# THE MENTAL HOSPITAL AND THE COMMUNITY*

M. MINDE, B.A., M.B., Ch.B.
*Physician Superintendent, Komani Hospital, Queenstown*

## HISTORICAL

In general it is accurate to state that psychiatry in South Africa has closely followed the European pattern with a time lag roughly corresponding with the rapidity of communication between the two continents. Thus during the 17th and 18th centuries, in the days of the sailing ships, the Dutch settlers at the Cape still treated the insane on the assumption that they were possessed by evil spirits, and the reforms introduced by Pinel in France during the revolutionary period took many years to reach us here.

During the period the Cape was governed by the Dutch East India Company, the European population was small, and most of the cases of insanity occurred among passing seamen, often due to exposure, dietary insufficiency and excessive alcohol, to which they were addicted. Special accommodation for these cases was mentioned in a report to the Hospital Commissioners[1] dated 17 February, 1710. They recommended the erection of 'a small enclosed apartment for locking up the mad who are now and then found in the Hospital'.

Lunatics were also detained in the Slave Lodge, which stood on the site now occupied by the Old Supreme Court Building at the upper end of Adderley Street. Thus a Resolution of the Governor and Council[2] dated 11 December, 1725, reads: 'Maria Nantas' husband is a dangerous lunatic. She begs the Council to take steps to confine him, and he is to be placed in a small room in the Slave Lodge. His wife and friends to pay for his keep.' Lunatics were also detained with safety on Robben Island from the early days of the Dutch occupation of the Cape, along with criminals and political exiles, and on 19 June, 1723, a lunatic, Willem Wilkens is reported[3] as having wounded a person on Robben Island. He had 'some years ago in the hospital here, while in a state of frenzy, killed a man lying in bed next to him, and wounded others'.

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A properly constructed lunatic asylum was eventually opened on the island in 1846. Before this, special wards for mental patients had been erected at Cape Town as part of the Old Somerset Hospital, opened in 1818 by Dr. Samuel Bailey, although the conditions under which they were housed left much to be desired.

At later periods in the 19th century other mental hospitals were opened at Grahamstown (1875), Port Alfred (1889), Valkenberg (1891) and Fort Beaufort (1894). The Queenstown Mental Hospital, now renamed the Komani Hospital, was opened in 1922, and was the first modern institution in the Cape to be specially designed for housing mental patients, the others having been converted prisons, military barracks, etc. Valkenberg was also specially built for the purpose of housing mental patients but too long ago to be taken into account in this context. The first physician-superintendent at Queenstown was Dr. F. D. Crosthwaite (1922-1928).

The reforms in mental hospital administration which we owe mainly to Philippe Pinel of France, began in 1792, and gradually during the 19th century spread over the whole civilised world, including South Africa. These reforms in essence introduced a more humanitarian approach to the treatment of the insane, and did away with the chains, bolts, shackles and straitjackets in which they had for centuries been confined. All this was, of course, of vital importance to the well-being of the patients, and improved their lot immeasurably, but it had no real effect on the medical treatment of the insane which remained in essence custodial throughout this period. Medical treatment consisted merely in the treatment of symptoms. Thus an excited patient was given sedatives or sleeping draughts, his appetite was stimulated by digestives, his anaemia was treated with iron tonics, etc., but no specific treatment was known which directly attacked the mental illness itself.

### THE PERIOD OF ACTIVE TREATMENT

We had to wait until 1936 before this phase began with the development of insulin treatment by Manfred Sakel and cardiazol shock treatment by Von Meduna. These advances ushered in a period in which the mental illness itself was attacked directly with considerable success. Electro-shock, electro-coma, and pre-frontal leucotomy are all phases of this epoch which have utterly transformed the outlook for the patient suffering from mental disease. But what is almost equally important, the doctor's outlook on mental disease has been changed just as radically. He now no longer has to stand by with folded arms waiting for the disease to get better or worse, he can do something active to speed up recovery. As a result the atmosphere of the mental hospital has been entirely transformed, and what were previously places where all who entered might have been quite justifiably adjured to abandon hope, are now full of cheerful doctors and nurses and hopeful patients who confidently expect to recover from their illness within a relatively short period—and in very many cases do indeed so recover.

