims of sexual abuse and neglect.

Allegations were levelled at Millsite Hospital, near Johannesburg, which is run by the private Lifecare Group. Lifecare said yesterday its comment was still being formulated.

Millsite's wards were overcrowded and patients rarely discharged, said the report, alleging this was because the state subsidised the company for each patient and it made financial sense to have as many patients as possible.

For this reason, it recommended that all patients admitted to private hospitals should be admitted by state doctors rather than by those of the institution. There should be a regular review of patients by state doctors and if a patient was kept in an institution for more than a year, their case should be referred to the ombudsman.

All agreements with private organisations providing in-patient psychiatric care should be reconsidered.

The report heard many claims from patients and staff of sexual abuse, but when these claims were followed up, the standard response of hospital authorities was that the patient was hallucinating.

Patients' rights to dignity implied they should have privacy and supervision, but this was often not the case.

At many hospitals male patients were allowed access to women's sections. With the lack of supervision at Ekuhlengeni in KwaZulu-Natal, girls as young as 12 were sexually abused by male patients. "This included young girls who were spastic," said the report.

At Ekuhlengeni it was "not unusual" for patients to have sex in the open, watched by others and by the public.

Comment: Page 14

Fees protests swamp educational institutions

BD 22/2/96

BOYCOTTS and other protests yesterday developed at a number of educational institutions, mainly around the issues of admission and fees.

Police were called to maintain order at Free State Technikon in Bloemfontein where about 400 people were demonstrating outside the campus.

They were protesting against bail conditions set for 137 demonstrators, including students, arrested on Tuesday and charged with either defying a court interdict obtained by the technikon or trespassing.

In the Free State town of Trompsburg yesterday businesses closed as hundreds of Madigetla Secondary School pupils marched in the streets before handing over a petition at the local police station.

Damage of thousands of rands was caused to houses and businesses in Trompsburg on Tuesday when pupils rampaged through the streets after being chased away from Trompsburg Secondary School by white parents.

University of Zululand students on Wednesday staged a one-day lectures boycott to protest against increased tuition fees, it was reported. — Sapa.

Helping the healing process

'Every South African has a story to tell – the story of what I did, what I failed to do and what I was forced to do'

(88) ~~(89)~~ ARG 23/2/96

ROGER FRIEDMAN
Staff Reporter

THE Trauma Centre for Victims of Violence and Torture – housed in a 19th century Anglican monastery in Woodstock – is contemplating a shift in focus in keeping with the realities of the new South Africa.

It was set up in response to an unjust, racist system which tortured and incarcerated its opponents, and traumatised a nation for more than four decades.

It was located at Cowley House in Woodstock where relatives of Robben Island prisoners used to meet – and which was later used as the reception centre when the island prison was emptied of its political prisoner cargo.

Funding was obtained from the Danish government days after the execution of South African Communist Party general-secretary Chris Hani in April 1993 – South Africa was burning, political violence was pervasive and the so-called New South Africa appeared a whimsical dream.

Almost three years down the line the dream has become a reality. Except, it's a dream with a grey lining. Political violence has given way to criminal violence.

This is one of the issues that staff at The Trauma Centre for Victims of Violence and Torture have to grapple with in their quest to maintain the organisation's relevance in the changed society.

Another is the Truth and Reconciliation Commission.

Because, in spite of its stated aim of not conducting a witch-hunt, the Truth and Reconciliation Commission will undoubtedly open old sores among both victims and aggressors.

"People who may not have used our services before, are suddenly going to start thinking again of events that may have taken place 30 years ago," explained one of the centre's triumvirate of directors, Tom Winslow.

less than six percent of its annual torture rehabilitation budget to Africa."

"So," said Dr Winslow, "part of our job is to convince people to start shifting resources and start caring for Africa."

But the responsibility was not the First World's alone.

"We hope the South African government will begin to take responsibility for healing the wounds the South African government created in the past.

"I think it should be done through non-governmental organisations. Therefore, the state has a responsibility to subsidise organisations like ours."

Torture and Captivity Project

Comrades don't cry – although many show the symptoms of unspeakable inner suffering.

The Torture and Captivity Project provides mental health and socio-psychological services for torture survivors and former political prisoners and detainees.

It also runs the Big Buddy Programme for children on the verge of being released from prison.

According to the project co-ordinator, Marlene Bossett, the psychological implications of torture often only surface years after the event – sometimes decades after.

This is why some of the survivors of the Nazi concentration camps are still getting treatment. And it explains why someone tortured 40 years ago may still have trouble sleeping and interpersonal and intergenerational problems.

The most common forms of torture used by the apartheid regime included sexual assault, common assault and solitary confinement.

The aim of torture is simple: "To break a person psychologically and to force the person to break the bonds with society."

political violence, but on reviewing the project we quickly realised we could not limit ourselves to political violence," said Ms Walaza.

So although criminal violence, rape, sexual assault and domestic violence are not directly included in the Trauma Centre's brief, few services are offered in African townships and the project tries to cover these areas as well.

"In any case, when does political violence stop and criminality start?"

Ms Walaza believes political violence includes shack-burning, faction fighting, massacres, assassinations, taxi violence and police brutality.

Whereas the project historically concentrated on the Crossroads and Nyanga areas, gangsterism could force it to spread its wings.

Research Project

It is Donald Skinner's job to ensure that whatever programmes the Trauma Centre embarks on, they are relevant and in keeping with the realities of the new South Africa.

A clinical psychologist, Professor Skinner co-ordinates the Research Project and sees his primary role as serving the other projects. He is busy finalising an overall needs analysis which he started working on in August 1994.

Beyond that, Professor Skinner will conduct research on specific requests, for example, whether there is a need to organise a working group of returned-from-exile youth.

He has also delved into violence on farms and domestic violence, and is to start a project assessing gang violence.

"The idea is to spend some time talking to victims of gang violence, to see what traumas they experience, to try and isolate particular strengths that exist, and to intervene at that level.

"Every South African has a story to tell – the story of what I did, what I failed to do and what I was forced to do."

Working on an inter-faith basis, Father Michael is developing a religious response model aimed at helping survivors of torture and violence come to spiritual terms with their lives.

A series of Healing of the Memories workshops is underway, at which trainers are learning to take the concept throughout the country.

He describes the process as "the opposite of forgive and forget".

People will be encouraged to wrestle with their own truths, said Father Michael who sees the process as operating alongside the Truth Commission.

Father Michael is also the key figure in the Returned Exiles Project, offering counselling and support services to many of the 1 500 exiles who returned to the Western Cape.

While the liberation movements looked after their members in exile, when they returned it was to a climate of homelessness and joblessness.

The project is in the process of being re-evaluated.

Meanwhile, an Influx of Refugees Project, is gathering momentum.

TEAM LEADERS: Nomfundo Walaza, Marlene Bossett and Donald Skinner co-ordinate the Urban Violence Project, the Torture and Captivity Project and the Research Project, respectively.

Pictures: ANDREW INGRAM, The Argus

"The Truth Commission will be a catalyst for a number of different healing processes. We know it is not going to reach everybody. We know that people who suffered human rights abuses which were not gross abuses will not be appearing before the commission.

"We might be able to create a safety net," said Dr Winslow. "The commission is desperately in need of help."

The question is, does the centre have adequate resources, staff and capacity to make an impact?

And for how long can it rely on the so-called First World to continue funding humanitarian projects in the former colonies?

Dr Winslow said the kind of psychological-social services offered by the centre constituted a relatively new field in psychology.

There are now nearly 70 such centres in the world.

"The aim was to get European and United Nations money to set things up, in the hope that after three to five years the host nation would take over the function," he said.

"Globally, about four percent of the UN Voluntary Fund for Victims of Torture finance comes to Africa. South Africa does not contribute to this fund.

"The European Union gives

Ms Bossett – and her team of two full-time case workers and volunteer students from the University of the Western Cape – aims to impact on that.

How do they measure their success?

"We do an evaluation when the person comes in. Then we do whatever intervention is required, and on completion of the therapy we do another evaluation.

"For many people there is a sense of being able to access old memories and pains that brings a measure of relief," said Ms Bossett.

Urban Violence Project

One of the biggest challenges facing Urban Violence Project co-ordinator, Nomfundo Walaza, is educating people on the role of psychological services.

"People are used to medical and social services, but psychology is still very misunderstood," she said.

"Black communities really struggle with the notion of how psychology can help because they were deprived of psychological services in the past."

The project provides social-psychological services to individuals, groups and communities affected by political and organised violence in the Western Cape.

"The main focus when I came here in August 1994 was

Strengths might include community organisations, potential for neighbourhood structures or potential for setting up after-school activities."

Other essential parts of Professor Skinner's work are evaluating existing projects and answering specific research questions.

And he will have a close look at secondary trauma arising out of the Truth and Reconciliation Commission.

Chaplaincy Project

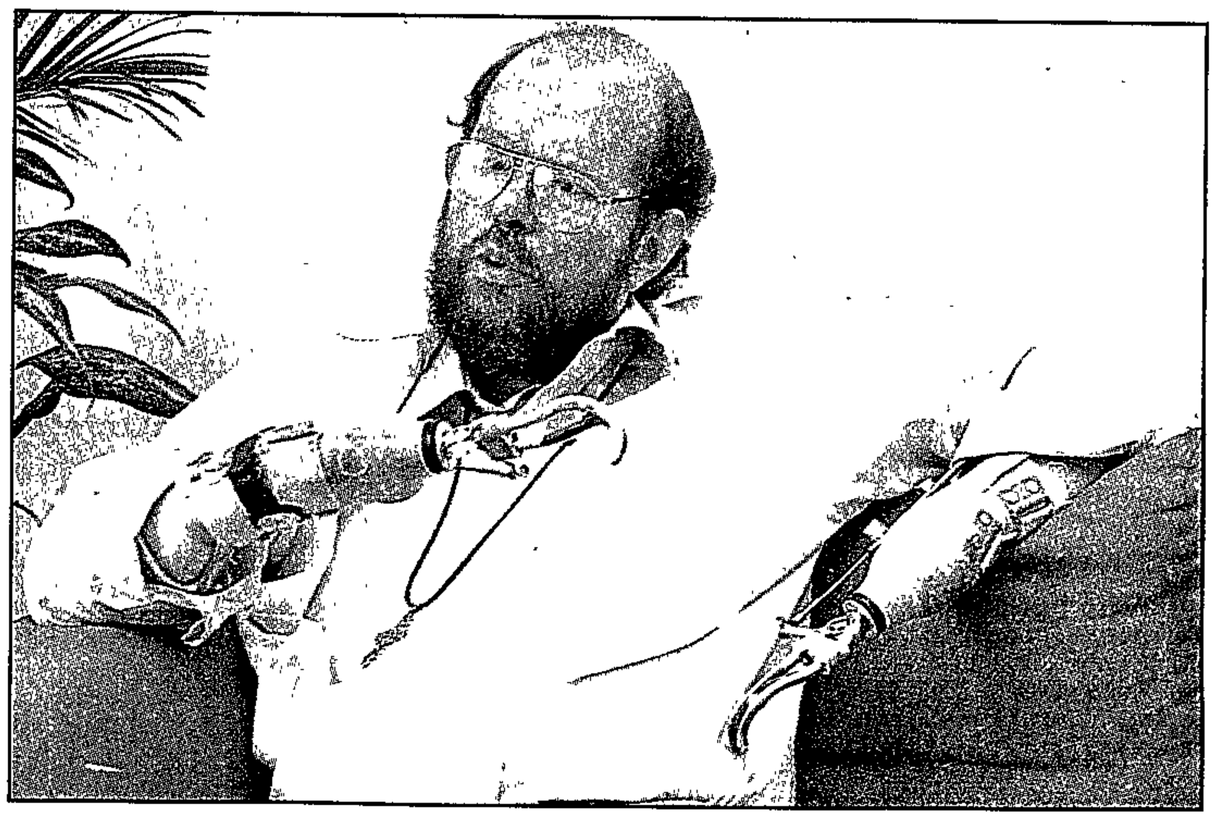
Michael Lapsley, a Trauma Centre director and former African National Congress chaplain in exile, sees the role of the Chaplaincy Project as supporting other projects.

As the victim of a letter bomb which ripped off his hands in 1991, Father Michael is also in the unique position of being able to offer "peer counselling" to others who have lost limbs.

And delve into questions such as: Why did God do this to me? Why did God allow this to happen? How must I endure? How can I have hope?

"We have about 45 million traumatised people in South Africa who were messed up by apartheid.

"The Truth Commission will hear stories of gross human rights violations. But that is a small percentage of South African stories.



SURVIVOR: Former African National Congress chaplain Michael Lapsley lost his hands in a letter bomb containing the pages of religious magazines, which was sent to him while in exile in Zimbabwe in 1991. Today Father Michael, one of the centre's three directors, runs the Chaplaincy Project – when he's not dealing with refugees and returned exiles.

Mental-health reform a priority after damning report

Star 23/2/96 (38)

Finding accommodation fit for humans a problem, but no one will be turned on to streets, promises health director

By Janine Simon
Medical Correspondent

Gauteng's department of health has made reform in mental health a priority, but will not be summarily closing wards as a result of the damning report on human rights abuses and malpractices at some psychiatric hospitals.

Among other problems, the report has found that 200 patients at Westfort Hospital near Pretoria are living under conditions unfit for human occupation.

Speaking at Weskoppies Hospital near Pretoria yesterday, Gauteng's director for mental health, Dr Ruth Zwi, said alternative accommodation was a problem, but patients would not be turned on to the streets, as had happened in other countries.

Westfort was a priority capital project and the department planned to sell some of the hospital's extensive land holdings to fund upgradings.

The department was also reviewing contracts that the previous national health department had signed with private contractors to run seven state-subsidised facilities in the province.

Zwi added that all formal complaints of abuse or malpractice would be investigated but, as the report was based on confidential interviews, and no specific examples were given, the findings were difficult to pursue.

Many statements in the report, for example on electro-convulsive therapy, lacked context and therefore had little meaning.

"We acknowlege there is abuse," Zwi said. "And however good the internal environment is for investigating those cases, our aim is to set up democratic hospital boards so that those complaints can be reviewed by an outside body."

Eleven Gauteng hospitals were investigated by the 10-member committee briefed by the national Department of Health to delve into numerous complaints of abuse at psychiatric institutions.

Their investigation was the final part of a broader probe last year into general issues in mental health.

Gauteng's health department welcomed the report, saying it had thrust a subject previously shrouded in secrecy and neglect into the public eye, and was a sobering reminder of the immense task of overhauling the system of psychiatric care in the province.

Director-general Dr Ralph Mgijima said the deficiencies highlighted by the report mirrored many of those in the poorly administered institution-based health service inherited by the new government.

But it was "very thin" on the question of health workers, and the strenuous conditions under which they worked.

Gauteng had overhauled its approach to mental health in the past eight months, and was gradually reintegrating mental health services into the wider network of health care.

The community health services were being boosted, the number of acute psychiatric beds in general hospitals across the province was being increased, and the department planned to gradually increase the budget allocation for bodies which offered community care in day-care facilities and half-way houses.

MOTLHALEFI MAHLABE

Under the spotlight ... a recent report has sharply focused the public eye on conditions at psychiatric hospitals. This is one of the wards at Weskoppies Hospital, west of Pretoria.

Weskoppies staff dispute findings on psychiatric institutions

By Janine Simon

Staff at Weskoppies Hospital yesterday disputed some of the findings of a report on human rights violations and malpractices in psychiatric institutions, but threw their weight behind many of the report's recommendations.

The 1 189-bed hospital said that while the formation of the committee had been seen as a positive step, the presentation and publication of the report had been viewed by nursing and medical staff as an attack on their integrity and professionalism.

It distanced itself from claims of over-use and abuse of electro-convulsive therapy, non-attendance by doctors, inadequate diagnostic treatment regimes or inadequate control.

Responding to the specific remarks about Weskoppies in the report, which was released last week, acting superintendent Dr LeAndre Gauché said the hospital agreed with findings that conditions in some wards were unacceptable and had been trying to draw the department's attention to this for years.

"No specific wards are mentioned, so we don't know, but several are in the process of being demolished, and others improved," he said.

Staff objected to claims that patient abuse was reportedly rife at Weskoppies. All complaints were fully investigated, regular reviews and spot inspections were held, and charges had been laid in three cases of physical abuse, they said.

Prof Wilhelm Bodemer, head of the department of psychiatry at the University of Pretoria, agreed that an external review body would be better equipped to deal with such complaints.

Bodemer also said the report's findings that treatment protocols were not adhered to did not apply to Weskoppies.

Weskoppies is an academic hospital, and standards of practice there are generally regarded as better than average.

By CAS St LEGER

'FILTHY DUNGEONS' OF ABUSE WHERE THERE IS LITTLE HOPE

(88) (88) ST 25/2/96

HEAVILY medicated patients doze on the grass at Westfort psychiatric hospital. Their meals are delivered by lorry and served outside. At night they stumble groggily back to their wards, a scattered collection of run-down cottages.

A report released last week describes many South African mental hospitals as "filthy dungeons" of abuse where patients and staff appear drunk or high on cannabis.

And the worst of these hospitals is Westfort, a century-old former mission hospital and leper colony on the outskirts of Pretoria.

The report was prepared by the Mental Health and Substance Abuse Committee, which was appointed by the Minister of Health, Nkosazana Zuma, to investigate alleged human rights violations and malpractices at 32 psychiatric institutions.

Westfort is described as literally unfit for human occupation. "For any government to allow it to be used as a hospital is a gross violation of the fundamental rights of the patients," the report says.

It found bedding and patients' clothing to be filthy and tattered, and the patients appeared to be poorly fed.

Buildings were old and also in a state of decay, while toilet and ablution facilities constituted a health hazard.

"There were clear symptoms of the dehumanising conditions under which they are kept," the report says.

This week the gates of Westfort were thrown open to the Sunday Times by superintendent Dr Leandre Gauché. The only restriction placed on the afternoon-long visit was on photographing any of the 211 patients, 95 percent of whom are state certified.

Admission to the grounds is tightly controlled by a guard but there is no complete perimeter fence around Westfort's 356ha even though some of its patients have been committed for rape and murder.

We asked to see the worst conditions and were taken to ward five, for acute patients, on a road that almost required a four-wheel drive.

Like the rest of the hospital, aside from leper wards, it is not a ward at all but a collection of cottages and flatlets surrounded by a fence. The gate is locked only at 5pm, leaving patients free to wander almost at will.

This layout — intended for lepers and not mental patients — causes the most problems as nurses can not monitor patients.

Patients in ward five are heavily medicated and spend most of their time dozing under trees. Those we spoke to seemed cheerful and claimed to be content and well-fed.

We found extreme dilapidation but no signs of filth, or even litter.

Much of the paintwork is peeling so badly that the original colour cannot be seen and there is more raw plaster than paint.

Tiles in shower cubicles are missing and toilet cisterns are holed and rusty. Despite this, they are clean and working. There were clear signs of renovation work and fresh paint in other wards.

Some patients are dressed shabbily, but their clothes are clean and show fresh ironing marks.

Bed linen is scant but clean. Plastic-covered mattresses are ageing but hygienic.

The most disturbing thing the Sunday Times found — which was not mentioned in the report — was the outdoor arrangement for serving meals, common to all wards.

Food is prepared in a central kitchen and distributed throughout the hospital by lorry. Meals are off-loaded and served from an area covered only by a carport-like roof. Patients have no protection from the weather. They must collect their food and eat either outside or crowded into small, TV-equipped rooms where there are a few small tables and chairs. There is not enough space for the average of 50 patients to a ward.

At night, nurses and patients, groggy from medication, stumble over the uneven pathways in the dark. The overhead lights often didn't work, said the matron, Maryanne Evans.

Dagga abuse among patients was rife and impossible to stamp out, she said.

Patients had reacted by toyi-toying when the practice of rewarding them for garden work with cigarettes and tobacco was stamped out in line with Dr Zuma's anti-smoking policy. Smoking is now banned officially but patients obtain tobacco and roll their own cigarettes.

Ironically, Westfort is a victim of the new government's change in focus.

Before the elections, there were plans for a new hospital to house the mentally-ill, AIDS patients and lepers. Some of Westfort's land was to have been sold off to finance the project but it has since been put on hold.

Another project that has been put on hold would have seen buildings on the south side of Westfort demolished when a new road from Pretoria sliced through the property.

Limited resources in the hospital's budget, which has not been increased for five years, were spent elsewhere.

A quote for R6-million-worth of urgent renovations has been gathering dust on Mrs Evans's desk for months. There is no money for the work.

Dr Gauché said he had been begging for years for someone to inspect the poor state of buildings at Weskoppies and Westfort and attend to the lack of funds to fix them.

He had been delighted that investigators were finally on their way and had ensured they were shown the worst conditions at the hospital.

But he was devastated when the report apparently blamed him.

The committee chairman, Professor Tyron Pretorius, dean of psychology at the University of the Western Cape, said he had emphasised to Dr Zuma that massive injections of funds would be required

PEOPLE ARE LIVING THERE . . . Westfort psychiatric hospital was described as almost unfit for human occupation. We found it to be dilapidated but clean Picture: CHRIS COLLINGRIDGE

NEWS FOCUS

Funding gap highlights reason for mental hospitals' conditions

BD 28/2/96 (88)

Kathryn Strachan

A NEW study on the funding of psychiatric hospitals highlights the huge gap that exists between these institutions and general hospitals — a gap which explains the appalling conditions in psychiatric hospitals.

The review by Cape Town University's department of psychiatry found marked underfunding. "Adequate staff patient ratios cannot be provided at these funding levels, especially for inpatient units for psychotic patients, and it is not surprising that the safety of patients can no longer be guaranteed," says Karen Ensink, a researcher in the department.

The study focuses on the Western Cape, but its findings throw light on trends in other regions. While treatments at psychiatric hospitals are less expensive than at general hospitals (which perform expensive surgery, for example), many more nurses are required for supervision at psychiatric institutions.

Daily unit costs at inpatient facilities for the mentally handicapped are among the lowest, an average of R64. Unit costs at psychiatric institutions are about R100 to R120, whereas unit costs of psychiatric care in academic general hospitals tend to range between R180 and R220. Psychiatric unit costs are on average a quarter those of general health unit costs in academic hospitals and half those in secondary hospitals.

Average psychiatric unit costs are equivalent to unit costs at TB hospitals, which are generally recognised as requiring the lowest level of inpatient care.

The Western Cape psychiatric beds to population ratio of 61:100 000 falls far short of World Health Organisation recommendations for Western countries of 100:100 000 where no outpatient service infrastructure exists, and a minimum of 50:100 000 where there are these services.

Acute services

Contrary to international trends, in the Western Cape beds for short-term psychiatric cases are located predominantly in tertiary psychiatric institutions, rather than at general hospitals. Although international experience indicates that general hospitals can provide effective acute services there has been resistance to implementing this model locally.

The psychiatric bed occupancy rate of 87% is as much as 18% higher than the average rate for all other public general hospitals in the Western Cape and 5% higher than in academic hospitals.

Problems also emerge in the accessibility of outpatient services. Here, blacks make up only 4% of total attendances, and children and adolescents are distinctly underrepresented; only 18% of people attending outpatient or day facilities are under 18 years, while this group comprises 36% of the population.

During the year under review, mental health care in the Western Cape made up 8% of general health expenditure.

Ensink said that while it was imperative that community services were developed, resources for this development could not be released from institutional services without the risk of compromising psychiatric care.

It is important, therefore, that additional or interim funding be obtained for developing community services. These funds will not be required for capital expenditure, but for employing professionals who can provide training and supervision of primary care personnel.

Investing in primary care and community services is likely to result in a decrease in admission rates and may potentially open up possibilities for releasing personnel from institutions in the long term.

Mr R K SIZANI: Mr Speaker, arising from the Minister's question . . .

The DEPUTY SPEAKER: Order! You mean "reply". I hope the Minister did not put a question to you!

Mr R K SIZANI: Yes, arising from the Minister's reply, if the information that he has given us is correct, why is he instituting an inquiry into the fishing quotas and corruption under a judge?

The MINISTER: Mr Speaker, the hon member has not listened to the details of the investigation which has been instituted. The allegations investigated concern members of the quota board who are not qualified in terms of the Act—that is the allegation—to serve on the quota board. It has nothing whatsoever to do with public servants. [Interjections.]

The DEPUTY SPEAKER: Order! Are there any further questions? Mrs De Lille, are you happy?

Mrs P DE LILLE: No, Mr Speaker. I will engage the services of the *Mail and Guardian*. I think they will help me to get those names.

The DEPUTY SPEAKER: That is a great pity, because this is perhaps a better forum. Be that as it may, we have to be friendly to the press.

List of State assets

*7. Mr C A WYNGAARD asked the Minister for Public Enterprises:

(1) Whether her Department is compiling a list of all State assets; if not, why not; if so, when will the task be completed;

(2) whether such list is to be tabled in Parliament; if not, why not; if so, what are the relevant details:

(3) whether she will make a statement on the matter?

N256E

The MINISTER FOR PUBLIC ENTERPRISES:

(1) Yes. We are dealing with two aspects here, namely:

— State assets of a non-commercial nature; and

— State assets of a commercial nature.

In so far as the assets of a commercial nature are concerned my Department is compiling a list of these assets. With regard to what I might call physical assets, the responsibility lies with the Ministers of Public Works and of Land Affairs.

(2) Although it has not been requested by Parliament, I am willing to table it when the list is completed.

(3) No.

Business interrupted in accordance with Rule 199(3) of the Standing Rules for the National Assembly.

Prisoners: previous convictions

*9. Mr A J LEON asked the Minister of Correctional Services:

(a) How many persons currently in South African prisons had previously been convicted of other offences, (b) what percentage of the total prison population does this constitute and (c) in respect of what date is this information furnished?

N259E

The MINISTER OF CORRECTIONAL SERVICES:

(a) The figures in prisons country-wide are not readily available and can only be obtained through a time-consuming, expensive and manpower-intensive national survey. However, the following figures applicable to sentenced prisoners at three of the country's prisons have been made available in order to provide some perspective on the matter:

- Pretoria Local Prison — 571
- Pretoria Central Prison — 750
- Pretoria Maximum Prison — 192

(b) 57,5% of the total prison population at Pretoria Local Prison
67,3% of the total prison population at Pretoria Central Prison
61% of the total prison population at Pretoria Maximum Prison.

(c) Pretoria Local Prison — 96/03/18
Pretoria Central Prison — 96/03/06
Pretoria Maximum Prison — 96/03/06

Primary School Nutrition Programme: amount budgeted

*10. Mr M J ELLIS asked the Minister for Health:

(1) What amount was budgeted in the 1995/96 financial year for each child to be fed in terms of the Primary School Nutrition Programme;

(2) whether her Department and/or any provincial departments have established the actual cost per child of this programme, if not, why not; if so, what is the cost?

N260E

The MINISTER FOR HEALTH:

The following table reflects the situation per province and at national level.

(1) (2)

Province	*Average budget allocation per child*	*Average actual cost per child*
Western Cape	50c per child per day	Fixed allocation of 50c per child per day irrespective of actual cost
Northern Cape	88c per child per day	150c per child per day
Eastern Cape	53c per child per day in urban areas 68c per child per day in rural areas	61c per child per day
Free State	25c per child per day	25c per child per day
KwaZulu-Natal	55c per child per day	Fixed allocation of 55c per child per day irrespective of actual cost
Gauteng	88c per child per day	96c per child per day
North West	76c per child per day	58c per child per day
Mpumalanga	68c per child per day	Fixed allocation of 68c per child per day irrespective of actual cost
Northern Province	73c per child per day	73c per child per day
National Average	64c per child per day	71c per child per day

Health care: restructuring

*11. Mr M J ELLIS asked the Minister for Health:

(1) Whether her Department produced any documentation in 1995 in regard to the restructuring of health care in South Africa; if so, (a) what was the name of each such document produced and (b) on what date was each document released;

(2) whether such documents were made available to the Portfolio Committee on Health; if not, why not; if so, on what dates;

(3) whether the said Committee is being fully and timeously briefed in regard to such documents and other activities of her Department; if not, why not, if so, what are the relevant details?

N261E

The MINISTER FOR HEALTH:

Yes; (a) and (b).

(1) Restructuring the National Health System for Universal Primary Health Care (Draft); released on 19 June 1995.

(2) Position Paper on the Decentralisation of Hospital Management (Draft); released on 8 December 1995.

(3) Towards a National Health System (Draft), released on 3 November 1995.

Conditions in mental hospitals

*14. Mrs D GOVENDER asked the Minister for Health:†

(1) Whether she has been informed about the alleged appalling conditions prevailing in mental hospitals; if so,

(2) whether she intends taking any action in this regard; if not, why not; if so, what action; Hansard 20/3/96

Hansard 20/3/96

(3) whether she will make a statement on the matter?

N265E

The MINISTER FOR HEALTH:

(1) Yes. The Department of Health appointed a Committee to evaluate Mental Health Services with a specific instruction to investigate alleged human rights violations in mental health facilities. The report was submitted on 12 February 1996.

(2) Yes. Short-term measures include the development of remedial plans by the provinces to address management issues, investigation into allegations of human rights violations; consideration of close wards and/or facilities found unsuitable for patient care, finding suitable alternative accommodation for affected patients.

Medium to longer term measures include the development of norms and standards for mental health facilities including staff to patient ratios and patient management guidelines; appointment of Hospital Boards at facilities to oversee the management of such facilities; review of legislation governing mental health matters; review of resource allocation to mental health facilities; assessing the physical viability of building through the National Health Facility Audit; and taking appropriate steps to rehabilitate existing facilities or build new ones; review of contracts with private mental health care providers.

(3) Yes.

Shobashobane massacre

*17. Mr J A MARAIS asked the Minister for Safety and Security:†

(1) Whether the investigation into the Shobashobane massacre has been concluded; if not, why not; if so, (a) when will legal action be taken against guilty persons and (b) against how many persons will such action be taken;

(2) whether there is any evidence that the massacre was carried out for political reasons; if so, what are the relevant details?

N269E

The MINISTER FOR SAFETY AND SECURITY:

(1) No. The Shobashobane massacre occurred when approximately 2000 persons attacked residents at Shobashobane on 25 December 1995. 18 people were killed and 12 injured. A case of this magnitude requires extensive investigations. Numerous witnesses need to be interviewed and many leads need to be followed up. To date 109 suspects have been positively identified.

In addition, the investigations into the Shobashobane massacre have provided the police with numerous clues and leads relating to other murders and massacres which were perpetrated in the past along the South Coast of KwaZulu-Natal. The police have investigated these leads and as a result 23 additional cases involving the murder and massacre of 60 persons, are being investigated. Some of these incidents occurred as far back as 1992. 26 arrests have taken place in respect of these 23 cases and 81 suspects have been positively identified.

Some of the suspects in the Shobashobane massacre are linked to some of the 23 additional cases. The investigation into the Shobashobane massacre is therefore interlinked with the investigation into the 23 additional cases and will take time to conclude.

(a) and (b) Not applicable.

(2) It would not be proper for me to reflect on the nature of the evidence. If the Attorney-General for KwaZulu-Natal decides to prosecute, it will be up to the court to evaluate the evidence and to draw conclusions.

Government Departments: tender procedures

*18. Mr M F CASSIM asked the Minister of Finance:

(1) Whether tender procedures followed by Government Departments are still being strictly adhered to; if not, why not; if so, what are the relevant details;

(2) whether he will make a statement on the matter?

N270E

The MINISTER OF FINANCE:

(1) Yes. In terms of section 187(1) of the Constitution the procurement of goods and services for any level of government shall be regulated by an Act of Parliament and provincial laws, which shall make provision for the appointment of independent and impartial tender boards to deal with such procurements. Where Government Departments do not adhere to the tender procedures, such deviations will be reported by the Auditor-General. The accounting officer concerned will have to account to the Joint Standing Committee on Public Accounts.

(2) No.

Transfer of N3 to private sector

*19. Mr M F CASSIM asked the Minister of Transport:

(1) Whether his Department intends ceding 100% of the control, development and maintenance of the N3 to the private sector; if not, why not; if so,

(2) whether he intends taking any steps with a view to curbing possible frequent and inordinate increases in toll fees; if not, why not; if so, what steps;

(3) whether he will make a statement on the matter?

N271E

The MINISTER OF TRANSPORT:

(1) It is envisaged that government will grant the private sector a concession to design, build, fund and operate the N3 Toll Road for a period as agreed between the contracting parties.

At the end of the concession period the concession right will be handed back to government free of charge. Being a concession agreement it is important to realise that the road always remains government property. 100% control will not be ceded to the private sector as all matters regarding design, build, funding and operations are subject to government approval.

(2) The National Roads Act (No 54 of 1971, as amended) stipulates that toll fees and the adjustments thereto are subject to the approval of the Minister.

(3) No.

Prisoners injured accidentally

*20. Mr A J LEON asked the Minister of Correctional Services:

How many persons serving terms of imprisonment were injured accidentally in 1995?

N272E

The MINISTER OF CORRECTIONAL SERVICES:

3 136.

New postal code system

*21. Mr J A JORDAAN asked the Minister for Posts, Telecommunications and Broadcasting:

Whether any progress has been made with the introduction of a new postal code system; if not, why not; if so, (a) when is such system to be introduced, (b) what are the estimated costs involved and (c) what are the further relevant details?

N273E

The MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING:

The Managing Director of the SA Post Office Limited has informed me as follows:

Yes.

(a) At this point in time it is not possible to furnish an estimated date of introduction of a new postal code system. This can be mainly attributed to the fact that other Southern African countries are very keen to investigate the possibility of sharing in a common system with South Africa. A study in this regard has already commenced.

(b) It is very difficult to forecast the cost implications at this stage as the structure of the proposed new postal code system has not yet been finalised.

(c) The current system facilities outward but not inward sorting, i.e. the finer sorting of mail into postmen's walks. The opinion is that the new system should provide for inward sorting as well. For this purpose a five to six digit postcode would be required which would have a marked impact on the computer software of the present high speed sorting equipment.

Tara provides many mentally ill patients with the will to carry on

Star 15/4/96 (88)

By Winnie Graham

As a mother of five, Susan Morris (not her real name) believed child-rearing could hold no surprises for her

Yet when her daughter, Mary (17), started behaving in bizarre fashion she was puzzled. Why would a perfectly normal, lovable young girl suddenly decide that her friends were conspiring against her, that "they" were going to kill her and that she had been warned to lock every door in the house?

