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AN EXAMINATION OF THE RESPONSE OF THE CAPE MENTAL HEALTH SOCIETY TO THE MENTAL HEALTH NEEDS OF BLACKS IN THE WESTERN CAPE

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"You have powers you never dreamed of

You can do things you never thought you could do

There are no limitations in what you can do except

Limitations in your own mind as to what you cannot do

Don't think you cannot, think you can"

By Darwin P. Kingsley

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ABSTRACT

This study examined the response of the Cape Mental Health Society to the mental health problems of Blacks in the Western Cape. This response has been examined against the organisational and the community contexts in which such services are provided. Environmental constraints which surround service provision were examined at macro- and micro-level. The macro-level covered the unfavourable political, social and economic aspects as experienced by both the organisation and its clientele. The micro-level covered those aspects which impinge on service delivery but are within the scope of the organisation. It is agreed that these aspects affect the nature of the response of the organisation to mental health needs of blacks negatively. The study emphasizes the need to define mental health within the South African context from a psychiatric and socio-political perspective as such a definition allows for appropriate service provision.

Data was collected from primary and secondary sources. Interviewing was used as a technique for collecting primary data. Structured and unstructured interviews were carried out with people from various disciplines, community members, present and prospective service consumers. The exploratory-descriptive approach was used. The problems and needs of clients were quantified in terms of the organisation's waiting lists and other criteria. Services rendered by the Society were quantified in terms of clients being served and the number of projects and programmes undertaken to meet different mental health needs. Ideas have been developed about mental health services amongst the black communities and their cultural perception of mental health needs.

The findings emphasize inadequacy of the response of the Cape Mental Health Society to mental health needs of blacks. The present facilities are insufficient and inappropriate to mental health needs of blacks. They are characterised by inaccessibility, inefficiency and ineffectiveness where they do exist. A marked inequality in the provision of services to the two population groups, that is, Coloureds and Blacks, has been identified.

A framework for developing mental health services for blacks in the Western Cape has been recommended. This framework proposed various steps which can be taken in such development.

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LIST OF ABBREVIATIONS

1	OASSSA	:	Organisation for Appropriate Social Services in South Africa
2	WHO	:	World Health Organisation
3	KTC	:	A squatter camp near Cape Town
4	COBERT	:	Council for Black Education and Research Trust
5	CRIC	:	Career Resource and Information Centre
6	UNICEF	:	United Nations Institute for Children's Emergency Fund
7	SHAWCO	:	Students' Health and Welfare Centres Organisation (run by the University of Cape Town)
8	NICRO	:	National Institute for Crime Prevention and Rehabilitation of Offenders

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INTRODUCTION

1. BACKGROUND AND MOTIVATION

This study examines the manner in which the Cape Mental Health Society responds to the mental health needs of blacks in the Western Cape.

The area of study is the three townships, namely, Langa, Nyanga and Khayelitsha, designated for blacks in terms of the Group Areas Act, No. 36 of 1966. These were the only townships chosen, because the townships for blacks in Western Cape have similar social and political characteristics. This area constitutes only a small part of the geographical area served by the Cape Mental Health Society ("the Society"), as indicated in its constitution.

The study addresses one of the crucial issues of South African social work, which is the response of the service provider to consumer needs within a specific area. This is an ongoing debate within the social service profession. It is also emerging very strongly within the social planning and administration sphere. The focus of the debate within social planning and administration is linked to how organisations sometimes ensure their own survival at the expense of meeting community needs. Organisations are increasingly called upon to look towards meeting community needs rather than focussing on their survival. However, organisations are

caught up in the historical process of meeting needs of certain communities and neglecting others. The field in which the debate takes place in the mental care provision is multi-dimensional and filled with controversy. This is also related to what constitutes mental health or mental illness. The present political situation contributes to this controversy.

There is increasing evidence that the South African Government's separate development policy and differentiation according to race (apartheid) are related to a rise in mental illhealth. In addition, large scale poverty also causes mental health problems. Several writers agree with these effects[1]. They are of the opinion that these cannot be treated as independent factors, but form a closely intertwined network with other factors.

Present and prospective service providers and consumers should have a wider view of the mental health needs and problems which supposedly determine the nature of mental health programmes to be embarked on by mental health organisations.

The assumptions that mental health services are characterised by inadequacy, inaccessibility and are administered on racial and geographical lines, has been a great motivation for the researcher to undertake the study. If one examines the assumptions mentioned above more closely in specific relation to the black communities, it becomes necessary to analyse whether organisations have planned the allocation of resources to meet the needs within a rational, limited rational or incremental planning approach[2].

Planning mental health services for blacks in the Western Cape is influenced by the Society's orientation, understanding of mental health and its cultural and value base. This aspect is crucial in the provision of services for black communities because of the cultural dimensions of mental illness amongst blacks. These dimensions

have been defined in Chapter Two. One can say that reviewing the response of the Society to the mental health problems and needs of blacks is a lot more complex than would normally be the case because of the various factors that impinge on both the organisation concerned and the communities it serves. It is for this reason that the Cape Mental Health Society is described and analysed with a full realisation that it is a private human service organisation which cannot be seen as being responsible for meeting all mental health needs, but can only render mental health services within the boundaries of its resources. However, it is acknowledged that if the Society wishes to render relevant and effective mental health services in a changing South Africa, it is necessary for it to identify mental health needs and the causes for such needs, and to administer welfare programmes which are responsive to those needs. Study of mental health needs and the analysis of mental health problems of blacks in the Western Cape by any service provider should be done within the former's cultural context.

This study is thus an attempt to identify the need for the Cape Mental Health Society and other similar human service organisations to review their policies, processes, procedures, goals and programmes so as to be able to respond appropriately to the mental health problems and needs of blacks. Furthermore, such reviews should enable these organisations to better understand the constraints placed on them through State policy, through their own internal operation and the needs which they say they are addressing.

2. AIMS OF THE STUDY

The study is directed at achieving the following aspects:

2.1 describing the organisational and community contexts

within which mental health problems and needs are being dealt with;

2.2 identifying major environmental constraints which impinge on mental health service provision at macro- and micro-levels. The nature of this study does not allow a detailed review of every factor hence the focus is more on an organisational analysis so as to look at its resource capacity. Focus is also more on environmental and community analysis;

2.3 focussing on different perceptions of mental health or mental illness. These include community perceptions, normative perceptions by the organisation and the professionals, and the comparative perception between blacks and whites. The definition of mental health in Chapter Two expatiates on this;

2.4 developing ideas on how to improve mental health service provision to blacks within the limited rational planning perspective;

2.5 highlighting the controversy surrounding the environmental impact on the quality of life of blacks with specific reference to their mental health and the extremely limited potential of private human service organisation in coping with this impact;

2.6 designing of a framework for the planning of mental health service for blacks in the Western Cape.

3. ASSUMPTIONS

The assumptions upon which this study is based are listed below:

3.1 mental health services for blacks are characterised by inadequacy and inaccessibility;

3.2 mental health services are administered on racial and geographical lines;

3.3 the trend followed by mental health programmes is an irrational response to the mental health problems and needs of blacks;

3.4 problems surrounding mental health provision are underlined by the exclusion of the cultural context in which blacks define mental illness;

3.5 differing perceptions of factors which influence mental health in black communities and consequent inability to render appropriate services.

4. METHODOLOGY

The research method used in this study is the exploratory-descriptive one. This approach provides certain guidelines in furthering the aims of the study. These include sources of information used in the study, types of data collected and the use of such data[3].

4.1 Rationale for the Use of the Exploratory-Descriptive Research Method

The researcher used this research method because she wanted to achieve new insights into an area in which there has been little or no research performed. The researcher believes that mental health services have not been

planned, implemented and monitored within the context of blacks' perception of mental illness.

The researcher has no precise hypothesis to test, but has undertaken the study so as to

- highlight areas for further research
- gain better understanding of the problem investigated
- test the possibility of undertaking a more detailed study
- develop methods which could be employed in a more detailed study[4]

The descriptive-exploratory approach allows some flexibility in developing ideas in a variety of data collection procedures. (Specification of the procedures used and how each procedure provides the necessary information have been provided in 4.3 below). It uses both qualitative and quantitative data giving less concern to the systematic representativeness of the samples used[5].

4.2 Types of Data Gathered

Data was collected from primary and secondary sources. For the former resource inventories on mental health were used; the Cape Mental Health Society statistics and the register of need, social surveys and census data were also used. Literature on mental health was readily available from the University of Cape Town libraries. Special reference was made to data which dates as far back as 1975.

Primary data was collected by utilising research techniques as discussed below. The response system was chosen according to the type of information desired for the study.

4.3 Data Gathering Procedures

Different procedures were used for collecting data. These included the organisational profile, the community profile, readings of related literature, interviews and participant observation.

4.3.1 The Organisational Profile

A careful study of the Cape Mental Health Society was made so as to understand how it works. Careful consideration of its projects, past and future plans and other related matters were taken into account. This was for the purposes of avoiding misrepresentation of the organisation, and the organisation's goals regarding services.

4.3.2 The Community Profile

The community profile was used to illustrate the conditions under which the blacks live in the Western Cape. The community profile was used to show the social, economic and political conditions which form the environment of blacks and their possible effects on the mental health of blacks.

4.3.3 Observation

Data was also collected by using observational techniques. The researcher spent six months at the Cape Mental Health Society observing its processes and procedures. Participant and non-participant observation were employed. The researcher fully participated in the Society's daily programme at middle management level. She engaged in organisational activities, attended different meetings - six staff meetings, a board meeting, and an annual general meeting. For two weeks the researcher spent time at the intake department doing intake of all new cases of black clients. The purpose of this was to get a clear picture of the organisational procedures regarding treatment of black clients.

Non-participant observation was employed in those aspects related to social programme planning and administration, line staff and management functioning, mental health service consumers in their natural setting like family, their work place, for example, the protected workshop, and, in the community. Units of observation were chosen in accordance with the type of information to be collected or verified.

4.3.4 Interviews

Unstructured and structured interviews were used for gathering data. These interviews were conducted with great sensitivity to the respondent's feelings, opinions and behaviour. Respondents were motivated to be honest and

open, clear and relevant in their response. Interviews were conducted in a friendly but professional manner. Respondents were told beforehand what type of information was desired from them and approximately how long the interview would take.

A series of interviews were conducted over a period of six months. People who participated included professionals like social workers, community workers, teachers, ministers of religion, psychiatrists, psychiatric nurses, research workers, students, governmental officials, community leaders, mental health service consumers and indigenous healers.

The respondents were categorised into four major groups, namely:

- community leaders
- service providers
- service consumers
- Cape Mental Health Staff members.

Community leaders consisted of formal and informal leaders. Formal leaders according to this study, are those leaders who are appointed by the government or who play a leadership role in formal structures.

Informal leaders, on the other hand, are either self-appointed or community appointed. These

are leaders of cultural groups; political groups like trade unions, progressive organisations, community based organisations and church groups.

Service providers consisted of people from the various professions, namely, social workers, grassroots community organisation workers, teachers, ministers of religion, psychiatrists, psychiatric nurses, research workers and students.

Service consumers consisted of two sub-groups, the present and prospective mental health service consumers. Present consumers are clients - already in receipt of mental health service - those currently registered as clients. Prospective consumers are those who appear in the Society's register of need - those awaiting for one or another mental health service.

The Cape Mental Health Society's staff members were categorised as an individual group for the purposes of studying the organisation extensively. Staff members were interviewed in connection with the departments in which they work.

The researcher used interview schedules for conducting interviews (See Annexure 1 : Introduction to the Interview Schedules, which was used in all interviews for the purposes of introducing research interviews; and Annexures 2, 3, 4 and 5 : Research Interview Schedules).

The venues for interviews varied from the researcher's office and home, classrooms, school offices, private homes, the Society's Workshop in Langa and the Society's training centre in Nyanga.

The interviews followed this procedure: researcher would introduce herself and explain what the research was about by using the first annexure, "Introduction to the Interview Schedules". Questions which appeared in the interview were then used as guidelines to conduct the interviews. The respondents would then be shown the dictaphone whose purpose would be explained. The interview would be recorded in writing as soon as possible thereafter. Interviews were conducted in English and Xhosa, depending on the interviewee's choice.

4.4 Sampling Procedures and Units of Analysis

The non-probability sampling methods were used in the study[5]. Accidental sampling was used to choose the most readily accessible set of sampling units available. Sampling units were chosen on the basis of the possibility of being knowledgeable about the information desired for the study. Respondents were chosen irrespective of gender. The respondent's ages varied from sixteen to to sixty-five years of age. Complementary to the accidental sampling method, the snowball sampling method was used so as to locate more respondents until the desired information has been gathered. The sample size chosen depended on the extent to which the respondents from the different groups

(as categorised above) are able to provide information desired for the study.

Six representatives from community leaders were interviewed. Four of these were formal leaders and two were informal leaders.

From the service provider group twenty-one representatives were interviewed. These consisted of a psychiatrist, a psychiatric nurse, two psychiatric social workers, three community workers, three indigenous healers, two community workers, one student, one research worker, two hospital social workers, a minister of religion, a principal of the Kwa-Nothemba Special Care Centre for the mentally retarded children in Nyanga, one training school principal, one primary school principal, and one pre-primary school principal.

Twelve representatives were interviewed from the service consumer group. These consisted of six people chosen from the Society's current caseload. Two clients were chosen from each area of study. The other six representatives belonged to the prospective consumer group. These were chosen randomly from the Society's register of need - the waiting list. Two representatives were chosen from each area of study.

Twelve staff members of the Cape Mental Health Society were interviewed. These consisted of the director, the acting deputy director, the finance manager, the psychologist, the departmental heads of field services, intake community services, mental health promotion, student training and administration, respectively. The two social workers who are responsible for rendering mental health services amongst the black communities were also

interviewed. The two mental health workers who are responsible for certain mental health projects, for example, support groups, were also interviewed.