During the last few years the psychiatrist has been given another potent weapon in the shape of the tranquillizing drugs, which though not able to cure many cases of mental disease, are valuable in controlling and modifying many of its worst features, and have turned what were previously the most disturbed wards in the hospital into havens of peace and quiet.

### THE CONCEPT OF REHABILITATION

While a high proportion of the admissions to our mental hospitals can thus look forward to a rapid recovery with the aid of modern methods of treatment, it does however remain true to say that a proportion of them will not get well enough to go out in spite of receiving the best possible medical treatment.

Some of these are patients who by the very nature of their ailment can hardly be expected to recover. As an example one may mention the elderly patient who comes into the mental hospital with a senile psychosis due to organic changes in the brain brought on by old age. Because of the increased expectation of life in modern times, far more people than formerly survive into this age group and eventually are placed in a mental hospital.

A more important and more tragic group is made up of the people suffering from schizophrenia. This disease attacks young people, just when they reach the stage of becoming useful and productive citizens, and it not infrequently attacks young men and women with brilliant mental powers who would have become valuable assets to the community. This is the commonest of all forms of mental disorder, and over one half of the admissions to mental hospitals suffer from this disease.

The outlook for those attacked was gloomy indeed 25 years ago, and only about 30 out of every 100 could expect to leave hospital again. This figure has been more than doubled by modern methods of treatment; nevertheless there still remain a considerable residue of schizophrenics (perhaps 30 out of every 100) who will never get well enough to leave hospital permanently or to maintain themselves in the community in the economic sphere.

This is the reason why all our mental hospitals gradually fill up with incurable cases—we admit more than we discharge, so that over a period of years more and more wards are filled with these uncured schizophrenics. In any mental hospital they probably comprise two-thirds of the patient population at any given time and thus far they have proved resistant to all forms of medical treatment. They are essentially our therapeutic failures. Until recently they used to be hidden in the 'chronic' wards, which were the poorest staffed and equipped. Visitors were usually discouraged, and were preferably taken to the acute or admission wards where everything was bright, cheerful and gay. It is only in recent years that serious attempts have been made to deal with this neglected section of the hospital population.

Even among those patients who do leave hospital there are a considerable number whose recovery can only be described as relative, in that they show no active symptoms of disease. They do in many cases show some residual signs, and the illness has definitely left its mark on them. They are simply not the people they were before their attack, either in intellectual capacity or in their social adaptability. Thus a young man who had a brilliant career at a South African university, obtained high honours in mathematics, won a scholarship to Cambridge, and there broke down with schizophrenia, had to spend 2 years in mental hospitals and was eventually discharged as recovered. He had to be content with a teaching post at a secondary school, and to abandon what might have been a brilliant scientific career.

If one observes a large number of these cases over a considerable period of time one notices that many of those which fail to respond to treatment do not continue to deteriorate progressively for the rest of their lives. Their disease is arrested spontaneously after 3, 4 or more years, their illness 'burns itself out'. The mental symptoms either disappear entirely or else become so modified as not any longer to impose a serious handicap on the patient; they are more of a nuisance than a real disability, and the patient learns to ignore them. Unfortunately by that time the patient has become so habituated to mental hospital life, has so 'deteriorated,' that he has neither the desire nor the ability to face life outside and he frequently resists strongly any effort to discharge him. If he does try life outside, he finds adaptation so difficult that he is only too happy to return to the shelter of the hospital.

Perhaps the outstanding feature of mental hospital life from the patient's point of view, is the fact that it is entirely self-contained and self-sufficient. Everything the patient needs is provided and he does not have to make even the simplest effort or decision. All his thinking is done for him. This is very valuable during the active stages of his illness, for one of the characteristics of sufferers from mental illness is their inability to make decisions. If prolonged unnecessarily, this state of affairs becomes a danger which insidiously undermines all the patient's will-power and initiative and even if the original disease should come to an end, leaves him merely the husk of the man he was previously.