Almost overnight the terrified teenager withdrew into her own world, refusing to speak to anyone. When she would not go to school, Susan Morris took her daughter to their doctor – a man who had known her from childhood. He prescribed medication and though Mary returned to school for a time, the problem persisted. Sometimes she was reassuringly normal but when "voices" instructed her, she behaved very strangely indeed.

It took a long time for the family to discover that Mary had the cruellest of illnesses: schizophrenia. Reality hit hard. Shattered by the news, the family almost fell apart. A much-loved daughter had become a difficult member of the family. They did not know how to treat her. They knew nothing about the illness and wondered if she could ever be cured.

There seemed to be no ready information, no structured programme to assist families and certainly nowhere their daughter could go to learn a skill. Their orderly existence became filled with confusion and chaos.

Susan Morris tortured herself with feelings of guilt. Had she done something to cause her child's illness?

Then someone suggested they visit the outpatients' department at Tara Hospital and their life changed. For the first time, mental health professionals tried to help the family gain insight into its dilemma.

"I had become aware that mental illness carries a heavy burden of shame," Susan Morris says. "I couldn't even discuss the problem with a friend without feeling my child was considered mad. Not even the medical profession understands the anguish and turmoil families experience as a result of living with a mentally ill relative."

Health workers gave family insight

Mary is the victim of a tragic illness which invariably strikes without warning in adolescence or early adulthood. It is an illness which plunges 1% of the country's youth into a twilight world filled with scary shadows and strange figures, making it impossible for them to live a normal life.

At Tara the family finally found the support and help of a caring medical and nursing staff. Mary was assessed and placed on daily medication. Her condition improved slowly and the family finally came to terms with the fact that although she would probably never be "cured" as such, her condition was entirely manageable with the help of medication.

However, not all the problems disappeared. Mary is constantly frustrated both by her inability to find work and her lack of motivation.

"The money we once saved for her university education we have now set aside for a time when we will no longer be here to support her," Mrs Morris said. "That anxiety is constant. What will become of her when we die?"

Tara will be there to help, although there is no doubt that the 141-bedded institution, founded just 50 years ago this year, is under increasing pressure to assist the growing number of mentally ill people in Gauteng and beyond.

The hospital was built in 1938 as a family home by a man of Irish descent, Walter Tillett. He named it after a hill in County Meath, Ireland, where his family had come from.

In 1942 the government bought the property for £37 000 to be used as the inland command headquarters of the Union Defence Force. For a time it functioned as a plastic surgery unit run by the Red Cross but at the end of World War 2, 150 military psychiatric patients were transferred there.

Sanctuary ... at Tara hospital, built in 1938 as the home of an Irish businessman who named it after a hill in Ireland.

Dr Hymie Moross, who had enlisted in the SA Military Corps at the start of the war, was the first medical superintendent of Tara. He pioneered the concept of the psychiatric team. His ideas laid the foundation for the treatment of psychiatric patients in South Africa today.

The first matron was Iris Marwick, who instituted the SA psychiatric training diploma and was instrumental in starting courses in many aspects of mental health. Dr Alice Cox was yet another veteran whose laudable work was recognised when Wits University awarded her an honorary degree of Doctor of Laws.

The hospital today is staffed by a highly qualified and integrated multidisciplinary team consisting of psychiatrists, psychologists, social workers, occupational therapists and nurses. Schizophrenia is just one of a number of mental disorders treated at the biological unit.

Treatment for all by the year 2000

In fact, all conditions with an organic or biochemical cause, including anxiety disorders and depression, which can be treated primarily by physiological and pharmacological means, are referred to the unit.

There is also an adolescent unit where young patients with behavioural problems, diminished functioning and suicidal tendencies are helped, with a school on the premises for pupils to attend once their condition has stabilised.

A children's clinic catering for youngsters up to the age of 13 is run as a separate unit. Here, staff conduct a range of assessments including perceptual, developmental, intellectual, socio-emotional, psycho-educational and familial evaluations.

The Eating Disorders Unit offers two programmes: one for bulimic patients and the other for anorexic patients. The psychotherapy unit emphasises pyschosocial and emotional problems while the occupational therapy unit is seen as a holistic problem solving unit where each patient's problems are treated through purposeful activity.

Tara staff believe that the statement "health care for all by the year 2000" has decided implications.

"Firstly, everyone has the right to know how to care for his health and how to obtain assistance if needed, irrespective of religion, race or social status," they say. "Secondly, it presupposes a health system that supplies the individual with such information and a comprehensive health service which will provide for physical, psychological and social wellbeing."

■ Tara, the H Moross Centre in Hurlingham, Sandton, celebrates its 50th anniversary this year and as part of its celebrations will hold a tea party next month. But South Africa's foremost psychiatric hospital is not intent only on socialising. By inviting the public to visit on May 18 from 9 am to 12 noon, it wants to share its knowledge of mental health by giving a talk and inviting questions.

Staff shortage delays mental health revamp

(88) Star 26/4/96

By Janine Simon
Medical Correspondent

Action on poor conditions in psychiatric hospitals is being thwarted by staffing problems in both the Department of Health's Directorate for Mental Health and provincial health departments.

Minister of Health Dr Nkosazana Zuma promised immediate and medium-term action when, on February 15, she released a damning report on human rights violations – including physical and sexual abuse, poor health conditions and alleged malpractices – in some of the country's 33 psychiatric institutions.

But the head of the Directorate of Mental Health, Hlengiwe Mkhize, has since been seconded to the Truth and Reconciliation Commission, and three others have resigned, leaving it with only junior skeleton staff.

Gauteng is the only province to have a directorate of mental health and a clear policy on the issue. In other provinces, individuals at various levels of seniority are in charge of setting right the monolithic, isolated psychiatric institutions and integrating mental health – always the poor cousin of health care – into general health programmes and facilities.

"I can't argue about the delays, said Dr Harm Pretorius, deputy director-general in the Department of Health. "If your leader is not available, that's what happens."

The department had instructed the provinces to set up hospital committees to investigate the allegations and terms of the contracts held with private suppliers, and to report back last week, he said.

But, by yesterday only three – Northern Province, KwaZulu Natal and Gauteng – had replied.

Pretorius said responses from Northern Province and Gauteng were very positive, and he would be questioning other provincial heads of health about the delays.

Gauteng director-general for mental health Dr Ruth Zwi said that well before the report was released, the province had set its direction of moving from custodial care in large institutions to smaller, community-based care.

Private contractors Lifecare had been asked for a thorough audit of facilities; decision-making on renovations had been speeded up; significant work was being done on getting independent hospital boards in place; and the poor nurse-patient ratio, the surest indication of underfunding, was being addressed.

Squatters' kids need mental health services

(88)

CT 5/6/96

THERE IS an urgent need for mental health services in informal Khayelitsha settlements, says the Medical Research Council annual report tabled in Parliament this week.

ABOUT 19% of children and adolescents in informal settlements in Khayelitsha have diagnosable psychiatric disorders, according to a study by University of Cape Town researchers.

These include depressive, antisocial and anxiety disorders, researcher and clinical psychologist Ms Karen Ensink said.

The percentage in unserviced areas without shacks, running water or sanitation was higher.

The study, highlighted in the Medical Research Council annual report tabled in Parliament this week, showed an urgent need for mental health services in informal settlements, she said.

Only day hospitals, which were overcrowded, provided these services now.

The research indicated that 65% of children in the area suffered from symptoms associated with psychiatric disorders, she said.

Twenty-one percent of children between six and 16 were not receiving any schooling.

A total of 24% of families urgently needed food and 29% of the children in these families needed psychiatric help.

This constituted a larger percentage than in families that had food.

This reflected the importance of psychiatric services in informal settlements.

Mental health services in these areas were radically underdeveloped, she said.

Contrary to expectation, only three of the 500 people interviewed made use of traditional healers. This was mainly because the healers were very expensive.

Psychiatric disorder research had never been done on white South African children, project leader and University of Cape Town Professor of Psychiatry Brian Robinson said.

Following their research, UCT's psychiatric department arranged for R500 000 of British government funding to start the Empilweni project in Khayelitsha. It trains community members to provide child mental health services and informs people where they are available, he said.

Empilweni — started in 1994 — was a three-year "demonstration" project, at the end of which it would have to prove it had delivered a valuable community service to get the British to continue funding it.— Sapa

Half of Sou 'without se

BD 5/6

MELANIE GOSLING
ENVIRONMENT WRITER

OVER 21 million South Africans lack proper sanitation, and this could contribute up to 80% of the national disease burden, says Health Minister Dr Nkosazana Zuma.

Speaking at the launch of the National Sanitation Policy White Paper in the city yesterday, Zuma said the policy was strongly biased in favour of the rural poor, who had suffered diseases as a result of poor environmental health.

The policy document was the result of co-operation between six government ministers.

Water Affairs Minister Kader Asmal, who announced yesterday that his department had allocated R75m to sanitation, said it was "historic" to have a policy developed by so many departments.

"The simple building of toilets does not serve the purposes of

Teaming up to combat killer disease

ESANN de KOCK
Staff Reporter

RG 27/6/96 (88)

RESEARCH into the biggest killer of South Africans – heart disease – has been given a major boost with the establishment of a joint chair in heart research by the University of Cape Town and University College, London.

Announcing the venture at UCT this week, representatives of the two universities said they hoped to make inroads into the high incidence of heart disease and cardiovascular deaths in South Africa.

The collaboration, to be based at UCT, will focus on the problems of the enlarged heart – a condition afflicting all South African population groups.

In the black population group, the major cause of the condition is chronic hypertension (high blood pressure), while in other population groups the main cause is coronary artery disease.

Known as the Roche Chair of Cellular and Preventative Cardiology, the research project boasts a R2,5-million sponsorship during five years by Roche Products in the United Kingdom and South Africa.

It will aim to sustain a first-rate research facility at the UCT Heart Research Laboratories and to create a formal and unique collaboration between the heart research centres at the two universities.

The UCT laboratories, attached to Groote Schuur Hospital, have a long tradition of original heart research, achieving international recognition for their pioneering work after the world's first heart transplant operation by Chris Barnard.

● South Africa has one of the highest levels of heart disease in the world. An estimated 123 000 South Africans will die from heart and cardiovascular disease this year, and between 30 and 40 percent of the population are at risk of some form of cardiovascular disease.

SA society is 'most stressed'

(88) BD 5/8/96

SA HAD one of the most stressed societies in the world, said the Psychological Society of SA in a report released yesterday.

Society president Theo Veldsman said there were worrying and unmistakable signs that the psychological wellbeing of South Africans was under severe threat.

The society called for the urgent implementation of a national strategy to deal with the problem.

Veldsman said the society would forward its proposals for a national wellbeing strategy to the health ministry.

"The South African society is one of the highest, if not the highest, stressed societies in the world," Veldsman said.

He said this was manifested in the frequency, severity and widespread occurrence of acts of violence and aggression, child and substance abuse, family breakdowns, depression and lifestyle diseases.

Veldsman identified the most important sources of stress as:

- The cultural and sociopolitical transformation occurring in SA.
- The process of working through the many past injustices, traumas and guilt.
- The realignment of individuals and communities with the new dispensation.
- SA's transition from a developing to a developed country.

He explained that urbanisation, unemployment and the constant need to adapt emotionally to change, caused most of the insecurity, anxiety, stress and distrust.

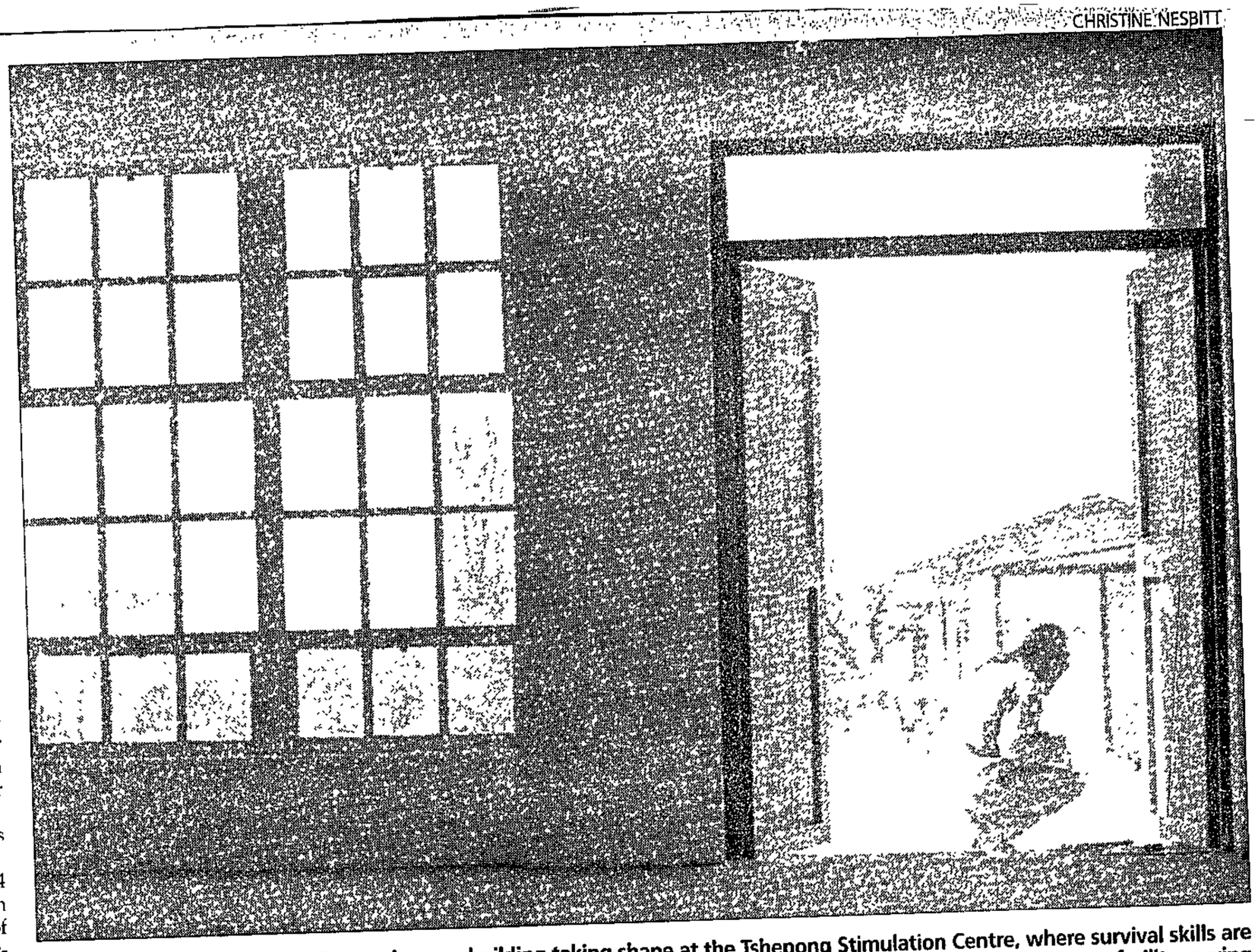
Veldsman said these provided fertile breeding grounds for psychosocial pathology.

The situation was exacerbated by a shortage of psychologists and government resources and skills for dealing with the problems, Veldsman said. — Sapa.

Mental health project gets hard-earned new centre in Katlehong

(88)

By Audrey Sekwakwa



CHRISTINE NESBITT

An artisan adds finishing touches to the new building taking shape at the Tshepong Stimulation Centre, where survival skills are taught to mentally handicapped children. Under the guidance of a former nursing sister, the centre has grown into a facility serving 35 children. The old building can be seen in the background.

Star 19/8/96

When Nonhlanhla Ngwenya (10) from Katlehong first went to school, she could not speak or walk. She was very reserved and would not play with other children. She is severely mentally handicapped.

She was 6 years old when her parents brought her to the Tshepong Stimulation Centre in Katlehong to be taught self-help skills.

Today, with the love and training she received from Sister Doreen Semelane and the other teachers at the centre, Nonhlanhla is happy and has adjusted to her handicap.

She can play sports such as ball throwing.

She recently joined the 34 other children from the centre in singing joyously as a token of their appreciation to the Germiston Rotary Club and Gauteng Mental Health Society for building their new centre.

Semelane, the project co-ordinator, said she was a nursing sister at Natalspruit Hospital when she realised in 1981 that mental health services were sorely needed.

She was especially concerned about the children who needed care and facilities.

So she started the Zimeleni project, meaning "Be Independent", and the hospital gave her the use of a room where she worked with the children and their parents.

She depended entirely on the hospital for therapy facilities.

A year later, after realising that the project would be a long-term one, she decided to take it out of the hospital to Katlehong, where she was offered a church hall which was falling apart.

Tshepong Stimulation Centre was established in 1986 when Semelane realised Zimeleni did not cater for the severely mentally handicapped.

Facility had inauspicious start in one room at a hospital

The project was then located in a two-roomed building in Katlehong next to a dumping area, which was hopelessly inadequate, short of equipment and too small. So she launched a project to upgrade and expand the facility.

Through a friend, Semelane was introduced to the Rotary Club of Stockpot-Lamplighter in England which had a branch in Germiston. The Germiston branch undertook a study of the community's needs.

Donations from South African Breweries and the Development Bank of SA gave the project a financial boost.

Apex, a skills training centre for the unemployed, trained about 144 builders who helped to put up the new centre.

The project resulted in a well-equipped building. It consists of a north wing with four therapy rooms and toilets, a south wing with four therapy rooms, as well as toilets and offices.

These two wings are connected by the west wing, which has a kitchen and a dining hall.

Now there are 8 therapy rooms, dining hall, offices and kitchen

Above each door, a donor's name has been written to show the centre's appreciation.

The centre has always relied on donations from the private sector to run projects and to pay salaries.

Semelane said the centre was using the Gauteng Mental Health Society's fundraising number to raise funds.

"We do not get government funding but I have applied to the Nelson Mandela Children's' Fund for a donation and I am looking forward to a positive response.

"We also hope to get funds from the Reconstruction and Development Programme, the Government and private companies for the running costs and salaries, and to be able to employ more teachers and accept more children at the school," said Semelane.

'No reason why mental health care should not be widely available in SA'

Star 9/10/96 (88)

By Janine Simon
Medical Correspondent

There is no reason for mental health care to be the preserve of the wealthy, nor any excuse for public health systems to ignore the challenge of making such care widely available, says Dr Ruth Zwi, Gauteng's director for mental health.

Speaking at a press briefing held ahead of International Mental Health Day tomorrow, Zwi said between 15% and 20% of any population experienced some form of psychological problem, and one to three percent suffered severe psychiatric disorder.

However, most health systems ignored mental and emotional aspects of health, despite the fact that prevention and treatment was effective and affordable.

Zwi, the only provincial director of mental health in the country, said the Gauteng directorate was working to integrate mental health services into the primary health care system and aimed to use October 10 to alert the public to provincial sector resources.

The department was encountering problems, for example in attracting psychiatrists to fill newly-created posts at the regional hospital level.

Fifty nurses had been trained in mental health care, and out-patient psychiatric services in underserved areas extended.

A pilot lifeskills course for people working with children at risk would be launched next month.

New clinic services for children and adolescents had opened in Krugersdorp, Sebokeng, and Vereeniging, and admission facilities for acute psychiatric patients were being created in each of the province's five regions.

Zwi said the directorate was shifting emphasis from psychiatric-based care in large institutions to community-based facilities, and had increased funding to NGOs from R8,3-million in 1995 to R12,6-million this year.

In underserved areas, residential capacity had increased by 20%, and capacity for day care patients from 350 to 750 patients. There had also been a 12% drop in the number of subsidised "places" which were in residential institutions.

Zwi said there was now a real possibility of closing Pretoria's Westfort Hospital, a former leprosy hospital.

Medunsa and Pretoria University had agreed to revamp Westfort as a joint training centre for acute psychiatric cases, and the goal now was to return patients to their province of origin or find alternative accommodation, she said.

NEWS

A refuge tries to break down walls of ignorance

'See for yourselves' at hospital festival

ARG 18/10/96 (88)

JENNY VIALL
HEALTH REPORTER

The white-haired elderly woman, frail and tiny in her chair, holds the doll close to her, cradling and talking to it.

Others hug their teddy bears, cuddling them tenderly. It's a touching sight and one that remains long after we visit Alexandra Hospital, home to about 630 profoundly mentally-retarded people.

It's an image that's hard to reconcile with the high barbed-wire-topped walls that surround the sprawling grounds of the hospital in Maitland. But I'm told the walls are to keep people out rather than keep people in.

Showing me around the hospital are head of nursing services Herman Ellis, superintendent Linda Hering and Raymond Moore, chairman of the Friends of Alexandra Hospital.

The mentally handicapped are the stepchildren of psychological services, says Dr Hering. And a society which is materially and intellectually exclusive has shunned them.

To ease our discomfort they are put behind high walls, out of sight and out of mind.

And then, because they have been removed from society for so long, we no longer know about them, and their isolation contributes to the mystique and fear that surrounds them. That all has to change, says Dr Hering, and the mentally retarded must become part of mainstream society as far as possible.

To open up and celebrate its 75th year as home to mentally handicapped people, Alexandra Hospital is holding a festival on October 19. "We ask that the people of Cape Town come to see for themselves," says Dr Hering.

Alexandra Hospital is for the severely retarded, people with IQs below 30 or with severe behavioural problems.

"Our aim is to get people as independent as possible in the activities of daily living, and feeding yourself and going to the toilet on your own are two important goals," says Dr Hering.

■ The Alexandra Hospital's festival is on October 19 from 9.30 am. There will be a beer festival, band, dog show, puppets, fire department display, Scottish country dancing, a craft market and a fun run. There will also be an art exhibition and the mill will be open. For more information contact Ray at 511 3878 or 589 326.

ROY WISLEY

Helping hand: superintendent Linda Hering with a resident at Alexandra Hospital. The institution celebrates 75 years as a home for the mentally handicapped

Ray of hope for the handicapped

(88) Star 22/10/96

On a dusty afternoon in Skhosana Section in Katlehong on the East Rand, a new era dawned yesterday for mentally handicapped children in a township which, until two years ago, knew nothing but violence and bloodshed.

The launch of the Tshepong Stimulation Centre has raised hope for the 50 mentally handicapped pupils who, were it not for the construction of the centre, would be left to vegetate at home.

The centre was established through a R250-million job creation programme initiated by the National Economic Forum (NEF) and incorporated into the National Public Works Programme.

The NEF funded the development of phase one to the tune of some R1,6-million – R536 760 for skills training and R1 064 664 for capital – which has seen the construction of therapy rooms, dining facilities and staff offices. – Political Correspondent.

NGOs give support to psychiatric facilities

BD 30/11/97 (88)

Kathryn Strachan

IN A cramped Zozo hut adjoining Soweto's Orlando health care clinic, nurse Florence Makobanyane treats almost 900 schizophrenic patients each month. The facility never sees a doctor, and she is the only nurse available to support the overwhelming number of severely disturbed patients.

Orlando is one of the six Soweto clinics with a psychiatric service. Under very similar conditions, the psychiatric facilities treat more than 5 000 schizophrenic patients in the township.

Without adequate staff and faculties, there is no one to follow up and check that patients are taking their medication — which means they very often relapse into psychotic episodes.

As the health department's scarce resources allow for very little in the way of community-based psychiatric services, the task has fallen on the nongovernmental sector to fill the gap. In Soweto clinics, the state has provided the facilities and the medicines, and nongovernmental organisations such as the Talisman Foundation, raise funds to pay nurses' salaries.

Clinical psychologist Alison Newton, who runs the Talisman Foundation's outreach into Soweto, said the focus was moving towards rehabilitation and integrating patients into the community, rather than the situation where patients were locked up and given medication.

She said attempts were now being made to establish daycare workshops to give patients sheltered employment and allow them to become self-sufficient.

Foundation psychiatrist Frans Korb said that while business had accepted physically disabled people, it was still closed to the mentally disabled world, and it was only through raising awareness in the business sector that the stigma attached to mental illness would go.

Truth body to probe medical profession

Stephen Laufer

THE role of doctors, nurses and other medical staff in perpetrating, colluding with or preventing human rights violations under apartheid would be the subject of a special truth commission hearing in mid-June, commissioner Wendy Orr said yesterday.

One of the special submissions planned was on the death in detention of black consciousness activist Steve Biko in 1977. Two doctors called in to examine him were found guilty by the SA Medical and Dental Council of professional misconduct.

The council and the Medical Association of SA (Masa) had employed researchers to go through their archives and help draw up submissions. BD 30/11/97

The Democratic Nursing Organisation of SA and the Psychiatric Association would make submissions, as would the national department of health. Individuals were also invited to make submissions, Orr said.

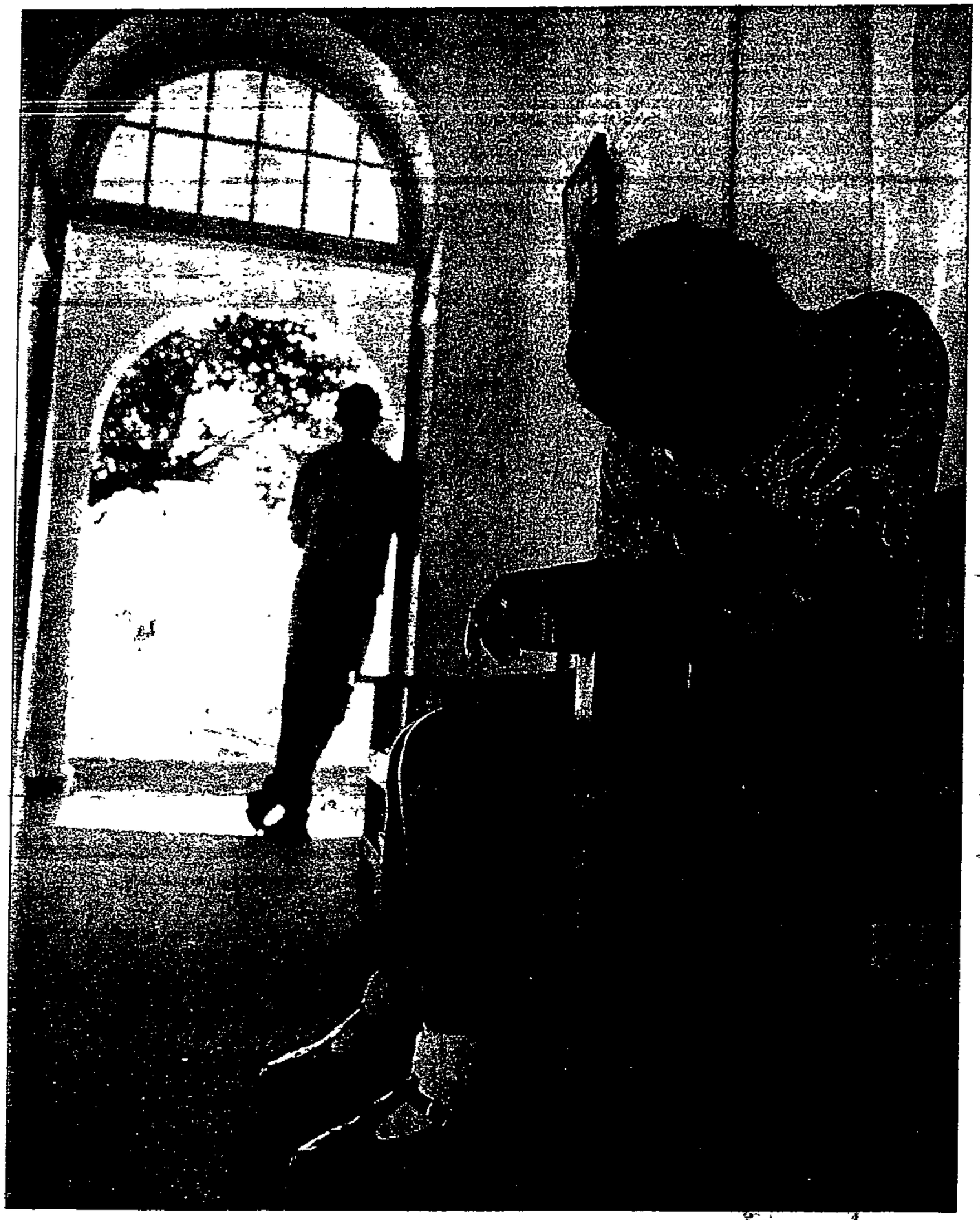
The willingness of a wide range of medical organisations to co-ordinate submissions to the truth commission stood in marked contrast to the failure of journalists to agree on how to examine the role of the media under apartheid.

Orr praised Masa for recruiting doctors willing to provide free treatment to victims of violations. Referrals were made by the commission's Cape Town office.

Comment: Page 11

Hospital sends patients home

CT 12/3/97



GOING HOME: This young patient is excited about leaving full-time hospital care and living with her family. Health Department budget cuts and a worldwide trend to get mentally handicapped people out of hospitals means a greater burden will fall on their families. PICTURE: GARTH STEAD

A PSYCHIATRIC hospital is to send more than 100 patients home next month to cut costs, a move that will also launch a programme to encourage all South Africans to look after the mentally handicapped.

The 1997 Budget to be announced in Parliament today will highlight the need to cuts costs in this way as the state battles to balance reduced spending with massive demands for better education, health care, housing and safety and security.

The Alexandra Hospital in Maitland is to reduce its patient numbers from 604 to about 500 as a direct response to budget cuts in the national health service.

Yesterday Dr Linda Hering, the senior medical superintendent of Alexandra, said opening institutions to all races had pushed the demand for places in the hospital much higher.

"Care for black patients, especially in the Western Cape, was non-existent before," she said.

To cope with the growing pressure and budget cuts, Alexandra would now serve mostly mentally handicapped patients who were also mentally ill.

This meant healthy mentally handicapped patients, for example people with particularly low IQs, would be entrusted to their families unless they developed psychiatric disorders.

Priority would also be given to retarded patients who were physically disabled and needed full-time nursing.

"Last year, our hospital received no extra funds from the government, even though it was operating with only 40% of the staff it needed to provide a safe level of care to all patients," Hering said.

Patients sent home would be able to "check in" again for a month to give their families a break.

There also would be regular group therapy sessions to help families cope.

Hering said there was a worldwide trend away from placing retarded patients in institutions.

"In the past, mentally handicapped patients were an embarrassment to society and putting them in institutions kept them out of the public eye."

Now it is believed these patients are integrated into society more naturally if they are surrounded by their families and "normal" life.

An independent psychiatrist said the new approach was unavoidable because of a shortage of funds, but it would have a devastating effect on many families who would not cope with the added burden of a handicapped relative.

"These people need to be watched 24 hours a day and usually it is a wife, mother or sister who has to leave her job to fulfil this care-giving role.

"For a family that needs two incomes to survive, it can be economically devastating and a major upheaval in day-to-day life."

This could expose the patient to abuse, especially if his or her presence was resented.

Although "de-institutionalising" was a growing international trend, many mentally handicapped people had been found on the streets as vagrants, unwanted by their families and unable to fend for themselves.

Dr Elizabeth Peter, a psychiatrist at Alexandra Hospital, said there had been "wide resistance" among families to taking responsibility for handicapped relatives.

"Some people are being fairly resourceful about how they are going to deal with the situation, while others have just resigned themselves to it."

Hering said the decline in the number of nurses at Alexandra and other institutions meant the incidence of abuse among patients could rise.

"The less handicapped sometimes abuse the more handicapped patients — we don't have the staff to watch people every moment of the day."

For patients to gain any real benefit from being in an institution, one nurse was needed for every eight patients. At the moment, this figure was 1:20 during the day in some wards and 1:40 at night.

"This is difficult nursing because your patient never gets better. Staff with too heavy a load can — and do — suffer from burn-out."

NEWS

120 mentally-handicapped patients sent home

Hospital asks parents to take children back after more than 20 years

(88) (88) ARG 27/3/97

JENNY VIALL
HEALTH REPORTER

About 120 mentally-handicapped people face an uncertain future when they are discharged from hospital next month into the care of their families – many of which cannot or do not want to care for them.

But the superintendent of Alexandra Hospital in Maitland, Linda Hering, says the institution is no longer a safe haven for mentally handicapped people. She says appalling conditions exist, with patient-on-patient abuse common, and wards that are overcrowded and understaffed.

Dr Hering told patients' families yesterday that there was sometimes one nurse on duty for 37 patients. There are 220 nurses out of an optimum number of 550, and with budget cuts and retrenchments there is no relief in sight.

The hospital has given notice to families that 122 patients (of a total 604) will be discharged on April 30. At an emotionally charged meeting, parents, siblings and other family members spoke of the hardships they would face if patients were to live with them.

Patients being discharged are under 50 and are "high functioning" people – those with lower than average IQs, but able to carry out basic human functions – who have called Alexandra Hospital home for 20 to 40 years. Many parents are elderly and frail and say they cannot look after their adult children. Distraught family members have made an impassioned plea to the people of Cape Town to not close their eyes to the plight of the mentally-handicapped.

Earlier this century parents with mentally-handicapped children were advised to institutionalise them and forget about them. This happened in many cases and of the 122 patients, about 20 have no traceable relatives. Parents were also not required to contribute financially. It costs about R3 300 a month to keep a person at the hospital.

But Dr Hering assured parents no patients would be put out on the streets and left to fend for themselves.

Group homes for mentally retarded

(88) CT 24/4/97

ESTABLISHING group homes for retarded patients the health system can no longer afford to keep in hospital is seen as essential by the provincial health department. **CAROL CAMPBELL** reports.

GROUP homes accommodating some of the mentally handicapped patients who will be discharged from the Alexandra Hospital, a psychiatric home in Maitland, at the end of the month have been approved by provincial Health MEC Mr Ebrahim Rasool.

In a statement yesterday Rasool said establishing the homes was essential to helping the 97 patients concerned to integrate into the community.

The patients are to be discharged as part of a provincial programme to cut costs in the health service.

The Western Cape health budget was cut from R2,364 billion last year to R2,165 billion.

This means the province no longer has money to maintain the existing health system.

Details of the group home scheme have yet to be worked out, but hospital superintendent Dr Linda Hering said a proposal would be submitted to the state treasury.

Who would fund the homes, where they would be situated, who would qualify to live in them and who would staff them, were major details that had to be worked out over the next three months, she said.

"We have some spare beds and cupboards which could be used to equip these homes."

The outgoing patients at Alexandra were chosen because of their individual circumstances and the circumstances of their families.

They are being discharged to make way for "acute" patients who are physically disabled or mentally ill, as well as retarded.

"What we need now is the commitment of the patients' families to get these homes going — this is a workable compromise," Hering said.

It cost the state about R3 200 a month to "keep" a patient in a hospital at Alexandra full-time, she said.