4.5 Designing of Interview Schedules

To avoid duplication and unnecessary labour, the researcher designed a common introductory interview schedule which was used in all the interviews. (See Annexure 1 : Introduction to Interview Schedules). She then designed four interview schedules for the four major groups of respondents (see annexures 2, 3, 4 and 5 : Research Interview Schedules). These served to collect information about the mental health service provision and consumption, available resources in the community and the environmental constraints surrounding mental health provision. The interview schedules for the community leaders and service consumers were translated into Xhosa by the researcher.

4.5.1 The structure of the interview schedules

The interview schedules were structured in such a way that they draw information of optimal accuracy.

The interview schedules consisted of open-ended questions. These questions were designed to draw free and appropriate reponse which is basic and necessary to the study. The factual but pertinent questions were asked in the beginning, followed by the more substantial questions. Questions relating to specific subjects were grouped together. Probing was

done in cases where responsdents could not provide clear or sufficient information.

5. LIMITATIONS

It is unlikely that some of respondents like the Cape Mental Health employees and service consumers could provide information which precisely reflects true perception against the Society. This could lead to the low reliability of some of the information.

Information on Khayelitsha was not readily available. Information available on Khayelitsha was on development plans. These plans were never followed accurately because of the rapid population growth of this area. Population census of 1985 was also outdated because of the same reason.

It has been very difficult for the values, principles and experiences of the researcher not to have an impact on the study. It is therefore with a strong belief that black communities have been under physical and psychological attack, that this study emerged.

6. THE STUDY OUTLINE

The following chapters deal chronologically with different aspects which furnish the purpose of the study.

Chapter Two provides definitions of major concepts used in the study with special reference to their meaning and relevance to the study.

Chapter Three concerns itself with the organisational context of the Cape Mental Health Society. This is essential to the understanding of the organisation's response to mental health needs. In addition,

agency goals and objectives, planning procedures, management, evaluation procedures, resource allocation, fundraising, structures and services rendered by the Society have been studies. This chapter is descriptive in nature.

Chapter Four looks at the community context. The three previously mentioned townships are described in terms of their mental health problems, needs and resources. Profiles of the communities concerned are provided. Various factors which influence community mental health problems and needs are examined.

Chapter Five is analytical in nature. It examines the implications of both the organisational and community contexts with regard to mental health services and needs. This chapter highlights macro and micro environmental constraints experienced by the Society and its clientele. The macro constraints include welfare policy and legislation, which is based on "apartheid"; theories on which mental health care is based; dynamism of mental health needs and problems; the economic and socio-political conditions which impinge on the mental health of black communities, to count only a few. This chapter also demonstrates the extensiveness of mental health problems and needs. It also critically examines the Society's processes and procedures which adversely affect service delivery to black clientele - micro environmental constraints. It also critically examines the level of appropriateness of the present mental health care services to the needs and problems.

Finally, it looks at the implications of the socio-economic and political conditions on the mental health of blacks as endorsed by research studies.

The final chapter draws conclusions and proposes guidelines for a more appropriate response of the Cape Mental Health Society to the present and projected mental health needs of these black communities.

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CHAPTER 2

DEFINITION OF CONCEPTS AND TERMS

1. INTRODUCTION

The aim of this chapter is to introduce and discuss some of the terms and concepts dominant to the study. Concepts are firstly defined in their abstract form and secondly in their operational form. This, however, is applicable only to those concepts which require operational definitions or where a concept has more than one operational definition. Definitions are made with special reference to their relevance to the study.

Concepts which need to be operationally defined, but are not included in the list below, are defined in the respective chapters where they are used.

2. DEFINITION OF CONCEPTS AND TERMS

The following concepts and terms are defined in this chapter:

- blacks / Africans
- the Cape Mental Health Society (the Society)
- the townships of Langa, Nyanga and Khayelitsha

- goals and objectives
- values
- mental health problems and needs
- the residual model
- the institutional model

2.1 Blacks / Africans

Although it is generally inapropriate to make differentiation on racial basis, in terms of this study, it is necessary to do so. The term "Africans" is used to refer to the black population group as defined by the Population Registration Act of 1950. This Act determines the different race groups to which all individuals in South Africa are held to belong, in terms of apartheid. According to the South African legislation, the term "blacks" replace the old term "Bantus", and this refers to Africans. In this study the two terms are used alternatively and they refer to the same population group.

2.2 The Cape Mental Health Society

The Cape Mental Health Society, hereafter referred to as the Society is the human service organisation under study. It is registered as a welfare organisation in terms of the National Welfare Act of 1983. It has its own fundraising number. Its area of operation as indicated by its constitution consists of all places which are within the boundaries of the magisterial districts of Riversdale, Ladismith, Laingsburg, Sutherland, Fraserburg, Calvinia,

Williston and Namaqualand, and along the West Coast and Southern Coast to the abovementioned areas.

The approximate size of the population supposed to be served by the Society is in excess of 1,5 million.

The pioneer in mental health care in the Cape was Sir John Graham, who, on his retirement, effected the formation of the Cape Province Committee for the Care of the Feeble-minded, forerunner of the Cape Mental Health Society, in 1913. The main function of this committee was to compile information on the feeble-minded persons and to arouse public interest in their care. This committee changed its name to the Cape Province Society for Mental Hygiene in 1918. In 1921 it assumed all responsibilities for mental health work. Voluntary workers and doctors also came to the fore to provide mental health services. Special schools and care facilities were provided. There were large caseloads especially from the lower socio-economic groups. Services to the black comunities started in 1977.

The Nompumelelo Day Care Centre for black children started in 1978. It is in receipt of state subsidy.

The goal of the Society at present is to promote the quality of life of both the mentally handicapped and the psychiatrically ill persons, and their families, irrespective of race, colour or creed. While it has this goal the culture of the organisation and its structure influences the extent to which it has to realise its goal. This has been discussed in greater detail in Chapter Five. A profile of the Society is provided in Chapter Three, Section 3.2.

2.3 The Townships of Langa, Nyanga and Khayelitsha

The townships of Langa, Nyanga and Khayelitsha are the townships under study. They have been designated, in terms of the Group Areas Act No. 36 of 1966, as group areas set aside for blacks.

Langa is thirteen kilometres from the Centre of Cape Town, Nyanga twenty, and Khayelitsha thirty-five. The estimated population is 22 792 for Langa, 148 227 for Nyanga[1], and 105 000 for Khayelitsha[2].

2.4 Goals and Objectives

There is evidence of confusion in human service organisations around definitions and differences between goals and objectives. Definition of these concepts is therefore essential to eliminate confusion.

Goals and objectives serve as guidelines towards the solution of community problems and needs. In order for human service organisations to be more responsive to these problems and needs, goals and objectives must be determined by the different kinds of problems and needs.

York and Granger define goals as broad statements of what is to be accomplished[3]. Furthermore they define objectives as being specific statements of measured amounts towards the attainment of goals.

This study analyses the goals and objectives of the Cape Mental Health Society. It investigates as to whether there are any objectives set out which are based or are in line with the general goals. This analysis is based on what Perlman and Gurin refer to as "ends-means analysis"[4]. It

aims at distinguishing between means and ends and showing their inter-relationship. This helps in revealing whether broader goals are in fact put into action by setting definite objectives.

2.5 Values

The question of values plays a major part in this study. Values and ideologies are determinants of the nature of response of human service organisations to the problems and needs of communities served. This is with particular reference to the values of decision-makers. Values of the management are often reflected in the formulation of goals and objectives and resource allocation.

This study argues that values play an important role in decision-making, programme planning and in the distribution of resources.

Some scholars define the concept of values as determinants of social behaviour[5]. Others refer to values as the criteria or standard for selection among different alternatives[6]. Values are sometimes referred to as conception of the desirable by an individual or group, which influences the selection from available modes, means and ends of action[7].

This study defines values in terms of the criteria and standards used in determining and selecting means and ends of action, among different alternatives. Special attention is paid to the relationship between organisational values (i.e. values of the Society's top management) and organisational response to mental health problems and needs.

The study acknowledges the various factors which are accountable for gaps in service delivery. These are discussed in detail in Chapter Five under the heading dealing with macro-environmental constraints.

2.6 Mental Health Problems and Needs

The Society has, as one of its goals, a responsibility to ameliorate mental health problems. It is therefore necessary for these to be defined. The concept of mental health is defined independently. The cultural dimension of mental health and mental illness are explored later in the chapter. Finally, a distinction is made between problems and needs.

There is tendency amongst scholars not to define the concept of mental health, but mental illness. This tendency has caused the researcher to further split the concept of mental health into two for the purposes of defining it.

Collins Pocket English Dictionary defines "mental" as an adjective pertaining to the mind[8].

The World Health Organisation defines health as ".... a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity."[9] This definition is conceptual since the state of completeness if rarely attainable. It can be assumed, according to this definition that there is actually nobody who is mentally healthy.

Health should be viewed as a product of many variables, for example, genetics, diet, smoking, drinking, drug and alcohol use, exercise, cleanliness and sanitation, the state of one's emotions, medical care and prevention of

diseases.[10] Health must therefore not be viewed as static perfect state but as a dynamic process which includes high level of wellbeing.

This study analyses mental health as a sub-system of social and mental systems. It acknowledges that for the mind to function normally, the socio-political system must provide an environment which is conducive to the achievement of socio-cultural - (education, attitudes and values); economic - (income, finance); and spatial - (location and type of facilities required) goals.

This study further explores the cultural dimension of mental health to provide a deeper insight to the understanding of this concept. Such understanding is important in that it shapes the manner in which mental health service programmes are developed.

Dr Cliff Alwood, the Head of the department of Psychiatry at the University of Witwatersrand, has cited the need for an establishment of a model for Africa in psychiatric care[12]. He suggests inclusion of traditional or indigenous healers in the model.

Blacks do not define mental illness within the Western psychiatric and psychological context only but also according to their own cultural context. They believe that mental illness is a process through which ancestors communicate their will to their descendants[13]. In some instances, blacks define mental illness within the context of their beliefs which is based on supernatural powers and traditional ways of worship.

Psychiatric and psychological disorders are not perceived by blacks purely from the Western medical perspective. If

for example, a child is borne mentally retarded, that child is an indication for the parents or the family clan to recover values and customs. Psychiatric illness is associated with failure to communicate with ancestors. Hallucinations are associated with witchcraft, etc.

However, it must be noted that the African society is not a homogenous group. Different groups according to tribal, social, economic, educational and other factors are dominant in this society. There is a tendency for the educated group not to attach more importance in respect of traditions and other cultural factors.

The different professional groups involved in the rendering of mental health services may perceive mental health from their theoretical biases and this could have an influence on the practised mental health care.

The Society needs to be sensitive to the cultural dimensions of mental health. This sensitivity could help in the development of cultural factors affecting treatment or could help in alleviating societal groupings. Treatment and care of the mentally and psychiatrically ill persons without considering their culture is, according to Kiev "... tantamount to treating him as a fragment rather than a whole person; this attitude is anti-therapeutic"[14].

For the purposes of this study, mental health is hereby operationalised as a high level state of wellbeing which includes adequate and fulfilling socio-political conditions, e.g. proper and adequate housing, health care, employment, participating in decision-making and sharing of political power by the different population groups; to mention only a few.

Mental health problems, like social problems, may be defined as any condition of people or their environment, that is deemed undesirable[15]. Such conditions undesirably change the conditions of its victims making them more susceptible to mental ill-health. These conditions may include poor health and mental health services, unemployment, low income, detention and imprisonment, poor housing, poor education, non-participation in decision-making and political matters.

This study defines and analyses mental health problems of the black communities in the three townships (Langa, Nyanga and Khayelitsha). It identifies situations or conditions of people or their environment that are deemed undesirable and which impinge on their mental health.

A distinction is made between problems and needs. Needs are conceived as connotations of the extent to which mental health problems exist.

York asserts that the term "need" has often been used "... to mean such diverse notion as the potential intrinsic necessity of a group of people for a specific service, what it will take to bring a program up to some set of acceptable standards, what the community is likely to be willing to provide, and what people want"[16]. The above meaning, according to York, does not define the underlying concept but gives an example of a type of need identified in a particular data base.

Martin Wolins defines "need" as "..... a tension state generated in the process of physiological, psychic and social functioning"[17].

Bradshaw prefers to identify four types of needs, depending on the particular data base from which needs have been drawn. These are, the normative needs, felt needs, expressed needs and competitive needs. Normative needs are needs which are defined as such by experts or professionals, usually by use of certain standards. Normative needs provide a specific target that is easily quantifiable. The second type of need is felt need. This is what people perceive to be their need. This type of need is equated to want. Thirdly, expressed needs are defined as felt needs that are turned into action by demand for something. The need, in this perspective, is viewed as what people demand and the extent of need is determined by the number of people that request the service. Finally, a comparative need is perceived by Bradshaw as the gap between the level of services that exist in different areas, weighted against the relevant differences of population characteristics, i.e. the extent to which a service is available to one group as compared to the level of utilization of that service by a comparative group[18].

This study uses the different categories of needs interchangeably. The felt need perspective is used to determine types of mental health needs as perceived by the black communities in question. This is equated to what they say they want as per previous social surveys and conducted interviews.

The felt mental health needs of blacks are those needs reflected by the register of needs of applications for various services or facilities and those needs expressed during interviews with present consumers.

Comparative needs are referred to by the study as a way of

highlighting the gap between mental health services to the black communities and other population groups. This gap is weighted to account for non-representativeness and non-participation of the black communities in the hierarchical decision making structures of the Society.

2.7 The Residual System of Welfare Provision

The residual model is based on the belief that individuals' needs are primarily met through the family and the private market. Only when there is a breakdown, should social welfare institutions come into play, but only on a temporary basis[19]. The underlying principle of this model is the partnership between the state and the voluntary human service sector. The former's responsibility is to formulate welfare policy, whilst the latter administers that policy in its service delivery.

The Republic of South Africa's welfare policy is a residual one. This residual system is underlined by the policy and philosophy of racial discrimination, subsequently referred to as "apartheid". Social services are, for example, provided unequally to the different population groups.

This study critically examines the residual model with special reference to the constraints and deficiencies it poses to the mental health of black communities and mental health care. The residual model has major implications for private social service organisations in South Africa, because it limits distribution of rational resources and places the burden on the private sector.