It is towards the prevention of this state of affairs and to its cure in those cases where it has been allowed to develop, that the most modern concept of treatment is directed in mental hospitals. This aspect has gripped the imagination of some of the most forward looking psychiatrists, particularly in England. The outstanding exponent of this viewpoint is probably Dr. T. P. Rees,[4] until recently Medical Superintendent of Warlingham Park Hospital, which he has made world famous for rehabilitative psychiatry. The essence of his therapeutic philosophy is that every minute of the mental patient's day should be used therapeutically, and that every single activity in the hospital should be therapeutically orientated; that it should aim at having curative influences. Medical treatment, whether it be electrical, insulin, or drugs, thus only forms part of the total concept of treatment at Warlingham Park, and the rehabilitative aspect, including the prevention of deterioration, is considered of even greater importance than the medical.

### REHABILITATION MEASURES

Of all the influences which hasten deterioration in mental patients, perhaps the most potent one is the loss of contact with the world outside, This includes separation from family ties, absence of loved ones, deprivation of opportunity for work, social activities, cultural activities, and even such common day to day acts as shopping and reading newspapers, which we perform almost subconsciously, but which nevertheless help powerfully to keep us in contact with the world around us.

At Warlingham Park[5] determined efforts have been made to replace these losses, and a recently opened social centre provides a replica of a village square with a shop, post-office, recreation-room, library, etc., all helping to 'normalize' life for the patients.

A very important curative activity for a mental patient is work and the concept of 'occupational therapy' is of course an old one. But there is a considerable difference between occupational therapy and work in the ordinary sense of the term and a great deal could be done to approximate the one to the other. One way of doing this is by making patients produce articles as part of an industrial set-up—in fact bringing the factory to the mental hospital. This entails payment for work done, team work between groups of patients, work during set hours in a place specially set aside for this purpose, and the system differs markedly from the *laissez faire* outlook which usually reigns in the occupational therapy department, where the patient has little or no interest in the result of his labours, and no real incentive to work.

In an experiment on the lines described above at the Umgeni Waterfall Institution, Howick, conducted in 1956 with the co-operation of the South African Rubber Manufacturing Company, a branch workshop was opened at the Institution. The patients, mental defectives of all grades, were given the task of packing rubber rings, used for sealing jamjars, into cartons, and were paid by piece-work. They were first taught their task by the Company's instructors, and after this preliminary period worked singly or in groups of 2, 3, or 4, according to their inclinations and temperament, some doing best on their own, while others preferred a division of labour. The patients varied from low grade imbeciles to high grade defectives, and for those who could not count a special counting board was constructed with twelve raised wooden circular blocks, so that all the patient had to do was to put a rubber ring on each of these and then place them in the carton, which took 12 rings. Even the blind were catered for by a special board with a raised solid wooden cylinder on it, When the rubber rings were placed on this and reached the level of the top of the cylinder they numbered exactly 12.

It was found that the speed and accuracy of the patientswork' could not be correlated with their intelligence, and the best and most reliable workers were frequently the placid medium-grade imbeciles rather than the higher grade patients. The former easily earned themselves £2-£3 per month pocket money for about four hours work per day. There is no reason why this type of experiment should not be extended to our mental hospitals with the most beneficial results to the patients, and some relief of the acute labour shortage in industry.

The rehabilitation of deteriorated patients and the prevention of the onset of deterioration should thus be a most important part of the therapeutic programme of any mental hospital which professes to practise the modern techniques, but I regret to say that we in South Africa have not progressed as far as we might have done along these lines. For far too long our mental hospitals, whose standards of medical treatment compare favourably with those in any part of the world, have failed to provide adequate rehabilitative facilities, and have existed in isolation, largely cut off from the communities around them, those communities whose co-operation is vital in any rehabilitative programme. I myself have always been a keen protagonist of co-operation between the mental hospital and the community in which it is set, and in my experience the community has always responded enthusiastically whenever any demands on it have been made by a mental hospital in its area.

Thus in 1952 at the Sterkfontein Hospital, Krugersdorp, I approached the Municipal Library and obtained its ready agreement to start a branch service at the hospital. This service is still in existence and provides the patients with all the books they can read—to the number of many thousands per annum. The Queenstown Public Library has already agreed to begin a similar service at the Komani Hospital in the near future.