"The current policy is that once a patient has been admitted for longer than three months the family's financial responsibility ends and the government pays."

If the group home concept works, this type of policy will have to be reconsidered because the hospital no longer has the money to support all mentally handicapped patients.

Rasool said a self-sufficient farm for the mentally handicapped was an option which also needed to be further explored.

Hering said the farm was an "ambitious plan" which could be developed over a number of years.

"For the type of person we are dealing with, the idea of seeing something like green peppers growing from seeds into a fruit could be very satisfying."

Rasool said there were 15 000 moderately to profoundly mentally handicapped people in the Western Cape, but only 3 481 beds in local psychiatric institutions — and only half of these were for the mentally handicapped.

● Some families who are upset with the hospital's decision to discharge patients have sought legal advice.

Mr Cyril Prisman, from the law firm Hofmeyr Herbsteins, said letters had been sent to Hering, Rasool and national Health Minister Dr Nkosazana Zuma, advising them of the families' concerns.

"Dr Hering was very co-operative, so we have not had to get a court interdict to stop this discharge, but we have sought legal counsel on the issue," he said.

One family member said the patients' basic human right to safety and shelter were being violated by the discharge.

"If this goes to court it will test the Constitution — let's hope it doesn't go that far."

DESPERATE: At the end of the month Pat Albrecht will have to find new accommodation for her autistic daughter Belinda-Ann, 28, because of a decision by a psychiatric hospital to discharge "healthy" mentally handicapped patients. *PICTURE: KAREN RETIEF*

Loving mom needs assistance

CAROL CAMPBELL

PEOPLE say there is nothing greater than a mother's love.

Mrs Pat Albrecht, a Muizenberg mother of three, has proved this by not turning her back on her autistic daughter Belinda-Ann, who lives at Alexandra Hospital, a state-funded home for the mentally handicapped in Maitland.

Belinda, 28, with 122 other mentally handicapped patients, is to be discharged from Alexandra on April 30 because budget cuts to the Western Cape health department mean the government can no longer support them.

"Surely the state has some responsibility to Belinda too. They've looked after her since she was 21 and now they are just pushing her out."

In future only the "very worst" mentally handicapped patients will be eligible for full-time state support and although Belinda cannot talk, go to the toilet unsupervised, bath or make herself a cup of tea, she does not qualify.

For Albrecht, the news of her daughter's pending "release" has been disastrous.

"Belinda needs to be watched round the clock. This means I will have to give up my career to take care of her," she says.

"I am not going to fetch her on April 30 — I can't bring her home and lock her in a room while I go to work."

Albrecht is a single mother. Her two healthy daughters, Tracey-Lee, 26, and Lee-Ann, 20, have left home, and except for her 81-year-old mother, Mrs Daphné Furter, she has no one to help her look after Belinda.

"Belinda's father left when she was two years old and my second marriage failed because I always had to put her needs first," said Albrecht.

The problem for Albrecht now is finding a place to take Belinda. The few homes who do take mentally handicapped adults are full and have waiting lists of more than 100.

Although Belinda has been in an institution for most of her life, her mother has fetched her every second weekend, phoned her every other day and tried to create a "normal" home for her two sisters.

"All I've ever asked is for her to be safe. I don't expect the state to teach her, just to keep her out of harm's way while I'm at work. I'll pay what I can but, please, somebody has to help me," said Albrecht.

Pinelands farm could solve psychiatric housing crisis

CT 24/4/97 (88)

HEALTH WRITER

A FARM where mentally handicapped adults could live and work could be the solution to a growing crisis in the Western Cape over where to place retarded patients who no longer qualify for full-time state care.

Budget cuts in the provincial health service mean 97 mentally handicapped residents of Alexandra Hospital in Maitland are to be discharged on April 30 to save the government money — a decision that has turned their families' world upside down.

Although other state-run hospitals for the mentally handicapped (Lentegeur, Stikland and Valkenberg) have not discharged any patients yet, Mr Arthur Willey, secretary for the Friends of Alexandra, believes it is a matter of time before they do.

"Everyone's watching Alexandra Hospital to see how this mass discharge is handled," he said.

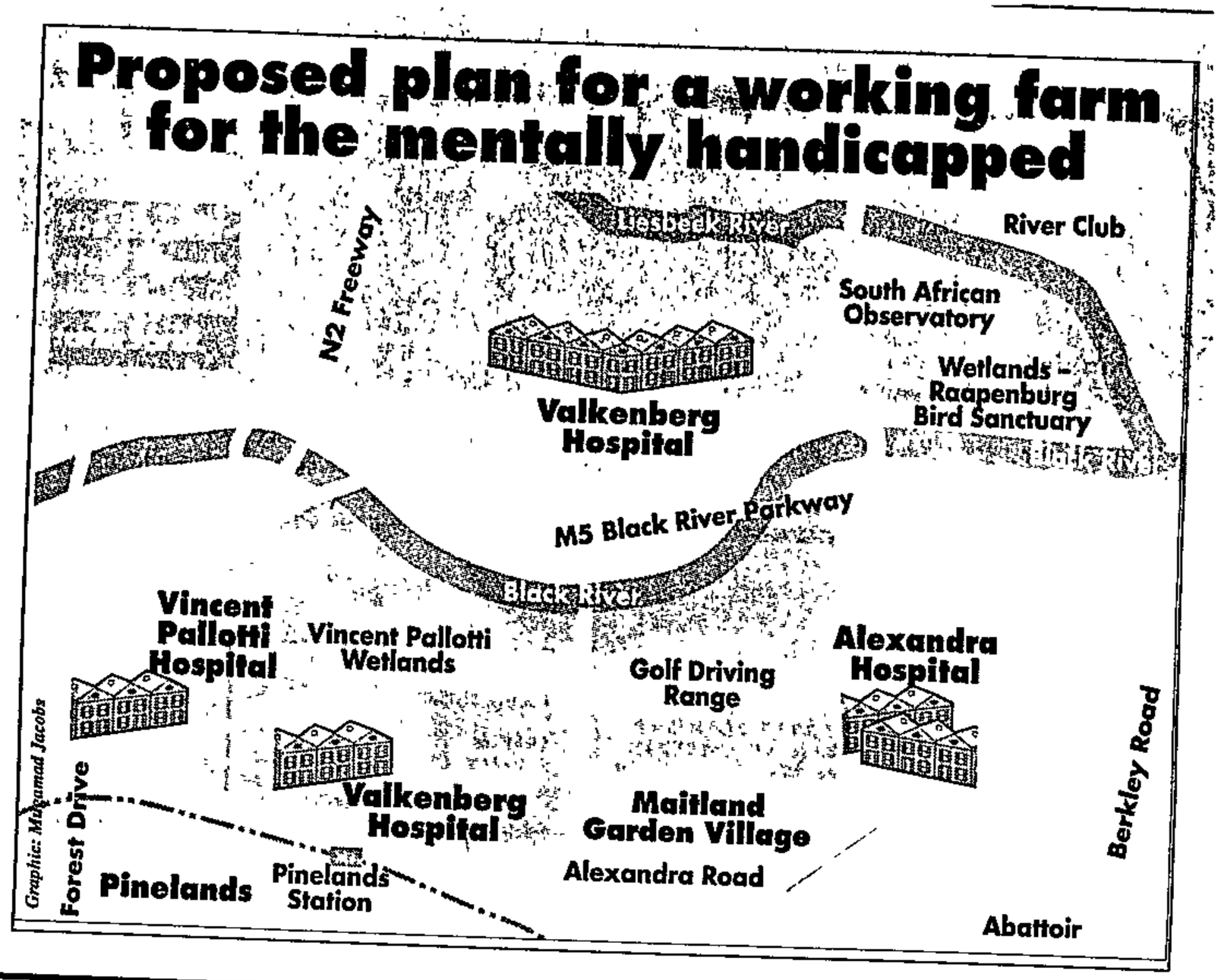
Willey is one of the main movers behind the farm project and has repeatedly asked the health authorities to consider it — so far without success.

"There is municipal land along the Black River near Pinelands, which is ideally situated for a working farm," he said.

The property was close to Alexandra and Valkenberg Hospitals, where many mentally handicapped patients are housed and could create up to 600 jobs for people who could never be accommodated in formal employment.

"The whole project will cost about R12,5 million to establish and could be self-sufficient once it's up and running," said Willey.

Meanwhile, the fate of the 97 Alexandra patients, some middle-aged, who are to be "returned" to their families at the end of the month is still uncertain. Some families are refusing to take them because they are a major disruption, nor do the families have the money to pay a nurse to watch them while they are at work.



Tobacco is a uniquely dangerous product which deserves unique treatment. It is the only consumer product that can kill when used exactly as the manufacturer intended. And there is no longer any doubt that tobacco causes death and disease on a very large scale.

Since the middle of the twentieth century, tobacco products have killed more than 60 million people. The death toll is also increasing not decreasing, with the bulk (70%) of future deaths from tobacco expected to occur in the developing countries which have become the focus of the multinational tobacco company's marketing efforts.

The World Health Organisation has labelled the tobacco epidemic a "global public health emergency" and has called upon governments, communities and individuals to "Unite for a tobacco-free world" and take concerted action to beat the epidemic.

Further, in 1992, President Mandela issued the following message:

"On May 31, World No-Tobacco Day, I appeal to smokers to quit for one day, as a first step to conquering their habit. They say the hardest part about stopping smoking, is making the decision to do it. Make that decision for one day on May 31."

I call upon all members of the National Assembly who smoke to heed the President's words and not smoke on May 31. Take the first step to beating your addiction.

The Department of Health is in the process of discussing and consulting about further legislation. It will probably be in Parliament next year.

Mentally handicaped patients sent home

*7. Rev K R MESHOE asked the Minister of Health:

Whether any hospitals are sending home mentally handicapped patients who still require care; if not, what is the position in this regard; if so, what are the relevant details? N1110E

The MINISTER OF HEALTH:

No, psychiatric Hospitals and Care and Rehabilitation Centres are undergoing a process of restructuring so as to render a more cost- and treatment effective service. Wherever possible, people have the right to live in communities rather than in institutions.

In line with this, certain hospitals have had patients assessed by multi-disciplinary teams, and where appropriate, people have been discharged to their families or other community facilities. In the majority of cases patients have been discharged to "half-way" facilities where rehabilitation programmes will continue, rather than being sent home.

Local authorities bankrupt/nearly bankrupt

*8. Mr A J LEON asked the Minister for Provincial Affairs and Constitutional Development:

(1) Whether any local authorities are (a) currently bankrupt or (b) facing bankruptcy during the course of 1997; if so, how many in each case;

(2) whether his Department has (a) allocated any funds and/or (b) developed any management plans to cope with the situation facing such bankrupt local authorities to ensure that services continue to be rendered in the areas of such local authorities; if not, why not; if so, what are the relevant details;

(3) whether he will make a statement on the matter? N1111E

The MINISTER FOR PROVINCIAL AFFAIRS AND CONSTITUTIONAL DEVELOPMENT:

(1) No. My Department is not aware of (a) any bankrupt local authorities or (b) any local authorities facing bankruptcy during the course of 1997.

(2)(a) No, my Department did not allocate, or budget, for any funds to cope with any bankruptcy which could occur.

(b) Yes, at a joint Finance and Local Government MINMEC on 19 September 1996, a Framework for Intervention Programme was approved. In terms of the above intervention framework, it is the responsibility of the MEC's for Local Government in the Provinces to appoint Management Audit Teams. These Teams conduct management audits in those local authorities who seem to have financial difficulties as identified by an ongoing quarterly survey conducted by the Department of Constitutional Development through Project Viability. On the basis of the findings of these management audits, the particular MEC is empowered in terms of Section 10(G)(2)(m) of the Local Government Transition Act to take corrective steps. This is an ongoing process which is being conducted in all provinces simultaneously.

(3) I have issued a comprehensive press release regarding the, Framework for Intervention Programme on 30 September 1996. A comprehensive document known as "The Present State of Municipal Finance and Action Steps taken by Government to Manage the Situation" has been distributed widely. A press briefing was held in Cape Town on 18 March 1997 where above report was released.

Brigadier involved in hitsquad activities

*9. Mr A J LEON asked the Minister or Safety and Security:

(1) Whether, with reference to his reply to Question No 6 on 6 March 1996, the investigation into allegations that a certain brigadier was involved in hitsquad activities in KwaZulu-Natal has been completed; if not, (a) why not and (b) when is it anticipated that it will be completed; if so, what were the findings;

(2) whether any action has been taken as a result of the findings; if not, what is the position in this regard; if so, what action? N1112E

The MINISTER FOR SAFETY AND SECURITY:

(1) Yes.

(a) Not applicable.

(b) Investigations have been completed in all cases:

Murder (7 cases were investigated) – The Attorney-General decided to prosecute.

Defeating ends of justice – Case docket currently with the Attorney-General for his decision.

(2) No, actions have been taken as yet as this office is still awaiting the Attorney-General's decision in the matter as mentioned above.

Doctors sent to SA at expense of Egyptian government

*10. Mr A G EBRAHIM asked the Minister of Health:

(1) Whether Egypt has offered to send doctors to South Africa at the expense of the Egyptian government; if so, what are the relevant details;

(2) whether this offer has been accepted; if not, why not; if so, what are the relevant details;

(3) whether the Egyptian government will pay the travel costs and salaries of such doctors; if not, what is the position in this regard; if so, what are the relevant details? N1113E

The MINISTER OF HEALTH:

(1) The Egyptian government has initiated a discussion with the South African government on this issue and the matter has not been finalized.

(2) and (3) fall away.

Mdlezana – a haven for child mental health

JENNY VIALL

Community caring: co-ordinator of the new Khayelitsha infant mental health centre Nosisana Nama with, left, Veliswa Mvumbi and her child Sinesipho and Nontsaba Mba with Zandile

JENNY VIALL
HEALTH REPORTER

It's a bare container, brightly painted, in Site C, Khayelitsha.

Inside, Veliswa Mvumbi and Nontsaba Mba sit on the floor playing with their babies. The container, near the Nolungile Clinic, houses the Mdlezana Centre, a parent-infant mental health centre which offers women support, counselling and group education.

It's a new centre, urgently needed to address mental heath problems in children.

A study done by the University of Cape Town parent-infant mental health service found major differences between problems of children from middle class homes and those from Khayelitsha. The study of infants and mothers who had been referred to the UCT Mental Health Service found that emotional and temperamental difficulties between mother and child were the most common problems found in the middle-class setting of the Rondebosch referral centre.

In this population, 75 percent of fathers were involved in the family to varying degrees.

In Khayelitsha, neurological damage and failure to thrive were the main concerns. Nearly half the mothers were teenagers and in 75 percent of cases, the father was not present in the family.

"One of the major problems that we needed to overcome was the fact that infant mental health is a concept that is entirely new to the local community where physical survival is often the prime concern," says Astrid Berg, a child psychiatrist who heads the service.

Services for the psychological well-being of infants are sorely lacking in South Africa and early intervention and detection is important to prevent later emotional and behavioural problems.

A breakdown in the mother-child relationship can start during early infancy with problems such as feeding and sleeping difficulties, excessive crying and communication disorders.

The emotional response by the mother to the baby is vital in the infant's development of its sense of self.

"There is no doubt that early emotional stress has overwhelmingly destructive effects on self-organisation, emotional reactivity, the ability to form relationships and motivation. The earlier problems are identified and dealt with, the less likely they are to become entrenched in fixed behavioural patterns and personality traits," says Dr Berg.

Weekly group activities at the centre such as sewing and handcraft bring mothers and infants together so their interaction can be observed and common problems shared.

The service gets no government funding and relies on contributions from patients. It has been established with support by Gerbers Purity, which also supplies cereal to the mothers. Mdlezana is in dire need of clothing, toys and financial assistance. If you can help, contact Dr Berg at 685 4103.

(88) Argus 2/5/97

The government plans to release psychiatric patients from state hospitals into the community, writes **Stuart Hess**

Thousands to leave mental homes

(88) (88) M+G 9-15/5/97

THE government is planning to shunt thousands of mental patients out of state-run institutions and into the care of their families and friends.

The Health Department said this week its fledgling, community-care programme involved closing hospitals and wards, and moving out many of the 10 000 to 15 000 mental patients currently under the state's care.

A two-year pilot project in the Eastern Cape and Kwa-Zulu Natal is already under way, with patients treated at the new clinics that form the central plank of the government's primary health-care drive. The scheme will be rolled out across South Africa should the pilot prove successful.

The initiative follows a similar drive in the United Kingdom and the United States, where savage cutbacks in state-provided mental care left tens of thousands of former patients on the streets or in prison.

The department's director for mental health and substance abuse, Mervyn Freeman, said this week that the British and American programmes "weren't run properly". However, the South African pilot programme would be overseen by experts from both countries.

The pilot programme would also throw up potential cost savings — the current budget for state-funded mental institutions stands at more than R756-million — although Freeman said cost-cutting was not the priority.

"Until we are sure of exactly how many can be moved it is difficult to determine how many beds are needed," he said.

"The department is in favour of moving people into community-care facilities wherever possible. Many people prefer the option of returning patients to the community."

The new clinic network would be called on to offer psychiatric care, and the government was also looking at establishing "halfway houses" and daycare centres for newly released patients.

Chronic patients would remain in state care, in institutions controlled for the past 20 years by the Life Care Company — now part-owned by the listed black empowerment group, Real Africa Investments.

Freeman said the programme formed part of a national plan to improve conditions at mental institutions.

Gauteng's Sterkfontein and Weskoppies have both been restructured, he said, while Westfort — roundly condemned in an official investigation last year — is to be closed. Other institutions remain below standard.

But serious concerns remain about the new clinics' ability to provide normal healthcare to their communities — many don't even have staff — let alone specialised treatment for mental health.

Overseas experience, where care-in-the-community policies have been associated with the worst excesses of Reaganism and Thatcherism, have also left independent experts anxious.

"We must learn from the US and UK experience and not rush into this programme," said Lage Vitus, national director of the South African Federation for Mental Health. It co-ordinates various mental health NGOs in South Africa.

The programme had several pitfalls, he said, not least the need for adequate training of clinic staff and education for families and communities. "The bulk of the work falls to members of the community, people who act as friends to support mentally disabled members of the community," said Vitus.

Freeman said much of this education would involve teaching families how to "deal with patients and to make sure they take their medication"

He added that a major obstacle was actually tracking down the families. "In some cases they are simply dumped at the institution and their families totally disown them."

Rhona Chetty, a social worker at the Aryan Benevolent Home in Durban, said more emphasis was needed on care in the community, particularly as institutional care was so expensive

But the state should also look at patients' functional ability before admitting them to mental homes.

"We don't need high-tech electronic security at the homes," she said. "It could be a place where people care for themselves."

Self-help: Patients at Zola help to make ends meet PHOTO RUTH MOTAU

Tara: The five-star experience

(88) (88) M+G 9-15/5/97

ON a hilltop overlooking Johannesburg's northern suburbs, Tara —the H Moross psychiatric centre — looks like a five-star hotel with well-groomed gardens and lawns, a nine-hole golf course, two tennis courts and a swimming pool

Behind the glitzy appearance is a hospital providing intensive treatment of mental illnesses such as schizophrenia, depression and anxiety disorders. It also deals with eating disorders like anorexia and bulimia.

"The enviroment provides a haven for those in psychological distress," says the 141-bed hospital's brochure.

Tara is presently at 80% capacity and also has 1 000 out-patients. A means test determines payments with a maximum of R258 per day for the first 30 days for long-term patients.

Built as a family home in 1938, it was transformed into an army headquarters during World War II. In 1945 it became a plastic surgery unit, and later a psychiatric hospital.

The hospital caters for patients as young as 12, and also has a child clinic. A children's ward is planned.

Ward 3 mainly treats teenage patients, such as Jenny (not her real name) who, when admitted three months ago for anorexia, weighed 34kg. "I don't want to be fat, I want to be thin, I want people to like me," she says.

An economics student, she describes the anorexic programme "as very hard".

Sophie, a 27-year-old former office secretary, is in Ward 1. She has been there for six weeks and says she believes she will be a bulimic until she dies.

But a few minutes later she says: "I believe there's a light at the end of the tunnel."

She adds: "I know I have a very low self-esteem and lack of confidence. The point of me being here is to get better so that I never come back".

Jane is a 23-year-old schizophrenic. "I felt my parents were against me and I reverted to taking acid which would send me on a six-hour trip," she says. "Sometimes I get a natural high, where I feel very warm inside and I think I have special powers."

Jane continues: "Nurses here are cool, they are very nice." Her treatment consists of group therapy where patients talk about their disorders and try to establish a "better understanding of ourselves".

Every comfort: Tara is a haven for the distressed PHOTO: RUTH MOTAU

Or Zola: Refuge for one day a week

M+G 9-15/5/97 (88) (88)

A FAR cry from the upper-class conditions and surroundings at Tara is the Zola Clinic in Soweto. Established ten years ago, the Zola clinic looks from the outside like a small shopping centre.

A three-metre high brick-wall with razor wire running around the top surrounds the building. A few faded graffiti, mainly old political slogans, are on the walls.

The functions of this primary health-care clinic include caring for up to 800 psychiatric patients a month, mainly schizophrenics and people suffering from depression. Struggling for finance, the clinic was recently able to carry out improvements — such as providing doors for the psychiatric ward's offices.

As part of the rehabilitation programme, patients take turns every day to clean the ward. Outside, young men work at making a small wooden bench for the ward.

'I like it here, it's quiet and I can paint'

Ernest (45) makes frames for paintings and photographs. "It helps me forget about my problems," he says, while showing how to spell his name. He is a schizophrenic but due to the treatment he has received at the clinic he is able to help himself, thereby earning "a few extra rand".

His friend Cedric (28) — also a schizophrenic — is painting "Mother Mary".

"I like it here, it's quiet and I can paint," he says. "My life has been very difficult but I feel happier when I'm painting."

Debbi Gould, a psychologist at the Zola clinic, believes the patients' families should become more involved with care.

"Some chronic patients should be treated by families and really sick ones should go to halfway houses during the day, where they can come closer to the community."

Gould says that institutions such as Tara can be "bad because patients are alienated from the community".

She believes that the patients and staff at the clinic use "space better" than at Tara. "There's not a rigid format here like they have at other institutions with better resources," she says.

Gould and the ward's head nurse, Dumi Masondo, stress the need for community involvement in the care of mental patients.

"We must make the community more aware that psychiatric patients must be treated with care and understanding," says Masondo.

She says they are paid very little by the government and have to earn their own money to offer proper facilities. "We need halfway houses and remedial schools because we have kids who can't go to normal schools," says Masondo.

What's the pattern for the future? Tara or Zola? Asked this, health department representative Mervyn Freeman said the government was focusing more on primary health-care clinics.

At the same time, hospitals like Tara were needed and would remain, he said.

NEWS

One city psychiatric hospital faces axe

1000 beds set to go as cuts bite

ARG 11/6/97

ANDREA WEISS
CITY EDITOR

Nearly 1000 psychiatric hospital beds face closure and one of Cape Town's four psychiatric hospitals could also be shut down under a rationalisation plan.

Health officials confirmed yesterday that the process, first mooted three years ago, has been speeded up because of budget cuts.

The four affected hospitals are Valkenberg, Alexandra, Lentegeur and Stikland.

A workshop has been convened to look at a dramatic reduction in psychiatric hospital beds from 3 453 to about 2 500 as a first step.

Alan Barnard, a deputy director in the provincial department of health, said the provincial rationalisation plan was to have been carried out over five years.

This plan was aimed at reducing the number of mentally handicapped patients who were institutionalised at psychiatric hospitals and reintegrating them into the community.

Because of the tight budget, however, this process had had to be speeded up because "we haven't got five years".

He said the first step in the rationalisation would be to reduce the number of beds, which could lead to the closure of one of the hospitals.

Mr Barnard said it made sense to consolidate services and not to run all four hospitals at 60 percent occupancy.

Dr Miles Bowker, a senior medical superintendent in charge of the process, said a first step was to look at a way of discharging "a significant number of patients".

He described the process as "very difficult and extremely sensitive" because of expectations created through previous health policies.

Dr Bowker said no hospital had been singled out for closure because each of them had "very strong reasons" why they should remain open.

On the issue of the large land holdings at Valkenberg and Stikland hospitals, Mr Barnard said there had been several approaches from interested parties wanting to acquire the land but any sale would have to be by public tender.

Mr Barnard said the land would not be sold unless the Western Cape and the health department would benefit directly.

Currently, the proceeds of state land go into national coffers and would not necessarily be disbursed back to the Western Cape.

MAIL & GUARDIAN
July 25 to 31 1997

M+G 25-31/7/97(88)

Mental health patient dies after isolation in Sterkfontein room

Mukoni T Ratshitanga

A WEST RAND mental patient died after being held overnight in a seclusion room during a recent cold snap. Frank de Kock, a long-term patient at Sterkfontein Hospital, was found next morning suffering from exposure and died hours later of pneumonia.

Staff at the hospital are dissatisfied and angry about the lack of official action over the death.

De Kock was admitted to Sterkfontein in 1993 with a diagnosis, according to health authorities, of "mental retardation and epilepsy". After a spell at Rand West Sanatorium he was returned to Sterkfontein.

Quite how he died remains a mystery. Gauteng's provincial health department refuses even to disclose De Kock's age, though it is thought he was in his forties. And details of the death might never have emerged if concerned employees at Sterkfontein had not spoken out.

What is known is that De Kock was put into a seclusion room at the hospital on the night of May 31. Apparently, other patients had been assaulting him and nursing staff put him in there for his own good.

Though nursing staff say they checked on him every half-hour through the night, De Kock was found to be suffering from hypothermia the next morning. He died early on June 1 from pneumonia in nearby Leratong Hospital.

"The cause of death was deemed to be natural," said provincial mental health director Ruth Zwi this week. "No post-mortem was required."

Zwi added that De Kock had been a "profoundly handicapped man, always physically frail".

She said that a full inquiry had been conducted by management at Sterkfontein — the largest state-run mental institution in the province.

But several staff members said that they find it difficult to understand how a patient in the state's care 24 hours a day could contract pneumonia, and be left untreated to the point where intravenous antibiotics — which he was given at Leratong — could not save him.

They say it is also difficult to understand how, if De Kock was provided with blankets and constantly checked, he was found suffering from exposure. The seclusion room where he was kept, they note, is normally cool. The night of his seclusion was at the height of the cold snap that claimed at least six lives in Gauteng — although these victims were living on the streets.

No one at Sterkfontein, the staff members say, has been called to account for what looks like a preventable tragedy. "Society has an obligation to protect these people," says one senior staff member.

Other staff members believe many of Sterkfontein's nurses are not interested in working with mental patients: "They would rather work at an ordinary hospital where they wouldn't have as many problems."

CONTENTS

QUESTIONS

†Indicates translated version.

For written reply:

Hospitals: staffing/vocational training for medical doctors

493. Dr R RABINOWITZ asked the Minister of Health:

(1) Whether she and/or the Interim South African Medical and Dental Council has negotiated a mutually agreeable solution with the Junior Doctors Association of South Africa (Judasa) in regard to the (a) staffing of rural hospitals and (b) extended period of vocational training for medical doctors; if not, what (i) facilities will be made available to students for training at understaffed rural hospitals and (ii) training students will receive before working in such hospitals; if so, what arrangements have been agreed upon by both parties;

(2) whether incentives will be given to students to work in these hospitals; if not, why not; if so, what incentives;

(3) whether the time spent by such students in these hospitals will contribute towards specialisation; if not, what is the position in this regard; if so, what are the relevant details? N783E

The MINISTER OF HEALTH:

There are ongoing discussions in this regard.

New regulations regarding vocational training of doctors

523. Dr R RABINOWITZ asked the Minister of Health:

(1) Whether the South African Interim Medical and Dental Council has introduced new regulations regarding the vocational training of doctors; if so, what was her reaction thereto;

(2) whether the Junior Doctors Association of South Africa (Judasa) has opposed these regulations; if so, what are the relevant details;

(3) whether Judasa has (a) recommended that the full two years of generalist vocational training contribute to a general practitioner's specialisation period and (b) requested that further negotiations take place in order to reach consensus; if so, what are the relevant details;

(4) whether she has responded to the above recommendation and/or request; if not, what is the position in this regard; if so, what was her response in each case? N864E

The MINISTER OF HEALTH:

(1) No regulations have been introduced by the Interim National Medical and Dental Council of South Africa.

(2) Not applicable.

(3) (a) No. The Department of Health did not receive any recommendations from Judasa regarding full two years of generalist vocational training, contributes to a general practitioners specialization period.

(b) The Department of Health is not aware of the request.

(4) Not applicable.

Foreign doctors: lifting of moratorium on employment

525. Dr R RABINOWITZ asked the Minister of Health:

Whether she has endorsed the lifting of the moratorium on the employment of foreign doctors, other than Cubans and Germans, from areas outside Africa; if not, how does she intend attracting first-world doctors to South Africa; if so, according to what objective criteria will foreign doctors be registered? N866E

The MINISTER OF HEALTH:

No. There is a specific agreement with the United Nations Development Programme (UNDP) for "UN Volunteers Support to the Health Sector in Rural Areas."

Mental institutions: ongoing audit

724. Mrs J N VILAKAZI asked the Minister of Health:

Whether there has been an ongoing audit of mental institutions as promised in the Report on Mental Health; if not, why not; if so, what were the findings? N1268E

The MINISTER OF HEALTH:

A number of processes have taken place with respect to auditing mental institutions, while other processes are currently taking place.

1. All State psychiatric facilities were audited during 1996 as part of the detailed physical facilities audit undertaken by the Health Department. A number of psychiatric hospitals and/or wards were found to be in a poor and even condemnable condition. (See Appendix A)

   In certain instances where conditions were extremely poor, alternative arrangements have been, or are being, made. For example, Westfort hospital in Gauteng will be closed. Patients have been moved from psychiatric wards in the Northern Province where conditions were considered inhumane and other wards in this province will be closed soon.

   In some circumstances patients have been moved to community facilities, thus reducing overcrowding.

2. A study to determine norms and standards for psychiatric care, including psychiatric hospitals, has been commissioned by the Department. The results of this study will provide information regarding input measures such as staff-patient ratios and acceptable quality standards.

3. Six hospitals (2 each in Northern Province, KwaZulu/Natal and Gauteng) are currently undergoing detailed assessment with regard to quality of care and rehabilitation programmes provided. Cost and efficiency of management are also being evaluated.

   Preliminary findings indicate that chronic care tends to be custodial rather than rehabilitative, and quality of care requires a number of improvements.

   Once the results of this study have been evaluated, the instruments used will be assessed regarding their feasibility and effectiveness for ongoing routine evaluation of all psychiatric hospitals.

Upgrading of road in Thohoyandou district

821. Col N G RAMAREMISA asked the Minister of Transport:

(1) (a) What progress has been made with the upgrading of the road (i) from Tshililo-Duthuni to Phiphidi along the Phundamalia Road and (ii) from Phiphidi via Gondeni to Vhufuli in the Thohoyandou district, Venda, (b) what was the date of commencement of the upgrading project, (c) when will the project be completed and (d) (i) to what tenderer was the contract awarded and (ii) on what grounds was the contract awarded;

(2) whether the upgrading of the said road has been budgeted for; if not, why not; if so, what amount has been budgeted for the project;

(3) whether he will make a statement on the matter? N1445E

The MINISTER OF TRANSPORT:

The roads listed by the hon Col. Ramaremisa are Provincial Roads. Upgrading and maintainance of all provincial roads is therefore a provincial competency. (Schedule 5: Functional Areas Of Exclusive Provincial Competence – The Constitution of the Republic of South Africa, Act 108 of 1996).

My department has requested the answers to the hon member's questions from the relevant authorities and they will be forwarded to the hon Col Ramaremisa as soon as they are received by my office.

I will not issue any statement on this matter.

National Industrial Participation Programme

910. Mr D DE V GRAAFF asked the Minister of Trade and Industry:

What are the details of the Government's National Industrial Participation Programme as approved by the Cabinet in September 1996? N1560E

The MINISTER OF TRADE AND INDUSTRY:

Cabinet approved the principle of implementing an Industrial Participation Programme in September 1996. Cabinet approved the Programme and its operating guidelines on 30 April 1997.

The Programme utilises the instrument of Government Procurement to leverage economic benefits for South Africa. All suppliers selling to all levels of Government will be obliged to participate in the South African economy if the contract has an imported content of R45 million or greater. The types of commercial arrangements that are encouraged are investments, joint ventures, export promotion, sub-contracts and technology development. All these arrangements must be mutually beneficial to the seller and to the South African economy.

The Industrial Participation Obligation is equal to 30% of the imported content i.e. the seller must generate economic activities such as turnover, job creation, training, R&D and exports that equal or exceed the 30% obligation.

A financial model has been developed to evaluate business projects on their viability and the economic value relative to the Industrial Participation Obligation.

Over 100 countries practise Industrial Participation in one form or the other.

The Industrial Participation Secretariat, which manages the Programme, is currently negotiating with approximately 30 companies covering 8 projects.

They have concluded six contracts that commit companies to business plans and performance plans. The companies involved are General Electric, Ericsson, Altech-Alcatel, Lucent Technologies, Thompson CSF and Rolls Royce.

MISCARRIAGES OF JUSTICE 'POSSIBLE'

No fixed sentences at the 'Blue Sky Hotel'

CT 9/9/97

(88)

A PRISONER IN JAIL can count the days until the end of his sentence, but for a state patient at Valkenberg Hospital there is no end in sight. Health Writer **CAROL CAMPBELL** reports.

BLUE Sky Hotel. That's the name patients have given to Valkenberg Hospital's maximum security forensic ward. Held between high walls, all they ever see is blue sky.

The forensic wards house mentally ill male patients who are believed to have committed a crime. The women patients are sent to Lentegeur Hospital.

Among them are murderers, rapists and thieves but, in terms of South African law, none of the patients is fit to stand trial.

Dr Sean Kaliski, the psychiatrist responsible for the patients in "forensics", does not doubt that many would be free men if they had had the chance to have their say.

"We usually have a very good idea of what happened and why they did it. The problem is that according to our law we are not allowed to reveal these to the court unless it has direct bearing on their mental state at the time.

"In other words, if we receive information and the people tells us categorically that they were defending themselves at the time we can't communicate this to the court (it is basically hearsay)."

In Pollsmoor a prisoner can count the days until the end of his jail time.

A convicted prisoner usually gets time off for good behaviour and is released at the end of his sentence without question for the safety of the community.

"Here no date is set for freedom. A patient is discharged when conditions allow and this could mean a wait of decades or even a lifetime."