2.8 The Institutional System of Welfare Provision

The institutional model views social welfare as a major

integrated institution in society, providing universalist services outside the market on a principle of need. The underlying theories of this model are multiple effects of social change and the economic system and in part on the principle of social equality It also incorporates systems of redistribution in command-over-resources-through-time.[20]

This model sees certain functions as major institutional activities of the community. These include:

- production and distribution of market goods for consumption. Economic institutions should be responsible for this.

- socialisation of the societal members. This responsibility is assigned to the family.

- social control. This must be assumed by political institutions.

- social integration. This should be the responsibility of religious bodies, and, finally

- mutual support should be looked after by social welfare institutions.

The institutional conception is viewed by the study as both humanitarian and patriarchal in nature. By being humanitarian, it sees to fair distribution of social security among different communities and/or racial groups. By being patriarchal it allows a certain degree of power and participation of community members in welfare programmes. In addition to these, it stresses redistribution of prosperity so as to eliminate poverty, inequality and inequity, together with all the negative products of the capitalistic system.[21]

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CHAPTER 3

THE ORGANISATIONAL PROFILE

1. INTRODUCTION

The purpose of this chapter is to outline the organisational context in which mental health services are provided and to give a general background to the social policies which govern provision of these services with special reference to the Mental Health Act No. 18 of 1973 and the Social Welfare Policy as approved in 1987.

An organisational profile which includes the structure, goals, programme services, organisational processes and procedures, planning, fundraising, budgeting and evaluation methods is provided. These highlight the manner in which the Society responds to mental health needs and problems in the Western Cape and also enables one to isolate defects and weaknesses in the response process.

2. THE SOCIAL WELFARE POLICY

The South African Welfare system is based on certain philosophies and service roles. It is residual in nature, sharing the roles and partnership between the state and the community. The state is responsible for developing welfare policy within the framework and philosophy of differentiation according to race. The state is also

responsible for financial allocations in the form of subsidies. Private human service organisations provide the bulk of welfare services according to their areas of interest.

The Social Welfare Policy has three major features, namely, differentiation, devolution and privatisation.

Differentiation implies that welfare is "own affair", falling under "own affairs" government departments. It determines that separate welfare organisations should be established and maintained for various population groups on national as well as regional and local levels. Welfare structures according to this policy are divided along racial lines. (See Annexure 6 : Schematic Presentation of the Welfare Structures in South Africa).

Devolution means the transfer of authority from central to regional government. Functions and services previously delivered by the central state have been transferred to provincial administrations. These services include education and health services. (See Annexure 6 : Schematic Presentation of the Welfare Structures in South Africa).

The third major feature of the policy is privatisation. Privatisation implies the entrusting of more responsibility of welfare provision to the private sector for supporting existing and new human service organisations; simplification and trimming of welfare bureaucracy while duplicating and expanding it; encouragement of private sector which charges fees for services rendered; to mention only a few. The policy does not clarify which aspects of welfare will be privatised, and how.

The constraints posed by the residual approach and the Social Welfare Policy together with their implications for mental health services are discussed in Chapter Five.

3. THE MENTAL HEALTH ACT NO. 18 OF 1973

Mental health services are rendered under certain guidelines and conditions as prescribed by the Mental Health Act and other relevant social policies and regulations.

The objectives of the Mental Health Act are many. In its broader goal it seeks to provide solutions to the problems of mentally ill persons. Furthermore it gives guidelines that regulate the identification, admission, institutionalisation, care and protection against sexual abuse and negligence of mentally ill persons. This Act provides the framework within which human service organisations rendering mental health services maintain stability while improving the mentally ill person's condition. It also assists in maintaining uniformity and in co-ordinating service delivery.

The Mental Health Act prescribes the extent of state involvement and voluntary welfare provision. The manner in which the Act is implemented by organisations such as the Cape Mental Health Society indicates that the state sees the family and the community as important components in the treatment of the mentally ill. This is in line with the principle of the residual model which emphasizes the responsibility of caring for individuals by their families and communities.

This Act has been formulated on the value premise that responsible communities take care of their mentally ill. This is why the responsibility for the identification of the mentally ill and their admission to institutions is entrusted to any member of the community[1]. However, it is understandable that the problems inherent in such a value premise are many when the examination of communities and resources (Chapter Four) indicate that the struggle for survival is a priority and the needs of groups such as the mentally ill are relegated to the background.

One aspect of the Act which causes some concern is its highly bureaucratic application and admission procedures. This includes taking the patient to a doctor for a medical certificate and also taking him to the magistrate who may require two additional medical practitioners to examine the patient, either jointly or separately. This long procedure poses difficulties to the black people (Africans) who live in the townships. The townships are far from the magistrates' offices. There may also be financial problems since most of the black families are poor. In addition, it causes relatives and friends of the mentally ill to attend only to those patients who are a danger to the community and to themselves, neglecting others who may need institutionalisation. There is a need therefore for the mental health care providers to close this gap in the service. This could be done by helping to identify the mentally ill in the community and helping with applications for admission to institutions for the mentally ill. Alternatively they could help in cutting down bureaucracy in this procedure.

The mental and the health policy has some parameters within which the Cape Mental Health Society operates and these are discussed below.

4. GOALS AND OBJECTIVES OF THE SOCIETY

The Society strives for a non-discriminatory service to all deserving persons. Its aims are stipulated in its constitution as follows:

- to promote the highest degree of mental health in the community regardless or race, colour or creed

- to render and promote services for the care of persons suffering from mental illness or mental handicap and, where necessary, provide food, meals, board, lodging, clothing or

other necessities, comforts or amenities to such persons

- to initiate research into the causes of mental illness and defects, and social attitudes towards this; to determine conditions which are conducive to mental disorders and take steps necessary for elimination (or amelioration) of such conditions; to work for public participation by disseminating information relating to the incidence and prevention of mental disorders.

- to strive for co-operation and co-ordination between welfare organisations, state departments and psychiatric units; to bring about an interdisciplinary team approach to all matters pertaining to mental health including the rehabilitation and care of the mentally ill

- to co-operate with training institutions which teach social work, psychology, psychiatry, nursing, occupational therapy, remedial teaching and any other discipline that may contribute to the realisations of the objects set above.

5. ORGANISATIONAL STRUCTURE

The Society has a formal structure through which services are rendered. (See Annexure 7 : The Non-Statutory Structure of the Cape Mental Health Society, and Annexure 8 : The Organisational Structure of the Cape Mental Health Society).

5.1 The General Committee

Control of the activities of the Society are vested in the general committee which is elected annually. This committee consists of not less than five and not more than ten members. One representative of each branch

committee may serve in a consultative capacity and as a representative rather than elected member. Black (African) representation consists of only one member who has a representative member status. There are no African elected members on the general committee.

5.2 The Executive Committee

It consists of five members: the chairman, the vice-chairman, the treasurer and two members of the General Committee. It meets monthly to deal with functions and duties delegated to it by the general committee. The director sits ex-officio on the executive committee. No other staff members are represented on the executive committee. There is no African (black) representation on the executive committee. All other population groups served by the Society are represented on this committee.

The implications of the non-representation of the blacks in the middle and top structure of the Society has been discussed in Chapter Five.

5.3 Standing Committee

There are five standing committees which represent various interest groups or projects. These committees use the Society's fundraising number for fundraising events. Out of the five committees, one is black and it consists of ten members. This committee represents the Nompumelelo workshop project in Langa, for the mentally ill.

5.4 Staff as at 31 March 1988

5.4.1 The Director

The director is the executive head of the organisation and is accountable to the executive and general committees.

5.4.2 The Deputy Director

The deputy director is responsible for professional fieldwork and directly supervises departmental heads (except the fundraising head and the financial managers who are accountable to the director).

5.4.3 Departmental Heads

Departmental heads for various functions within the agency are appointed. These are: intake, fieldwork services, community services, mental health promotion, student training and administration. The departmental heads are responsible for professional and administrative work within the functional departments. Their duties entail planning of services, monitoring, administration and supervision of respective departments.

There is no black representation in the middle and top staff ranks mentioned above.

5.4.4 Field Staff

There are eighteen social workers who render

case-, group- and community work services. They are all graduate and registered social workers. There are three black (African) social workers. One of these three is on study leave. Only two social workers render fieldwork services to the blacks in the Western Cape.

5.4.5 Para-professionals

Although there is no provision for para-professionals in the organisational structure, there are two black para-professionals who are involved in community work projects in the townships.

6. SERVICES AND FACILITIES

The focus of agency work is said to be on the psychiatrically ill and mentally handicapped and is through the promotion of mental health. However, this is discussed in greater detail later in the chapter. Services are rendered through the methods of casework, group work and community work. Research is also conducted for the establishment of other programme services and facilities.

6.1 Casework Services

Casework services are rendered on a clinical basis, using different models depending on the nature of problems, clients and conditions underlying the problems. These include investigation, observation and treatment of clients and their families.

Table One below gives an estimated number of psychiatric

and mentally handicapped persons registered by the Society between May 1987 and May 1988.

TABLE 1 : REGISTERED CASES OF PSYCHIATRIC AND MENTALLY HANDICAPPED PERSONS IN THE CARE OF THE CAPE MENTAL HEALTH SOCIETY BY RACE IN 1987/1988

	Blacks	Coloureds	Whites	TOTAL
Psychiatric*	61	281	270	612
Mentally Handicapped*	228	910	178	1316
TOTAL	289	1191	448	1928
Percentages	15	62	23	100

Source: Compiled from the Society's statistics

Psychiatric*: Psychiatric persons are those who acquired psychiatric disorders through illness.

Mentally handicapped*: are those clients who have a lower than average IQ, for example, the mentally retarded.

The above table indicates that black clients account for only fifteen percent of the Society's entire clientele. This could be attributed, amongst others, to the fact that the

Society started serving Africans only in 1977.

However, the Valkenberg Psychiatric Hospital gave higher figures of the black psychiatrically ill persons from the townships under study for the past five years, as follows:

TABLE 2 : THE NUMBER OF BLACK PATIENTS ADMITTED TO VALKENBERG PSYCHIATRIC HOSPITAL FROM 1983 - 1987

Year	Number
1983	659
1984	752
1985	807
1986	757
1987	815

Source Compiled from the Valkenberg Hospital's statistics.

A larger proportion of the above were referred by the state community nurses and not by the Cape Mental Health Society.

The table above indicates that the Valkenberg Psychiatric Hospital registered 815 patients as against the Society's registered sixty-one black clients. The percentage interpretation of the figures is that the

Society could only render services to seven percent of the black psychiatrically ill persons of the Western Cape in 1987 to 1988 and this is only of those persons referred for treatment.

Table 1 indicates that out of the 1988 registered clients known to the Society, sixty eight percent of them are mentally handicapped. It can therefore be concluded that the tendency for the Society is to concentrate on services for the mentally handicapped.

The townships under study, accordingly to the Valkenberg Psychiatric Hospital's community nurse, have a vast number of psychiatrically ill persons. Table 3 provides details only of those who sought or were referred for treatment.

TABLE 3 : VALKENBERG PSYCHIATRIC HOSPITAL'S BLACK PATIENTS FROM LANGA, NYANGA AND KHAYELITSHA FOR 1987/1988

	Female	Male	TOTAL
Langa	30	60	90
Nyanga	64	73	137
Khayelitsha	65	91	156
TOTAL	159	224	383

Source: Compiled from the Valkenberg Hospital community files.

The total number of psychiatric clients known to the Society ever since it started is shown in the table below.

TABLE 4 : THE PSYCHIATRIC CLIENTELE KNOWN TO THE CAPE MENTAL HEALTH SOCIETY SINCE ITS INCEPTION IN 1913 (AND SINCE 1977 IN THE CASE OF BLACK CLIENTS)

	Number of Clients
Blacks	731
Coloureds	4277
Whites	1055
TOTAL	6063

Source: Compiled from the Cape Mental Health Society's records.

The 1985 population census found the total number of people in Langa to be 22 792 and in Nyanga 148 227[2]. Khayelitsha's population was estimated to be 105 000 at the end of December 1986[3]. These townships, excluding KTC squatter camp, Crossroads, New Crossroads and Guguletu, give a total population of 276 019. These are official figures; real figures are difficult to find since many people shy away from

authorities and census officials for various reasons. It is therefore assumed that the real figures are larger than official figures.

If the total number of black psychiatric clients known to the Society since 1977 is 731, the percentage services it renders to this part of the black population (townships under study) consists of only 0.26%. This percentage implies that psychiatric services rendered to the black communities are extremely limited.

According to Gillis "A conservative rule-of-thumb is that seriously incapacitating mental illness will occur in at least one percent of the population at any one time, or at least ten percent at some time in their lives"[4].

Using the rule mentioned above, the estimated number of black psychiatric clients in the three townships would be 2 760. If the Society's estimated number of blacks who were served during the 1987/1988 financial year is sixty-one (Table 1) and that of the Valkenberg Psychiatric Hospital (Table 3) is 383, therefore only sixteen percent of the estimated number of psychiatrically ill persons (2 760) in the townships under study were in receipt of mental health care. This service was provided within a narrow conception of mental health.

6.2 Community Work Services

Community work services are based on helping communities to establish community based facilities like toy libraries, training centres, group homes, clubs, workshops and others. These are in line with the Society's goal which is to develop appropriate services

and facilities for its clients.

The following sections provide tabulated community facilities run by the Cape Mental Health Society by race and the future development plans for the development of the services for the mentally handicapped and the psychiatrically ill persons, respectively.

6.2.1 Facilities and future development plans for the mentally handicapped

These facilities for the mentally handicapped persons include training centres, pre-school facilities, parent support groups, sheltered employment and other services.