At the Umgeni Waterfall Institution in 1955 I persuaded a number of enthusiastic people, mainly from Durban, to start a group we called the Friends of the Umgeni Institution, whose aim was to provide links with the outside world for the patients. This body did an enormous amount of good. They gave the patients a monthly party which was looked forward to as the high-light of the Institution's life, they made friends with individual patients, visited them when ill, sent personal reports about them to parents living hundreds of miles away, and in general provided that missing element of personal affection which no hospital, however good can entirely supply, and which plays so vital a part in any individual's happiness and mental well-being. On the practical side they brought patients little personal gifts, equipped a modern hair-dressing saloon for them, provided special tools for the occupational therapy department, and each Christmas gave a huge annual party which was attended by parents from all over the country. The change they effected was quite remarkable and could be felt by everybody. Escapes became rarities, patients' behaviour improved out of all recognition, and the Institution radiated an atmosphere of happiness which could be felt by the most casual visitor.

I now wish to appeal to the National Council of Women, a body which has always taken a keen interest in mental health, to take the initiative in founding a similar organisation to the one just described, at Queenstown. Its aim should be to help to approximate life at Komani Hospital as closely as possible to life in the world outside, and thus to prevent that insidious deterioration which is the most potent factor preventing the return of our patients to normal life.

The biggest loss a patient suffers by prolonged detention is the loss of the love of his fellow men. Many even lose touch with their own families. It is a sad fact that families tend to forget about relatives suffering from mental illness after a time, and one notices time and again that those patients who feel assured of continued affection and persistance of home ties tend to recover better, even after years of illness. Then there is the loss of the intellectual stimulus of contact with normal people, and the loss of initiative. After a time the patients become so habituated to the institutional type of existence that they fear to face life outside. Deterioration is also hastened by absence of the powerful incentive of having to earn one's living.

We at Komani do our best by providing Occupational Therapy of various kinds, although we are handicapped by the European patients' objection to doing certain rypes of manual work which would keep many of them constructively occupied and at the same time improve our hospital and its grounds.

We have recreational facilities like cinema shows, dances and games for our patients, as well as a well-equipped tuck shop. More recently we have founded a patient's club which is run by patients for patients, and which provides many forms of additional amenities.

To expand all these and to provide additional facilities the support of the local community is essential, and my appeal is both on the grounds of humanity and of enlightened self-interest. Our hospital is a considerable asset to the Queenstown Community, and even if regarded purely in terms of money, it pays out £10,000 in wages and salaries each month, a large part of which is spent locally. But I do not wish to stress that side, as my experience in the past has been that people are only too ready to help once the need has been made clear to them.

### SUGGESTED NEW SOCIETY

What I wish to suggest is the formation of a broadly based body in Queenstown to include representatives of all the main elements in the community, and embracing such social agencies as the National Council of Women, Die Vrouefederasie, Church bodies, Toc H, Rotary, Round Table, etc. In addition interested persons in their individual capacities could of course also join. This body could be called the Friends of the Komani Hospital (or any other suitable name), and its main functions would be:—

1. Cultivation of personal contacts with individual patients, to fill that void in their lives caused by the absence of their families and loved ones.

2. To co-operate with the patients' club already in existence to provide additional recreational amenities e.g. musical entertainment at patients' parties, lectures on topical subjects, debates with patients on matters of interest, etc.

3. To provide facilities for work outside the Hospital for patients fit for it. There are a number of patients fit for work

outside whose relatives are unable to provide a home for them. By a recent decision of the Commissioner for Mental Hygiene such patients can continue to reside in the hospital while going out to work daily. They will be treated as non-paying patients and can thus retain all their earnings. This is a most valuable stage in the rehabilitation of a patient in certain cases, as a preliminary to final discharge.

4. To provide facilities for other activities outside the hospital, such as attendance at the patients' normal place of worship, visits to town for shopping, concerts, sporting functions, etc.

When sufficient public interest has been aroused, it is hoped to call a public meeting for the organization of such a body, but in the meanwhile I hope you will all give this matter your urgent consideration, and discuss it widely with your friends. In time I hope that Queenstown will pioneer a type of social service which will bring all its citizens untold satisfaction, and set an example which will be followed by all those communities with a mental hospital in their midst.

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