Is there a chance an innocent man has been wrongly "sentenced"?

Kaliski says this could well happen.

He tells the story of a 19-year-old who latched onto a local gang and watched them collectively murder an opposing gang member.

"He was arrested with the others. In court his mother claimed he was mentally ill (hoping to save him from prison).

"Then he was sent for 30 days observation and we diagnosed schizophrenia and, following our recommendations, he was declared a state patient.

"His co-accused were released because the court could find no witnesses.

"He remained with us for four years. When we tried to discharge him the attorney-general insisted on comprehensive reports because he was charged with murder (even though we knew he was not directly involved).

"He was eventually discharged but really need never to have been admitted to the unit at all."

As the doctor walks through the courtyard, where the men are killing time in the afternoon sun, he is mobbed by patients who beg him to arrange their discharge.

"They see him as the one person who can get them out. He is their only hope for freedom," said chief warden Mr Ismail Cassim.

Getting into forensics is easy, says Kaliski, getting out is difficult.

"When someone is charged with a crime and accused of being insane he is sent here by the court for 30 days observation.

"If he is mentally ill he goes back to court and, often the same afternoon, is back as a permanent resident."

Two thirds of patients who are sent for observation are not mentally ill and go on to stand trial

PACIFIER: This man, a patient at Valkenberg Hospital's maximum security forensic ward, hears the voice of dead paedophile Gert van Rooyen in his head. He says that when he is released he will take the name "The Pacifier" and punish the world as it punished him mentally, physically and spiritually.

PICTURES: GARTH STEAD

Getting out, when it runs smoothly, takes over a year and involves a long process of psychiatric evaluation, a report from the medical officer and a report from the hospital superintendent.

The psychiatrist has to be sure the patient will have adequate supervision for two to three years after his discharge, is of no danger to society and will not take drugs and drink alcohol.

"It's impossible to make those kind of promises because you just don't know what's going to happen outside," says Kaliski.

Life "inside" is a human hell.

The building is designed like Pollsmoor Prison and hasn't been painted since it was built in 1976.

There are no windows so a heavy smell of human sweat and disinfectant hangs low in the gloom of the cells.

Posters pulled from magazines are "glued" to the walls with toothpaste, which is all the men have to make their "rooms" look like home.

Above one bed a patient has drawn tiny birds flying in formation. A sign of his dream to fly away?

"It's all aspirational stuff. It's what the good life is all about," says Kaliski of the posters.

Six to eight men share one room, although some of the longer serving patients have their own cells.

The average stay for a patient is three to four years but many have been there for over 10 years.

A shortage of beds means some patients sleep on the floor. There are no lockers or places to hide personal belongings.

Fish is their favourite meal, says Cassim. "Chips are too expensive so it's just fish."

Television, especially "skop, skiet and donder" movies and sport, help the men while away the endless days. They gamble at cards and dominoes and exercise is usually soccer.

They are dangerous and violent and this is made worse by the intense frustration of being cooped up in an environment that is not meant to heal.

Last week a doctor had her nose broken and for the nurses there is always the chance of an unexpected attack.

Cassim has worked in the ward for 23 years and in that time has seen delusional patients who believe they were anything from secret agents to the state president.

"Once we had two Jesuses and there was a terrible fight when they discovered each other.

"Both refused to accept the 'impostor' and they beat each other up."

There is also a man who believes the CIA are watching his every move via satellite and another who thinks he is the state president.

"He became very agitated when Mandela was made president because he believed he was being pushed out of his job."

Another patient twice broke into the Cape Town office of former state presidents and was found sitting in their chairs playing "boss".

He was eventually locked up in Valkenberg.

"A psychotic patient can come across as normal, but if you know which buttons to push very soon you realise you are talking to somebody who is sick," says Kaliski.

Every day, just like today, the men sit around the courtyard waiting until the sun disappears over the high walls and the blue sky turns to night.

There is nothing else to do but wait.

'POLITICAL' PATIENT: This patient in Valkenberg Hospital's maximum security forensic ward is a former United Democratic Front member who began hearing voices during a disciplinary hearing, and thought everyone could hear his thoughts. So he ended up in the ward known as the Blue Sky Hotel.

Valkenberg hospital set to close

ST (CM) 21/9/97 (68) (48)

YVETTE VAN BREDA

VALKENBERG hospital is set to close as part of a major cutback in psychiatric services.

The Western Cape's psychiatric institutions are only 60 percent full and there is pressure to reduce psychiatric services at the Department of Health's five institutions by 1 000 beds.

The cut-back decision, which still needs to be ratified by the health ministry, comes after a tortuous process of choosing between Lentegeur, Valkenberg, Stikland, Alexandra and Groote Schuur's G22 unit.

Valkenberg has 21 wards and serves 700 resident patients and about 1 000 outpatients a month.

The impending closure of the hospital is almost certain to provoke an outcry from environmental groups fighting to preserve one of Cape Town's last surviving greenbelts. The Liesbeeck and Black rivers run through the 44 ha site, which is estimated to be worth R100-million on the open market.

Logan Wort, spokesman for Health and Welfare MEC, Ebrahim Rasool, said the process of cutting back psychiatric services started three years ago and was meant to take five years. But it eventually had to be pushed forward because of severe budget pressures.

Chairperson of the standing committee on Health and Welfare, Lynne Brown, said the department had no other choice but to close one of the hospitals as psychiatric care was over-serviced.

Black River/Liesbeeck Confluence Alliance spokesman Ed Tilanus yesterday urged the city to draw up a policy plan for the area before any drastic decisions were taken.

"This is public land after all and the public should have a say before it goes to private use," he said.

The city had previously sold off stretches of Valkenberg land in the face of fierce criticism from environmental groups.

All four psychiatric hospitals to stay

ARCT 23/9/97

(88)

But land and beds must go

JENNY VIALL
HEALTH REPORTER

All four psychiatric hospitals in the Western Cape will be scaled down and parts of the land on which they stand will be sold. But no hospital will be closed at this stage.

Chief director of Supra-Regional Services Gilbert Lawrence said 50 to 100 more beds would have to go. Over the past 18 months 640 beds in Alexandra, Stikland, Valkenberg and Lentegeur hospitals had been closed.

Vacant land at Valkenberg, Stikland and Lentegeur, which was becoming too costly to maintain, would be sold. The land belonged to the State so the provincial health department would not benefit.

The Pinelands section of Valkenberg would be sold but the future of the forensic unit had yet to be decided. The high-security forensic unit, the only place in the Western Cape where State President's patients were kept, could be retained, Dr Lawrence said.

Many staff had taken retrenchment packages over the past few years and staff at all four hospitals were stretched to the limit.

"We have reached the point of no return in terms of staff-patient ratios," he said. "We need to consolidate the four hospitals."

They would have to be run with a combined management. "We will run one psychiatric service, not four institutions."

Psychiatric patients able to cope in the community or in group home situations had already been discharged from psychiatric hospitals.

"The next phase becomes more difficult. If we cannot operate within budget constraints, then yes, we will have to close a hospital.

"But it must be done slowly and in the context of building up regional and community psychiatric services," Dr Lawrence said.

Bill on release of state patients is published

BD 1/10/97

CAPE TOWN — Draft legislation to allow state patients detained on criminal charges in mental institutions to apply for their own release was published yesterday.

A memorandum on the Criminal Matters Amendment Bill says the provision seeks to get around the possibility of an attorney-general frustrating the release of a patient who is well enough for release.

At present, only an attorney-general can initiate a release application for people detained on violent charges, such as murder. Those held on lesser charges can be released by the hospital board.

The bill proposes to replace this system with a single procedure, allowing applications to be lodged with a judge in chambers by the patient, any other person or body on the patient's behalf, the superintendent of the institution, or an attorney-general.

The memorandum says a major objection to present law on mental illness and criminal responsibility is that it allows an accused who was mentally ill at the time of an offence and therefore "criminally incapable", but sane at the time of trial, to be detained as a state patient.

It also allows an accused who was criminally incapable at the time of trial to be detained as a state patient even though no offence has been proven.

The memorandum says the indefinite period of detention of state patients and the discharge procedure has also provoked much criticism.

The bill proposes to make it compulsory for the superintendent of an institution to report to the health director-general every six months on the condition of each patient. Present law requires a report every year for the first three years, then once every three years.

The bill proposes that accused be given access to state legal aid at hearings to decide whether they are fit to stand trial, or criminally responsible. — Sapa.

dents no longer had to lock their doors by ■ About 30 community organisations ■ Three sportsfields used by sports clubs

Mental patients suffer in staff crisis

ARG 8/10/97 88

JENNY VIALL
HEALTH REPORTER

Mentally handicapped patients at Alexandra Hospital in Maitland are given coffee, bread, stew and whatever else is available for supper mixed together in a single cup.

Some are battered and bruised because they have fits and lash out at one another, with no one to stop them. So says the sister of an Alexandra resident.

"These are the very people who deserve the utmost pity and compassion," she said.

"My brother has withdrawn into another dimension, sitting on a certain chair all day long with no hope of stimulation, change of environment or love from anyone.

"They are all too busy and frustrated to worry about him."

The problems at Alexandra Hospital are those of institutionalised care and understaffing, and superintendent Linda Hering is the first to admit them.

In March, overcrowding reached crisis point as posts were frozen and more and more staff took severance packages or left.

Nearly 100 mentally handicapped people were identified as suitable for discharge and families were asked to take them home.

Six months later, fewer than 10 families have done so.

Today, three group homes open to accommodate 13 people from Alexandra and 13 from Lentegeur Hospital. Another six houses are available for group housing – supervised care in a home setting.

"But we still sit with an enormous problem of overcrowded wards," said Dr Hering.

"We have 30 fewer patients but we have lost more staff since March and are now down to 200 staff members."

The hospital has been given permission to fill 10 professional nursing posts in the next three months, and this will bring some relief. But at times there are two or three staff members caring for 40 patients.

"If one should be absent, there's a problem," she said. Ideally, there should be a nurse to every six patients.

"It is difficult to work out stimulating programmes under these conditions."

Dr Hering said there had been a rise in injuries ... "and yes, there are a number of incidents when nobody sees what has happened. If one staff member is at the dispensary and another is taking a patient to the toilet, there is no one to watch people."

She said the only way for three staff members to feed the number of patients in their care, many of whom had difficulty swallowing, was to mix their food together.

"We have to address the lack of individual care that happens in institutions. We encourage families to help."

In August, Dr Hering called a meeting of relatives to tell them once again that the hospital had reached breaking point and the nurses were exhausted.

"We said that even if they were not prepared to take relatives home, it would help if they took them home two days a week. We said it was not sufficient to bring them food, they should feed them as well. We asked the meeting of over 100 people to assist us practically. Six came forward.

"Hospitals cannot make it on their own, neither can the health department, NGOs or families. We need to all take ownership of the problem. It's no use rolling over and dying. We have to keep things going."

Valkenberg stares closure in the face

CAROL CAMPBELL AND ANDREA WEISS
STAFF REPORTERS

ARG 28/10/97

The death knell has sounded for one of Cape Town's oldest hospitals.

After months of speculation, Valkenberg psychiatric hospital has been officially identified as the institution to close in a bid to rescue the Western Cape health department, which is in dire financial straits.

The provincial health department said it believed the Western Cape needed only three psychiatric hospitals and "the most appropriate to close would be Valkenberg".

Stakeholders and citizens have been given until Monday to say why they do not agree with this decision.

The announcement has been greeted with shock and dismay by hospital staff, patients and numerous support organisations, including old age homes, sheltered workshops and group homes.

Dr Tom Sutcliffe, head of the provincial

To page 2

Valkenberg to be closed

ARG 28/10/97

From page 1.

health department, says the final decision has not been taken. Provincial health minister Ebrahim Rasool is expected to make an announcement in about a week.

Lisa Wolter, director of the Abri Foundation which houses 27 schizophrenic and manic depressive patients, said the decision would be "catastrophic" for the foundation. She said the residents, able to cope in a stress-free environment, were in a state of panic about the closure.

Brian Robertson, head of psychiatry at the University of Cape Town, said patients and their families were not being considered. "Many people struggle to get to Valkenberg hospital, especially people from informal settlements in places like Hout Bay and Noordhoek. The extra distance to Mitchell's Plain would make it very difficult for them."

Dr Sutcliffe has been told he should expect a health budget of R2,2-billion next year. His budget this year was R2,47-billion which placed enormous strain on the health service.

"The health department proposes that the most appropriate hospital to close would be Valkenberg but we are nowhere near a final decision yet. This is not an easy decision to make," he said.

Valkenberg closure may put dangerous patients on street, psychiatrists warn

ANDREA WEISS
City Editor

Increasing numbers of psychiatric patients could find themselves on the streets of Cape Town, – some a danger to themselves or to others – unless they get the help they need.

This is the dire prediction of psychiatrists who are fighting the impending closure of Valkenberg Hospital, which they say will deal a "disastrous" blow to psychiatric care in the Western Cape.

At a press conference at Valkenberg yesterday, principal psychiatrist François Daubenton said psychiatric care in the province was already desperately under-funded.

He argued that psychiatric hospitals were the "soft underbelly" of the health service: "It is easy to close psychiatric hospitals because the patients are not vocal. There is a stigma attached to their illness and they do not wish to identify themselves."

Only 8% of the provincial budget (half the international standard) is dedicated to mental health, and the cracks have already begun to show. In the past three months, Valkenberg and its counterparts at Lentegeur and Stikland have had to refuse new admissions several times.

Admissions to long-stay beds have been closed for the last four months, even though there is a dearth of facilities within the community for chronically disabled psychiatric patients.

These are the people most at risk of ending up on the streets, a phenomenon which accounts for more than half the homeless in cities like London and New York.

The fact that 60% of the admissions to Valkenberg Hospital are readmissions is indicative of the lack of care within the community.

Michelle de Benedictis of Cape Mental Health said it was "shocking that people most sensitive to change" were being subjected to this uncertainty. She said psychiatric patients responded best in a situation of routine, constancy and security.

People on the streets who were chronically ill had very little ability to protect themselves.

Graham Louw of Comcare in Observatory said the five homes and 10 flats it provided for more than 40 people were closely bound up with Valkenberg. "We take patients ready for discharge who have no family or no appropriate home to go to and the majority of our residents attend Valkenberg outpatients, particularly now that the clinics in the southern suburbs have collapsed."

Dr Daubenton said that closing a psychiatric hospital, without having psychiatric services in local clinics and regional hospitals, was effectively a case of "putting the cart before the horse".

In a letter, he and seven other consultant psychiatrists at Valkenberg have appealed to the public to speak out against the proposed closure of the hospital, because ultimately it would be "the community at large left to deal with this problem due to the deficit of resources".

Valkenberg allies press for indaba

ARG 31/10/97 (298) (88)

JENNY VIALL
HEALTH REPORTER

Opposition is growing to the proposed closure of the Valkenberg psychiatric hospital in Observatory and a public meeting has called for a planning process for the land before any further steps are taken.

At a meeting called by the Valkenberg Confluence Alliance, a group of civic and environmental organisations, it was decided that a comprehensive policy plan for the area was needed before a decision could be taken about the future of the hospital and the land on which Valkenberg is situated.

The hospital is on public land and any plans to develop it should be done with full consultation of all interested individuals and organisations, an alliance official said. As state land it belonged to everyone and everyone should have a say in how it was developed.

The provincial Health Department has said it will consider all submissions on its plans to rationalise psychiatric services which include closing the hospital.

The meeting of Observatory residents and other interested groups opposed any plan to close Valkenberg and said alternatives should be explored. There is at present no policy plan for the Black and Liesbeek rivers confluence area.

In the absence of such a plan and in the light of rationalisation of health services, this land is now threatened by piecemeal development and change of ownership, says Kate Snaddon, a spokeswoman for the alliance.

Meanwhile Gilbert Lawrence, chief director of supra-regional services, has said the prime objectives of the rationalisation process has always been to improve the quality of service delivery and ensure equitable distribution of services.

Dr Lawrence said stakeholders had until November 10 to comment on the proposals, and a decision would be made public on November 18 after a final evaluation.

See letter, page 11

Patients plead for their place of love

Valkenberg man: 'Please don't shift us, please don't shift us'

JENNY VIALL
HEALTH REPORTER

Valkenberg patients have made an impassioned plea to health authorities to not close their hospital which they say is their anchor, offering them support when they need it.

The threat of closure has left many patients unsettled, say staff. Many long-term patients have spent a large part of their lives at the hospital while short-term patients rely on it heavily.

"We are very depressed," said patient Monica Mtwecu who lives in Guguletu. "We are asking the community to speak up for us to the government. The outside world doesn't understand us. It is only here we are treated as humans with respect and dignity. So please, whoever can help us, do so."

Ms Mtwecu, who is spearheading a petition to keep Valkenberg open, has already appealed to TRC chairman Desmond Tutu for help. Patients and staff will march to Parliament today to highlight their plight.

"Please, tell them money isn't everything, feelings are more important than anything else," said one patient.

Valkenberg is special, patients say. For some it is the quality of care, for others it is the healing environment. "Here I've learnt to be a person again. Valkenberg is about love and care."

"Ask (MEC for Health Ebrahim) Rasool and (Health Minister Nkosazana) Zuma if they've ever been depressed," said another patient. "We are a cross section of people here, we all have mental illnesses. There is a great need for Valkenberg. I live in horror as to where I will go if it closes."

The main concern for patients is that the two other psychiatric hospitals, Lentegeur and Stikland, are far away from where they live. They are also familiar with staff here.

"Do you know that one in eight people will be touched by mental illness in one way or another?" one patient asked.

JACK LESTRADE

What next? staff members Nuruh Titoti, Sharon Naude, Lindiwe Marepula, Sharon Michaels and Benita Felaar discuss the proposed closure of Valkenberg hospital

Another said that because of the stigma of mental illness "they don't care about us".

"If Red Cross was closing, people would be so upset and would stand against it."

Jeremy King, a member of This Ability, a support group for people affected by mental illness, said his group wanted Valkenberg to stay open, perhaps in a consolidated form. "A lot of stress is involved with major change. I've built up relationships with a number of staff over the years. They know how my illness works and how to control it quickly. If Valkenberg goes, that would be lost."

A huge infrastructure has been built up in Observatory around Valkenberg, which is not duplicated around Stikland and Lentegeur. Places like Fountain House, Cape Mental Health and group homes offer shelter and support for people, an integral part of rehabilitation.

"If you close Valkenberg it's going to cause a lot of hardship to a lot of people," said Mr King.

Social worker Nuruh Titoti said that without these support structures there would be a high relapse rate.

"I'm about to be discharged," a patient said, "but this has been a little bit of a setback. If anything should go wrong I know I can come back. If Valkenberg is not here ..."

Asked whether they could instead go to Lentegeur or Stikland, patients said it would be impractical. Those hospitals were already overcrowded, far from the communities people lived in and off transport routes.

"I live in Guguletu, how am I going to get out there?" asked Ms Mtwecu.

Staff are also concerned about patients' wellbeing should they be discharged. Community psychiatric services are not equipped to deal with people who are mentally ill, they said.

Already, hard-pressed community clinic staff do not have time for home visits or to check that people keep up their clinic visits. A patient said: "A lot of people would end up on the streets. Mentally ill people would slip through the cracks."

In a long-term ward, an old man sums up patients' feelings: "Please don't shift us, please don't shift us."

■ A website has been set up for those who want to send comments on the proposed closure of Valkenberg to head of health Tom Sutcliffe. It is at http://freedom.co..za/valkenberg/webboard.html.

mining activities which resulted in the pumping of these substances into the water; if not, what is the position in this regard; if so, (a) what indications and (b) when will the system have recovered completely from the adverse effects caused by such substances? C286E

The DEPUTY MINISTER OF DEFENCE (for the Minister of Water Affairs and Forestry):

Mr Chairperson, the Minister of Water Affairs and Forestry is having to give a briefing to the Defence portfolio committee. It might seem ironic that the Deputy Minister of Defence is here answering questions on Water Affairs, and the Minister of Water Affairs and Forestry is in the Defence portfolio committee, but in fact it is his responsibility, in terms of the Bill they are discussing, which emanates from his committee, the National Conventional Arms Control Committee. Hence I am here on his behalf.

The reply is as follows.

(1) Yes, the quality of the underground mine water being discharged currently into the Blesbokspruit by the Grootvlei Pty Mines Ltd conforms to the standards, as set in Permit 31M issued on 1 July 1997 by the Department of Water Affairs and Forestry.

The underground mine water being pumped at the Grootvlei Pty Mines Ltd is of a neutral pH. The pH of the water being discharged (after liming) into the Blesbokspruit ranges from 7 to 9.

The total iron content of the water is generally less than 1 mg/l water which is acceptable.

Although the heavy metal problems have been solved to a large degree, the high salt loads being discharged into the Blesbokspruit and the Vaal River system are a course for concern. The Mine will probably not be in a position to afford the establishment of a full-scale desalination facility. This is of great concern to my Department and the timely securing of the necessary funding is of the utmost importance.

(2) No, the Blesbokspruit wetland system is not recovering fully.

Although some recovery (in terms of visual impact) has taken place, full recovery will take more time. However, there are many other issues which also have to be considered. The poor state of the wetland is the result of many years of neglect, but this is now being addressed through the Blesbokspruit Management Advisory Committee, formed in terms of the Cabinet decision of 16 April 1997.

For written reply:

Mental Health Act review (88)

45. Mr W F MNISI asked the Minister of Health:

(1) Whether the Mental Health Act, 1973 (Act No 18 of 1973), is currently under review with the view to bringing it in line with the new Constitution; if so, (a) which aspects of the Act are being reviewed and (b) when is it anticipated that the reviewing process will be completed;

(2) whether any aspects of the Act are not consistent with the Constitution; if so, which aspects? C51E

The MINISTER OF HEALTH:

(1) Yes.

(a) The whole Act is being rewritten.
(b) Early 1998.

(2) Legal opinion is being sought.

Provinces: houses built (90)

90. Mr W F MNISI asked the Minister of Housing:

(a) How many houses were built by the Government in each province in 1996 and (b) (i) what is the current estimated backlog of houses in each province and (ii) in respect of what date is this information furnished? C95E

The MINISTER OF HOUSING:

(a) 106 692 individual ownership subsidies (project linked and individual subsidies) were approved during 1996 by the nine provincial housing boards within the framework of Government's Housing Subsidy Scheme in respect of beneficiaries who had bought residential properties. Once such subsidies are approved, conveyancers are instructed to register transfer of the residential properties in the names of the subsidy beneficiaries. In the case of existing houses or completed houses in projects, this means that

beneficiaries can take occupation of the homes soon after registration of transfer or earlier if the agreement of sale so provides. Where a housing unit is still to be constructed, indications are that construction is completed within two to three months after registration of transfer.

It should also be indicated that since the implementation of Government's Housing Subsidy Scheme on 15 March 1994 until 28 February 1997, 443 582 subsidies have been reserved by the various provincial housing boards in respect of housing units to be erected in more than 660 projects approved by the provincial housing boards and of these, at least 52% are active. The following is a breakdown of the number of subsidies reserved:

Project Linked Subsidies	:	365 246
Individual Subsidies	:	45 303
Credit Linked	:	35
Consolidation Subsidies	:	31 201
Institutional Subsidies	:	1 797
		443 582

The provincial breakdown of subsidies reserved and approved in respect of beneficiaries for the period 15 March 1994 until 31 January 1997 is provided in the accompanying table.

(b) (i) and (ii) The existing housing backlog in South Africa is estimated at 1,92 million units. At the current growth population the housing backlog would increase at an estimated rate of 204 000 units per (annum annual delivery excluded). The backlog is derived and based on projections from the 1991 census. The urban housing shortage per province during 1996 is estimated as follows:

Province	Shortage
Eastern Cape	195 632
Free State	102 012
Gauteng	761 321
KwaZulu-Natal	391 897
Mpumalanga	31 737
North West	113 560
Northern Cape	29 764
Northern Province	70 286
Western Cape	223 791
Total	1 920 000

The shortage of 1,92 million units is only in respect of urban areas since it is uncertain what can be regarded as acceptable housing for rural areas. Apart from people living in traditional housing in rural areas, approximately 300 000 households are living under unacceptable living conditions in shacks in rural areas, taking the total estimated backlog to 2,2 million units.

Progressive Housing Statistics: 15 March 1994 until 28 February 1997

Province	*Project Linked (Reserved)**	*Project Linked (Beneficiaries)***	*Individual ****	*Credit Linked (Savings Route) *****	*Consolidation Reserved +*	*Consolidation Beneficiaries ++*	*Institutional (Reserved) +++*	*Institutional (Institutions) ++++*
W Cape	49 026	10 201	2 983	19	4 097	149	203	13
Gauteng	78 156	28 706	11 647	9	2 000	1 631	779	0
N West	30 798	7 252	3 194	0	0	0	0	0
Mpumalanga	31 857	12 450	7 280	0	250	0	0	0
KwaZ/Natal	73 415	11 367	3 430	3	8 999	2 418	240	320
F State	25 144	9 394	3 881	0	8 258	1 225	0	0
E Cape	33 817	3 592	2 994	0	4 040	0	575	0
N Cape	5 603	1 742	3 324	3	205	0	0	0
N Prov	37 430	17 254	6 570	1	3 352	1 511	0	0
Total	365 246	101 958	45 303	35	31 201	6 934	1 797	333

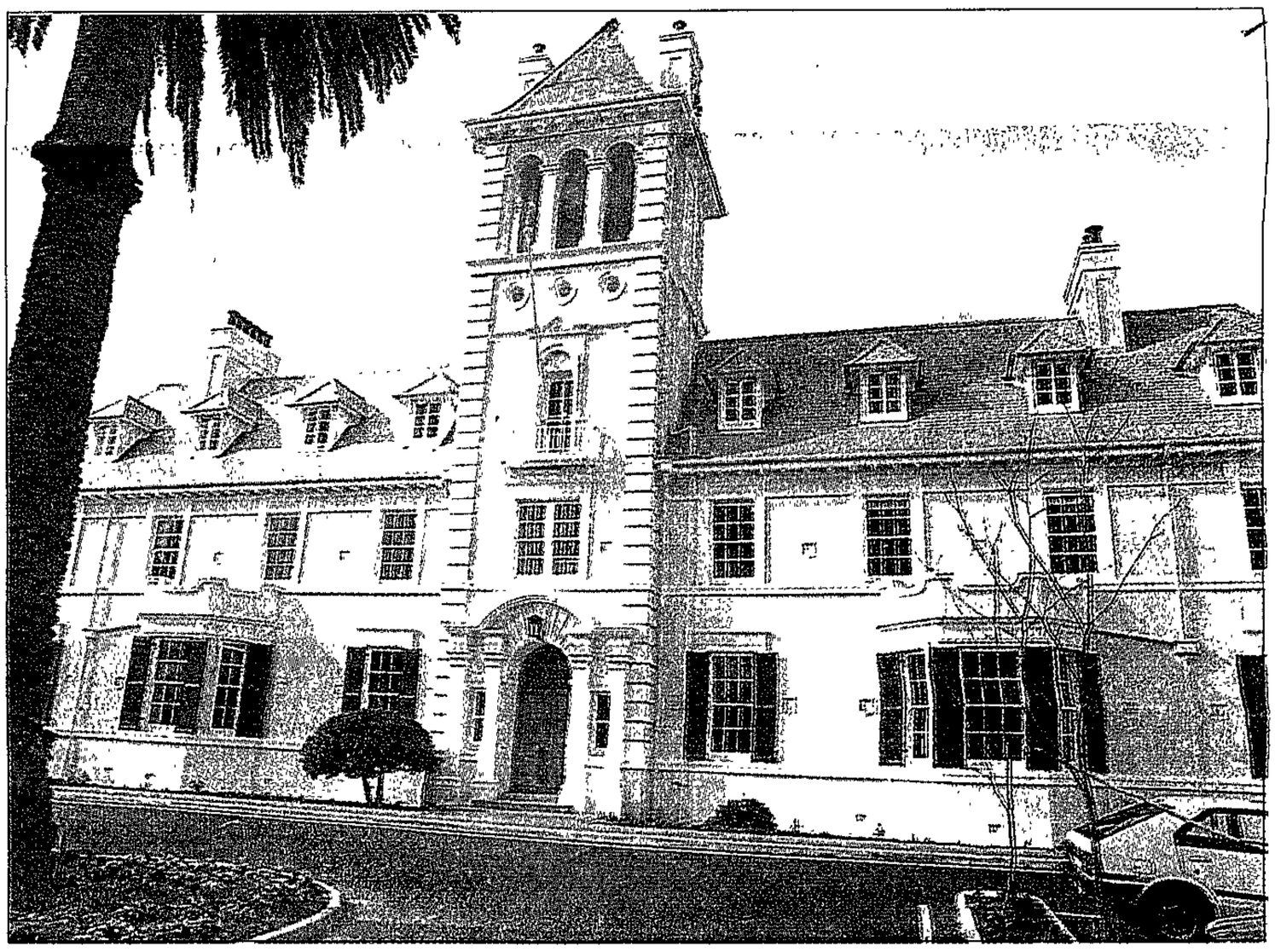
Valkenberg must keep faith with its patients

ARG 6/11/97 (88)

Closing hospital would not save much

INSIDE STORY

There are many reasons why Valkenberg psychiatric hospital should not close. In fact, there are good reasons not to close any of the three psychiatric hospitals. François Daubenton, principal psychiatrist at Valkenberg, spoke to Health Reporter **JENNY VIALL**



Bastion of mental health care: closing Valkenberg Hospital would save only between R5-million and R7-million a year, says Dr Daubenton

The proposal to close Valkenberg Hospital will do little to bring financial relief to the Western Cape health department, nor will it improve access to psychiatric services for the thousands of people affected by mental illness.

In fact, says Dr Daubenton, closing the hospital will mean a deterioration of psychiatric services and ultimately patients will suffer. "The best reason not to close Valkenberg Hospital has to be the consumers of psychiatric services, the patients and their families.

"Patients' well-being depends on stability. They are among the most vulnerable members of society and change affects them to a greater degree than change in physical health services.

"It's important to remember that a large majority are stabilised and controlled with treatment rather than cured, and they get to know us over long periods of time."

This, says Dr Daubenton, is the strongest argument for maintaining all three hospitals, albeit in a downsized capacity. "The counter argument is that people should be seen in the primary health care system. The reality is that effective community psychiatric services don't exist."

For example, Wynberg's community clinic did not provide psychiatric services for two months because of staffing problems, says Dr Daubenton. "And we (at Valkenberg) had difficulty getting access to their folders so we could treat them. It was unbelievable."

The result was a large number of patients had to be readmitted.

Valkenberg is the busiest, the best-staffed (except for nurses) and the most accessible psychiatric hospital in the Western Cape. It has also a lot of NGO support. Why then has it been chosen for closure?

The reasons are essentially threefold, believes Dr Daubenton.

■ A report by Health Minister Nkosazana Zuma on South Africa's psychiatric services found it difficult to evaluate Valkenberg Hospital as half the wards were excellent and half were in a terrible state of disrepair. These ought to be closed by the rationalisation process. "Unfortunately I think the bad of Valkenberg was emphasised and that remains in the minds of individuals. But we already have funding support to refurbish wards on the Observatory side."

■ There continues to exist a prejudice around psychiatric patients and units, he says. "Placing psychiatric services on the periphery of cities has always been the norm."

■ The property is valuable, being centrally situated. "A high proportion of our patient base comes from the less affluent sector of society, who rely on public transport. Fifty percent of our admissions are coloured, 30% black and 20% white. It's difficult enough for a patient from Hout Bay to reach this hospital. If you close it, how will patients get to Stikland (in Bellville) and Lentegeur (in Mitchell's Plain)?"

Protagonist: Dr François Daubenton

Dr Daubenton says closing down Valkenberg would save the province only R5- to R7-million a year.

"That's very little considering the R400-million present budget deficit," he says. "If the argument is that we need to close the hospital because of financial problems, the reality is that there is no significant saving. Of the R175-million spent on psychiatric services (out of the Western Cape's R2,47-billion health budget), 85% goes on personnel costs."

Although Valkenberg is on a valuable piece of land, that land belongs to the state, not the province. "The notion that selling state property is going to directly benefit health services is a possibility, but there are a number of steps to take before we get there.

"Psychiatric hospitals occupy immense tracts of land which are very valuable. There is no doubt that portions of land at all hospitals could be alienated. But it's a complex legal process to transfer the land to the province, with no guarantees it will be successful. And, once transferred, there is no guarantee funds will come to health.

"With privatisation of state assets, there is a strong lobby which says the money raised should be shared among all provinces," says Dr Daubenton.

Over the past eight years there have been three investigations into psychiatric services.

"All recognised the underdeveloped nature of psychiatric services and the need for them to be integrated into general health care services.

"When the strategic management team (SMT) looked at rationalisation, we from the psychiatric services supported the principles of ensuring services became more accessible, affordable and appropriate."

The mental health task team report, accepted by the SMT, indicated that no psychiatric hospitals should be closed, but all should be downsized.

That report also said there was a potential for a significant reduction in the number of beds to a point where it might be possible to close a hospital over a 10-year period provided the following were adhered to:

■ Psychiatric beds were opened in regional hospitals.

■ Efficiently staffed community psychiatry services were developed.

■ Primary health care nurses and doctors were actively involved with the delivery of psychiatric services.

■ In co-operation with the private sector and NGOs, alternative accommodation structures for long-stay patients were developed.

"However, without any of these being complied with, a proposal has been made to close Valkenberg Hospital. We can downscale. But closing will result in a deterioration of services.

"In the last three months, all three psychiatric hospitals have had to close their male or female admission beds for variable times because capacity had been reached. There is no way we can consider a reduction of acute beds. We could reduce long-stay beds by 80 (out of 227) in a fairly short space of time.

"The other cohort of patients for whom we're responsible are the criminally insane, the fastest growing population of psychiatric patients. The closure of Valkenberg would mean building another maximum security unit.

"I find it rather bizarre that they're seriously contemplating moving the unit in a socio-economic climate where there is no money."

Does he hold out any hope that health authorities will not close Valkenberg?

Dr Daubenton replies cautiously: "In my heart of hearts I believe sincerely that if the hospital is not closed it will be as a result of the community voice being heard on this issue.

"The people of the Western Cape will ultimately receive services dependant on their response to this proposal."

Psychiatric staff have been negotiating with decision-makers for eight years on how to best provide psychiatric services. "This proposal indicates we have been unsuccessful in convincing them.