(continued over)

TABLE 5 : TRAINING CENTRES FOR THE MENTALLY ILL IN JUNE 1988

		NAME OF CENTRE				
		Blouvlei	Beacon	Lente-geur	Nompu-melelo	Mary Harding
Centres per Ethnic Group	Blacks	-	-	-	1	-
	Coloureds	1	1	1	-	1
Placements/ Awaiting Exemption		61	41	89	63	206
Capacity		80	-	105	63	206
Vacancies		19	-	16	-	-
Waiting List		27	-	21	95	133
Shortage		8	-	5	95	133
Plans		-	to build centre for 60	-	to increase capacity by 33	-

The table above indicates the following:

- the Society provides training centres for blacks and coloureds only

- blacks are provided with fourteen percent of this service while coloureds receive eighty six percent

- the future plans to develop black services address only thirty three out of ninety five registered blacks who need the service. This amounts to thirty five percent of the blacks registered by the Society. This figure does not relate the broader population figures which are unknown to the Society.

- there is no centre which is for both coloureds and blacks.

TABLE 6 : PRE-SCHOOL DEVELOPMENT PROGRAMMES FOR THE MENTALLY ILL IN JUNE 1988

Type of Programme	Programmes per Ethnic Group		Place	Future Plans
	Black	Col-oured		
Toy library	-	-	Retreat	need cannot be met
Toy library	-	1	Mitchells Plain	to develop into weekly play group
Playgroup	-	1	Bonteheuwel	can be researched & run by student
Playgroup	-	-	Manenberg	Facilitator to be found
Toymaking workshops	-	-	-	to be held once a week depending on need
Child minding projects	-	-	-	to be researched (by one social worker) possibility of involving Mitchells Plain special care principal in project once off ground

Source: Cape Mental Health Society records

From the above table it can be deduced that

- there are no pre-school development programmes run by the Society in respect of black communities in the Western Cape

- there are no immediate future plans to meet this need. All the present plans are directed towards coloured services.

TABLE 7 : SPECIAL CARE FACILITIES WITH STIMULATION PROGRAMMES IN JUNE 1988

Place	Programme per Ethnic Group		Future Plans
	Black	Col-oured	
Mitchells Plain in the ground of Lentegeur	-	1	Consideration needs to be given as to whether the agency can afford to run more special care units

Source: Compiled from the society's records.

"General Comment: Subsidy for thirty children will come in 1988. Query whether they have to be housed in one building or whether they will be in different houses. Transport costs in black areas would be exorbitant."[5]

Commenting about the above table one would say

- there are no special care services for blacks

- the agency plans to have more special care units. It is not stated as to where, but presumably at Mitchells Plain

- Planners are worried about the "exorbitant" cost anticipated for transport in black areas. This is not a positive indicator that this service will be provided.

TABLE 8 : PARENT SUPPORT GROUPS IN JUNE 1988

Place	Programme per Ethnic Group		Future Plans and Remarks
	Black	Col-oured	
Khayelitsha/Langa/ Nyanga/Guguletu	1	-	There are 50 people who benefit from this project. Presently they have no place to meet
Manenberg/Heideveld	-	1	Students to run short term support group in the area.
Hanover Park	-	-	Skills group expressed need - students to get involved.
Athlone	-	-	A lot of planning needed and transport present a problem

General Comments: The Mental Health Promotion Manager offered to meet with social workers who wish to embark on this sort of project

- Workers must continue to assess the need in their own areas and determine what sort of format their groups of parents would desire.

The above table indicates that:

- there is one parent group support for blacks

- stipulated plans for the development of these services are for the coloured communities only

- there are no clear objectives for the black services. The General Comment indicates that social workers will generally have to take their own initiative.

It can be assumed that if black social workers and/or their supervisors are self-motivated workers, these groups can be started if there is a need.

(continued over)

TABLE 9 : SHELTERED EMPLOYMENT DEVELOPMENT PROJECTS IN NOVEMBER 1987

Type	Place	Projects per Ethnic Group		Future Plans
		Black	Col-oured	
Optimum work-shop size of 100			1	to be reached within 4 years
Workshop	Retreat	-	1	plan another workshop (for coloureds) to produce 20 graduates in addition to the present 10
Skills group Workshop	Athlone	-	1	to be piloted in a prefab in April 1988
Skills group Workshop	Athlone	-	1	to be piloted in a prefab in April 1989
Nompumelelo Workshop	Langa	1	-	to expand the workshop is a problem. To look at alternatives, viz.:- - to move into the old training centre premises in Nyanga - buy land from KwaNothemba workshop for Khayelithsa - renovate disused hostel in Langa

Source: Compiled from the Society's records.

Commenting on the above table, it can be said that:

- the workshop/sheltered employment service is provided by the Society for blacks

- this constitutes twenty five percent of the total service

- the remaining seventy five percent is for coloured consumption

- there are clear and specific objectives so far as future development plans of expanding the coloured services are concerned. They are either quantified in numbers or given specific target dates, stating the names of social workers to undertake duties and specific dates as to when to report back

- development of black services have no clearly stated objectives. No details as to who is supposed to achieve what, when or how.

(continued over)

TABLE 10 : OTHER SERVICES IN JUNE 1988

Type	Place	Quantity of Services Ethnic Group		Future Plans & Comments
		Black	Col-oured	
Group Home	Torrance	-	1	expansion of the cottage subsidy to be diarised for fundraising calendar
Social clubs	Athlone	-	1	transport to be extended to Athlone area. Explore fundraising possibility Need +- R1000 p.a. to cover costs.
Mental health workers projects (Social Group)	Langa	1	-	not yet fully established - to use the old Nompumelelo workshop premises in Langa
Nyanga New Crossroads KTC Guguletu	-	1	-	no venue - private house has been used but the group has dissolved in Guguletu

Source: Compiled from the Society's records

In addition to the table

- there are two black mental health workers (para-professionals)
- one of them is concentrating on establishing support groups for seriously handicapped children's mothers

- the other one is concentrating on the establishment of a social club for psychiatric clients in the townships

- the possibility of using the old Nompumelelo Training Centre is being investigated.

6.2.2 Facilities and future development plans for the psychiatrically ill at the Cape Mental Health Society

These facilities and services for the psychiatrically ill include psycho-social rehabilitation centres, social groups, social clubs, social skills groups, support groups, workshops, home industries and others.

The tables below provide information of the community work services rendered by the Society to the psychiatrically ill.

(continued over)

TABLE 11 : PSYCHO-SOCIAL REHABILITATION CENTRES / GROUPS IN NOVEMBER 1987

Service	Number of centres for Ethnic Group			Future Plans
	Black	Coloured	White	
Fountain House Social club for the Northern Suburbs	-	-	1	the possibility is being looked at for the Northern Suburbs
Social Groups for black areas	1	-	-	the Mental Health Care worker is helping to establish the group with the help of a social worker. Problems encountered: - no venue - no refreshments for members - only a few 'games' have been provided - poor attendance
'Drop in' type social group for Bonteheuwel	-	-	1	the need has been identified - this could be considered in '89
Manenberg drop-in type social group	-	-	1	the need has been identified - this could be considered in '89
Retreat social group	-	1	-	the present social worker to continue running the group fortnightly
Fountain House social club	multi-racial, mostly used by whites and coloureds, inaccessible to blacks			- pro's and con's of decentralisation are being investigated - the possibility of Cape Support Group buying the house next dsoor to Fountain House in order to extend, is being investigated.
Social skills group	assumed that this will be for coloureds and whites since there is no black disability grant clients'facilities at Observatory			the need has been identified. There is a possibility of including Disability Grant clients at Observatory after July 1988

Source: Compiled from the Cape Mental Health Society records.

TABLE 12 : OTHER SERVICES AND FUTURE DEVELOPMENT PLANS IN NOVEMBER 1987

Typee	Development plans per Ethnic Group			Place	Future Plans
	Black	Col.	White		
Support group for families of Portuguese clients	-	-	1		a need has been identified one social worker (named) to research need in order to ascertain degree
Educational support group		1		Lentegeur	-
Home industries	-	-	-	-	Field workers please to feed the names of people working from home to the intake workers
Employment coordination	-	-	-	-	the need for the employment of employment coordinators has been identified and is being considered
Clinic	-	1	-	Hanover Park and Athlone clinics	one social worker (named) to be available when needed
Lentegeur	-	1	-	Lentegeur	The Director of Cape Mental Health to contact the superintendent in this regard

Source: Compiled from the Cape Mental Health Society records.

The Cape Mental Health Society's psychiatric development programmes are less developed than those for the mentally handicapped. There are a very

few psychiatric programmes for Africans. These are limited to the newly established social groups which are not progressing because of problems mentioned above.

Lentegeur Mental Hospital and its clinics in Athlone and Hanover Park (which serve mostly coloureds) work closely with the Society.

The Society does not co-ordinate its mental health services with that of the Valkenberg Psychiatric Hospital which serves the psychiatrically ill and at which most black psychiatric patients attend. This view was endorsed by the psychiatric community nurse at Valkenberg who works in the black townships.

The Society's welfare programmes tend to concentrate on mental health services for coloureds. Providing for this sector does not affect mental health services for whites adversely as there are various mental health organisations in the Western Cape. The black mental health services are heavily negatively affected by this tendency because of the generally inadequate mental health care in the Western Cape and in South Africa as a whole.

6.3 Group Work Services

Group work services draw on clients who are already in receipt of either casework or community services. Some of the groups who benefit from the Society's mental health service have already been mentioned when tabulating services for the mentally handicapped and the psychiatrically ill above. For purposes of highlighting group work services rendered by the Society, these may be repeated in the following table:

TABLE 13 : GROUP WORK SERVICES RENDERED BY THE CAPE MENTAL HEALTH SOCIETY AT DIFFERENT CENTRES BY RACE IN JUNE 1988

Place	Type of Group	Population Group
Blouvlei	Training Centre	Coloured
Lentegeur	Hospital training centre	Coloured
Mary Harding Centre	Training centre	Coloured
Nompumelelo (Nyanga	Training centre	Black
Mitchells Plain (Beacon)	Toy library	Coloured
Nompumelelo (Langa)	Workshop	Black
Manenberg	Play group	Coloured
Athlone (Mary Harding)	Parent support group	Coloured
Fountain House	Social club	All groups
Torrance Cottage	Group home	Coloured
Garden Cottage	Group home	Coloured

Source: Compiled from the Cape Mental Health Society's documents.

The abovenamed groups are task-related groups formed for performing certain tasks.

6.4 Mental Health Promotion

The aim of this service is to help people to enhance their coping skills in the management of stress. Methods used include talks, workshops and seminars. This project covers a number of about 1 200 people per annum. According to the mental health promotion departmental head, there has been only one workshop which was conducted amongst the blacks. This was at Uluntu Centre at Guguletu in 1985.

7. THE PLANNING PROCESS

The planning process is used to select goals and determine how to achieve the organisational goals and objectives. Planning is done at different levels in the organisation, namely lower level - operational planning and at a higher level - strategic planning.

Planning is a continuous process. Strategic planning is engaged in by management and departmental heads at Cape Mental Health Society. All decisions and plans are then referred to the General Committee for its comment and approval. Strategic planning refers to basic issues which need to be addressed. It provides for a framework for operational planning. Strategic planning at the Society involves formulation of goals, identification of objectives, analysis of the environment, distribution and allocation of resources, tabulation of alternatives and general decision making.

Operational planning is done at a lower level by the departmental heads and field workers. The focus here is on present services and facilities and on effectiveness in meeting the objectives.

8. FINANCIAL ASPECTS

Financial planning is done by the director, the finance departmental head and the fund raiser. It involves ensuring that money is available so as to facilitate the meeting of goals.

8.1 Budgeting

In September/October of each year a budget for the following year is drawn up by the finance departmental head. He uses the zero-based budgeting method and

obtains information from other departmental heads, director and deputy director in order to produce the document.

8.2 Income

The larger part of the Society's income is subsidized by the state. During the 1987/88 financial year, the total income was R771 182, of which seventy percent was derived from state subsidies. Other income came from the community chest (eighteen percent), donations (five percent) and administration fees (three percent). A minimal amount comes from membership fees.

The Department of Constitutional Development and Planning subsidised mental health services for blacks by R58 959 which form eleven percent of the total government subsidy.

The workshops, pre-schools, day care centres, training centres and other facilities are subsidised separately and independently by the state.

8.3 Expenditure

Expenditure during the 1987/88 financial year was R770 486. Most of this was incurred in the payment of salaries (81.3%). Direct relief to the clients accounted for 0.18% and the balance, 18.52% was for normal agency costs. A sum of R8 684 was used to support the different projects. 21% of this R1 823 was spent on the black community workshop in Langa, namely Nompumelelo.

According to the Society's financial manager the expenditure of the Society for the financial year 1987/88 is as indicated in the table below.

TABLE 14 : PERCENTAGE DISTRIBUTION OF SOME RESOURCES BY RACE OF THE CAPE MENTAL HEALTH SOCIETY IN THE 1987/88 FINANCIAL YEAR

Race	Percentage Distribution			
	Social workers posts	Time	Program	Govern-ment Subsidy
Whites	53.8	27.2	54.8	28.9
Coloureds	34.6	45.4	33.7	60.1
Blacks	11.6	27.4	11.5	11.0
TOTAL	100	100	100	100

Source: Compiled on request by the Cape Mental Health Society's Financial Manager.

8.4 **Financial Control**

Budgeting is one form of control over income and expenditure for the future. The planned figures are standards used to measure actual performance. This forms an integral part of control.

Quarterly, the finance departmental head provides actual

figures and compares them to the original budget. He then draws up a revised budget, which is based on new information.

Finally, auditing is done annually, as another form of financial control.

9. FUNDRAISING

Fund raising is the responsibility of the fundraising co-ordinator who liaises with the director and the finance departmental head. There are two types of fundraising which are commonly used by the Society. The first one includes requests to donors in respect of problems which are identified, needs assessed and estimated funds requested. The second one is based on fundraising events by the Society. These events are mainly western-orientated, involving sums which a black man on the street in the townships cannot afford. Venues for fundraising events are also inaccessible to the black communities in the townships.

10. EVALUATION

Evaluation is conducted throughout the year. General evaluation is conducted during the September/October months each year. It includes examining the various sets of objectives - those achieved and those not achieved; and reasons for the outcomes are identified. The organisation is concerned with the evaluation of effort. York defines this as ".... the analysis of the quantity of service provided or the amount of activity undertaken."[6]

The role of the agency and its response to the problems and needs of its clientele can be made more clear by the community profile of the clients. Chapter Four provides this community profile.

11. STATE BUDGET ALLOCATIONS

Mental health care is political in nature. It is political because its control and decision-making are in the hands of the government. it is the government which decides who is to get what, how much, and when. The government's budget allocations show that welfare services are not the government's priority. In recent years, priority has been given to to defence and, of late, to education.[7] (See Table 15 below)

TABLE 15 : SOUTH AFRICAN GOVERNMENT BUDGET ALLOCATIONS FOR EDUCATION, DEFENCE AND WELFARE

Financial Year	Education	Defence	Welfare
1977 / 1978	14.9%	18.4%	5.7%
1987 / 1988	19.0%	15.0%	5.2%
1988 / 1989	18.2%	14.7%	5.0%

Source: The Minister of Finance Budget speech 1988/89.

The above listed figures exclude the national states, that is Transkei, Venda, Bophutatswana and Ciskei. They include Whites, Coloureds and Blacks living in the Republic of South Africa.

The decrease in welfare expenditure of the government's budget allocations despite the ".... increase of 21.6, 21.3 and 22.3 percent

during the three fiscal years"[8] is consistent with the government's determination not to promote welfare statism.

The above figures indicate that the vote for welfare service has not increased since the 1977/78 financial year. This implies that welfare service providers operate under financial constraints and tight budgets. For mental health care, it implies that there are not only some difficulties in expanding the services, but in maintaining the existing mental health programmes.

END-NOTES

1. The Mental Health Act, No. 18 of 1973 Section 8(1)

2. The Population census Report of 1985 on the Western Cape No - 02-85-08

3. The Annual Report of the Medical Officer of Health of the Divisional Council of the Cape Combined Health Scheme Region IV, 1986

4. Gillis, L.S.
   Guidelines in Psychiatry (3rd ed) Juta & Co. Ltd 1986 p.9

5. Psychiatric Evaluation and Planning. Meeting on 17/11/1987 (notes).

6. York, R.O.
   Human Service Planning. Planning, Concepts, Tools and Methods. The University of Carolina Press. 1982 p. 146.

7. The Minister of Finance Budget Speech. Statistical/Economic Review, 1988/89. Republic of South Africa, p. 32.

8. Ibid. p. 32

CHAPTER 4

COMMUNITY PROFILE

1. INTRODUCTION

This chapter concerns itself with community profiles of Langa, Nyanga and Khayelitsha. It looks at the political background under which these townships were established; social and economic patterns; educational aspects, health facilities, social welfare services; housing, community needs and problems. The purpose of all this is to highlight the various aspects which impinge on the mental health of the blacks, alternatively referred to as Africans in this chapter.

2. LOCATION

The three townships are located outside the city of Cape Town. Langa is about thirteen kilometres from the centre of the city. It covers an area of 340 morgen[1]. (See Annexure 9. The Map of the Cape Peninsula).

Nyanga is situated about twenty kilometres from Cape Town. It is about 427 hectares in size[2] (See Annexure 9. The Map of the Cape Peninsula).

Khayelitsha is about thirty-five kilometres from Cape Town. This

township is still being developed. It will eventually cover 1443 hectares but so far only 378 hectares have been developed[3]. The first houses were put up in 1983 at Driftsands. Khayelitsha is to the east of Mitchell's Plain and just south of the N2 freeway and it covers a vast area.

3. POLITICAL BACKGROUND UNDER WHICH THE TOWNSHIPS WERE ESTABLISHED

The black townships of the Western Cape are one of the manifestations of South African discriminatory laws. These laws include:

- The Group Areas Act, No. 36 of 1966 - which provides for different geographic areas for exclusive ownership and occupation of property by members of particular statutory defined race groups (thus making it impossible for members of other race groups to own or occupy property in certain areas).

- The Community Development Act, No. 3 of 1966; which makes provision for removal and resettlement of people within proclaimed group areas.

- The Black Land Act, No. 27 of 1913 and the Development Trust and Land Act, No. 18 of 1936 which provide for separation of occupation and ownership of non-urban Africans vis a vis other groups and

- the Black Community Development Act, No. 4 of 1984 which provides for the proclamation of townships for Africans in urban areas.

Statutory discrimination against blacks can be traced as far back as

1879, when the Native Location Lands and Commonage Act legislated racial segregation of all those Africans who were staying in urban Cape Colony[4]. Some of these discriminatory laws have either been repealed or amended as part of the National Party's reform strategy.

Introduction of Martial Law in 1900 made it easier to administer forced removals of Africans living in the centre of Cape Town as early as 1901, during the bubonic plague. These people were seen as a health hazard and were removed to Uitvlugt - later renamed Ndabeni. Twenty years later, Langa township was established in order to accommodate Africans from Ndabeni and those who were still living in the centre of Cape Town[5].

After the Anglo-Boer War, there was a demand for migrant labour for building projects to accommodate the increasing number of whites and coloureds in the Western Cape. Site and service schemes were started in Nyanga. Guguletu was built in 1959. By 1974, despite the labour and other restrictive laws, there were an estimated 90 000 "illegals" in the Western Cape. The "illegals" according to the influx control laws, were families that could not obtain migrant work and thus migrated to cities where there was a greater chance of finding jobs [6].

By 1976 there were at least 60 000 Africans living in squatter camps at Nyanga Bush and Crossroads. In 1978 Dr Connie Mulder, the then Minister of Plural Relations, now known as Department of Constitutional Development, demanded that Crossroads be demolished and that illegals be repatriated to Transkei and Ciskei from where they originally came. On 30th March 1983, Dr Koornhof, who followed Dr Mulder into office, announced the building of Khayelitsha township as a solution to the growing urbanization crisis in the Cape Peninsula.

In September 1984, during the Cape National Party Congress, the

State revealed new initiatives and made a significant number of resolutions which included:

- the scrapping of Coloured Labour Preference legislation

- the introduction of a ninety-nine year leasehold for Africans qualifying to be in the Western Cape and

- repatriation of the estimated 100 000 illegal Africans in Cape Town.

The above political background throws some light on the issues revolving around the establishment of some of the black townships in the Western Cape. The subsequent sections examine the socio-economic patterns under which blacks live in these areas. These aspects set the scenario for unique problems for blacks in the area.

4. POPULATION

The issue of population is examined in order to assess the extent of some of the mental health needs of Africans in the areas under study. Township demography, especially regarding numbers of people, their gender distribution, education and economic patterns and various other factors, make it possible to identify some issues which impinge on the mental health of people affected.

4.1 Gender Distribution

Figures below indicate that in these three townships there are more males than females. This can be attributed to the migrant labour system which allows males to come and work in big cities, leaving their wives and children in their rural areas. This is one aspect which plays a major role in

breaking down family life. Family life is the foundation of good mental health to family members.

TABLE 16 : GENDER DISTRIBUTION OF LANGA AND NYANGA IN 1985

	Males	Females	Total
Langa	13 390	9 402	22 792
Nyanga	75 272	72 955	148 227
TOTAL	88 662	82 357	171 019

Source : Compiled from the 1985 Population Census. The Khayelitsha figures of the 1985 population census are incorrect because of the rapid population growth. However, at the end of 1986, the population of Khayelitsha was estimated to be 105 000, and that of Site C 50 000[9].

In December 1986, the total number of Africans in the Western Cape was estimated to be 988 040[10]. This speedy rate of population increase has a negative impact on planning and distribution of existing resources which are unable to keep pace. The Cape Mental Health Society, like other service structures, is adversely affected by this rapid population increase.

5. EDUCATION

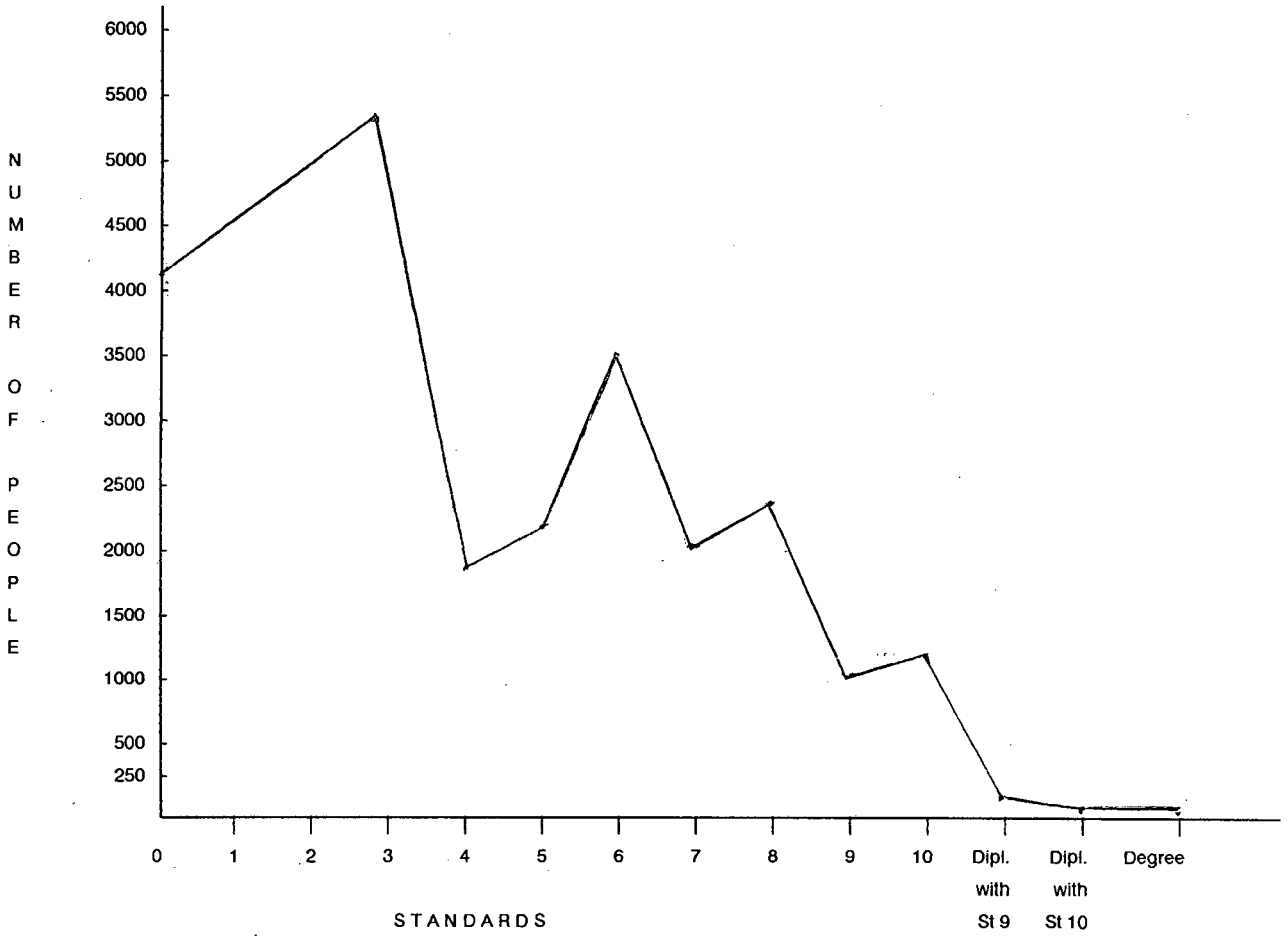
Education is one of the factors which determines the life style of individuals and communities. It is also one of the determinants of an individual's well-being. It helps in the moulding of a personality, develops an individual's perception, moulds his behaviour and various other

mental aspects. Low and non-education of individuals means fewer job opportunities, lower incomes earned and less stability. Education contributes to psychological development and maturity. It equips a person to cope with stressful situations more appropriately. Education is usually an indication of the level of development of a society. A high rate of illiteracy indicates the societal level at which individuals are able to intervene in decision-making. It also indicates the nature of stress that the individuals in the society are faced with.

The graphs below provide the educational distribution of the Africans in the areas under study as according to the 1985 census.

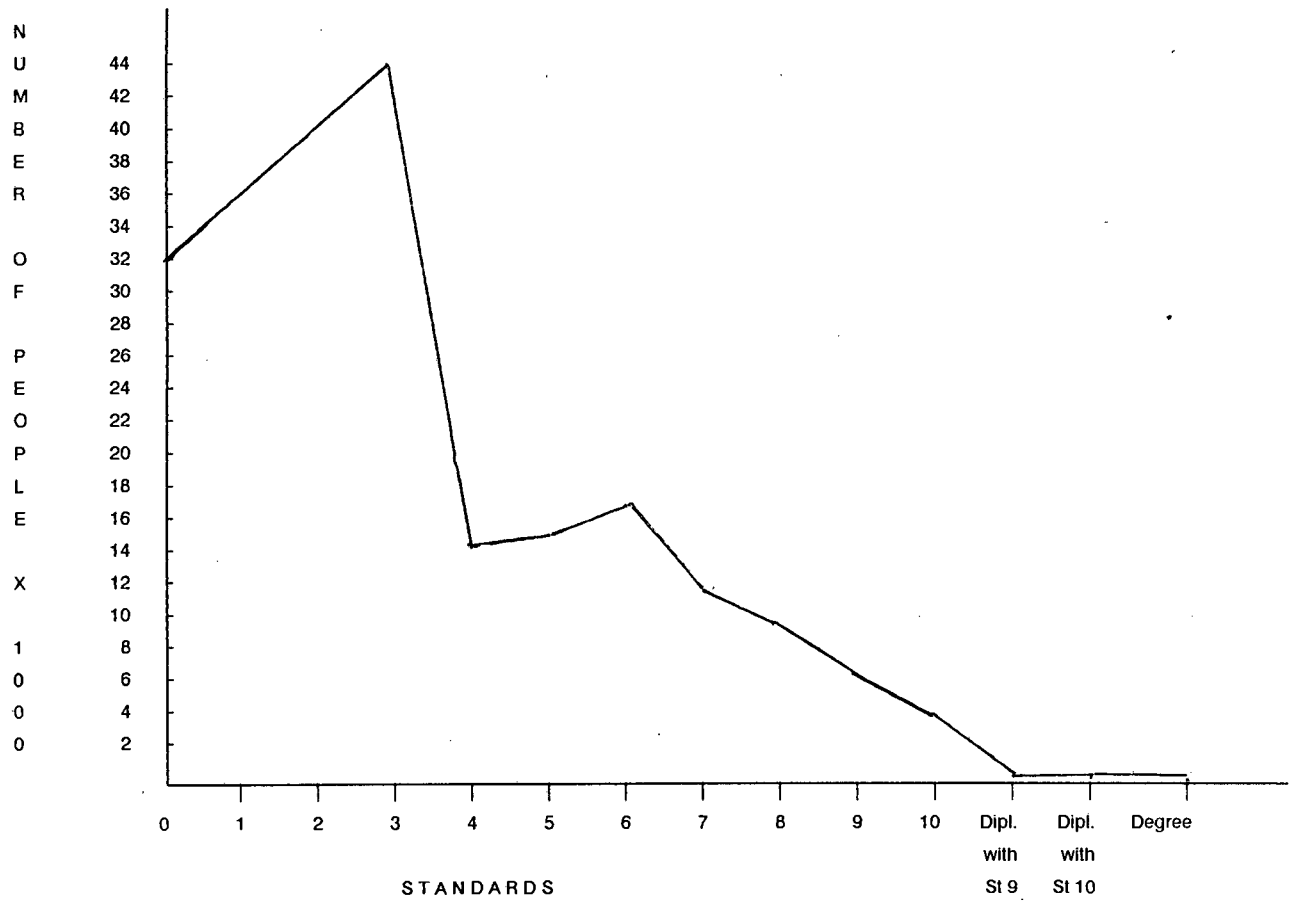
(continued over)

FIGURE 1 : THE EDUCATIONAL DISTRIBUTION OF PEOPLE IN LANGA IN 1985



Source : Compiled from the 1985 Population Census.