'I believe that if the hospital is not closed, it will be as a result of the community voice being heard'

"The health department is saying the proposal is for debate and they will make a decision after November 18. The way they put this proposal to the psychiatric sector is a mechanism utilised at the end stage of a decision-making process."

If the health department decides to close Valkenberg, the provincial cabinet has to approve the decision "hopefully according to the wishes of the population it serves".

Ex-pats from war-torn African countries find warm haven in hospital under threat

ARG 8/11/97 (88)

ADELE BALETA

Micky, a young Tanzanian, has made his mark in the male admissions section at Cape Town's Valkenberg Psychiatric Hospital.

His brightly-painted mural of an African sunset with a grazing giraffe and a palm beach lights up an otherwise grim sitting-room. For Micky it holds the promise of a better, healthier life in his East African country. Opposite the sunset he has painted a mural of Table Mountain silhouetted against the night sky.

The young man who has been treated for schizophrenia found his way to Cape Town from Tanzania, as have a number of patients from other African countries. He is one of an increasing number of foreign patients to be treated at the hospital, which is under threat of closure by the Western Cape Health Department.

Patients and staff are vociferously opposed to closing the hospital, a move they say is unethical and would violate patients' basic human rights. It would be like "kicking a dog when he is down. It is marginalising the marginalised," says consultant psychiatrist David Kibel.

He and other staff members feel that closure of the hospital would not save the department money, but result in a dramatic decrease in accessibility of mental health services and a severe decline in standards of care. Dr Kibel said foreign patients from war-torn countries in Africa, where there is a complete breakdown in services, were referred to the hospital by police and the Trauma Centre.

Closing Valkenberg Hospital would be like 'kicking a dog when he is down'

These patients place an extra burden on already stretched services. Psychiatric consultant Sean Baumann had recently treated patients from Mozambique, Angola, Zaire and Burundi. They had psychotic disorders and most were infected with HIV.

"There has been an increasing frequency in the number of people admitted with mental illness from across the border as far north as Burundi. These people come from countries where there have been extremely stressful and traumatic events.

"They mostly suffer from psychotic disorders and drift down to Cape Town because there is a complete breakdown in services in their own countries," he said.

Dr Baumann said the greatest problem was the language barrier and the fact that there were few aftercare services to offer. "They are at risk because there is often no family to support them."

He said treating these patients had to be seen against a broader context, which was the potential dangerous situation that would arise if psychiatric services in the Western Cape were under threat. Dr Kibel said that foreign patients were alienated from their families, they suffered economic hardship, cultural alienation and were the victims of xenophobia.

Attempts were made to send people home once they had been treated and stabilised.

The male admissions ward also witnessed a steady stream of black students from the University of Cape Town.

"These students, many of whom are disadvantaged, are under extreme pressure to perform, especially during exam time. They suffer from stress and paranoid illnesses," he said.

Dr Kibel says Micky is doing well and sometimes comes to outpatients.

ANDREW INGRAM

Valkenberg patient: Peter enjoys being outside in the hospital gardens. Valkenberg Hospital patients, their families and staff are planning a protest

Valkenberg objectors plan street protest

Patients and staff vow to march

ARG 8/11/97 (88)

ADELE BALETA

Hundreds of Valkenberg Psychiatric Hospital patients, their families and staff are planning to take to the streets of Cape Town to protest against proposals to shut down the hospital.

The Friends of Valkenberg, set up to raise funds to upgrade the hospital, is planning the march to the Wale Street offices of the Department of Health.

Members of the National Education Health and Allied Workers Union will be calling on all their members to join in the protest on November 17.

Chairperson of the Friends of Valkenberg, Francois Robertson, said: "The idea of the march is to give the patients a chance to express themselves. They want everyone to know what the closure of Valkenberg Hospital would mean for them and their families."

The Department of Health has proposed the closure of Valkenberg as part of the rationalisation of health services in the province and to increase the accessibility and affordability of the service for all.

The plan includes resettling the mentally ill patients at Lentegeur or Stikland Hospitals.

But the department's rationale for the closure has been criticised by medical staff, non-governmental organisations, patients and their families.

They believe that accessibility to services for the mentally ill will decrease and more and more patients will be left without anyone to care for them. They have warned of the potentially dangerous risks involved for the patients and the public.

Valkenberg Sunset: consultant psychiatrist David Kibel

This week a Matroosfontein grandmother, Petronella Kleinhans, 82, was fatally stabbed by her grandson who was discharged from Stikland Hospital. Despite appeals from his family, the hospital refused to readmit him.

'The patients want them to know what the closure will mean for their families'

Patients and staff have said that Lentegeur and Stikland hospitals are not an option for many patients who have to survive on a monthly R480 disability grant, and are not able to travel the distance to these hospitals. Taxis and buses did not adequately service the route.

Valkenberg sister Theresa Gogela who lives in Guguletu said it was "unsafe" for her to travel to Lentegeur Hospital.

In a report this week, principal psychiatrist of Valkenberg, Francois Daubenton, said that closing the institution would not mean a great financial saving.

The Friends of Valkenberg have embarked on an innovative advertising campaign to challenge the department's plans to close Valkenberg.

In the cleverly-worded advertisement in editions of this week's Cape Argus, members of the public who are concerned about the fate of the hospital are encouraged to contact health department head Tom Sutcliffe directly. A fax and phone number is supplied.

Since then, the department has been bombarded with petitions from organisations and individuals.

Mrs Robertson said that organisations linked to the hospital, such as the Ark and Adam's Farm, will not be able to take on mentally ill patients without the support of Valkenberg.

She said the Friends of Valkenberg, started two years ago, had recently lined up two major sponsors but they pulled out with the department's announcement that the hospital should close.

Mrs Robertson said that Lentegeur and Stikland hospitals would not be able to accommodate the extra patients that Valkenberg admits, especially patients with acute problems.

Valkenberg's consultants say the proposed closure of any psychiatric hospital in the province, without first addressing the deficits in clinics and regional hospitals, would result in the inability of the public sector to give psychiatric services, as guaranteed in the constitution.

The result would be individuals not getting the help they need, and could thus pose a danger to themselves and, perhaps, to others.

Patients to pay price of closing Valkenberg

CYNTHIA VONGAI

MS BELINDA CONRADIE is 27 years old, a mentally ill patient and she lives alone.

Conradie is a manic depressive and is currently a patient at Valkenberg Hospital after a "manic" attack. She, unlike other mentally ill people, is lucky enough to have a support structure once she is released.

Her parents are divorced. Her father lives in Pretoria and supports her financially, her mother lives in Kenilworth and visits her regularly.

Besides her family support, Conradie belongs to a mental support group, "This Ability", which meets once a week to help patients who have been reintegrated into society. She has also been admitted to a rehabilitation programme run by the Fountain House, an Observatory non-governmental organisation.

"I have been here five weeks but I have also been in and out of the hospital many times. When I came to Valkenberg a few weeks ago they could not admit me (because the hospital was full), so I was referred to Lentegeur, which turned out to be an acute lock-up.

"I know one thing for sure: If Valkenberg closed and I became severely depressed I would not return to Lentegeur. I would rather kill myself and I probably would, especially when I am in that state.

"People do not realise that when you are treated with respect, you heal. When you are locked up and treated like a child with no choice on your healing process, you become worse.

"I asked whether I would be locked up at Lentegeur and I was told no. When I arrived there, I was, and my medication was changed. I would never go back there," she said.

Unlike Conradie, Ms Monica Mtwecu, 23, does not have a good support structure once she leaves Valkenberg.

She lives in Guguletu with her parents, who, because of the stigma associated with mental illness, leave her to deal with her depression alone or send her to Valkenberg.

When she is well she stays at home and her problems are not discussed. There is no support structure for her except for a visit to the local day hospital or clinic.

"I am Xhosa. In my home I cannot sit down with my mother and tell her about my depression or illness," Mtwecu said. "My parents think I am acting like a child. They do not understand that I am ill and that I need help to cope.

"At Valkenberg I have group therapy and I can talk about my problems. If this place is closed, they will take away my right to live in a normal society.

"Lentegeur — I do not think I would go there — it is too far for me and I cannot start explaining and talking about my feelings all over again. I will probably stay at home. I do not know what will happen."

(88) (88) CT 11/7/97

Seeking sane solutions for mental health care dilemma

ARG 14/11/97

The storm unleashed by the proposal to close Valkenberg Hospital has obscured the bigger picture of mental health provision in the Western Cape, says Gilbert Lawrence, head of Supra-Regional Hospitals in the province. JENNY VIALL spoke to him

The debate on mental health services needs to brought back on track, says Gilbert Lawrence, with the focus on a vision of how to provide services to all the people of the Western Cape.

Two weeks ago Dr Lawrence tabled his report "Mental Health into the 21st Century" on rationalising mental health services and asked for comment on it. And comment he got.

The department was inundated with a flood of submissions, many initiated by the campaign to save Valkenberg Hospital.

Dr Lawrence said he was disappointed that while he asked for comment on the plan as a whole, the proposed closure of Valkenberg stole the limelight.

"I think the criticism has not been so much criticism of the plan as such but perceptions of pace and scale of change, for instance how great downscaling should be and what should be the sequence," says Dr Lawrence.

"Those are useful and we need to be addressing them. But at no stage did anybody say that Valkenberg is closing by such and such a time."

For mental health services to be effective, everyone needs to work together, he says. An adversarial situation is counter-productive.

Unfortunately the Save Valkenberg campaign has been "excessive" in trying to prevent the closure of the hospital, he says, while few inputs have been received on how to work together and look to the future.

The future for the health department is one in which budget cuts are getting worse and worse.

"We are faced with two issues," says Dr Lawrence. "We have to address budget constraints but we also have to have a vision for the future.

"If we just look at our shoes and try to save money then we will become totally ineffective and demoralised."

Why has a task team been appointed to further investigate mental health when there has already been years of discussion and consultation?

The debate has gone off track, says Dr Lawrence. There have been aspersions cast on Lentegeur hospital, voiced publicly, saying it should close, and now there is a Save Lentegeur campaign.

"So we have decided to suspend the issue and have a task team look at the inputs. Hopefully this will bring it back on track," he says.

The task team, to be appointed soon, will investigate various options of rationalisation and recommend appropriate cost-effective solutions. Its lifespan will be weeks rather than months, says Dr Lawrence, and then decisions will be taken.

"However, given budgetary constraints, and they've actually become worse since we issued that plan, I personally see no other way but to close one of the aggregated hospital sites," he says.

Financial constraints in the Western Cape have had a dramatic effect on health services. Staff numbers in April 1995 were 33 295; they are now 27 900, a decrease of 5 395. To meet the budget over the next three years another 7 000 posts will have to be shed.

Within this framework the health department has to provide more accessible health services to those who have historically not had access.

"We have to have a vision and redress some of the problems we are facing in spite of budget constraints," says Dr Lawrence.

Inundated: Gilbert Lawrence got response

"People say you cannot have services in other places because they are far, because they are gang-infested, there is no infrastructure. Well, that is a chicken and an egg situation.

"The arguments are that there are problems around travelling and safety. That's true, but remember our staff are working in those areas, there are people who have to travel the distance. So the problem is not the issue, how we address it is.

"We now have four institutions, the majority filled with chronically ill patients. We have to address the issue that there are more patients outside the hospitals who need services and we do not have the capacity to provide relief for those who need it.

"People say that closing a hospital means patients will be dumped on the streets. That's not so. Those patients, instead of being spread over four hospitals, will be in three hospitals. There must be economies in scale."

The health department will also make the vast sites more manageable by alienating some of the land.

"What we are addressing is basic principles of human rights. Now you can ask: is it only the right of that individual in a Valkenberg ward to have care or is it the right of a patient in Khayelitsha or Constantia who also has a mental health problem?

"We have to look at the bigger picture as well as the smaller picture."

Budget constraints may force a rapid acceleration of the province's plans for mental health, he said.

"We would like to ensure that we have facilities in place in communities, beds in regional hospitals to deal with psychiatric patients and we would like to have a referral network.

"But we are struggling to do that. So we have put a plan on the table. Certain things can be implemented rapidly. And there are longer time frames which will be constrained by other issues like the lack of resources.

"For example the current situation is that we may not be able to appoint a single staff member between now and the end of the financial year. That will have dire consequences for the health service, not just mental health services. Lentegeur and ,to a lesser extent, Alexandra hospitals, which don't have direct links to universities, also need to be assisted.

"People have said 'Why do you want to lose one of four hospitals, don't you need more hospitals?' And the answer is, not really, if you have this plan in place, if you have group homes set up and if you have regional beds. The debate is where do the 'ifs' come in. The crisis is facing us across the board and what I think has been very positive has been the way all NGOs have responded to the Save Valkenberg campaign.

"They are saying they are supportive of our programme. They've given all the reasons why it works, transport, accessibility, safety, consistency of interaction. Is it not selfish to say it works here, leave it alone?

"The question is how do we share those resources with other areas? It will be wonderful to get an indaba of NGOs to take up that challenge."

Mental illness costly to society — network

(88)

Josey Ballenger

BD 17/11/97

AN SA support group has joined an international network aiming to collect and disseminate information on what is becoming one of the leading causes of shorter life expectancy in industrialised nations — mental illness.

The World Health Organisation has predicted that mental illness will be the major cause of "disability-adjusted life years" among noncommunicable diseases by the year 2000, according to the Global Alliance of Mental Illness Advocacy Networks, whose SA affiliate is the Johannesburg-based Anxiety Disorders Support Group.

About 189-million people worldwide suffer from depression and anxiety disorders, according to Global Health Statistics.

The network contends that mental illness is also costly to society. In the US in 1990, the "conservatively estimated" economic cost was more than $90bn, 75% of which was due to absenteeism, reduced productivity and suicides.

At the same time, mentally ill people were underdiagnosed and under-treated around the world due to social stigma, the cost and accessibility of health care and lack of health insurance coverage for such patients, negative side effects of medication and a belief in self-treatment, it said.

A 1991 study had found that only one in 10 people suffering from depression in the US — a nation with advanced mental health treatment — was receiving adequate treatment.

A 1995 US study showed that only about one-third of those who entered a primary care clinic suffering from major depression were diagnosed and prescribed antidepressants.

The network is conducting a worldwide survey to identify the predominant attitudes and behaviours that prevent mentally ill people from receiving proper medical treatment.

Planet of delusions, hospital of hope

M+G 28|11-4/12/97 (88)

Closing Valkenberg hospital would involve a sacrifice by the people least able to bear it, writes **Lin Sampson**

Protest: Patients and staff from Valkenberg march through Cape Town's streets. PHOTO: RODGER BOSCH

Valkenberg: one alights rather than arrives on its pulsating terrain, as if on another planet. It is an eccentric place, a hovering satellite of hope and despair, dishevelled in part, but with pretty gardens that stretch down to the river, known by patients as "the waterfront".

At 9.30am in Dr Baumann's office the place seems sane, but there is the knowledge that all around are lives in disarray. Indeed, a cursory look from the window reveals a head clutched despairingly in a pair of hands. It turns out to be a worker taking a break from building. That has always been the problem in these places: telling the patients from the staff.

Baumann is clearly practised in the art of disguised firmness, and it does not escape notice that he gets his way by a charming slight of hand. However, the proposed closing down of Valkenberg has brought his firmness to the fore.

"One major cause of our outrage is that the closing of this hospital represents to us a massive step back, an alienation of people suffering from mental illness Also Valkenberg must be seen in the broader context of health services in the Western Cape. The closure of the busiest and most accessible of hospitals will do irreparable harm to the non-governmental organisations in the area which form such vital links with the hospital."

The plan is to tour the hospital and talk to patients and visiting expatients Here is Marc Vervitsiotis who brings his blue eyes close to mine and whispers: "Have you ever had the torments?"

He is of Greek descent, a vivid character who suffers from severe mood swings. He trained as a hairdresser, but has spent 16 years of his 37 years in and out of Valkenberg.

For nine years Vervitsiotis never left the place. He has now been living in a Salvation Army hostel for a year and has come in specially to talk to me. He is well-built and carries a haversack bulging with books on Jesus, one of which he gives me as a parting present, signing it with a flourish.

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Shutting another door on the mentally ill

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Only a core psychiatric service, to treat seriously mentally ill patients, and the maximum security forensic unit would continue to operate at Valkenberg hospital because of government budget cuts.

However, already the department was running on a deficit of between R400-million and R500-million a year, and in the last few months closure of the entire hospital was deemed necessary.

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Several organisations showed an interest in buying it. A cry went up, petitions were bandied around. Patients themselves began to agitate.

Consultant psychiatrists at Valkenberg, who seemed particularly slow on the draw, signed a letter with the ominous wording: "We believe that the closure of any psychiatric hospital in the Western Cape, without first addressing the deficits in the clinics and the regional hospitals, will result in the inability of the public sector to provide the psychiatric services guaranteed in terms of the Constitution."

Everyone connected with Valkenberg realises that rationalisation is needed, plus better and more efficient accommodation and services.

But most also know that closing Valkenberg for a fistful of cash will only exacerbate the crisis of treating mental illness in the Western Cape.

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He believes Valkenberg hospital saved his life "I feel I have spent 16 years fighting for my sanity. You know when you're ill, everywhere is awful, but I knew I had to be here If I wasn't here I would have killed myself."

He says he is now able to cope with life in a better way and has even thought about getting a girl friend. "I was married for three-and-a-half years and I never spoke once. I just

A lot of people are lying on the floor like the wrangled remains of a car accident. "Hi doc," one pipes up. A male nurse puts on Duran Duran, enough to drive anyone bats, and narcosis hovers in the air

Outside in the garden people sleep "I think if people are to get well it is important to be in a nice place," Baumann says.

Strangely, Ward 14 is not a frightcluding something many of us single women on the outside lack — your own man banged up right next to you.

Jacoba has Lionel with whom she has been going steady for 30 years.

Marilyn's Ian is trundled in as she whispers urgently: "I am terribly in love with him." Ian seems to be into smoking in such a serious way that even the thought of love is secondary.

As we leave Jacoba tugs my sleeve: "Please lady don't close this hospital. It is my home."

At the end of the day I feel overwhelmed by this tide of human intricacy. Valkenberg exists in our midst as a hospital and a symbol: "You'll end up in Valkenberg" has ricocheted across the Western Cape for decades.

And, in fact, I did end up there for a hallucinatory few weeks with anorexia. Of course, I witnessed tragedies. There was a girl who received messages via the wall plugs and was always standing beside a three-prong.

Perhaps I was lucky, they all revived. The girl who talked to plugs became a land surveyor

Valkenberg is a place that is a shining light for many — like Gareth Davies (35), a paranoid schizophrenic who now lives in Abri, a community-care house in Observatory.

If Davies's medication goes awry, life can be hazardous. Only the week before he threw a dumb-bell through a TV screen. "In the beginning it was quite scary to go to a mental hospital. Now Valkenberg just over the way seems like a light I can see from here "

At the top of the main Valkenberg building is a room where brown paper files allotted to each patient have piled up, each representing some unique set of circumstances

Here psychosis, neurosis, murderous intent and broken-heartedness, together with splendiferous names of medication, the padded cell, the *grid* of shock treatment, all blend to form an intimate narrative.

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On two visits to Professor Frances Ames in 1991 at Out Patients, I saw Trevor Manuel, now finance minis-

the closing down of Valkenberg.

Conradie, who declares herself to be Bi-polar Two (a type of manic depression), says: "I think mental illness makes you vulnerable and open to abuse I have decided I do not want to be a victim. I feel that as patients we have to say that this is enough We do not want this hospital to close.

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He tells me that over the years he has tried to obliterate himself in every way known to man. Once he hurled himself at a car on the N2. He has cut his wrists and set his bed on fire.

However, today he seems very much alive. When I ask him how old he is, he says: "Thirteen snails. A snail lives for three years, so I am thirteen snails. You are probably 14 snails," he guesses.

Vervitsiotis thinks his illness might have started when he got involved with some occultists. (I was to discover that most people pinned the onset of their illness to a specific event.) The occultists took him to the beachfront in Hermanus where he watched the full moon come up.

"It got bigger and bigger in my head and all the planets started moving at tremendous speed and I imagined everything was on top of me. It was mind-blowing," says Vervitsiotis. It sounds like the sort of experience a few people I know would spend a couple of bob to have.

He believes Valkenberg hospital saved his life. "I feel I have spent 16 years fighting for my sanity. You know when you're ill, everywhere is awful, but I knew I had to be here. If I wasn't here I would have killed myself."

He says he is now able to cope with life in a better way and has even thought about getting a girl friend. "I was married for three-and-a-half years and I never spoke once. I just wept. I didn't know what I was weeping about but the tears were just streaming down, for the broken-ness of it. Ah, and my wife didn't know what to do, a girl with big cheeks. She really loved me that girl."

It is 2pm at Ward 14, acute male admissions, Baumann's special turf. It is as strange a place as you might ever connect with, the rumbling engine room of mental illness. By the end of the day there will be 25 admissions, many of them re-admissions in what Sister Edith Smith, who has worked at Valkenberg for 16 years, calls "the revolving door" of mental illness.

There is a mural of Table Mountain on the wall and the curtains have been donated by Biggie Best. But, without wishing to be unduly cynical, the patients in Ward 14 seem a little beyond interior decorating.

A lot of people are lying on the floor like the wrangled remains of a car accident. "Hi doc," one pipes up. A male nurse puts on Duran Duran, enough to drive anyone bats, and narcosis hovers in the air.

Outside in the garden people sleep. "I think if people are to get well it is important to be in a nice place," Baumann says.

Strangely, Ward 14 is not a frightening place. The atmosphere is casual, almost homely. Smith says most of these people will get better — at least for a time. As I leave a man puts his arms around me and says: "Bye Di."

Princess Diana, Prince Charles, Jesus and Nelson Mandela often feature at this hospital. At one time there were three Nelson Mandelas in one ward. But if a statue were to be erected it would probably be to Peter Stuyvesant. Smoking is an art form here.

As we move through wards, the most noticeable thing is the thesaurus of gaits — people click, slouch, clomp, scuttle along.

In the neuro-clinic Belinda Conradie (27) and Monica Mtwecu (23), both of whom have been in and out of Valkenberg for years, have arisen out of depression to launch their own amazingly vociferous resistance to the closing down of Valkenberg.

Conradie, who declares herself to be Bi-polar Two (a type of manic depression), says: "I think mental illness makes you vulnerable and open to abuse. I have decided I do not want to be a victim. I feel that as patients we have to say that this is enough. We do not want this hospital to close.

"When I came to Valkenberg a few weeks ago they could not admit me [the hospital was full], so I was referred to Lentegeur in Mitchell's Plain, which turned out to be an acute lock-up. I know one thing for sure: if Valkenberg closed and I became severely depressed, I would not return to Lentegeur. I would rather kill myself." This is not a threat to be taken lightly.

Mtwecu says she does not like the idea of Lentegeur. "It is too far away. My family do not like to go there. We know this place."

In Ward 8, Marilyn recalls the days of living in Hollywood Hotel Port Elizabeth, with Prince Charles — a union, if I am getting the gist of the conversation, that produced not one, but two sets of sextuplets.

Her friend Jacoba nudges me: "Don't listen to a word she says."

In a way these delusions are easiest to bear, way beyond repair, and in-

[illegible] observatory.

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On two visits to Professor Frances Ames in 1991 at Out Patients, I saw Trevor Manuel, now finance minister, sitting between two policemen, probably getting a break from prison. But still.

Although the uniqueness of the hospital has been preserved in articles and documentaries, its blend of success is as fugitive as the sudden onset of madness.

Valkenberg has doctors of a calibre you might spend your life trying to find in the national health system in Britain, and nurses — sadly many recently took a retrenchment package — who retain a sense of vocation

Whatever is wrong with Valkenberg — and I suggest there might be quite a lot — it is certainly not a hospital without hope

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Patients who are certified, or have been in the hospital for a long time, are not allowed to have their surnames used

Big boost for mental health drive

Non-participation of psychiatrists in TRC indicates that they feel immune

By Mokgadi Pela

THE campaign for a better Mental Health Act has been given an added boost with the Citizens Commission on Human Rights circulating copies of the model mental health Bill to Cabinet Ministers and other pressure groups in the country.

The purpose, according to CCHR chairman Mr Paul Sondergaard, was to create an awareness about a field that "will soon come up for review when the new Bill is debated in the first sitting of Parliament next year".

"We also want to get responses from those stakeholders so that by the time the debate starts, they are familiar with the contents of our model health Bill," Sondergaard told *Sowetan* in Johannesburg yesterday.

A key goal of the campaign is to ensure that the controversial Section 66A is scrapped. The section prohibits the scrutiny of psychiatric institutions, including the banning of photographs.

Further recommendations in the model Mental Health Bill include access to medical records, the rights of inspection of facilities and a comprehensive reporting and clinical auditing procedure for psychiatric hospitals.

"The reviewing of the current Mental Health Act has been long and tedious, with no clear progress to date. We want to see a mental health field that focuses on the well-being of citizens rather than allowing psychiatrists the ability to exercise dictatorial control," Sondergaard said.

A few weeks ago, CCHR submitted copies of the model mental health Bill to the Truth and Reconciliation Commission, calling on the psychiatric profession to confess its "complicity with apartheid medicine". The CCHR said: "The clear lack of participation by psychiatry in the TRC demonstrates an attitude in the profession that they somehow feel immune to the process.

"One of the greatest crimes that an individual or group can do is to do nothing when they have an obligation to act. Psychiatry did nothing to stop abuses in the field of mental health."

● Anyone with information on abuses by psychiatrists or adverse reactions to drugs is asked to contact CCHR's Psychiatric Abuse Line at 088-125-8723.

Calls for probe into death of patients

Sowetan 17/12/97

(88)

By Mokgadi Pela

THE Citizens Commission on Human Rights (CCHR) has reiterated its call for an inquiry into the deaths of patients in psychiatric institutions during the apartheid era.

In an interview with *Sowetan* yesterday, CCHR president Ms Colleen Wiltshire said the Truth and Reconciliation Commission should "unequivocally condemn the psychiatric abuses committed against South Africans in psychiatric facilities. We urge them to condemn those professional bodies, health authorities and practitioners who were party to them."

Wiltshire said by adopting this attitude, the TRC "will make it broadly and publicly known these abuses, especially the state-funded private institutions do fall within the TRC's mandate".

She asked that the:

● TRC call on all psychiatrists and psychologists who committed patient abuses, in violation of the Hippocratic Oath and other ethical codes, to take the amnesty offered by the body;

● System of accountability is established for professional bodies allegedly involved in creating, covering up or denying the abuses of blacks in such institutions; and

● Investigation be carried out into the drug practices within these facilities and any causal link to any death.

The TRC should also establish who were the medical officers responsible for investigating and reporting on each death.

Who did they report to and what annual reports exist on these deaths.

Wiltshire said the TRC should determine which deaths should be reported to the police for criminal investigation.

"The TRC should initiate appropriate criminal proceedings against any mental health practitioner for whom there is evidence of murder or assault in accordance with the law," she said.

H & D

— MENTAL HEALTH —

1998 - 1999

The Star ... Tuesday January 20 1998

Home's staff boot out director

Star 20/1/98

By Stuart Kelly

Striking workers at the Takalani home for the mentally handicapped in Soweto threw their director out on to the street yesterday to protest against what they claim is his poor management of the home.

About 50 workers waving placards demonstrated outside the home for much of the day after warning the director, Dr Jacob Semela, not to come back until he was prepared to deal with the problems faced by the 105 staff members and 600 child residents.

They also took away his car keys and locked them up inside the premises.

Spokesman for the workers, Elizabeth Mokone, said nurses and other employees were finding it increasingly difficult to carry out their duties.

"There is plenty of food coming in, but for some reason Semela keeps it locked in storage until it is no longer good for eating. No maintenance is being done at all. Children cannot be looked after well because the money Semela receives from donors does not reach us on the ground," Mokone claimed.

She stressed that, although the nurses and other staff were on strike, they would ensure that the children were cared for.

A small police contingent kept vigil outside the home last night. Semela was believed to have been taken home by the police earlier in the day and could not be reached for comment.

When The Star visited the home last night, exposed electrical wires were evident on many broken heaters, mattresses and blankets were shabby, and a number of the geysers were not working.

CAPE ARGUS, TUESDAY, JANUARY 27, 1998

Fate of New Kings patients in balance

Kalk Bay aims at restoration

(88) (89)

ARG 27/1/98

PETER GOOSEN
METRO REPORTER

The decision to close the New Kings frail-care facility and residence in Kalk Bay, home to about 200 disabled people, has come as a shock to residents who know no other home.

The New Kings, which is run on behalf of the Western Cape Department of Social Services by private contractors, Johannesburg-based Life Care Special Health Services, is to be phased out by the end of June, a casualty of provincial budget cuts.

The New Kings and the next-door Majestic house 200 mentally and physically disabled residents, who, says Social Services, will be transferred to other frail-care centres where there are vacancies.

The department has said it can no longer afford the New Kings contract and believes that it could rehouse residents satisfactorily.

However, an alternative will have to be found for at least 60 patients, those with the most severe disabilities.

The closure of the New Kings will mean that a large area of the False Bay seafront is likely to be available for restoration.

"The fact that these people are to be moved is tragic, but at the same time it's a tremendous opportunity to take another look at this area, which needs upgrading," said chairman of the Kalk Bay Development Steering Committee Neville Riley.

"The buildings are basically sound and they could be restored to their former glory."

Both the New Kings and Majestic, built on Main Road, Kalk Bay, early this century, were formerly hotels. The Majestic, in its heyday, was considered the coastal alternative to the Mount Nelson.

Although a number of schemes to redevelop the New Kings and the surrounding area had been put forward over the past few years, there never had been a formal application, said Mr Riley, who is also chairman of the South Peninsula's urban and environmental planning committee.

Louis Moolman, managing director of Life Care, which owns the New Kings, said the company's only concern at present was the welfare of its patients.

The New Kings was home to about 200 people and by the end of May only 60 would remain. It was up to the department to arrange frail-care accommodation for the remaining patients, but Life Care still might be given responsibility for them, somewhere else.

It would be uneconomic to keep New Kings open for only 60 patients.

Dr Moolman said he had had a number of approaches from developers, but until satisfactory arrangements had been made for all the patients at New Kings, the company would not consider any other use for the buildings.

New support group to ease SA's mental health burden

(88) BD 12/2/98

Josey Ballenger

THE escalating incidence of mental illness in SA, and the cost to society through absenteeism and decreased productivity, would hopefully be alleviated by the country's first national support group, medical experts said yesterday at the group's launch.

The Sandton-based Depression and Anxiety Support Group, backed by 18 major SA pharmaceutical companies, will provide telephonic counselling, regional support groups and an "extensive" referral system to psychiatrists, psychologists and general practitioners who specialise in mood disorders.

It will also offer workshops and educational programmes to schools, corporations and the general public, with a special emphasis on reaching out to poorer, rural communities.

Dr Dan Stein of the Medical Research Council said among international research "achievements" of the past 10 to 20 years was the definition of depression as a mental, rather than somatic, illness.

The World Health Organisation has projected mental illness will be the biggest cause of disability in developing countries in 2020 (it is currently fourth largest).

Yet mental illness was "a critically important area that has been ignored," said Wits University Prof Michael Berk, a member of the group's advisory board.

Berk said the group aimed to "destigmatise" mental illness and decrease the number of untreated illnesses. A US study, for example, indicated that less than 20% of patients diagnosed with mental illness received proper treatment — "and in SA, it is far worse," he said.

The group said only one-third of the "cost" of depression was related to treatment, with the other two-thirds being borne by employers on account of a sufferer's reduced productivity ... as well as absenteeism.

Dr Franco Colin, also a support group advisory board member, said international research indicated that ethnicity, education, income and marital status did not influence the onset of mental illness.

Gender and age, however, do play a role, with women twice as likely as men to suffer from such illnesses during their lifetime, and the 25- to 44-year-old age bracket the most prone.

Women have a 10% to 25% chance of having mental illness in their lifetime, while men have a 5% to 12% risk. More than 80% of all cases see repeated episodes, thus making it a "chronic, lifelong disorder," he said.

Colin said trauma-related symptoms — often suffered after a crime or violent event — ought not to be confused with anxiety or depression. Yet trauma could trigger a person's susceptibility to mental illness, which was partly genetic.

Focus on mental health system

(88)

Sowetan 23/2/98

CCHR aims to influence the TRC in transforming mental heath system

By Zanele Baqwa

RECENTLY *Sowetan* published two articles on mental health that should be commended.

This has helped the nation to become more aware of this issue and participate in discussions on mental health.

The articles featured the attempts of the Citizens Commission on Human Rights (CCHR) to influence the Truth and Reconciliation Commission's (TRC) recommendations on transforming the mental health system.

I wish to add to the total picture.

The CCHR has been active in trying to have a bearing on influencing the TRC's Reparations Committee to adopt policies that deal with alleged malpractices, or the human rights, of patients in psychiatric hospitals.

Its main thrust has been the alleged malpractices at certain private mental health institutions.

The American Psychiatric Association (APA) visited South Africa in 1978 and later compiled a report that identified "abusive practices, substandard care and violations of medical ethics in the psychiatric system".

The APA was not allowed access to public facilities, a consequence of Section 66 of the Mental Health act of 1973, which prohibits the scrutiny of psychiatric institutions and also bans photographs of these.

'Fascist Act'

CCHR chairman Paul Sondegaard has repeatedly appealed to the relevant forums to abolish this fascist Act, as reported in *Sowetan.*

Part of the intention of Section 66 could have been to protect the psychiatric patient – a "consignment to secrecy" – as distinguished psychologist and philosopher Michel Foucalt once claimed.

But the aura of mysticism must be removed from psychiatric hospitals and its patients. Transparency in both management issues and community involvement will give credence to the democratic principles of a liberated nation.

A report in January 1996 by the Mental Health and Substance Abuse Committee, formed by Health Minister Nkosazana Zuma in 1995, gave a thumbs-down to several private psychiatric hospitals.

Several other public psychiatric hospitals were also identified in this report, that had as its mandate "to investigate and report on any malpractices or violation of human right, in psychiatric hospitals".

They unravelled issues of abuse both sexual and physical, differentiation and inequality of treatment, racism, low morale among staff, no monitoring of irregularities and inhumane conditions.

The recommendations have as yet to bear fruit. Minor cosmetic changes have been instituted and one or two psychiatric hospitals have been closed down.

CCHR chairman Paul Sondegaard.

The slow, grinding bureaucratic machinery needs some oiling.

Systematic change is not easily achieved in a few years but the pace is maddening.

The fact is the patients in these institutions are the most vulnerable and weakest group in our society.