FIGURE 2 : THE EDUCATIONAL DISTRIBUTION OF PEOPLE IN NYANGA IN 1985



The educational distribution of the people of Khayelitsha, as according to the 1985 census is very low as compared to the present estimates. These have, therefore, not been provided.

The graphs above reflect that the educational level of Africans in these townships is very low. They also reflect a high level of illiteracy.

The Human Awareness Programme has submitted the figures below to demonstrate the inferior and poor standard of education for blacks in South Africa:

"* In 1985/6, R2746 was spent on each White child's education, and R387 on each African child's education.

* About 10 000 children under the age of 16 drop out of school in the Western Cape each year, mainly because of dissatisfaction over school, family violence or parental absence.

* In the 1986 matriculation examinations, White pupils achieved a 92.1% pass rate, Indian pupils 85,9%, Coloured pupils 65,6% and African pupils 51,99%. Of the White pupils, 43,2% achieved university entrance passes; 33,3% of the Indian pupils; 15,3% of the Coloured pupils and 13,07% of the African pupils.

* In 1985 the pupil/teacher ratio in African schools outside the homelands was 41.2 to 1. For Coloured schools it was 25,4 to 1; for Indian schools 22,5 to 1, for White schools 18,7 to 1."[11].

The above factors illustrate the current condition of black education

in South Africa. Its implications concerning the mental health of the Africans is discussed in Chapter Five.

5.1 Schools

Schools in the Western Cape suffer the same problems as all other South African black schools. These problems include shortage of schools; classrooms and educational facilities; high teacher-pupil rate; high dropout rate - about 250 000 African pupils who enrolled at the beginning of 1986 were out of school by the final term;[12] low salaries and insufficient training for teachers - "among African teachers 94,6% are underqualified or have no qualifications at all.[13] Classrooms have no heating systems. Pupils are exposed to extremely bad weather conditions.

The table below shows different types of schools available in the area under study.

TABLE 17 : SCHOOLS IN LANGA, NYANGA AND KHAYELITSHA IN 1988

	Senior Sec.	Training College	Primary	Private	Reg* Pre-sch	Non-reg* Pre-sch	TOTAL
Langa	3	0	6	2	8	8	27
Nyanga	1	0	6	1	9	11	28
Khayelitsha	1	1	19	0	8	16	45
TOTAL	5	1	31	3	25	35	100

Source : Compiled from primary data.

*Registered pre-schools are those which have met the requirements for registration as formal pre-schools. *Non-registered pre-schools are those which are run in private homes, church halls, shacks, etc. They are informal in nature and are sponsored by private human service organisations. Private schools are those schools which are neither subsidized nor controlled by the government. These are owned by the private sector, for example, churches.

5.2 Informal Educational Services

Basic informal educational services are offered by parents, guardians and relatives during the upbringing of the children and during the process of socialization.

Informal education is also provided by private organisations like the Council for Black Education Research Trust (COBERT), the Masifundise Education Project and the Career Resource and Information Centre (CRIC).

COBERT runs the following projects:

- training unemployed women in sewing and knitting so as to promote self-reliance and self sufficiency. It has co-operatives and small businesses where people work after training in order to produce goods for selling. COBERT has centres in Langa, Guguletu and Site C, near Khayelitsha.

- a reading room in Guguletu where school pupils get reading material relevant to higher primary education up to degree level.

- lectures which are held at St Francis Community Centre in Langa where pupils are taught about Africa, poetry, religion and drama.

- youth programmes are also run for pupils. These include educational tours, holiday programmes, piano lessons and conversational lessons for primary school pupils.

The Masifundise Educational Project also runs projects similar to the abovenamed. In addition, it gives financial assistance to deserving pupils. This organisation has a centre in Langa and is also using the Methodist Church of Nyanga as a venue. It has another centre in Site C near Khayelitsha.

CRIC's offices are situated in Claremont. It operates satellite offices in Guguletu and Langa. It is planning to open another satellite office in Khayelitsha. This organization runs a number of projects, for example, career counselling; training in lay counselling for teachers; work experience programmes in which pupils are put in a work situation for a week during school holidays, exposing them to the "real world situation". Field workers are employed to visit schools and give career guidance support to teachers. It also operates resource libraries for teachers.

The informal educational services provide organic facilities which are lacking in state education.

6. HEALTH FACILITIES

Health facilities, like most of the services to Africans, are

inadequate, inaccessible and of low standard. Lack of services create anxiety and other psychological problems.

The UNICEF/WHO Joint Committee (United Nations Institute for Children's Emergency Fund/World Heath Organization Joint Committee) on Health Policy[14] pointed out that in politically unfavourable situations of repression, economic and social control, the State will tend to run a community oppressive health service, with excellent care for the rich and second rate care for the poor.

The Human Service Awareness programme provides the following figures[15] which support the UNICEF/WHO view:

- about one hundred out of 1 000 African children born in rural areas die before the age of one. In urban areas the figure is fifty out of 1 000. For urban whites the figure is less than twenty out of every 1 000. According to these figures, a child dies from hunger every fifteen minutes in this country.

- the average life expectancy for whites is seventy years, while that of Africans is about fifty-five years.

In the preceding chapter, figures were provided for black psychiatric patients attending Valkenberg Psychiatric Hospital and its satellite clinics in Langa, Nyanga and Guguletu.

6.1 Formal Health Services

Langa, Nyanga and Khayelitsha have health care services that cater for their basic health needs. The following are existing services.

TABLE 18 : FORMAL HEALTH STRUCTURES IN LANGA, NYANGA AND KHAYELITSHA IN JUNE 1988

	Day Hospital	Clinic	Total
Langa	1	1	2
Nyanga	0	1	1
*Khayelitsha	2	3	5
TOTAL	3	5	8

Source: Compiled from the community survey of the area.

*Khayelitsha here includes Site C.

Clinic services include dealing with tuberculosis, child health, sexually transmitted diseases, family planning, geriatric services, minor ailments and general matters like immunization, breast feeding and nutrition.

Psychiatric clinics are run on a weekly basis at the satellite Valkenberg clinics in the day hospitals. Community psychiatric services are rendered by the psychiatric nursing and social work staff. Both the social worker and the community nurse at Valkenberg confirmed that their cases are not referred by the Cape Mental Health Society, nor do they co-ordinate their services.

Day hospitals provide out-patient services, social work services, family planning, district nursing services, eye

clinics and others. Most people in the black townships prefer to go to other hospitals such as Groote Schuur, Conradie and Tygerberg because of better facilities and services. The Guguletu day hospital is unpopular because of the quality of its treatment to patients and the inadequate number of doctors[16].

Health services are also rendered by the Students' Health and Welfare Centres Organisation (SHAWCO) and the Cape Nutrition Project - both of these are University of Cape Town projects.

6.2 Indigenous Mental Health Services

There has been a tendency to scorn indigenous and traditional ways of healing mental illness. There are various factors now which favour recognition of indigenous healings. These include the following:

- the idea that indigenous healing has a positive role to play has been receiving support from the World Health Organisation[17]

- Western medicine cannot explain satisfactorily, nor address successfully the significances of a large variety of conditions or some of the culturally specific syndromes such as "thwasa"[18]

- the methods used by indigenous healers are based on their knowledge and faith in the use of cultural beliefs, customs and values of their own people. These aspects re based on sound psychological principles[19].

There are an estimated fifty indigenous healers in all the

black townships in the Western Cape[20]. Most of the black people, whether educated or not recognise and sometimes make use of these services. Services differ from faith-healing by water and prayer to using pharmaceutical products and herbs.

7. SOCIAL WELFARE SERVICES

There are various organisations, public and private, which render social services in the three townships under study. These include:

- Child Welfare Society, Cape Town, which offers social work and child care services and specialises in child-minding training in Khayelitsha

- SHAWCO, which offers food parcels, runs feeding schemes in crêches and pre-schools

- the Cape Nutrition Education Project - is offered by University of Cape Town students

- the Cape Mental Health Society which renders mental health services

- the Red Cross Society provides community work services

- the Department of Constitutional Development and Planning renders generic social work services

- Ulwazi Christian Association runs informal pre-schools in Khayelitsha

- the National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO); the Association for the Disabled;

Association for the Aged; the National Cancer Association of South Africa; World Vision; Black Sash; Grassroots Educare Trust; Operation Hunger; Mfesane also run different projects in these areas

- mutual aid groups like "imigalelo", stokvels, burial societies are all fundraising groups. These groups have a great impact in acting as support systems in the black townships.

8. RELIGIOUS ACTIVITIES

Religious organisations play a vital role during the difficult times of repression. Christianity is the most popular religion in the black townships. Mot religious bodies have taken a stand against racial discrimination. Religion can alleviate emotional disturbances during unrest and political turmoils in the townships, but in spite of this blacks still suffer from stress and trauma because they are precluded from meeting their survival needs because of structural problems and the lack of facilitation in meeting these needs.

Each township enjoys the benefit of having various denominational groups with accompanying physical structures. Those religious bodies who do not have structures yet, use schools and private houses for their gatherings. The following religious groups exist in the townships:

- the Old Apostolic Church
- the Methodist Church of Africa
- the Dutch Reformed Church in Africa
- the Reformed Presbyterian Church

- the African Methodist Episcopal Church
- the Baptist Church
- the Presbyterian Church
- the African Congregational Church
- the Reformed Presbyterian Church of South Africa
- the Jehovah's Witnesses
- the African Independent Church
- the Anglican Church
- the Catholic Church

Churches render both material and spiritual aid. They run projects like feeding schemes for pre-school children, give food parcels and organise Christmas parties for the aged, run private crêches, conduct services for the bereaved, the ill and the aged.

9. ECONOMIC ACTIVITIES AND EMPLOYMENT PATTERNS

Economic activities and employment patterns are the major determinants of the quality of life, the quality of physical and mental health and the capacity of individuals and families to cope with problems and meet needs.

Economic sectors in which black people are employed are both formal and informal.

9.1 The Informal Sector

In his 1986 annual report, the City Engineer of Cape town agrees that the informal sector ".... is not a panacea for unemployment, although its importance for supporting family income particularly among the poor should not be underestimated."[21] In addition, the informal sector helps in supplying those services that do not attract the interest of big businesses or those services which are inadequately supplied.

The informal sector in the black townships can be divided into three areas of involvement. The first area is homemade products such as cooked meat, boiled eggs, pancakes, fish, fishcakes, beers, etc. The second one consists of retail shops ranging from small ones selling various household items such as matches, cigarettes, beer, paraffin and cold drinks. The third category is the services which are offered by "bush" (unqualified) mechanics, carpenters, plumbers and shoe repairers. There are several taverns (shebeens) in the townships which serve as liquor outlets.

(continued over)

9.2 **The Formal Sector**

TABLE 19 : TRADING AND BUSINESS FACILITIES IN LANGA, NYANGA AND KHAYELITSHA

	PLACE			
	Langa	Nyanga	Khayelitsha	TOTAL
Fisheries	1	1	1	3
Eating houses	3	-	1	4
General dealers	25	11	-	36
Supermarkets	-	1	2	3
Cafees	6	2	2	10
Butcheries	6	2	2	10
Dairies	3	4	-	7
Others	57 handcraft stalls	1 shoemaker	2 shoemakers 2 hardware stores 1 clothes shop	63
TOTAL	101	22	13	136

Source: Langa: Crawford M et al. Community needs Analysis: Profile of Langa, 1987.

Nyanga: Dinga, S. An Area Study of Cape Town. Carnegie conference paper No. 10(9).

Khayelitsha: Compiled from community survey of the area.

In these townships there are other formal sector services like undertakers, doctors' surgeries and post offices. There are no formal liquor outlets in the townships. Bottle stores which were owned by the Cape Administration Board were burnt down during the 1976 riots in the townships.

9.3 Employment Patterns

According to the 1985 census, many people in the townships are not economically active. The table below shows numbers of of such people.

TABLE 20 : OCCUPATIONAL DISTRIBUTION OF SOME PEOPLE IN LANGA, NYANGA AND KHAYELITSHA

	Unskilled workers		Workers not classified		Not economically active		TOTAL
	Male	Female	Male	Female	Male	Female	
Langa	3 400	73	1 053	1 077	4 494	5 683	
Total	3 743		2 130		10 177		15 780
Nyanga	11 314	737	5 723	5 648	39 792	50 411	
Total	12 051		11 371		90 203		113 625
Khayelitsha	177	7	70	90	946	1 345	
Total	184		160		2 291		2 635
TOTAL	15 708		13 661		102 671		132 040

Source: Compiled from 1985 Population Census.

The figures above show that out of the total population of these areas which is 132 040 people, seventy six percent are either unskilled, not classifiable nor economically active. It means that many people are without means of livelihood in these areas.

Unemployment is a source of various other social problems. In 1986, the Black Sash Johannesburg office reported that at least forty six percent of all problems presented arose from unemployment[22]. Chapter Five discusses the implications of economic deprivation in relation to mental health and these implications are quite serious.

10. HOUSING

Shortages of houses is one of the major problems in black townships. Data provided by the Human Awareness Programme indicates that:

- in black urban areas there is an average of sixteen people occupying each house

- one incident of forty two occupants was found

- the average area of living space per person is three square metres for washing, eating, sleeping, recreation and study.[23]

Nature of Housing in Langa, Nyanga and Khayelitsha

There are various housing schemes in the townships under study. The most popular type is three-roomed terraced houses in Langa

and Nyanga. The residents refer to these as "carriages", associating them with train carriages. The following tables provide types of dwellings in these townships.

TABLE 21 : TYPES OF DWELLINGS IN LANGA

Houses	Semi-houses	Flats	Old age homes	Hostels	*Other	Total
1 660	9 600	-	1	2 200	6 399	19 860

Source: Crawford, M. et al. Community Needs Assessment: Profile of Langa, 1987.

*"other" gives an estimated number of backyard shacks. Semi-houses refer to unauthorised extensions of houses.

There is a large number of houses for the elite which are owned by higher salaried people like civil servants and those with private businesses. A new area called Settlers' Way is being developed. Phases one and two will have an estimated number of one hundred and sixty houses which are built by private companies.

TABLE 22 : TYPES OF DWELLINGS IN NYANGA

TYPE OF DWELLING	FINANCER	NUMBER OF UNITS	TOTAL NUMBER OF ROOMS
Family	State Employer	1 825 13	5 260
Hostel	State Employer	126 210	1 314
TOTAL		2 174	6 574

Source: Dinga, S. An area of study of Cape Town: Profile of Nyanga, Carnegie Paper No. 10(a) 1984.

Building of houses by employers is an acknowledgement by industries that the health of their workers is vital and is affected by factors surrounding inadequate and improper housing.

The Nyanga township has many backyard shacks which serve either as additional rooms for family members or to house other families.

Khayelitsha's Town One which consists of villages one, two, three and four has been developed. Site B has 14 455 sites, 9 000 of these sites are site and services and 5 000 are completed core houses. this means that occupants are only provided with toilets and a tap at the back of the toilet. They then build a shack made of zinc or planks to live in. Site C has 3 461 sites with two dwellings on each site.[24]

11. RECREATIONAL FACILITIES

Recreation plays a very important role in mental health by providing psychological and physiological relaxation.

The communities and schools in black townships lack recreational facilities. There are no parks an the houses are close to each other, consequently children play on the streets.

Langa has a sports stadium where rugby, cricket and soccer are played.

Boxing is also popular in this area. The existing swimming pool which was built in 1963 is badly maintained. The community hall and the community library were burnt down during unrest in the township. The community is making use of the St Francis Community Centre for community gatherings and recreational activities.

Nyanga has three soccer fields, two rugby fields, one netball field and one tennis court. The netball and tennis courts are presently not used. The Nyanga community is making use of the Zolani Community Centre, use of which is restricted by the Cape Provincial Administration. This centre is also used for indoor sports like karate, judo and boxing.

Very little has been done in the development of recreational facilities in Khayelitsha. The existing community hall is administered by the Cape Provincial Administration under strict control.

The Monwabisi project which provides for a beach and braai spots is an additional facility for the Africans in the Western Cape.

12. TRANSPORTATION

People in the townships, especially those in Khayelitsha have to travel long distances between their homes and places of employment. This has a bearing on family life. Parents are away from home for long hours, leaving children by themselves with no or inadequate pre-school and after-school care facilities.

Transport facilities include railway transport, buses, taxis and private cars.

A central railway line runs through Khayelitsha. It connects Khayelitsha to the metropolitan rail system via the existing Philippi-Nyanga railway line. Tramway Bus Service provides bus services. Taxi services are very popular in these areas. The Western Province Black Taxis Association and the Western Cape Taxis Association serve Langa, Nyanga and Khayelitsha.

13. OTHER FACILITIES

Nyanga and Khayelitsha have no cemeteries but are using the Guguletu cemetery which is at the end of NY108. Langa has one cemetery.

The community profiles above reflect the environment scenario under which mental heath services are rendered by the Society. There are various socio-economic problems in these areas. These include:

- gross overcrowding which has obvious negative effects on mental and physical health and family life. This could lead to other problems, for example - vagrancy, juvenile delinquency, sexual abuse, truancy and alcoholism. It has been stated earlier that in black townships there is an average of sixteen people occupying each house.[25]

- unemployment and poverty are other major problems experienced by these communities. There is no doubt that these problems have an effect on the mental health of the community. Unemployment results in an atmosphere of permanent insecurity, poverty and undernourishment. Inability to fend for one's children contributes to deep depression and other mental disturbances. It also induces feelings of inferiority.

- adverse environmental conditions which include backyard dwellings and overcrowded houses with no or insufficient sanitary facilities affect the quality of life in the townships. Excessive refuse and derelict vehicles in the townships are a health hazard and a breeding place for criminal behaviour.

- unrest in the townships which has resulted in the full time occupation of these areas by the South African Defence Force has without any doubt had a negative effect on the mental health of the community members. Individuals who may have a family member, relative or friend in detention under Emergency Regulations, or who may have been detained themselves, surely suffer psychological trauma.

The community context provided in this chapter helps the reader to understand the individualize the situation of the Cape Mental Health Society's client system. The following chapter (Chapter Five) identifies and analyses some aspects of the client system, the environmental system, and the agency which is perceived as a change of system.

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CHAPTER 5

IMPLICATIONS OF THE ORGANISATIONAL AND COMMUNITY CONTEXTS FOR THE MENTAL HEALTH SERVICES FOR BLACKS IN THE WESTERN CAPE

1. INTRODUCTION

This chapter draws on information that has been provided by preceding chapters. It examines the organisational and community contexts in terms of operational definitions of mental health provided in Chapter Two. It looks at implications of macro- and micro environmental constraints on the Cape Mental Health Society and the black communities it serves. Macro environmental constraints for purposes of this study are those aspects related to policy and social welfare structures. Micro environmental constraints are perceived as organisational procedures and processes.

2. MACRO ENVIRONMENTAL CONSTRAINTS

Annexure 6 (Schematic Representation of the Welfare Structures in South Africa) indicates how the social welfare services are regulated.

Chapters Three and Four indicated that human service organisations and the communities they serve are exposed to

socio-political conditions which generate stress and are beyond their control. Black people are the target population. The three black townships studied lack what the development theorists have agreed upon to be constituent parts of development. These include: reduction of poverty, increasing political participation, increasing access to economic resources, improvement of human capability through the provision of education and health care, increase in the degree of self-sufficiency at both community and national levels and improvement in the quality of life of the majority. Most people in these areas are faced with the problem of survival.[1] They have to fend for their families to get the basic necessities of life.

The Society on the other hand is faced with difficulties of rendering services within fragmentary, bureaucratic and discriminatory welfare structures which delay and inconvenience service provision. In addition, the state is exercising an excessive control of social services while it continues to cut the state welfare budget. This forces the Society and other human service organisations to eliminate a number of projects deemed necessary for the development and upliftment of the standard of life of their clientele. The following sections examine these macro environmental constraints in detail.

2.1 The Social Welfare Policy

This policy and other acts mentioned in Chapter Four, section three, promote the South African Government's ideological policy of apartheid. The Act expands the area encompassed by welfare by including the conditions necessary for physical, emotional, social and environmental health for individuals, families and groups. All these have been cited as being necessary for the mental wellbeing of people as according to the operational definition of mental health in Chapter Two. However, the

implementation of the policy does not promote the wellbeing of the majority of the people in this country.

Privatisation implies that the government abdicates its social responsibility and passes it to the private sector. The private sector chooses and deals with its respective areas of interest. Mental health care may not attract the attention of the private sector. Since the private sector is not a social agency it is not obliged to provide welfare services. Its interest in doing so is determined by its concern for profit and investments. Mental health is therefore inevitably left in the hands of a few concerned individuals. Without definite financial support, the Society finds it difficult to provide adequate mental health services.

The Social Welfare Policy does not specify as to which social welfare services are to be privatised. Should mental health services be privatised, the implication is that mental health service consumers will have to pay for these services. It is difficult to comprehend the practicability of this because of extreme poverty and unemployment prevailing in the black townships under study.

Hansen sees depoliticisation and decentralisation of welfare services as claimed by the government as".... a ploy, allowing the central state to shift the burden of contentious political decisions to local bodies" and thus fragmenting the focus of opposition and accountability from the central government to the local authorities.[2] Non-provision of social and other services necessary for mental wellbeing like housing, health care, education - schools, pensions and grants are to be seen as failure of the Primary Local Authorities. Primary Local Authorities and the Joint Management Committees form part of the government political structures. They have replaced the

old structure's City Council. (See Annexure 10: Political Structures Parallel to National Security Management System). These are not acceptable to the black communities. They have been imposed upon them. They are perceived as the state's mechanisms for social control. Human service organisations also do not like the role played by Primary Local Authorities in controlling welfare services. The policy does not specify as to what role human service organisations like the Cape Mental Health Society must play.

According to this policy, human service organisations are expected to initiate grassroots projects, collect information on their respective areas of involvement, to write detailed funding proposals and provide the state with detailed welfare plans which are subject to selective funding.[3] This implies that before any mental health programme is to be approved, the Society is to prove beyond reasonable doubt that such a programme is necessary. This means that concentration has to be on the reactive welfare programmes, that is, programmes which address needs and problems already expressed by the clients. Pro-active programmes, that is, preventive welfare programmes do not enjoy priority and may not be engaged in at all.

Social welfare policy and the whole South African political structure is based on the ideology of precluding black people from choosing what they want. The following section expatiates on the residual approach upon which the welfare system is built.

2.2 The Residual Approach to Welfare versus the Institutional Approach

The residual approach to welfare as defined in Chapter

Two is totally inappropriate for South Africa. It does not cater for the interests of blacks who live under third world conditions. It promotes the concept that individuals, families and the society are responsible for their own development and that the society allows the former (individuals and families) to become self sufficient. Those individuals, families and communities that are unable to provide for themselves are seen as having certain pathologies or as deviant. The residual approach, therefore does not cater for the interests of blacks who live under third world conditions. Most third world countries accept that it is the responsibility of the state to promote development of the people. This approach perpetuates structural inequalities and underdevelopment of the majority of people who are blacks in this case. The shared partnership between the state and the private sector is inevitably enjoyed by the white population. This is because of the historical dominance of whites in the provision of social welfare services. Furthermore blacks have no access to material and other resources. The majority of blacks are too poor to afford time and money for sharing such partnership. Furthermore the whole social and political structure does not allow them either representation or participation in decision-making. However, if there is a change in the approach at policy level, this can only be initiated by organisations such as the Cape Mental Health Society and other human service organisations.

The institutional approach could appropriately address the needs of people in health, welfare and educational matters because such services are seen as a main line function of the state. This approach is more comprehensive in that it allows the state to acknowledge its responsibility. The majority of people in South Africa do not have the capacity to meet their basic needs because of the level of

industrialisation. The economic system, together with the education system of blacks, does not promote self-development. The institutional system is based on the redistribution of resources and institutionalisation of community services as mentioned in Chapter Two section 2.8. The present government is unlikely to voluntarily bring change in welfare policy in terms of the institutional model because of its policy of apartheid. There is a need for human service organisations, social action - and political groups to pursue the change in social welfare and other apartheid policies.

The residue approach has serious implications in regard to mental health care and other social services. Black are neither represented nor do they participate in decision-making. This has led to inappropriate social welfare programmes which are non-responsive to their perceived mental health needs and other social problems and needs. This has also led to discrepancy in service delivery amongst them and other population groups. Such discrepancies have also been identified by Grover in the field of mental health care in the Western Cape and by this study.[4] In addition, the residual welfare approach primarily responds to the human misery produced by the apartheid system and does not address the people's real needs.[5]

All the constraints mentioned above have a definite bearing on any organisation's capacity to meet the needs of black communities.

2.3 The Mental Health Act

The Mental Health Act is practised under the wider policies of apartheid. It can therefore be argued that this policy is ineffective in improving the quality of life and the mental

health of black communities. Unequal, separate and lack of mental health facilities are the consequences of the Act's inability to ensure appropriate mental health services for blacks. It is based on western perception of the concept of mental illness. It ignores the cultural values of the majority of people it supposedly seeks to help. It fails, for example, to recognise that blacks respond differently to mental illness and that indigenous healing forms part of the treatment of the mentally ill. The Act fails to acknowledge that mental illness amongst the blacks needs to be addressed in the context of their cultural understanding of this concept. Furthermore, it totally neglects the environmental factors which impinge on the blacks' mental health, but instead entrusts the responsibility of looking after the mentally ill to the already impoverished black communities.

2.4 State Budget Allocations

These are also seen to form environmental constraints in service delivery. Without proper funding, social welfare delivery is adversely affected. The South African budget allowance for welfare services has been kept at a minimum level of five percent for the last ten years. (See Table fifteen in Chapter Three). This is despite the increasing number of people in need of social services. These allocations show the government's determination to reject welfare statism.

The Cape Mental Health Society like many other human service organisations is faced with continued budget cuts and programme elimination. It must contend with the possibility of the reluctance of resource providers to sponsor certain mental health programmes. The Society compiles a register of need and keeps statistics of clients or services, for years and has no financial means to

address these needs sufficiently. It loses its credibility and the confidence of its clientele. Service effectiveness without sufficient financial support is impossible. The Society is struggling for survival. It only concentrates in maintaining the existing social welfare programmes. Implementation of new programmes or expansion of existing ones is almost impossible.