The care-givers and service providers have so long been practising blind eye, non-policies and been self-regulating, that the culture of psychiatric service could well be likened to madness itself.

As a psychiatrist, I am determined not to be bogged down, or culture-shocked into passivity and acceptance of the seemingly rotten state of affairs and lack of self-reflection by many in the psychiatric sector.

Attempts at creating change are perceived as personal threats.

Those from the apartheid past are still guarding their territory – that is, the psychiatric service and leadership thereof.

The media release of February 15 1996 by the Department of Health professed a deep concern about the findings of the committee looking into the provision of mental health services.

We in the mental health services are still deeply concerned.

The media has a vital role to play in exposing this shaky and unethical world of mental health service in our country.

(Dr Baqwa is a psychiatrist at the Medical University of Southern Africa, Pretoria.)

In the prisons of the mind

Lynda Gledhill *reports on the steps being taken by the Department of Health to deal with the mentally ill*

Cages of despair: Idleness leads to prisoners' feelings of depression, and there is often no psychological counselling available

Many patients who suffer from a mental illness describe the disease as like being in a fog. Perhaps it is not surprising then that the government is having such a difficult time getting a solid grasp on the problem.

Although the Department of Health announced plans last year to release as many as 15 000 mentally ill patients out of hospitals and into the community, less than 50 have actually left hospital grounds.

Currently, each province is initiating its own programme. In Gauteng, an audit is under way to assess all patients in state-funded care to see who might be released. In KwaZulu-Natal, trainers in psycho-social rehabilitation were sent to the Netherlands for training, and rehabilitation programmes are planned in three regions.

One of the first pilot areas for the release into the community was to have been the Western Cape, but only 167 patients have been discharged and 97 stay on the hospital grounds.

"The process of moving psychiatric patients from hospitals into the communities has to be very carefully managed," says Mervyn Freeman, national director of mental health and substance abuse. "Experience in countries like the United States and the United Kingdom indicates that without careful community planning and sufficient community resources, patients tend to end up in the streets and in prisons."

To help South Africa avoid these pitfalls, a group of international practitioners visited the department recently to offer insights into successful programmes.

One private organisation, the Depression and Anxiety Support Group, is attempting to reach out to those suffering from mental illness and hopes to break through the stigma attached to these diseases.

"People need to know this is an illness, not a weakness in character," says Wits University Professor Michael Berk, chair of the group's advisory board. "For people with mood disorders, there are treatments available."

Among the people the support group is reaching out to are prisoners at the Mogwase prison in North West province. The prison does not have a psychologist available and must send its prisoners to a nearby private hospital for evaluation.

"The resources are so stretched that we want to do anything we can to help the prisoners help themselves," says Zane Wilson, the group's communications director. "A lot of prisons don't even have visiting psychologists, so this is better than nothing. The same percentage of the population is going to be affected, whether they are in prison or not."

Dr Jue Kabugutjo, the Mogwase prison doctor, agrees there is evidence of some mental illness, but says many of the symptoms might have other causes.

"I'm sceptical about claims that there is a lot of depression," he says. "No one goes to prison and is not depressed. I tell them I understand their situation and I sympathise, but the system says they have to be here. On a broad scale I'm sure there is some level of depression, but it is a question of degree."

The prison's lack of resources does have an effect, Kabugutjo adds, because if prisoners are idle it will help contribute to a feeling of depression.

Wilson points out that mental illness still carries a stigma, not only in South Africa, but in much of the world. "It's very much like Aids was 10 years ago. If you are interviewed for a job, it doesn't matter if you are black or white, you will be looked at differently. The Aids stigma has been greatly reduced, and we are working to do the same thing."

Berk says it is this lack of understanding and stigmatisation that leads to minimal financing for treatment.

"But depression is a massive problem and there is a very high incidence rate in the population. According to the World Health Organisation, by the year 2020 depression will be the single biggest cause of disability in developing nations."

Five bring hope to brain-damaged children

A group of unemployed women revolutionise their community's attitude towards the mentally handicapped

Star 20/4/98 (88)

By Winnie Graham

PICTURES BY WINNIE GRAHAM

They made a difference ... the five Levubu mothers outside the school built for children with mental handicaps. With them are Sister M Matthew (centre) and Solomon Raphulu, the father now helping them. The mothers are Nancy Munyai, Sarah Ndou, Elisa Tshirurvhela, Gladys Sitholimela and Nunu Munyai.

Five mothers in the Levubu area of the far Northern Province have revolutionised the attitudes of an entire community to mentally handicapped children by opening an educational centre for their brain damaged offspring.

The women, Gladys Sitholimela, Elisa Tshiruruvhela, Nunu Munyai, Nancy Munyai and Sarah Ndou, all unemployed rural housewives, made a momentous decision when they agreed they would no longer hide their handicapped children in back rooms.

Instead, they would pool resources and with the help of a social worker and a tutor from the local nursing college, would

> **Birth of a defective child brought family shame**

open a "school" where their youngsters could be taught skills that would make them reasonably self-sufficient.

So it was that just two years ago, the Una Rine (meaning "the Lord is with us") Day Care Centre for Handicapped Children came into being. The school is at the foot of the Tsianda Hills and the children are from the villages of Tsianda, Tshkhuma and Hamutsha.

The establishment of this centre was a brave gesture in the poorest province of South Africa. Here there are reportedly more handicapped children – inflicted by various abnormalities ranging from blindness to physical disabilities – than elsewhere in this country.

But the mothers' decision to start a school was important for a good reason. Since time im memorial, the birth of a defective infant in the community has been viewed as a shame on the family. The children have always been kept out of sight.

Disenchanted husbands, unable to handle the shame and pain associated with the birth of such a child, often abandon wife and family.

Now, at last, the mothers' decision has meant the concerns of handicapped children have been brought into the open.

The proposed creation of the centre evoked a surprising response from the community.

As the five mothers moved round telling others what they planned, they discovered there were literally hundreds of physically and mentally handicapped children hidden from society in back rooms.

Those who received disability grants from the government used them to support entire families. Little, if anything was being done for the children. The mothers realised there was work to do – and got started.

They found premises at a weaving centre – for which they were charged R200 a month – and offered to look after children, whose handicaps barred them from ordinary schools, on a voluntary basis. Twelve children joined the centre and the mothers used the R50 a month fee to buy food for them. Their own services they gave free. Since then the enrolment has grown to 29.

It has been tough going. In April 1996, the group approached Sister M Matthew from St Joseph's Catholic Mission in Levubu for help. She investigated and found their premises "most unsuitable".

"There were neither cooking nor toilet facilities," she said. She turned to the Missionary Sisters of the Holy Rosary in Ireland who gave her R30 000 for the project.

But the little nun was not finished. To build the centre she approached the Rev Murray Hofmeyer at the University of Pretoria and asked that the SA Students Voluntary Organisation help erect a functional building. They willingly agreed.

The local chief, Chief Netsianda, provided the land, and the local works department offered the services of four workmen who finished off the building – toilets, kitchen, storeroom and all.

A man across the road from the centre offered his services (unpaid) as caretaker and handyman. Various people made small contributions to get the new "school" started.

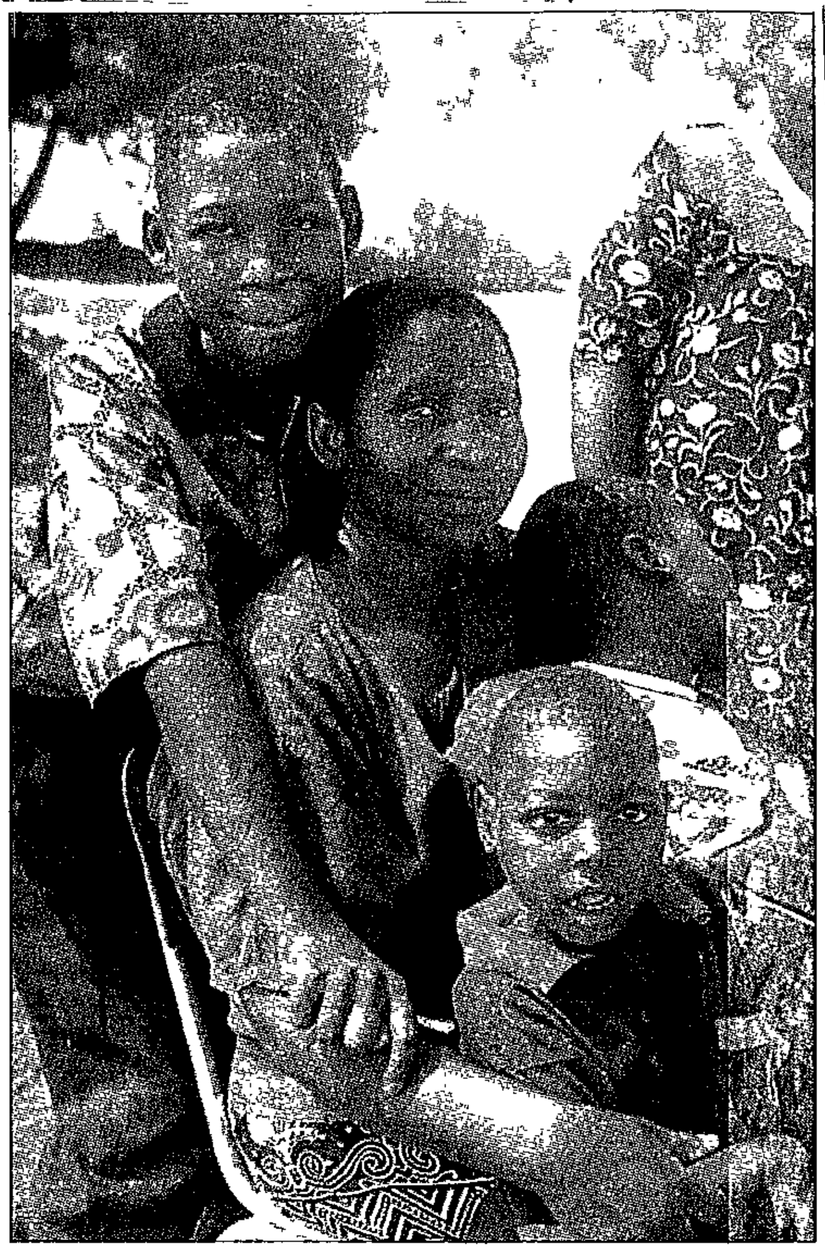
The pupils of the Holy Rosary Convent in Edenvale spent a few days at Unarine decorating the walls.

The goodwill was there but money remained a problem.

Sister Matthew added: "The centre is run on a shoestring. Most of the parents are single and unemployed and unable to contribute. But this is a centre for special children with special needs."

The mothers "teaching" at the school have had no formal training but have done short courses in pre-school management. The boys are taught skills such as gardening and bricklaying while the girls are taught to sew. A few are learning to read.

All five mothers now so closely involved in the centre endured the same misfortune when they gave birth to mentally handicapped children.



A mother's love ... Gladys Sitholimela with her son, Dowelane (14) and two smaller children at Una Rine, Northern Province.

Gladys Sitholimela, mother of Dowelane (14) who cannot walk or talk, says he was injured at birth after a prolonged labour. His twin is asthmatic. Elisa Tshiruruvhela whose child, Dakalo, (13) (the name means "happiness") was another victim of inadequate antenatal care. She says her baby "didn't cry" when he was born.

"He took a long time to come," she added.

Nunu, whose daughter is aptly named Fhatuwane Matiba (5) (meaning "wake up") also had a difficult birth. Her husband had difficulty accepting a mentally handicapped child and has since divorced her.

Sara Ndou, whose daughter is named Shanika ("suffering"), also had a prolonged labour. Nancy Munyai's daughter, Lindelane ("waiting") is an albino.

There is at least one father who works with the mothers for the centre. He is Solomon Raphulu, a retired employee of the Anglo American Corporation and the father of Livhuwani (22), (meaning "thank you").

It is no secret that the boy is the joy of his life.

"He is my only child," he said. "And I love him."

He and the women are now trying to raise funds to build a hostel for the children. If they can, it will ease the lot of the women who have difficulty getting their offspring to school.

One of their biggest problems is transport. Mothers pay between R25 and R30 a month to have their child picked up and dropped off. This prevents many handicapped youngsters from coming.

Sister Matthew says there is no water at the school. This is a major problem. The mothers remain unpaid (after more than two years) and the children receive no special care.

"Some would benefit enormously from remedial teaching as they have limited intelligence and should be given occupational therapy and a chance at a better life."

There are many obstacles still to be overcome but the five mothers are patient women. They have come this far so – Una Rine – the Lord must indeed be with them.

Anyone wishing to help should contact Sister Matthew at St Joseph's, Box 55, Levubu 0929, phone (01558) 30292.

Mental health policy aimed at community care

ET 11/5/98 (88)

JOVIAL RANTAO

LEGISLATION to change the institutional and custodial approach to the treatment of mental illness to one that is community-based is to be introduced in Parliament soon.

Health director-general Dr Olive Shisana, in an annual report tabled in Parliament, said submissions had been received about changes to the Mental Health Act of 1973, and drafting of the new bill had begun.

Shisana also said the Law Commission had drafted changes to the Criminal Procedure and Mental Acts to facilitate the intake of people for observation through the justice system and the discharge of state patients.

According to the World Health Organisation, at least 20% of South Africans suffer from some form of mental illness or psychological disorder.

In her report, Shisana noted that mental health promotion and the provision of services to South African communities had been neglected.

"Common manifestations (of mental disorders) are inter-personal violence, trauma, neurosis of living under continuous stress, post-traumatic stress reactions and disorders, substance abuse and suicide," Shisana said.

She said research analysing and comparing the quality and cost of state and state-funded psychiatric hospitals had been completed.

The study would assist provinces in deciding whether to contract out chronic patient care or to manage it themselves.

The study developed detailed quality assessment instruments to be used in setting standards for psychiatric care in the coming year.

"The Department of Health has embarked on a process to shift away from the current institutional and custodial approach to the treatment of mental health to one that is community based," Shisana said.

"This process will, however, take some years to achieve as community services need to be developed before patients can be referred to them."

She said the department was also developing a plan of action for violence-prevention and intervention with victims. The plan would include improved data collection, integrated services for victims of violence and the development of referral facilities and prevention programmes.

Community-based approach to mental-health care sought

Star 11/5/98 (88)

By Jovial Rantao

Cape Town – Legislation to promote a community-based approach to mental health is to be introduced in Parliament soon.

Health director-general Dr Olive Shisana, in an annual report tabled in Parliament, said submissions had been received regarding changes to the Mental Health Act of 1973. Redrafting of the new bill had started.

Shisana also said changes to the Criminal Procedure and Mental Health acts had been drafted by the Law Commission to facilitate the discharge of state patients and the intake of people for observation through the justice system.

According to the World Health Organisation, at least 20% of South Africans suffer from some form of mental illness or psychological disorder.

In the report, Shisana noted that mental-health promotion and the provision of services to South African communities had until now been badly neglected. "Common manifestations are interpersonal violence, trauma, neurosis of living under continuous stress, post-traumatic stress reactions and disorders, substance abuse and suicide," she said.

"The Department of Health has embarked on a process to shift away from the current institutional and custodial approach in the treatment of mental health to one that is community-based. This process will, however, take some years to achieve as community services need to be developed before patients can be referred to them."

Shisana also revealed that the department was developing a plan of action on violence. It would include improved data collection, integrated services for victims of violence, the development of referral facilities, and prevention programmes.

▶ **Depression chief cause of absenteeism**
Page 4

health services have been severely wounded by budget cuts

seven victims

M+G 22-28/5/98 (88)

Valkenberg all but froze the release process late last year, as the killings mounted. Kaliski estimates that discharged patients have now killed at least 11 people over the past three years. Many of them have since been returned to the institution.

"Either we've got to watch them closely, or someone else must, but we have great difficulty keeping an eye on everyone," Kaliski adds. "The only way we can keep control of them is to keep them in our walls."

He says the unit is unable to gauge what sort of treatment, if any, other discharged former patients are receiving.

Adequate community care will be vital in preventing the government's drive toward releasing state patients ending in a smash. The government's main motive is to modernise its approach to mental and psychiatric health care, away from often grotesque past practices such as simply locking patients away.

But similar experiments overseas have left many former state patients on the streets or in jail. Such results prompted the United Kingdom recently to reverse its care-in-the-community policy.

The Western Cape based its rationalisation plans partially on a task-team report finalised earlier this year.

The report warned that community care for psychiatric and mental patients, already hampered by staff shortages, had been further hurt by voluntary severances. It recommended that posts vacated under the pay-off programme be retained and filled.

But the department responded that it could not "guarantee" the posts would be retained. "Cognisance must be taken of the need to rationalise the total health department to set budget limits," the department noted.

Freeman says community care in the Western Cape "has not collapsed. However, there is little doubt that these services could be improved."

Lawrence adds that the province will only release patients into the community "at a rate that can be received". At the moment, such patients are being moved into halfway houses.

SA Health in need of treatment, PAGE 24

On the street: Where will Valkenberg patients go if the institution closes?
PHOTOGRAPH: JUSTIN SCHOLK

Subtle signs of relapse hard to detect

(88)

Andy Duffy M+G 22-28/5/98

Staff at the Valkenberg forensic security unit are busy retracing their steps to see what, if anything, could have been done to prevent the killing of seven people by former state psychiatric patients.

There are common threads. Each patient, despite their usually violent history, seemed to have responded well to rehabilitation treatment at the unit, each responded well to outside treatment at clinics, and then, one by one, each fell from the state's radar screen ... re-emerging only once they had killed.

Names and specific dates remain under wraps, often for legal reasons, often because Valkenberg fears for the safety of the patient. One Cape Flats community is still looking for the man who knifed to death one of its highest-profile women — the aunt who had taken him in when his family in the Eastern Cape refused.

One case, however, seems to sum up what's gone wrong. Valkenberg had held one violent patient for years, finally deciding early in the 1990s that he could be released.

"He did very well," says unit head Sean Kaliski. "He found a job, he got married, he was coming to a clinic. And then he stopped coming."

So nobody picked up the growing friction between the man and his stepdaughter. He wanted her to treat him like a father; she laughed at him for being a former psychiatric patient.

One afternoon, in the family's lounge, in front of her laughing friends, the girl pushed the ridicule too far. The man fled to his room, and returned with an axe that he swung high and sank deep into her chest.

The ex-patient was initially held at Pollsmoor, apparently because he did not appear sufficiently insane to warrant a place at Valkenberg. In a matter of months he had totally relapsed and was back at Valkenberg.

"We still don't know what went wrong," Kaliski says. "The early signs of relapse can be very subtle and you must see these people quite a lot. They should be seen at least once a month." But when they don't appear at the clinics little effort is made to find them. "We just don't have the resources to do that anymore."

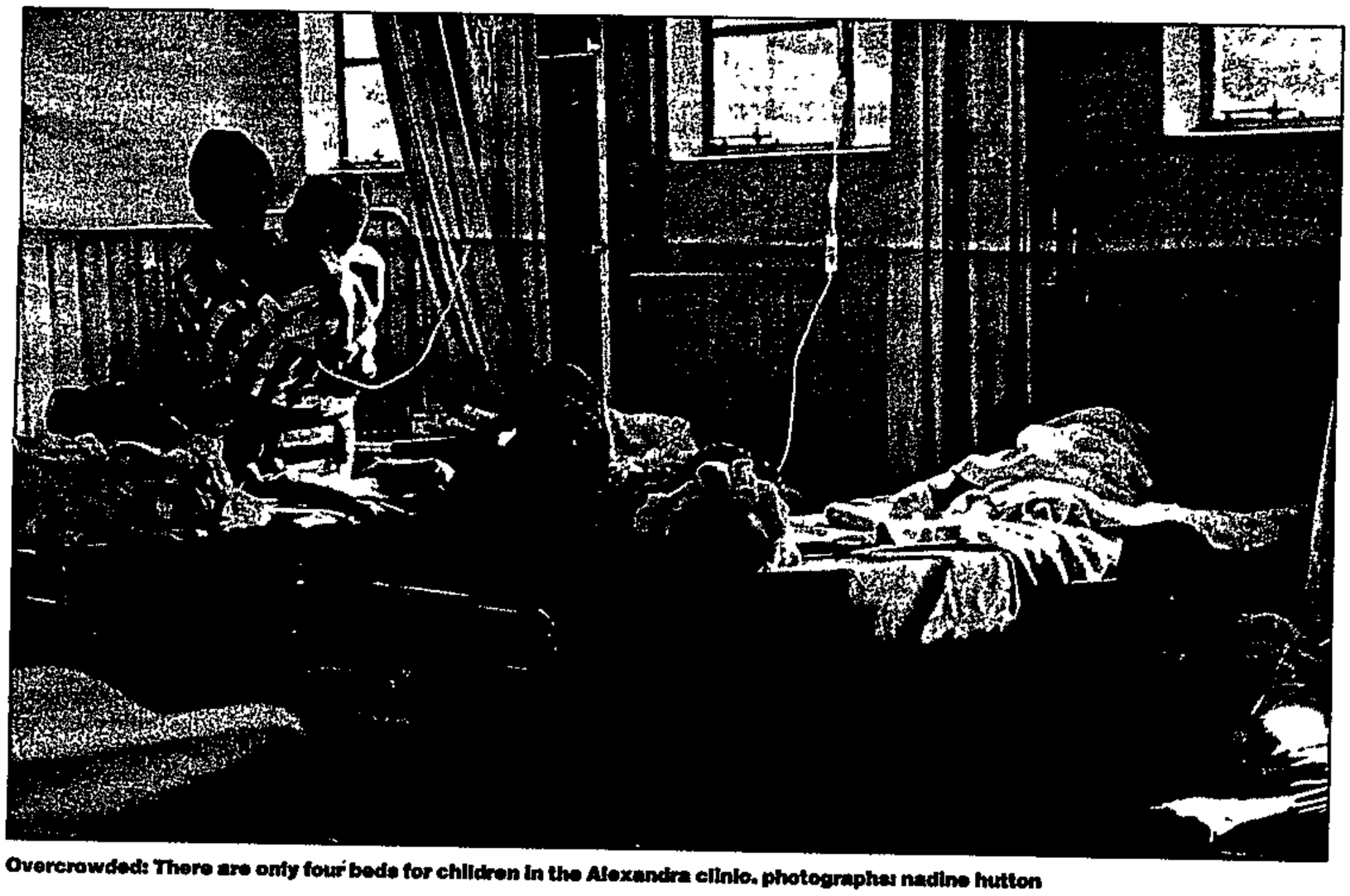
The unit is still chasing details from the Free State police about the abduction, rape and killing of two small girls by one of its ex-patients, early last year. The patient's case history shows that he too had been a very violent character, but after he had spent years in Valkenberg, staff "felt obliged to start the rehabilitation process".

He too disappeared after a few clinic visits, only to resurface in the hands of the Bloemfontein police. "We had no way of tracking him down," Kaliski says. The other cases include a patient stabbing his wife, and a patient who stabbed his mother.

One former patient, who had married and had a daughter, flipped when he was walking down the street, stabbing to death a man he remains convinced was a top gang leader.

Valkenberg has its successes. Kaliski has one patient who was held at the maximum security unit for 16 years after killing three people. The man is still a state patient, but he holds down a job in the city. Kaliski sees him regularly.

"It's only a very small section of those who become ill that are violent and they need extra care," Kaliski says. "But when budgets are cut we're cutting very important and very sensitive services."



Overcrowded: There are only four beds for children in the Alexandra clinic. photographs: nadine hutton

Just three hours to rest after giving birth

M+G 22-28/5/98 (88)

Bongani Siqoko

The road to Alexandra clinic is lined with filthy industrial buildings. But the large, brightly painted clinic looks cared for and cheerful. Many visitors mistake it for a creche.

Inside, however, it looks like any other state-funded health institution. Very long queues, busy nurses, crying children and wheelchairs fill the waiting room.

The clinic will be forced to close down if it does not get more funding from the government, staffers say. This follows a budget cut of R9-million by the Department of Health. "We were getting R21-million a year, but now we only get R12-million. What can you do with R12-million these days?" asks a senior nurse at the clinic.

Director Catherine Mvelase says although the clinic is expecting another R1,2-million from the Eastern Metropolitan Local Council, it still won't be enough. The clinic, which has been operating for 68 years, treats more than 1 000 patients a day from Alexandra township — which has a population of about 500 000 squeezed into 2,5km².

It is also struggling to pay the R5-million it owes the Gauteng provincial administration for drugs. "We are trying to pay what we can," says Mvelase. Every month the clinic has been buying R210 000 worth of drugs, but since the Hillbrow hospital closed down it has been forced to double that amount.

"We are getting more people from Yeoville, Hillbrow, Alex, Midrand and Berea who have been referred to us by Hillbrow hospital," says Sister Legora Marumo. As a result the clinic's pharmacy has run out of some essential drugs. "For weeks we have been telling people to come back later for these drugs," she says.

If the clinic shuts down, sick children and pregnant women will suffer. Although it has limited resources, the clinic still treats hundreds of children with diarrhoea, flu, pneumonia and asthma.

The children's observation area has only four beds. It is overcrowded and sometimes four children have to share one bed.

The adult observation areas are the same. Three women share one bed, and the women are sometimes housed with male patients. Only two professional nurses, a porter and an assistant nurse are on duty at any given time for all three wards.

The situation is even worse in the maternity ward. There are only two midwives to look after women who are about to deliver or who have just given birth. Women are given only three hours to rest after giving birth. "We cannot do otherwise, there are other women queuing up for the beds," says Marumo.

'Calculated risk' when criminally insane freed

STAFF REPORTER

ARG 22/5/98 (88)

Psychiatrists working with criminally insane patients "take a calculated risk when they release them back into society, and there is always a chance the decision will backfire".

This is the view of Gilbert Lawrence, chief director of supra-regional hospitals for the Western Cape Health Department.

He was responding to allegations that the Health Department was irresponsibly cutting resources to psychiatric hospitals like Valkenberg.

In an article in the Mail & Guardian today, Valkenberg's forensic unit head Sean Kaliski said seven people had been murdered by released patients in the past 18 months. He said there were not enough staff members in the unit to safely care for patients or to follow up once patients were released.

Most of the victims were family members of the killers – and included two children.

Dr Lawrence said the responsibility for releasing a patient rested with the doctor who recommended to the authorities that a patient be released.

"In any dealing with a patient a doctor has to use his best clinical judgment. Even in the most well resourced society there are failures. Many patients who go out are successfully rehabilitated."

But Dr Kaliski said the exodus of psychiatric nurses and social workers from the public service meant there were not enough qualified staff available to check up on patients once they were back in society.

He said many patients were being released for a month at a time because the hospital did not have the staff to control them. "We just hope to God they don't hurt anyone," he said.

Dr Lawrence said: "Obviously if we had more resources there could be better programmes inside and outside – but at the end of the day the doctor still has to make the final decision."

'You'll find a lot of bodies in these two rivers when it closes'

(88) ARG 28/5/98

Change is difficult, not only for patients, but for hospital staff who have to move to a new workplace.

Kate Josiah, a senior nurse working in the forensic rehabilitation ward at Valkenberg, said she has decided to leave the health service.

"I must go now; I can see the difference already at the hospital. We are going down," she said.

Mrs Josiah, who will take the voluntary severance package, has 11 years' experience in psychiatric nursing. She's a valuable member of the team and her leaving is a loss to

JENNY VIALL

HEALTH REPORTER

health services. "A few years ago I considered it but I thought maybe we'll come right with a new budget. But as time went by I saw the reality.

"I have no other option but to go. The staff-patient ratio is so bad, we are down to the bone.

"I have to do admin, stores, deal with the public. After a while you find your frustration affecting your patients, and that's not good," Mrs Josiah said.

The prospect of moving to another psychiatric hospital has no appeal for her. "I don't want to go through the emotional upheaval of moving to a new place, where you have to fit in to another structure."

"When they amalgamated the Pinelands and Observatory side of Valkenberg, the vibes were difficult, there were strong feelings of not being welcome, of people seeing you as a threat. I don't want that again."

She applied for the package on April 7 and heard on May 11 her application had been approved. "It was so quick," she said.

Mrs Josiah believes that closing Valkenberg will be a problem for her patients, many of whom are outpatients for three weeks of the month and return for a week to be assessed.

"They need stability. They get used to this hospital, the same staff. I'm afraid you'll find a lot of bodies in these two rivers when the hospital closes.

"Patients will default on their treatment and relapse. The route to the other hospitals is complicated, they won't go there.

"Here they know the staff, they need the same face, or a voice on the telephone they know. It's already a battle for them to get here from places like Ocean View – how will they manage to Lentegeur?

"Already patients are getting anxious – they're saying rather discharge me than move me.

"People will be on the streets. I feel sorry for them." Dennis, a patient with schizophrenia, echoes this sentiment.

He's been in Valkenberg 10 times. "It's nice to have doctors you know. I know Dr Baumann will help me," he said repeatedly.

"People on disability grants can't afford to go to Lentegeur, and anyway, they'll get lost.

"Why don't they just keep this part open?"

■ There will be a meeting of patients and their parents and relatives on Saturday at 2pm at Valkenberg's Education Centre.

JACK LESTRADE

Leaving: sister Kate Josiah is getting out

Valkenberg patients step into unknown

ARG 28/5/98 (88)

Shutdown part of plan to reshape mental health in W Cape

JENNY VIALL

Abel was making good progress at Valkenberg hospital and was close to being discharged.

Then the first announcement was made that the hospital would close and he suffered a relapse. He recovered from that, but then the second announcement came and he's had another setback.

Abel is a chronic psychiatric patient and just one of the many people at Valkenberg who have had relapses in the past months due to anxiety about the hospital's future, say staff.

Psychiatric patients are different from other patients, you can't just move them to another hospital, they say.

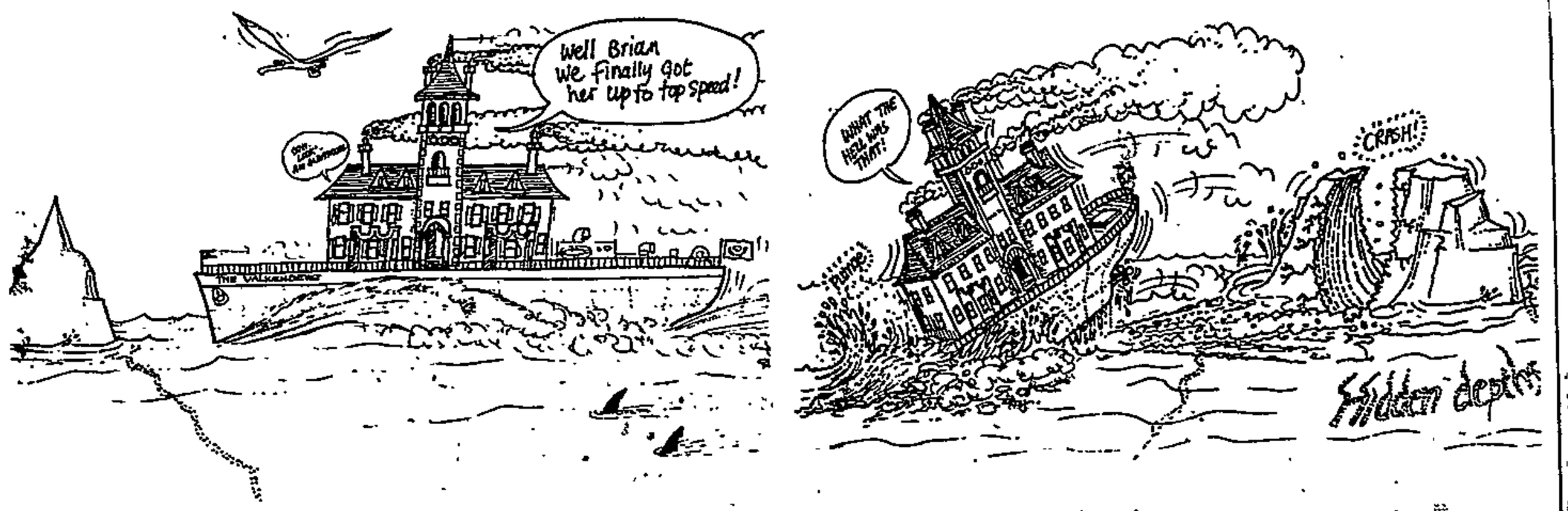
Sue Blyth, a psychologist at Valkenberg, says psychiatric patients need stability and the knowledge there is a safe place for them to come to when they need it. When their security is threatened, they relapse.

"There's an enormous amount of anxiety," she says.

Despite assurances that there will still be services at Lentegeur and Stikland hospitals, and outpatient clinics for them, there remains concern for the patients.

The nature of mental illness means that the majority of psychiatric patients relapse and need to be readmitted to hospital. Easy access to a hospital and a steady relationship with staff is essential.

"My experience is that it can take anything up to two years to build up enough trust to get patients to work with us," says Ms Blyth. Sean Baumann, a psychiatrist at the hospital, says fragmenting mental health services will create havoc and the relapse rate will increase, placing a heavy burden on families, patients and hospitals.



Sinking ship: patient Roy Foster's impression of the plan to close Valkenberg Hospital. 'Some people do adjust, but some will get lost along the way'

"Some people do adjust, but some will get lost lost along the way," he predicts.

Valkenberg hospital's future has been uncertain for many months. Now the health department has decided to close it, a decision which still has to be ratified by the provincial cabinet.

Patients and staff will be reassigned to Lentegeur and Stikland psychiatric hospitals and an out-patients unit will be established either at Alexandra or at Groote Schuur. This means there will be no loss of services, says the department. Staff at Valkenberg say it's not that simple.

About 50% of staff have indicated they won't move to the other hospitals. This is mostly for personal reasons such as travelling distances or lack of confidence in the future of health services.

What it means is that there will be fewer services for psychiatric patients at a time when more are needed. The head of psychiatry at the University of Cape Town, Brian Robertson, says the inevitable loss of services is serious. Wards for acute patients, many of them psychotic, at all three psychiatric hospitals are frequently closed to new admissions because they're full. Hospitals help each other out, but there have been times when all three have had no space. Staff question why a well-functioning, well-resourced hospital is being closed, when all it will save the health department is about R8-million this year?

The head of supra-regional hospitals in the Western Cape, Gilbert Lawrence, says Valkenberg will close for one reason only – it is part of the plan to reorganise mental health services in the Western Cape, to rescue a service which has been affected by staff taking voluntary severance packages over the past four years.

It is not about saving R8-million, nor is it about losing services. "We've had no say over the packages, that's why we need to rationalise. Otherwise we'll end up with only chronic mental hospitals. We have to protect our acute beds.

"I have to look at the bigger picture of mental health services. We either need more resources, which we don't have, or we must consolidate."

Staff at Valkenberg say they are not opposed to restructuring. Academics, staff, non-governmental organisations and Friends of Valkenberg have put forward alternative proposals. Professor Robertson says there has to be at the very least a 100-bed unit in the area to cope with patient demand.

"But we've been told we won't even get this at Groote Schuur Hospital."

But it's not yet the end of the Valkenberg story, says Eran Robertson, of Friends of Valkenberg.

"We are exploring legal avenues to stop the hospital from closing."

No one is fighting for us, say psychiatric staff

CAROL CAMPBELL (88)
SPECIAL WRITER

ARG 28/5/98

Three of the four psychiatric hospitals in Cape Town have no medical superintendents and staff fear no-one is fighting on their behalf to stop the reduction of psychiatric services in the Western Cape.

Worst hit is Valkenberg which is threatened with closure because of a shortage of cash in the Western Cape health budget.

Valkenberg medical superintendent Deon Schoombie left at the end of April. He emigrated to Australia.

At Alexandra Hospital, medical superintendent Linda Hering has been promoted, leaving her old post vacant, and Miles Bowker, medical superintendent of Stikland hospital, is on long-term sick leave.

"I want to know who is making the decisions for Valkenberg, who is fighting for us," said Sean Kaliski, head of the Valkenberg forensic unit.

The provincial cabinet was supposed to make a final decision on the future of Valkenberg yesterday but it was postponed for another week.

See page11

MAIL & GUARDIAN
May 29 to June 4 1998

Equipped to face our madness?

(88) M+G 29/5 – 4/6/98

Uneven standards of community care mean the state's new policy of releasing mental patients could be a bad plan, writes **Andy Duffy**

The deaths of seven people at the hands of former state psychiatric patients in the Western Cape have exposed a raw nerve in state health circles.

The Department of Health this week slammed a *Mail & Guardian* report on the killings, claiming it had sensationalised the incident, leading to "panic and unnecessary paranoia" about mental and psychiatric patients.

But state psychiatrists and NGOs across the country say the deaths are merely an extreme symptom of the lack of funds and staff that hamper the system.

Valkenberg, the Cape Town hospital that treated and released the six patients who killed, says the report was fair.

The *M&G* reported last week that six patients released from Valkenberg's high security forensic unit had killed seven people in the past 18 months, including two children.

Forensic unit head Sean Kaliski blamed weak community care structures. A recent provincial health department report also found that staff shortages had weakened community care.

The Western Cape provincial Cabinet was due to decide this week whether to approve a health department proposal to close Valkenberg, as part of a rationalisation of health services.

Other state institutions approached this week said the standard of community care for discharged state patients is often patchy, and in many poor and rural areas is non-existent.

The health department also concedes that, with its "limited sources" community treatment and monitoring of discharged patients "is not always as regular or comprehensive as we would like".

Three of four major state institutions have cases on their books of discharged patients committing new crimes, of varying seriousness.

The largest institution, Pretoria's Weskoppies, released a patient who last year killed a child in Mpumalanga.

The Free State's Oranje hospital, has taken 13 years to establish a community care network that ensures relapses among discharged patients are caught quickly.

State forensic patients, held because they are judged unfit to stand trial for a crime, represent a small minority of the thousands of harmless state psychiatric and mental health patients.

But effective community care is central to the government's attempts to release thousands of such patients into the community — a project led by health department director for mental health and substance abuse, Melvyn Freeman.

Freeman refused to respond to further questions this week. Instead, he issued a lengthy condemnation of the *M&G* report. "(This) article dramatises the situation and spreads false fears to the public regarding people with mental disorders," Freeman says.

"The result is public panic and unnecessary paranoia of people with mental disorders."

Freeman says the report also "undermines" the government's deinstitutionalisation programme — "an approach to care which is more humane and rights-oriented than the current system of largely custodial care".

But the South African Federation for Mental Health, which represents NGOs across South Africa, says Valkenberg fairly reflects the general problems facing state psychiatric and mental health.

The federation also has concerns about the government's deinstitutionalisation drive. "The health system just isn't equipped to look after these people," says federation director Lage Vitus.

"It is a major problem that we don't have the funds for community service. The [department] has left it for NGOs to pick up, and we're not really equipped for it either."

Weskopples senior medical superintendent Leandre Gauche says two of its discharged patients have killed in the past six years. In the most recent case which took place in Mpumalanga last year, the patient had originally been held at Weskopples for killing another child.

The 300-bed unit treats patients from across Gauteng, Mpumalanga and the Northern Province. "When [relapses] have occurred we suspect it's because of inadequate care," Gauche says. "We find the relapse rate is higher among people coming from these [rural, poorer] areas."

Dean Stevenson, forensic unit head at Sterkfontein, says the unit knows of one of the 20 patients it has discharged who committed a crime. "We may not always get to hear of it," he adds. "Where we do have a concern is the patients that are discharged to other [under-resourced] provinces."

John Dunn, principal psychiatrist at Fort Napier in KwaZulu-Natal, says the hospital does not regard its relapse rate as a major cause for concern. But he adds that half of its 180 patients come from far-flung rural areas, where community services are often thin.

Susan Otto, senior executive officer at Oranje hospital, says discharges can only go ahead with a sound community structure in place.

The Free State pioneered the programme, in 1985, that the national department wants other provinces to follow. "We don't struggle like other provinces do," she adds.

Around 500 patients were admitted to state forensic units last year. Freeman says the department would rather discharge those deemed rehabilitated than build new institutional facilities. Discharge conditions are stringent.

"The reality is that despite the fact that patients are assessed to the best of our abilities and that community facilities are provided (with resource limitations), there are, at times, awful consequences," Freeman says.

"However, the freedom of hundreds of people with psychiatric illness cannot be forgone because of unfortunate, and we agree, tragic exceptions."

Letters, PAGE 24

Home is where the health is

Angella Johnson

When Bafana Cele saw the car parked outside his Soweto home he ran and hid in the veld opposite. "He thought you had come to take him to Sterkfontein [mental hospital]," said his grandmother.

Martha Cele smiled toothlessly as she explained that the threat to institutionalise her 19-year-old grandson was the most effective remedy she used whenever he refused to take the medication that keeps him stable.

There has never been any doubt in her mind that he would always be cared for at home. "He's family and we will look after him. Just because someone is sick you don't just throw them away," she said.

It took Martha Cele (64) more than a year to realise that Bafana, who she has cared for since he was abandoned by his mother as a baby, suffered from a mental illness.

Doctors at the Chris Hani Baragwanath hospital in Soweto diagnosed him schizophrenic after he was admitted. They decided his condition could remain stabilised with monthly injections and a course of tablets.

So Bafana joined the ranks of patients who rely on a network of small outreach clinics for medication and other support, while being cared for in the community.

A shabby looking Bafana is eventually persuaded to vacate his hiding place, his bloodstained eyes darting wildly around as he shuffles into the cramped room the family use to entertain.

"I just feel sick," he mutters. "Sometimes I feel scared and want to go away. I think that my head hurts ... it's like a fever ... I feel so cold and shivery ... People laugh at me and sometimes I fight with them."

Martha Cele stares fondly at her grandson. "He's much better since the injections. Oh, but he used to go berserk, tear off his clothes and jump over the fence to run away. Then when he comes back he's wearing rags."

Bafana was a normal child; thoughtful, helpful and attentive at school, until about three years ago when he was beaten within an inch of his life by a gang of local vigilantes who claimed he had stolen someone's gun.

"I was away at the time. When I came back and saw him in intensive care at Baragwanath it seemed as if he would die," says his grandmother. Bafana survived but his mind was no longer the same.

He became restless and complained of seeing things. He stopped going to school, refused to wash and took to walking the streets, disappearing sometimes for days.

At home his two teenaged cousins became targets for bouts of violence. "We lived in fear that he would do something like burn down the house or hurt himself," says Martha Cele.

"Of course he was going mad, but we didn't really know what to do then." Now, thanks to medication from Chiawelo clinic the family is able to live a fairly normal life.

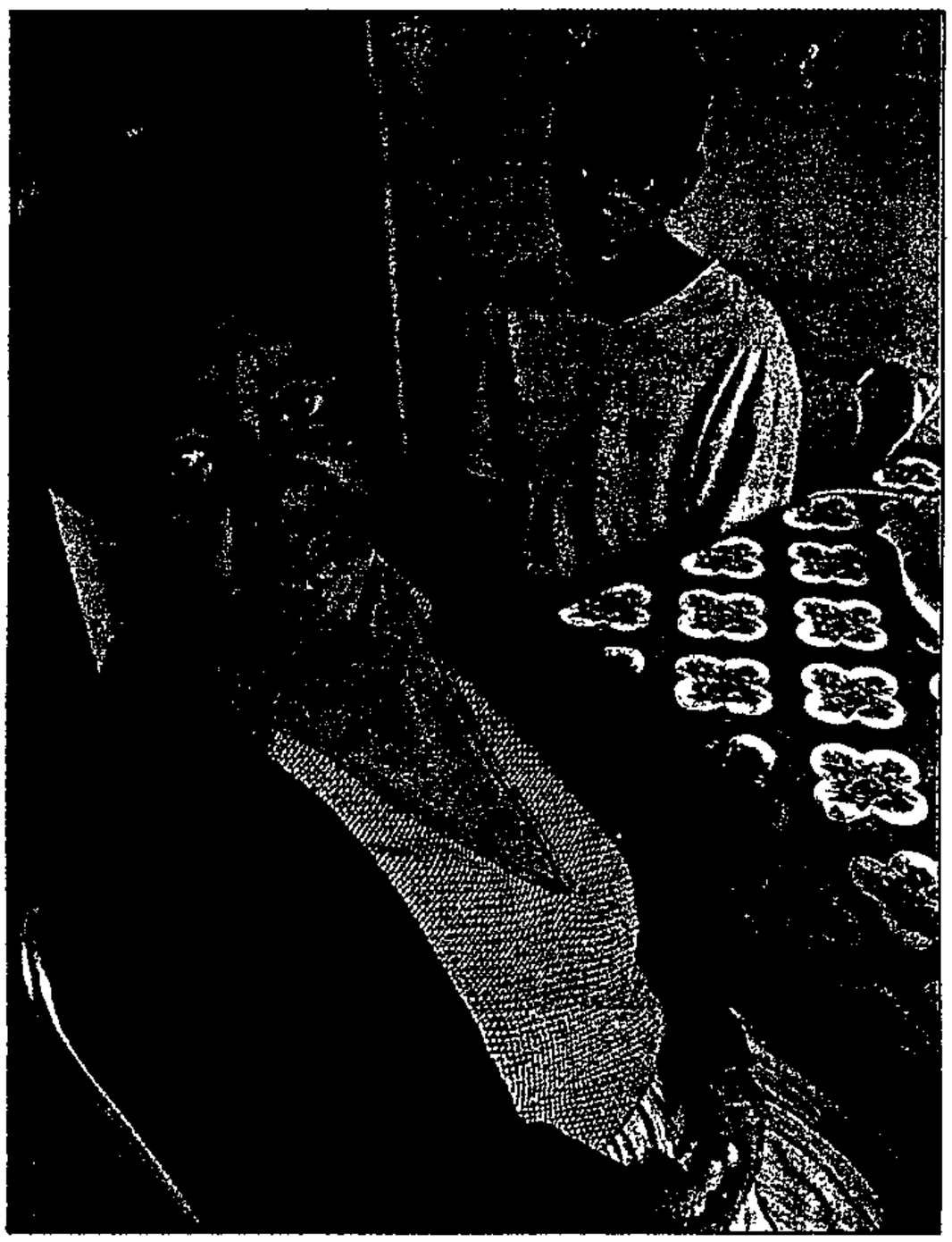
Caroline Siguba is the sister in charge of the clinic, one of nine in the township linked to Baragwanath, which treats some 700 patients monthly. Mainly males aged 19 to 60, they suffer from a range of disorders — including epilepsy with psychosis, paranoia and schizophrenia.

Siguba believes most people suffering from mental illnesses (she claims the numbers are increasing) need not be institutionalised. "As long as they have been stabilised in a hospital first, we can usually help them live useful lives (some of her patients hold down steady jobs) in a family environment.

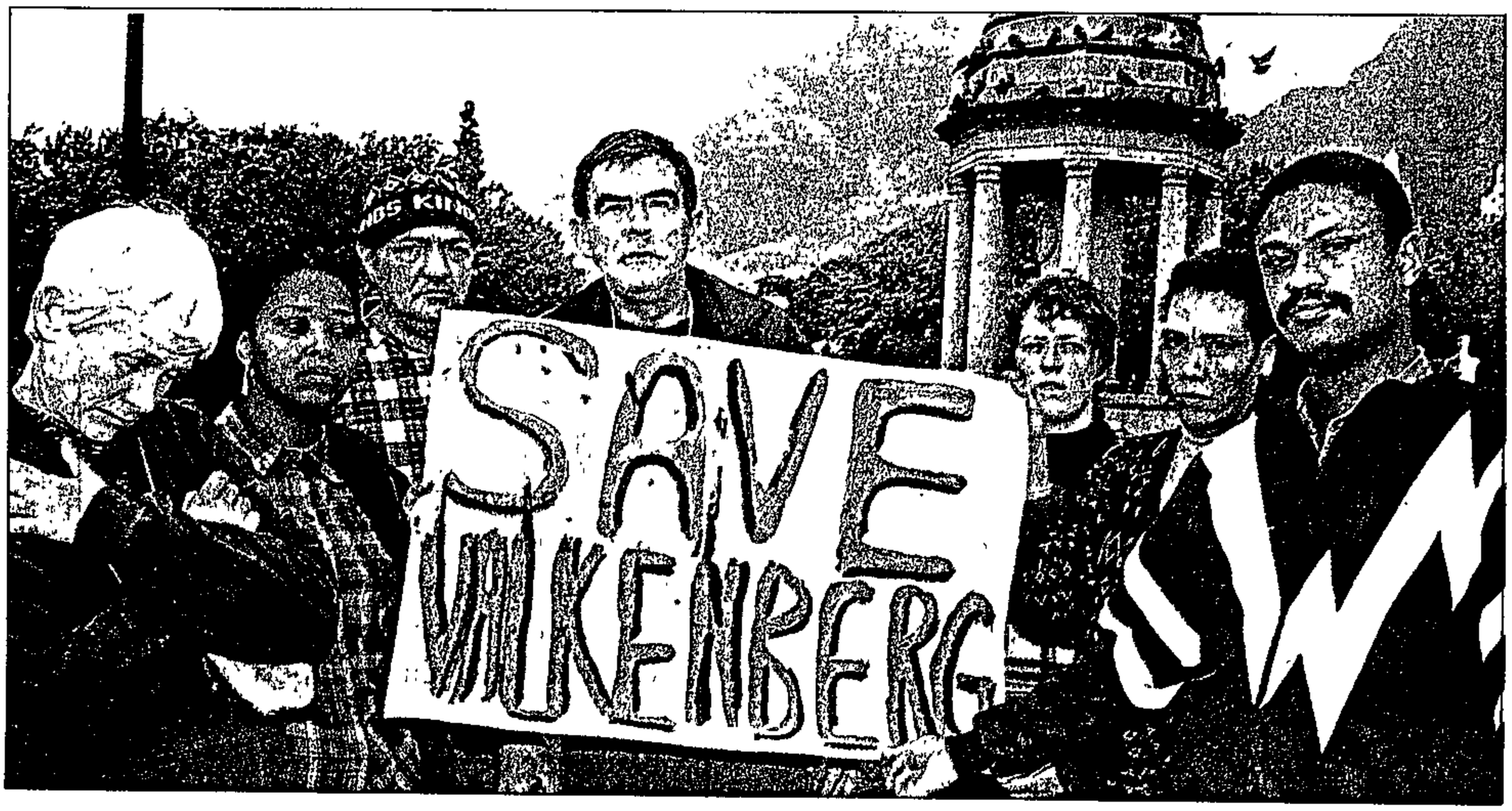
Siguba cites Baragwanath as one of the country's success stories in psychiatry. "We used to get patients released too early who could be dangerous. They came here agitated and aggressive, but we sent them back and that doesn't happen any more."

While the hospital was grateful for the approval rating, it admitted that a vast majority of its discharged patients never make it to a clinic for outpatient treatment. Dr Graham Behr, a senior consultant a the psychiatric unit, believes most just revolve through the doors.

Behr said one way to free more beds was for the government to provide halfway houses for the mentally ill. This would allow supervised care and some sort of rehabilitation process, for patients who have no family support base to help them cope on the outside.



Always cared for: Martha Cele with her grandson, Bafana. PHOTOGRAPH: RUTH MOTAU



COMBINED PROTEST: Fountain House worker Elma Badenhorst (fifth from left) was joined by Valkenberg outpatients (from left) Gillian Edwards, Elaine Tshuka, Richard Greyvenstein, Noel Bates, Desiree de Jongh and Roderick de Kock in a protest last week against the closure of the hospital. *PICTURE: THEMBINKOSI DWAYISA*

Mental illness the pauper of health budgets

CT 15/6/98

MORE hospital beds in South Africa are filled by people with schizophrenia than any other illness — including heart disease, cancer and diabetes put together — although new treatments for the disease mean that long-term hospitalisation could often be avoided. Professionals say that although mental illness is costly to treat, it is more costly not to treat it.

"Research has shown that 20 to 40% of people attending community clinics have some sort of undiagnosed mental illness. Often this presents itself as a physical illness, because people have no other way of expressing their distress," said Liz Dartnell of the Wits Centre for Health Policy.

The World Health Organisation names depression as the leading cause of disability and includes five mental illnesses in the top 10 disabling disorders. In the United States, every third dollar spent on health is spent on anxiety disorders.

In South Africa, the mental health burden is thought to be even greater, although — as is typically the case in this Cinderella of medical fields — very little local research into mental illness exists. To rectify this, the Medical Research Council and the University of Stellenbosch have launched a research unit to focus on anxiety and stress disorders.

"Studies have shown that stress and anxiety disorders are the most common psychiatric disorders, yet there has been very little research in South Africa," said Dan Stein, the head of the new unit.

"Failure to diagnose and treat these disorders at a primary level contributes to enormous costs."

Professionals say that South Africa has a high incidence of disorders like post-traumatic stress disorder because of our violent history. We also have a strong culture of substance abuse, with levels of risky drinking reaching 30% in some areas.

"We know that 25% of the population is affected by a mental illness at some point in their lives, and in South Africa this is probably higher," said Lage Vitus, director of the SA Federation for Mental Health.

"If this is not treated, the number of people who need hospitalisation will escalate."

The World Health Organisation recommends that 10% of a country's health budget be spent on mental health, yet South Africa spends less than half that. In some provinces it is as low as one percent.

The Western Cape has one of the better budgets, spending about eight percent on mental health, but most of this goes on psychiatric institutions which care for people once they have reached a crisis.

Robin Emsley, the head of psychiatry at the University of Stellenbosch, believes that many of these crises could be avoided.

"In the last few years the treatment of psychiatric diseases has changed dramatically. There are some very promising new drugs that offer sufferers a good chance of recovery.

"All the research shows that the most important factor in this recovery is early diagnosis and treatment."

Unfortunately this isn't happening. More than half of schizophrenics relapse in the first year. "Most of the patients come to us too late for effective treatment," said Emsley.

Patients upset by closure, officials blame protesters

ET 15/6/98

(98) (88)

GILLIAN EDWARDS spent a month in a locked ward at Valkenberg in 1987 and hasn't been back, except as an outpatient. She lives in Observatory and visits Valkenberg every three months.

"It's not pleasant being in a locked ward for psychotics, but Valkenberg got me right.

"All I need to stay right is five minutes with a doctor who knows me, every three months. Now they are proposing that we see a different psychiatrist every six months, and a sister in between at the day hospitals. That's not a service, I can't see how I will cope on that."

Noel Bates has been going to Valkenberg since he was 23. He is now 49. He has been an inpatient for the past four years, but has recovered enough to face the outside world.

"I'm leaving soon, but would like Valkenberg still to be there as a safety net, in case I need it again.

"I've had a lot of help, that's why I'm ready to leave. I really wish they wouldn't close it down."

Elaine Tshuka has been in and out of Valkenberg seven times.

"I go back every month for medication, I don't know how I'll get to the other places. It's easier for people in the townships to go there than to go to Lentegeur or Stikland, where there is no transport."

Edwards, Tshuka and Bates are part of the community that has grown around Valkenberg Hospital in Observatory. It's a community that has little resemblance to the stereotyped image of dangerous "mental" patients ready to kill anyone who crosses their paths. These people are unlikely to hurt anyone other than themselves.

They are friendly, interesting, sometimes slightly shy and often a little eccentric. They are also in crisis. The proposed closure of Valkenberg Hospital has shaken their already fragile worlds.

"People with mental health problems are particularly vulnerable, and all the uncertainty is very damaging for them," said social worker Michelle De Benedictis of the rehabilitation centre Fountain House.

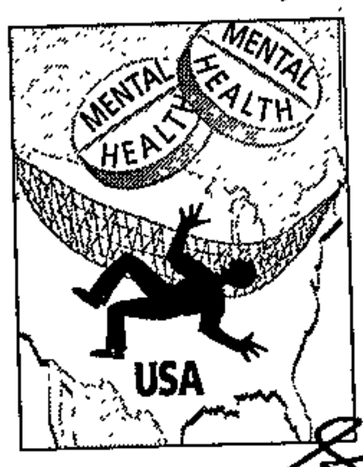
"We have seen so many people become unwell recently."

But the health department believes that the campaign to save Valkenberg has to take some responsibility for this disturbance.

"If patients were being reassured that services would continue rather than being taken out on protests, there would be less confusion and panic," said Greg McCarthy, head of the Western Cape mental health programme.

"These people are very insecure anyway; it's easy to use that insecurity to promote your own cause."

McCarthy's department knows that people who rely on Valkenberg will be hard-hit by the closure. "We are trying to minimise the damage by opening services at Groote Schuur. Although we know the short-term view is bad, we have to plan for the future."



Privatised mental care has real risks

SFCW 28/7/98 (88)

Opposition politicians say trying to save money may not be the way to go, writes Kim Murphy

Russell Eugene Weston jun's release from a state mental institution in December 1996 came just as Montana was embarking on a tumultuous transition to privatised mental health care – the most comprehensive in the nation – and one which has left mental health services for the poor in disarray.

Although Weston, the suspected gunman in the shooting at the US Capitol on Friday, was hospitalised under the old, state-run system, his release underscores the difficulty in assuring that patients – especially mobile ones like Weston, receive adequate follow-up care, several analysts said.

Caregivers at the state mental institution in Warm Springs, where Weston was involuntarily hospitalised for 52 days in 1996, made follow-up appointments for him with mental health providers in Illinois, based on Weston's assurances that he was returning to live there with his parents. But there was no mechanism to ensure he kept those appointments, Montana officials said.

"I think the mental health system has a problem with that linkage from when people leave in-patient treatment, in making sure there is follow-up," said Randy Poulsen, who has overseen the transition to private managed mental health care for Montana.

"If the person is prescribed medications, that somebody ensures they take it. That they have supportive case management. That's a problem for all states ... and when the person leaves the state, there's a problem of co-ordination," Poulsen said.

In Weston's case, neighbours raised questions about whether the state's April 1997 transition to managed mental health care could allow Weston to slip away. Was there someone available to ensure he took medication to control his paranoia? "He could very well be one of those people who fell through the cracks," said neighbour Cathy Maynard.

Montana leads the way with its transition to managed health care for the mentally ill.

Previous fee-for-service programmes were escalating at the rate of 10% a year, and state officials believed they could control costs while increasing the number of poor people covered, by turning them over to private management.

But the entire network perched on the brink of collapse during its debut last year after the private contractor, overwhelmed in paperwork and undergoing a corporate buyout, failed to pay claims and sign up health care providers.

Patients complained they were being forced to take cheaper medications with more side effects, and nearly everyone feared access to mental health care was getting worse, not better.

"We expected start-up problems, but we didn't ... expect it would go on this long," Poulsen said. "Certainly, I can't say accessibility has improved. I think maybe it has worsened."

In Helena, where Weston's follow-up services would have been undertaken if he had remained in Montana, some psychiatrists have been "alienated" by managed care and have been reluctant to serve the indigent, Poulsen said.

"I think that will change; they will come around if they can see that claims are being paid and the paperwork headaches are lessening," he said.

Patients resisted the idea of a private management company deciding what services they needed.

"We already know what we need. We don't need them telling us," said David Cockrell, a Missoula, Montana, resident who has been receiving state-sponsored treatment for schizophrenia.

"There's been a lot of doctors who've prescribed medications, and then the privatised funding sources would not authorise that. Or, certain people would want certain services, and the managed care companies would not approve it," Cockrell said.

"I think the psychiatrists and counsellors are competent, and they know what's appropriate. I don't think they need somebody who doesn't know anything about it, saying what we need," he said.

The transition has proved politically controversial, with Democrats going on the attack against Republican Governor Marc Racicot, whose administration has also moved to privatise prisons.

Bob Ream, state Democratic Party chairman, has written editorials against large scale privatisation. "Privatisation is fine, but there are some basic government services that have to be continued by government: police, fire protection, prisons and taking care of the very worst-off citizens, those who absolutely need help. Obviously this guy did," Ream said of Weston. – LA Times

(59)

Companies feel direct effects of escalating employee benefits and medical schemes costs

The impact of HIV/Aids on benefits

ET(BR) 18/8/98

AIDS has a tragic impact on human lives. Unfounded fear and prejudice lead to sections of society rejecting people suffering from AIDS when they need the compassion of others. AIDS is also starting to have a significant impact on business.

Some companies are already feeling the direct cost of AIDS in escalating employee benefit and medical scheme costs. In fact, the cost of an average set of benefits is expected to double for many schemes over the next five years, because of the anticipated higher mortality and disability rates arising from AIDS, says Metropolitan AIDS researcher, Dr Thomas Mühr.

The indirect cost of AIDS has, however, been largely ignored by companies so far, and these costs will also start emerging over the next five years. This includes the increased costs of recruiting and training staff, given the extra deaths and disabilities which are expected; additional sick and compassionate leave; the negative impact on staff morale; ensuring occupational health and safety standards are adequate; dealing with prejudice amongst staff when employees are HIV-positive, and ensuring that staff members' HIV status remains confidential.

Failure to develop a proactive, holistic response to AIDS may result in costly law suits and employer/employee conflict.

Consider, for example, the employer who has not paid much attention to occupational health and safety standards in the past. A simple decision to implement a corporate policy on AIDS, under the pretext of being concerned with the health and safety of employees, may run into unexpected resistance from employee groups who feel that the intention of the employer is to discriminate against people with AIDS.

Metropolitan has recognised the need for expert advice on managing all aspects of HIV/-AIDS, thus freeing management to concentrate on their core competencies. Metropolitan acquired a substantial stake in the specialist HIV/AIDS consulting and benefit management company, HIV Management Services (HMS).

This partnership harnesses the skills of leading experts in all fields relevant to producing a practical, holistic solution to managing HIV/AIDS in the workplace. Each client is treated uniquely, allowing customised and cost-effective programmes to be developed.

Winning companies have taken a proactive approach to managing HIV/AIDS and many companies are well down the road to developing practical, holistic HIV/AIDS management strategy. According to Dr Malcolm Steinberg of HMS, if a company just pays for treatment as and when HIV-related illness occurs among staff, it can expect to pay close on R600 a year per employee by 2004. However, if it decides instead to actively manage the health of a growing number of HIV-positive staff members and their dependants, it can expect to contain this cost at around R300 a year for each worker.

Companies that wait until the impact of AIDS becomes noticeable in their financial statements, will probably be too late to develop effective AIDS intervention programmes.

'Home of shame' investigated

(88)(98)

LAURICE TAITZ

ST 23/8/98

POLICE are investigating complaints of assault and neglect at South Africa's largest state home for the mentally handicapped.

The complaints came to light after a nurse was charged with assaulting two minor patients, aged 15 and 17, at the 1 100 bed Witrand Hospital in Potchefstroom in the North West.

Some of the accusations levelled against the hospital are that:

- On one visit parents found their 15-year-old son tied to a chair in the TV room;
- A mother of a 41-year-old woman found her wearing no underwear and weighing 39kg. She took her home, yet a month later received a letter from the hospital saying her daughter was making good progress; and
- The parents of one patient said they found her body covered in bruises.

The parents of one of the boys who was allegedly assaulted on July 4 — a 15-year-old who has a mental age of three — further charged that their son's assault was covered up.

They said they were only alerted to the fact that something was wrong one week after the incident when their son ran away.

The boy was found 14 hours later.

The mother was told he had climbed through a window and over a razor-wire fence into the neighbouring army base. He was found in an army truck, naked and bleeding.

"The man who found him followed a trail of blood. My son's clothes were still stuck in the razor wire," she said.

The teenager received 62 stitches for his injuries.

Soon after the incident, the parents met with hospital management to discuss their son's condition and a programme of activities for him.

"They never mentioned the assault during the meeting. I heard about it the following day," said the mother.

"My son is a lovable, beautiful kid. In the past I have seen marks on his body that I have not been happy about. But I was told he got into fights with other kids. I worry that he may have been assaulted before."

Although provincial policy is that relatives must be informed of any injury to a patient at the hospital, Michael Siebert, the hospital secretary, said the assault case was a police matter and it was not the hospital's duty to inform the parents.

Witrand has been described by doctors as "the last stop". It "gets patients other people cannot manage".

George Sekoele, 35, the nurse charged with the assault, appeared in the Potchefstroom magistrate's court last month. He was released on bail of R400 and is due to appear again on August 31.

This week, Captain Louis Jacobs, the Potchefstroom police media liaison officer, said the hospital had been unco-operative in the investigation and had not complied with a request to transfer Sekoele to another institution.

Responding to the other allegations, Siebert and Annetjie de Bruin, the nursing head matron at the hospital, said many of the problems at Witrand were the result of staff opposition to transformation — the institution's attempt to bring the hospital in line with government policies.

"The impact on staff has been severe and we have experienced a lot of turbulence during this process," Siebert said.

Valkenberg 'abuses' probed

BOBBY JORDAN (88) (98)

ST (CM) 18/10/98

THE Human Rights Commission is investigating reports of improper conduct by staff at Valkenberg psychiatric Hospital.

This follows the death of a 39-year-old patient — admitted to nearby Conradie Hospital with a chest infection — and the alleged sexual abuse of a male patient.

The commission's legal officer, Faranaaz Veriava, said it was waiting for a response from the Cape Town hospital before deciding on the next step.

According to a report, many inmates raised concerns about the sudden death of Joseph Damon on August 18.

"From the evidence there could have been some negligence on the part of those responsible for treating Damon," the report said. The hospital is also investigating an allegation that one of its staff assaulted and sexually abused a patient earlier this year.

Valkenberg medical superintendent Dr Garvin MacKay this week confirmed that the hospital had launched an internal investigation into the sexual abuse case and had reported the matter to the police. He said the hospital had to deal with many allegations against staff members but most had proved to be false.

"There will also be a thorough internal investigation," MacKay said.

Psychiatric hospitals are 'disgusting dungeons'

By Wilson Ramothata

THE alleged abuse of patients at psychiatric hospitals by staff members is an indication that the perpetrators take unfair advantage of the victims because they do not have to account for themselves, says the Citizen Commission on Human Rights (CCHR).

In the latest incident, two alleged suspects are to appear in the Cape Town Regional and Magistrate's Court on Monday on charges of rape and indecent assault respectively.

Inspector Johan Marais of the Maitland police station said a male nurse was arrested at Valkenberg Hospital after he allegedly used violence to force a young male patient to perform fellatio or sodomy.

Another man, an ex-employee at Alexandra Mental Institution in Cape Town, was arrested after he allegedly raped a 34-year-old female patient with Downs Syndrome while she was walking alone in the grounds of the hospital in October this year.

"If the victim is mute we use one of the nurses in charge to translate between the presiding magistrate and the victim during the court proceedings," Marais said.

According to CCHR, an international organisation spearheading the campaign to highlight the plight of people who are not mentally sound, their investigation has found these "heinous crimes" were committed because some of the victims were mute and could not read or write.

Cape Town based CCHR director Erica Chelser said her organisation has embarked on a nationwide campaign that is investigating abuses in mental health facilities.

Patients are denied their personal rights because they are mentally handicapped and their human rights are being violated.

"There is nothing worse than an act of violence carried out on a disadvantaged person who is seeking help from the perpetrator of the crime – only to be betrayed," said Chelser.

Marais said although most cases are held in camera, some are held in public, depending on whether the victim is able to relate the ordeal she or he endured.

In another recent incident (November 16) a male nurse and a security guard were arrested and appeared in the Potgietersrus Magistrate's Court, charged with rape and attempted rape of two female psychiatric patients.

Both suspects are employees at the Groothoek Hospital in Zebediela in Northern Province.

According to the police it appeared the two suspects took advantage of a power failure and entered a room with about 29 patients early in the morning.

One woman was allegedly raped and others managed to escape after the nurses responded to their screams.

A mental patient chained to a car engine block reaches out to greet a worker in the mental asylum run by traditional healer Papa Kitoco on the outskirts of Luanda, Angola. PIC: PAUL VELASCO

A recent report by the Mental Health and Substance Abuse Committee was quoted as saying to the Ministry of Health: "The conditions at this institution were of an unacceptable health standard; there was inefficient management of patients and staff; there was a lack of safety measures and allegations of human rights violations."

The CCHR described some of these mental health institutions as "disgusting dungeons" and said staff members were being booked off because they were on "unacceptable amounts" of anti-depressants.

"Countrywide many patients have been abused, physically and sexually," said Chelser.

Chesler said the report was commissioned by the Department of Health and was presented to Minister of Health Dr Nkosazana Zuma, who at the time said she was deeply concerned by the appalling conditions at these institutions. Zuma said she would implement corrective measures urgently.

"Nothing has been done to improve the rights of patients in mental institutions? Nothing.

"The conditions that existed in these hospitals 20 years ago still mirror this sorry state of affairs today," said Chesler.

According to the superintendent of Weskoppies Hospital in Pretoria, Dr Leandre Gauche, abuse of mental patients is rife in some institutions because of lack of security.

He said although hospitals have closed wards aimed at regulating the movement of patients, such incidents do occur.

According to the rules and regulations governing hospitals, patients are not allowed to move around freely on their own without the supervision of nurses.

"We are currently investigating a case where an employee of the hospital allegedly assaulted a patient in a closed ward. The alleged perpetrator was suspended," Gauche said.

He said although the case was referred to the police for investigation, they were are also doing their own inquiries.

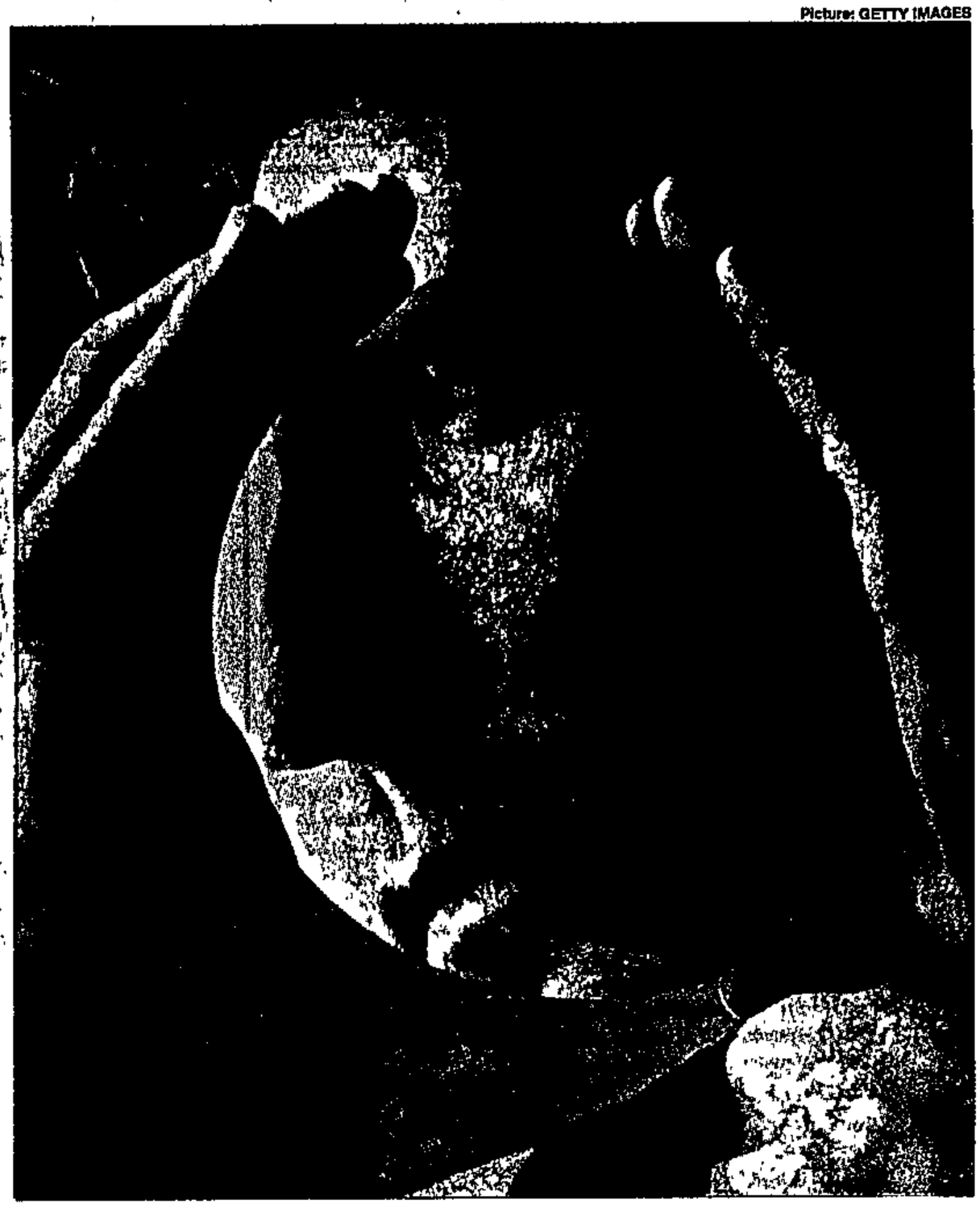
The West Rand Sterkfontein Mental Hospital superintendent Dr Botha refused to give information about the abuse of patients at the institution, but admitted that such incidents do occur.

He said despite reporting cases to the police, the hospital management was also applying strong disciplinary action against those found guilty of any misconduct.

SECTION 3

Business Times APPOI

Picture: GETTY IMAGES



LOW-DOWN ... employers need to create an atmosphere that acknowledges distress

SA business counts cost of mental illness

ST (BT) 10/1/99 (88)

One in 10 employees of all ages and races suffers from depression, writes JANETTE BENNETT

PAUL held a senior position in an insurance company for more than a decade before he went on his own. As a broker, he built up a solid client base and had achieved more than a measure of success after eight years. But then the darkness of depression fell.

"I couldn't function," he says. "There were days when I managed to do less than five minutes' work." His business suffered: "I worried because I wasn't earning money. That made the depression worse."

Paul found professional help quickly but, he says, it took 13 years to find the correct treatment. Today he is rebuilding his business and also counsels for the Depression and Anxiety Support Group (DASG).

The DASG says depression is one of the most misdiagnosed of illnesses and also one of the most costly to business.

About one in 10 employees of all ages, races and economic groups suffers from severe depression. Many go untreated, with an untold cost to their lives, their companies' productivity and the economy.

The Washington Business Group on Health says 200-million work days a year are lost in the US because of depression.

A Massachusetts Institute of Technology Sloan School of Management and Analysis Group study ranks depression as one of the most costly health concerns — up there with heart disease, cancer and AIDS. Depression costs the US about $43-billion a year. This includes costs related to absenteeism and lost productivity, medical bills, and lost earnings from depression-related suicides. Two in 10 people with severe depression may attempt suicide.

A Global Alliance of Mental Illness Advocacy Networks survey of 10 countries shows South Africa suffers from a dire lack of education and information about mental illness.

It reveals that many SA sufferers delay seeking help because they are initially misdiagnosed — 43% of the SA sample (compared with a global average of 35%) visited more than four doctors before they were correctly diagnosed. A shocking 45% dropped out of treatment, mostly because of medication side effects but also because many believe they can handle mental illness on their own. A belief that seeking treatment is a sign of failure plays a role, underlining the pervasive stigma surrounding mental illness.

Then there is affordability. Dr Franco Colin, a psychiatrist on the DASG advisory board, says medical aids discriminate against psychiatric treatment with limitations and exclusions. In many cases people just cannot afford to pay for treatment.

Colin says many people refuse to recognise depression at work because of the stigma.

He stresses depression is a real illness which produces an abnormal emotional state, "and emotions colour the way you see the world".

Bereavement, resulting from major loss, including the death of a loved one or retrenchment, presents similar symptoms to depression — for instance forgetfulness and low drive. If symptoms persist, usually for longer than four to six months, professional help is needed.

There is no clear indication on how SA employers handle depression. In Colin's experience, some employers are supportive, going as far as transporting employees to a professional's offices.

As a guideline for employers, he advises the creation, through good management, of an atmosphere which acknowledges distress. Managers should be equipped to identify possible depression. And lines should be open for an employee to be sent to a professional for diagnosis and treatment. Employers should also assist an employee to reintegrate into the workplace after treatment.

The DASG suggests managers look out for: decreased productivity; morale problems; lack of co-operation; safety problems, accidents, absenteeism, persistent fatigue, persistent aches and pains, and alcohol and drug abuse.

● Call the Depression and Anxiety Support Group between 8am and 8pm from Monday to Saturday on (011) 783-1474/6 and (011) 884-1797.

Caught in a budget st

Star 5/5/99 (88)

Mental institutions tend to conjure up images of straitjackets and patients strapped onto stretchers receiving electro-convulsive therapy. However, during a rare media visit to Sterkfontein Hospital outside Krugersdorp, The Star found that its more than 600 patients receive up-to-date treatment. It's the buildings and the facilities that belong in the Dark Ages.

REPORTS BY
ANSO THOM

PHOTOS BY
STEVE LAWRENCE

There are no straitjackets at Sterkfontein – and patients do not walk around drooling and attacking visitors.

The wards are orderly and the corridors are quiet.

In fact, Sterkfontein Hospital is a well-run institution where patients receive excellent treatment – comparable to the best in the world – from a dedicated, multi-disciplinary team using a variety of methods and therapies.

Drugging a patient into oblivion is just not an option.

However, the hospital's sterling work is being hampered by a lack of funds. Its budget, as with other state health institutions, has been cut.

This has caused a huge disparity between its treatment and its facilities, according to Dr Merryll Vorster, principal psychiatrist and acting superintendent of Sterkfontein.

"The medical treatment is excellent but the facilities are not," she says.

The buildings have fallen into disrepair and are in need of urgent maintenance.

"The facilities are incredibly important to patients," says Vorster. "It's nice to be able to go for a walk and sit on a hill while you're being treated.

"Visitors look at the place and they don't want their family member to be treated here. I can't blame them. The buildings are old, with communal showers and no privacy in the bathrooms."

The budget cuts have also forced Sterkfontein to cut back on staff and other necessities.

But unlike those institutions which use budget cuts as an excuse to downgrade professional services, Sterkfontein staff are going all out to use the little they have to improve the physical surroundings.

"We need to look at partnership with the private sector as it is more than just a case of maintenance," says Vorster. "Structural changes need to be made."

With this in mind, the hospital will be approaching companies with proposals to invest in the upgrading of the hospital to the benefit of their employees, who make use of the facilities.

"We can't wait for the Department of Public Works. If Plascon wants to give us paint, we can't stand around and wait for them. We say 'Thank you', and we paint," Vorster says.

Hospital secretary Ria van Rensburg agrees that the problem is not so much with the hospital budget, but with the Department of Public Works.

"We have a 30% shortage of personnel, but we are coping as long as patient numbers don't increase," she says.

"The real problem is that the patients are exposed to conditions they shouldn't be faced with. All Public Works do is fix broken windows or toilets. There is no repairing of a leaking roof or painting.

"The needs of the different wards vary and sometimes it is not really something big."

Vorster emphasises the team approach at the hospital. "We share experiences when treating a patient, and the emphasis is on trying to occupy the patients' time purposefully."

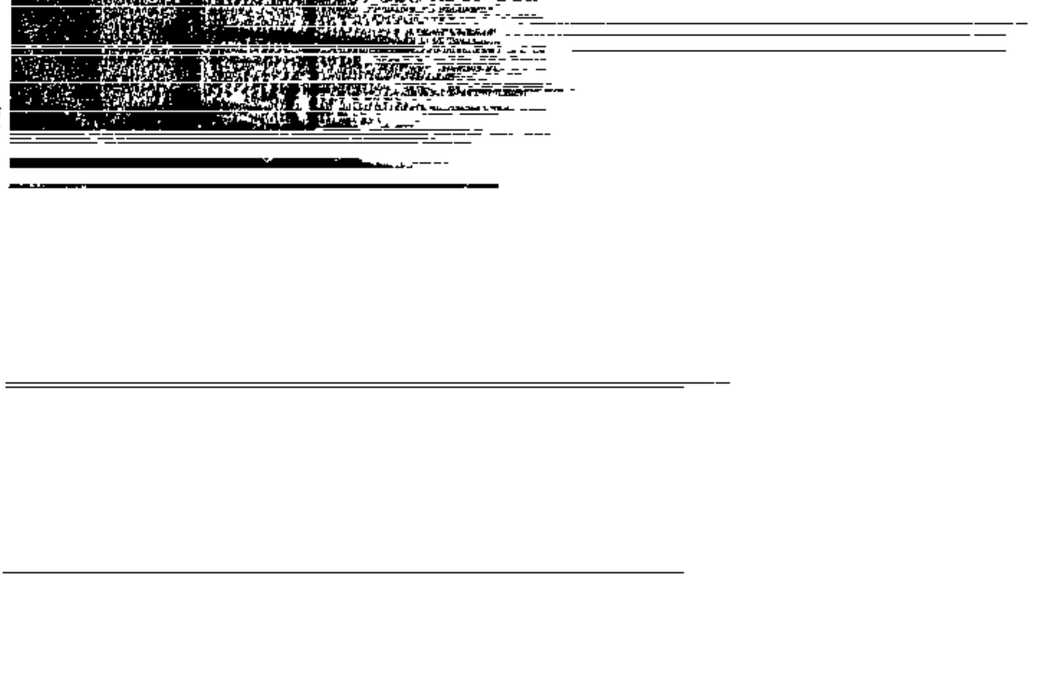
She says that many of the patients are bored. "How many tap washers can you put together? A patient stays here for an average of six-and-a-half years and we need to keep them occupied. At the minimum they need a decent bed and locker," Vorster adds.

Asked what the community can do to help Sterkfontein, Vorster lists a plumber to re-do the bathrooms and any help with repairs and painting.

What is also vital is material to keep the patients occupied, such as indoor games, sports equipment, books, magazines, paper, crayons and sound and video cassettes.

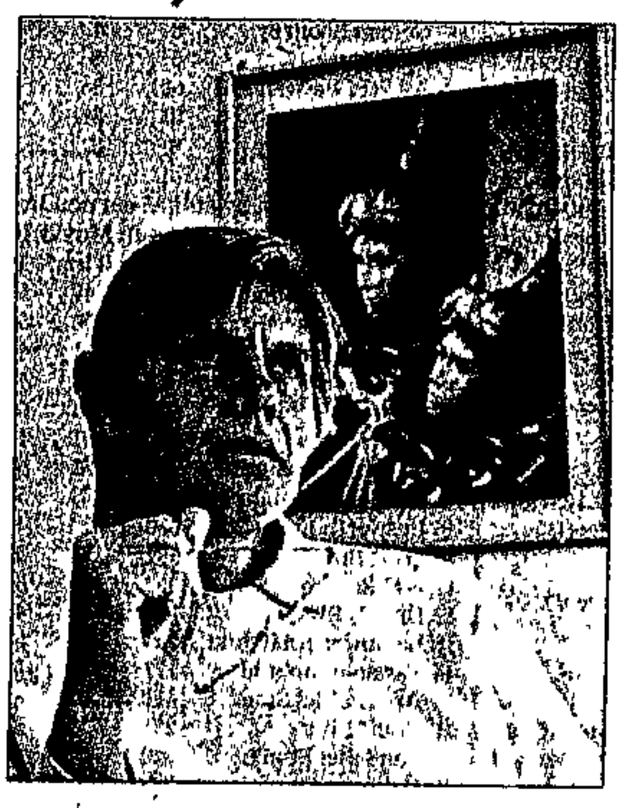
Equipment such as televisions and music systems are damaged regularly and are in need of constant replacement.

Anyone willing to help should telephone Joyce O'Connell at (011) 956-6324.



At the helm ... superintendent Dr Merryll Vorster (below) leads a small, dedicated team in providing the best possible care in difficult circumstances.

In a world of his own ... a young patient at Sterkfontein Hospital observed in [illegible] protection of themselves and others, before being allowed to move around outside a[illegible]



Work gives dignit

Lunchtime is hardly over, but already the patients are lining up outside the industrial and occupational therapy workshops at Sterkfontein.

There is no doubt that the workshop gives the patients a reason to get up in the morning and face the day

Senior occupational therapist Erla Venter says the staff there concentrate mostly on long-term patients but do assess short-term patients to give feedback to the doctors.

"With long-term patients, our main aim is to counteract the effects of institutionalisation," she says.

"Hospitals are very rigid structures, causing the patients to become immobilised, and it is important that we counteract this."

Venter says the hospital does try to create job opportunities for its long-term patients. "It gives [illegible] little bit of independence."

Although industrial [illegible] few and far between, [illegible] as Cobra support [illegible] awarding it contracts for [illegible] assemble taps. Patients are [illegible] cording to their output, [illegible] earning R40 and others R200 a

"Some women save their [illegible] and send it home or they buy [illegible] from the tuck shop or the tea [illegible]

Sport and social events [illegible] an important role, with [illegible] ing soccer, volleyball or [illegible] against each other. Highlights [illegible] social calendar include the [illegible] tine's Day dance and Arbor [illegible]

Patients are also taught life [illegible] such as self and stress [illegible]

All activities revolve [illegible] viding a work acti[illegible] leisure activity and [illegible] agement.

The department [illegible] managed to form [illegible] reach agreement [illegible] Mountain Lodge, a [illegible] Army shelter for the [illegible] cally mentally ill in [illegible] liesburg.

Occupational th[illegible] Lynnette Kallis says [illegible] provide training for [illegible] and have managed [illegible] cessfully place [illegible] tients there.

Anyone willing to [illegible] magazines, good [illegible] hand clothing, [illegible] and music equipment, [illegible] els, sporting [illegible] indoor games can [illegible] Venter on (011) 956-6324

Former patients take care of each other

Four women suffering from schizophrenia are living life to the fullest and in defiance of those who believe people with their condition should be locked up in an institution.

They live in a small cottage close to the hustle and bustle of Krugersdorp. The residents are all former Sterkfontein Hospital patients diagnosed with schizophrenia.

The cottage is one of two – there is also one for men – run by Friends of Sterkfontein, which raises funds and generally assists the hospital.

"We enjoy living here. We have no other place to live," says Marie, the matriarch of the household. "These women are my family. When one is sad, then all of us are sad. We console each other and then everything is okay."

Janet Crofts of Friends of Sterkfontein adds: "This is their home and it offers them the sheltered environment they need.

"I'm on call for them, control their finances and take them shopping."

The women do their own meal planning and take turns to prepare the food. Three times a week they return to Sterkfontein to attend occupational therapy sessions.

All the women receive a disability pension which contributes towards the rent and food bill.

Each of the two cottages can house seven occupants.

The cottages have been going for 20 years, with a great deal of renovations done to the buildings donated by Rotary.

"We care about each other and there is always a party when it is someone's birthday," says Sally, another resident.

Crofts says the cottages allow patients to return to the community instead of staying in an institution for the rest of their lives

Friends of Sterkfontein can be contacted on (011) 955-3876.

Taking a break ... a tea room run by the patients helps them to keep in touch with the outside world. They have the opportunity to make choices, an important factor with the long institutionalised.

budget straitjacket

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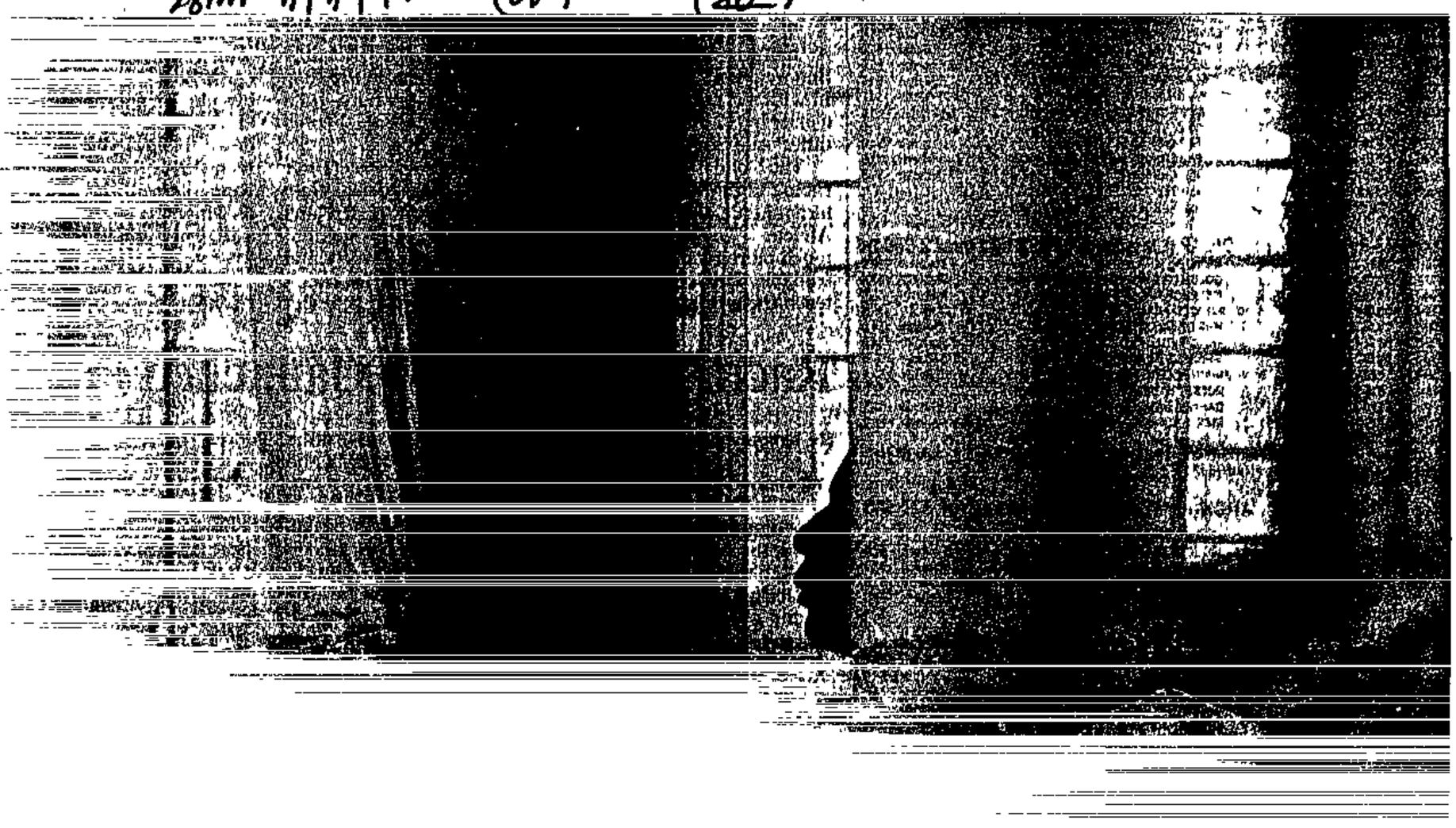

a world of his own ... a young patient at Sterkfontein Hospital observed in contemplation. Many of the patients at Sterkfontein are kept in closed wards for the protection of themselves and others, before being allowed to move around outside and mingle with patients from other wards.

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Senior occupational therapist Erla Venter says the staff there concentrate mostly on long-term patients but do assess short-term patients to give feedback to the doctors.

"With long-term patients, our main aim is to counteract the effects of institutionalisation," she says.

"Hospitals are very rigid structures, causing the patients to become immobilised, and it is important that we counteract this."

Venter says the hospital does try to create job opportunities for its long-term patients. "It gives them a little bit of independence."

Although industrial contracts are few and far between, companies such as Cobra support Sterkfontein by awarding it contracts for patients to assemble taps. Patients are paid according to their output, with some earning R40 and others R200 a month.

"Some women save their money and send it home or they buy basics from the tuck shop or the tea room."

Sport and social events also fulfil an important role, with wards playing soccer, volleyball or croquet against each other. Highlights on the social calendar include the Valentine's Day dance and Arbor Day.

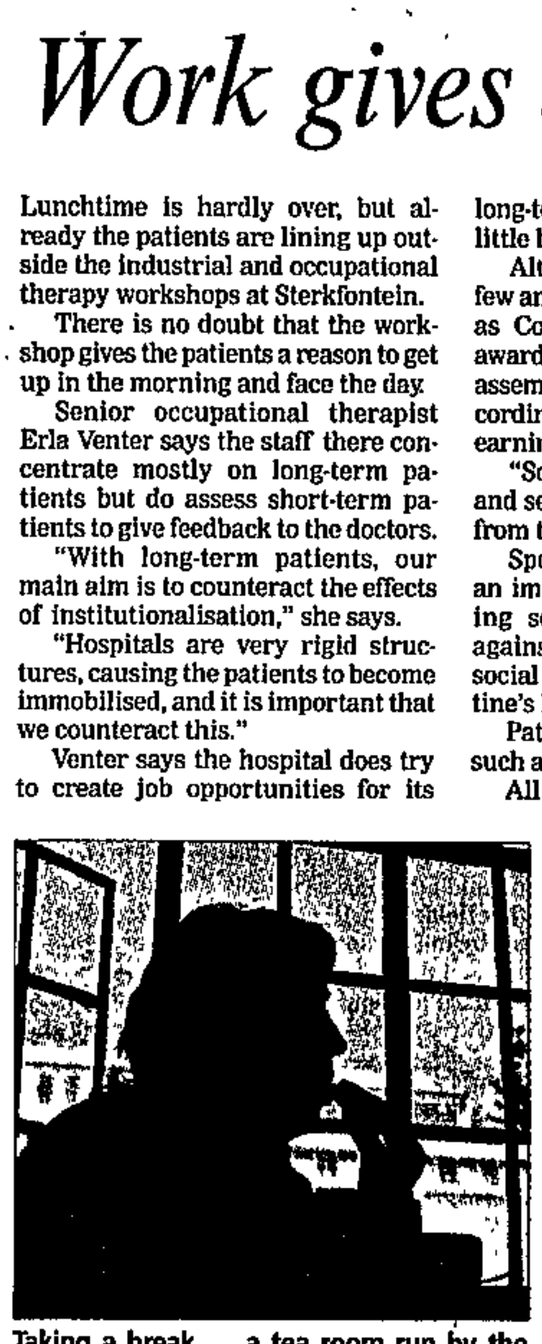
Patients are also taught life skills such as self and stress management.

All activities revolve around providing a work activity, a leisure activity and self-management.

The department has also managed to form an outreach agreement with Mountain Lodge, a Salvation Army shelter for the chronically mentally ill in Magaliesburg.

Occupational therapist Lynnette Kallis says they provide training for staff and have managed to successfully place several patients there.

Anyone willing to donate magazines, good second-hand clothing, televisions and music equipment, novels, sporting equipment or indoor games can phone Venter on (011) 956-6324.



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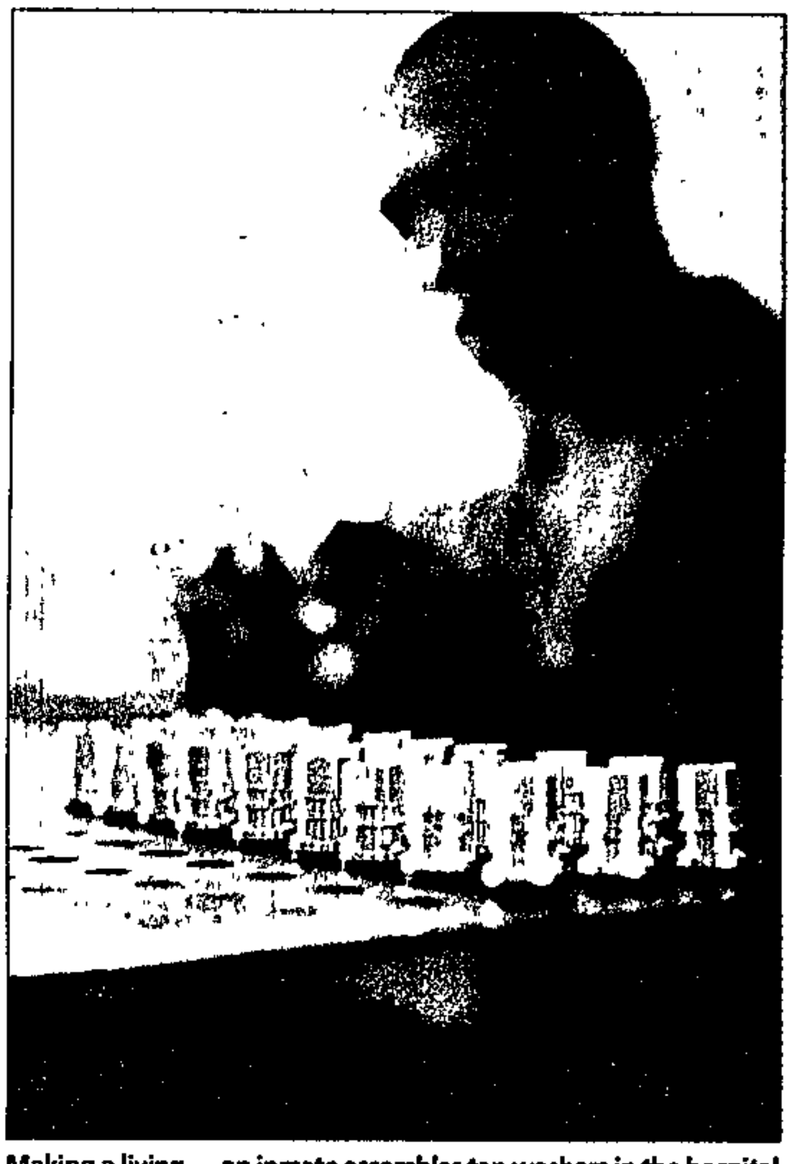

Making a living ... an inmate assembles tap washers in the hospital workshop. The work keeps patients occupied and earns them some pocket money, but such contracts are scarce. Patients are paid monthly in accordance with their output, with the maximum amount earned about R200 a month.

CAPE ARGUS, **MONDAY**, JUNE 14, 1999

Mental health care faces total collapse

(88)

Psychiatrists warn of 'national disaster'

ARG 14/6/99

The Society of Psychiatrists of South Africa has warned that unacceptably high levels of violent crime, combined with staff cuts, makes the total collapse of the country's mental health services inevitable.

Calling on the Government to declare violent crime in South Africa a national disaster, the society said that in some areas one in five people were suffering from violence-related mental health problems.

And the limited number of mental health workers were suffering from burn-out as a result of having to absorb the terror, agony and frustration of others every day.

"With little hope of improvement in the situation, this slowly destroys the capacity of the helper to help, and leads many to seek employment in other countries where levels of professional stress are perceived to be lower.

"This adds further burdens to those remaining, and the freezing of vacated posts is bringing the mental health services to the point where staffing will soon be below critical mass, and total collapse will be inevitable," said the society.

It put out a mission statement, signed by society president Margaret Nair and professors Brian Robertson and Clifford Allwood, to "place on public record" their grave concerns at the psychological, psychiatric and sociological consequences of levels of violence in South Africa.

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HEALTH WRITER

Violent crime had been accepted "as part of the nation's social landscape" and crimes, the brutality and senselessness of which would cause "a national outcry in any civilised country", here warranted only a line or two in the newspapers, they said.

The psychiatrists were also concerned at the long-term future for South Africa: "The effects of violence do not only threaten the individual, but also families, the fabric of communities and the very future of our country.

"However good the intentions and policies of a government, it is impossible to build a healthy nation with damaged people, especially when that damage will, in many cases, lead to the victims themselves becoming perpetrators."

While violence was not a new phenomenon in South Africa, what was new was the sense of helplessness "in the face of the apparent failure of all efforts to combat the current pandemic".

They said "the natural and universal taboo" against needlessly taking the life of another person held little power in communities here.

People responded with growing apathy, others emigrated in desperation, some took the law into their own hands, and others jumped on the bandwagon, encouraged by the apparent impunity with which criminals operated.

Their clinical research suggested that, in some areas, as many as one of every five people suffered from violence-related mental health problems, ranging from post-traumatic stress disorder and anxiety and depressive disorders, to schizophrenic and bipolar breakdowns.

Many of these people turned to alcohol, further endangering communities.

Many children, the psychiatrists said, were living in virtual war zones and had been found to have excessively high levels of chronic anxiety. This contributed to problems like youth suicide, early onset of substance abuse and juvenile criminal activity.

The psychiatrists called for "adequate capacity within the mental health system" so victims, many of whom needed long-term support and treatment, could be helped, and said: "Under the new constitution, citizens of this country were led to believe that their right to integrity of person and lawful possessions would be upheld and entrenched."

Sowetan 16/7/99

(88)

Mental patients need lots of support

By Zakia Salojee

THE South African Federation of Mental Health has declared July Mental Illness Awareness Month. The theme of this campaign is rehabilitation of the person with mental illness.

What is mental Illness?

Mental illness, also known as a psychiatric disability, entails disturbances of mood, observation abilities, thoughts, willpower, memory and behaviour which develop in people who previously did not display these disturbances.

There are many different types and degrees of illness which affect the mind.

Symptoms displayed by those with mental illness include hearing voices, seeing visions, changes in sleeping or eating patterns, neglect of personal care and hygiene, listlessness, false beliefs or wanting to kill themselves.

What are the causes of mental illness?

Although no exact cause for mental illness has been identified, some people are more at risk due to genetic and or environmental factors, as well as chemical imbalances.

How can people with mental illness be helped?

People with mental illness can often be helped successfully. With appropriate treatment, many symptoms can be controlled so that affected persons can lead healthy and productive lives.

The most effective treatment of mental illness is based on a multi-disciplinary approach. This means that medication, community support, life and work skills, understanding, love and support from family and friends all contribute to the stability of the person with a mental illness.

To enable a person with a mental illness to recover, treatment from various professions, support, care and an understanding from others is necessary, especially since people with mental illness sometimes do not realise that their behaviour is strange.

Rehabilitation services have traditionally been neglected in South Africa. In psychiatry, rehabilitation aims at improving the psychological and social functioning of people whose functioning has been impaired by a mental illness.

It consists of community and multi-professional support systems which aim at the development of self-esteem, basic living skills and employment skills.

It allows the person to develop and learn new skills and ways of behaving in order to reduce or eliminate the illness.

The ultimate aim is to enhance the person's social functioning and to restore his or her capacity to control his or her own life.

Rehabilitation services for the mentally ill have traditionally been neglected in South Africa. To correct this, the Department of Health has established a technical committee to develop a comprehesive policy on rehabilitation.

The fragmentation of services provided by professionals and the lack of community-based support are major barriers to the treatment and stability of people with mental illness, thereby preventing them from living productive lives.

It is widely agreed that for persons with mental illness to lead productive lives in the community they must have an array of treatments and support.

(This article was written on behalf of the South African Federation of Mental Health. The federation can be contacted at (011) 242-9600 or at Private Bag X46, Braamfontein 2017.)

DID YOU KNOW?

- 330 million people around the world suffer from a major depressive disorder, and 90 percent of them do not get adequate treatment.
- By 2020, major depressive disorder will be the world's second most debilitating disease. In terms of number of years of productive life lost, it will be surpassed only by cardiovascular disease.
- Mental illness costs South Africa R12,5 million a day in terms of cost and loss of production.
- Suicide is the third largest cause of death in South Africa in the age group 15-24 years.

FACTS

- The Department of Health has established a technical committee to develop a comprehensive policy on rehabilitation.
- The Department of Labour assists people with disabilities to acquire basic capabilities and skills requires for employment.
- The United Nations document *Principles for the Protection of People with Mental Illness and for the Promotion of Mental Health Care* provides clear guidelines for the protection and promotion of the human rights of people with mental and/or intellectual disabilities.