The Society is aware of the above constraints which threaten its existence. Consequently its tendency is to concentrate on organisational survival rather than on service effectiveness. This weakens its response to black mental health needs. Chapter Six recommends ways in which the Society could deal with external threats to its domain and how to explore opportunities and resources in its environment [6]. Service effectiveness is a key objective of social work, it is therefore appropriate that the Society concerns itself with how to maximise this objective.

Continued cuts in state budget allocations of social and other services for blacks form part of their environmental constraints. This forces them to live under very undesirable conditions which amount to 'social murder'. Frederick Engels claims that social murder has been committed when thousands of people have been deprived of the necessities of life or if they have been forced into a situation in which it is impossible for them to survive. Furthermore, he maintains that murder has been committed if the people have been forced by the strong arm of the law to carry on living under such conditions until death inevitably releases them.[7].

2.5 The Education System of Blacks

This section analyses the policy on education as a

constraint to the mental health of blacks. Chapter Four provided the economic and political structure of education in South Africa. It demonstrated discrepancies in the distribution of educational resources and the resistance of the government towards spending more money on the development of the education for blacks. The intention of the South African government is argued to be using education as a mechanism for social control to meet its economic needs and to reproduce capitalism under apartheid[8]. Furthermore it is alleged that education of blacks is intended to produce sufficient labour power to serve South Africa's economic interests and to perpetuate capitalistic class domination[9]. Unlike the education of a white child which prepares him for a life in the dominant sector of society, that of a black child is designed to prepare him for a subordinate society [10]. The present education system of blacks is based on the values of consumerism or affluence, of military adventurism and racism[11].

The implications of this system are that blacks do not obtain the ultimate aim of education which is preparation of people for total human liberation; promotion and development of creativity; preparation for full participation in all social, political and cultural spheres of society[12].

Deducing from the information provided in the community profile, the present educational system for blacks generates stress and has an impact on the mental health of its subjects. It develops an inferiority complex, allows blacks to internalise lack of self-confidence and also indoctrinates them to be subservient and docile.

The Cape Mental Health Society renders its mental services to blacks - people who are victims of stress, illiteracy,

ignorance and also victims of the capitalistic norms, namely individualism, stunted intellectual development and exploitation. The Society needs to be aware of the type of clientele with which it is dealing - people who have been socialised and educated to play a subordinate role within a class struggle; people who have been socialised and educated to accept an unequal distribution of wealth and other resources. The culture and the historical development of the Society may not easily allow this, but there is an urgency for change, if it claims to be non-racial.

The Society needs to change its approach of mainly addressing clinical mental health problems amongst the target groups in the community. The pre-school, primary and secondary school children are the target groups. They show some psychological scars suffered in the educational struggle and other factors whose roots are of political and economic origin. According to the report of teachers the typical signs of stress shown by school children in the areas under study are: memory impairment, restlessness, loss of appetite and absentmindedness.

Many primary and secondary school children have dropped out of school. What becomes of them? What kind of stresses are they subjected to? This is the lost community or the community at risk which needs the Cape Mental Health Society's attention. Christie maintains that most African children who go to school drop out after about four years of attendance. At this period the education that they have received would only have prepared them to do unskilled work and to fill lower class positions.[13]

The educational status quo provides the Society with the

enormous responsibility of taking care of the mental health of its victims.

2.6 Health Services

Health services, policies and structures also follow the same trend of unequal and inadequate distribution of resources based on colour. Although the Republic of South Africa has repeatedly stated that politics will not be allowed to intrude into health care,[14] health care services reflect and promote the present inequalities in our society.[15] Health care under apartheid rule reflects geographic, economic and racial discrimination. This is reflected in the concentration of health resources in urban areas, segregated hospitals and the ever rising hospital tariffs.

Cedric de Beer, et al, in the evaluation of health care in South Africa have found out that the three mental indicators, namely: nutritional status, infant mortality rate and life expectancy are worse for blacks than any other population group in South Africa and worse than most similar countries world wide.[16]

What are the implications of all these health constraints to a person in Langa, Nyanga and Khayelitsha? It means that these people are often blamed for their health problems, thus taking the blame away from the present system. The problem is that most hospital authorities (state health) do not recognise that health problems emanate from social conditions or if they (the authorities) do they accept that they are powerless and try to contain the situation.

The health constraints imply that blacks in these areas have to fight a constant battle to survive, to feed

themselves and to buy essentials for their families. But what ultimately happens is that a few survive, the rest are subjected to malnutrition, high mortality rates and shorter life-expectancy.[17]

What are the mental health implications of the constraints mentioned above? Theorists argue that mental illness comes about as a consequence of unfavourable conditions under which people live. These include poor working conditions, inadequate living standards, poor health services and that these cause a great deal of mental suffering and breakdown.[18] Recent research has shown that mental illness is a response to the social conditions under which people are forced to live[19] Blacks in the townships, because of the particular conditions of their oppression, experience a great deal of mental suffering and breakdown. They spend most of their time wondering how they are going to meet their daily needs.

The Cape Mental Health Society needs to base treatment programmes for blacks in the context of their socio-economic conditions and must avoid superficial treatment programmes which are based on treating the client without treating his or her environment.

2.7 Unemployment and Poverty

Table Twenty in Chapter Four indicated that at least seventy-six percent of the people in the townships under study are either unskilled, not classified or economically inactive. This is one indicator of unemployment and poverty.

Unemployment and the perceptual implications to its victims can be broken down into three categories. Firstly, it

brings personal frustration, a sense of uselessness to maintain one's family and inability to fulfill a breadwinner's or parental role. Secondly, it brings life of suffering - inability to afford better housing, sufficient food and clothes, and proper health facilities, better education for children and all the necessities of life. Finally, it brings total dehumanisation to people who might resort to criminal activity in order to survive.[20]

Wilson and Ramphele from their interviews with the unemployed state that unemployment brings loneliness, frustration, sickness, starvation and staying without clothes. They further assert that ".... unemployment is a fearful scourge in any society". They maintain that the political economy of apartheid has exacerbated both its magnitude and its consequences.[21] Unemployment sometimes demands that a family splits - the husband can leave the family to look for a job in a place other than Cape Town. It means sitting with heart breaking, hunger-crying children.[22]

How can one's mental functioning be normal under these circumstances? The Cape Mental Health Society, when dealing with its clients should note that having no source of income is disastrous even to normal human beings. It is worse for the family which has one of its members mentally ill.

Closely allied to unemployment is the problem of poverty. It has equal or more disastrous effects of destitution to its victims. The community profile (Chapter Four) indicated that seventy-six percent of the black people in the townships under study are either unskilled, not classifiable or economically inactive. These people are obviously without visible means of livelihood; they are poor. They

perceive poverty as hunger, political powerlessness, vulnerability to malnutrition, kwashiorkor, tuberculosis and other poverty related diseases; lack of confidence, negative attitude towards life generally, feelings of incompleteness.[23] This has been endorsed by Wilson and Ramphele who see the situation of tuberculosis suffering in Cape Town as explosive.

The poverty related symptoms of the mental health clients as perceived by social workers at Cape Mental Health Society are overcrowding, lack of houses, lack of facilities, financial non-maintenance, unemployment, low wages, no legal rights in the area and pass laws.[25]

The abovementioned factors set a scenario for unique problems for Africans (blacks) in the Western Cape. They generate stress and perpetuate mental instability. This has serious implications for the Society's social service delivery to the blacks in the Western Cape where there are only two social workers and two para-professionals who are expected to render a specialist mental health service to thousands of black people. This means that most people who need help are left unattended and have to cope on their own. In such cases people are likely to resort to violent acts and suicidal tendencies.

2.8 Housing

Tables 21 and 22 in Chapter Four revealed the seriousness of inadequate housing facilities for blacks in the Western Cape. Added to these are problems of overcrowding and bad sanitation - which is a health hazard. These have destructive implications for families. Insufficient housing means that the family has no privacy from visitors, married couples have no privacy, children have no privacy nor

space for studying or playing, the family cannot accommodate friends for sleeping over. This means that neither the parents nor the children have peace of mind at home. Consequently many husbands spend most of their time outside their homes. The popular place to go to is a "tavern". Children play on the streets where they run the risk of being run over by cars and are exposed to several dangers like joining street gangs and meeting bad peer group members.

In addition, inadequate and improper housing means overcrowding, poor sanitary conditions, crime, proneness to communicable diseases, and eventually, death. Although many diseases, for example, tuberculosis, gastroenteritis and malnutrition are preventable, they are still believed to be the major causes of the high mortality rate amongst blacks.[26]

Thousands of blacks are trying their best to survive despite these living conditions and only a few can afford to live a really decent life because ".... the strain can and does have devastating consequences".[27]

These conditions are undoubtedly stressful. They make people feel dehumanised and helpless. They make family and married life unbearable. They indirectly affect the work performance of those people who are fortunate enough to have jobs. They make school life for children uninteresting. Children from such underprivileged communities are unlikely to produce their best at school. Children from such families are unlikely to be socialised properly about the value of family and of married life.

Housing poses one of the major environmental constraints to blacks in the Western Cape.

2.9 Recreational Facilities

Mosts blacks in the Western Cape are faced with so many problems that the mentioning of recreational facilities seems like luxury and fantasy. However, this does not undermine the importance of social amenities and the consequent social destruction caused by the lack of them. Recreation relieves stress. There is no way that the few recreational facilities in the townships could meet the needs of the total population with the estimated number of 276 019 people. Non-availability and inadequate recreational facilities may result in juvenile delinquency, crime, drunkenness, rape, abduction and other serious crimes in the townships.

3. MICRO ENVIRONMENTAL CONSTRAINTS

The clientele does not suffer from macro environmental constraints only, but also from micro environmental constraints. These emanate from organisational processes and procedures. The following sections expatiate on these.

3.1 Problems in Service Delivery

The problems discussed in this section do not embrace the entire organisational problem area, but certainly include significant sections of it. The following aspects have been isolated for this discussion:

- availability and adequacy
- accessibility
- responsiveness

- accountability
- effectiveness
- efficiency
- appropriateness.

The Cape Mental Health Society has long identified the need for the development of black mental health services in the Western Cape[28] and has over the years been appealing to the public for funds.[29] The response has been very insignificant, in fact, almost non-existent. Unavailability of funds has led to inadequate mental health facilities. The waiting lists are very long. The time which elapses between applications for mental health facilities and the actual delivery of services varies between six months and fourteen years as shown by the Register of Need. The waiting lists include very serious and urgent requests, for example, applications for special care in respect of children who are sexually abused, neglected by their own mothers or who need hundred percent care. If these applications appear in the waiting list for a period of two years, one finds it very difficult to imagine what happens to these children, and whether there is no other possible crisis intervention that could be engaged. The Society's prompt and appropriate response to such matters of urgency is very crucial.

Unavailability and inadequacy of mental health services and facilities for blacks have been endorsed by various professionals and agencies.[30] The organisational profile has also confirmed this.

The inappropriate location of the existing inadequate

mental health services has been mentioned in Chapter One. This inaccessibility of mental health welfare services is cited as an organisational barrier. The Cape Mental Health offices for social workers are not located where the blacks in need of mental health services can easily take advantage of them. Blacks have to travel from the townships to Observatory where the offices are situated. This is quite strenuous for people with major constraints as mentioned in the above section.

Apart from physical inaccessibility, the present programmes are not properly responsive to consumers' needs. The recently established para-professionals' projects whose aims are to stimulate mentally handicapped children, to support their mothers and to establish a social club for psychiatric clients are an almost irrational response to clients who need basic materialistic help like food and shelter which can be provided in a form of feeding schemes, day care centres for the mentally retarded children and protective workshops for the psychiatrically ill clients. These services are inaccessible in that they do not reach the clients' needs. The Society's Register of Need gives no indication that the abovementioned mental health projects are priority needs. The failure of these projects or their inability to meet mental health needs (as mentioned in Chapter Three) could be attributed to their nonacceptability to the clients. These programmes are wasted effort unless materialistic community supportive programmes exist.

The Society's machinery does not reflect any means by which it is accountable to its actual and potential consumers. There are no task and advisory committees from the latter to give the clients a voice in the Society. Power and decision making is monopolised by other population groups without any representation of blacks.

The accountability of the agency starts and ends with the "input constituencies", for example, the board of management, private sponsors and the state.

Inadequacy, inaccessibility, unresponsiveness and non-accountability of the present mental health services make the question of non-effectiveness of the available service suspect. There is no way that the casework, mainly counselling services, could be either effective or efficient. Counselling services are not effective because there are no complementary resources like special care centres, day care centres, workshops, etc.

The efficiency and effectiveness of the mental health services for blacks is decreased by the factors mentioned above. Non-availability of one service to complement the present one leads to fragmentation and consequently to inefficiency. In addition to this, is the scarcity of financial means.

The question of inappropriate mental health service could be addressed by the Society and other relevant service providers by considering the cultural dimension of mental health care. Section 2.6 in Chapter Two has dealt with the dimension in greater detail. The present mental health care rendered by the Society excludes this aspect.

3.2 Problems in Organisational Structures

Jinabhai is of the opinion that the residual welfare system contributes to the domination of welfare structures by whites who can afford resources for partnership with the state in the welfare arena. He sees this as a constraint to welfare services.[31]

The Cape Mental Health Society has been forced to address the question of racially segregated service as according to the circular of the Department of Social Welfare and Pensions No. 29 of 1966,[32] but has ignored this. However, the manner in which it has done so has not allowed for appropriate intervention for mental health services for blacks. The Society's structures indicate that mental health services for blacks are rendered on an "output constituency" basis. This means that blacks are not afforded participation on a power sharing basis. They are not represented in planning and decision-making groups. Sherry Arnstein in her "Ladder of Citizen Participation" emphasises the critical difference between going through the empty ritual of participation and having the real power needed to affect the outcome of the process.[33]

The Society's claim that it cannot find blacks suitable for representation in its top and middle structures is taken as an excuse rather than an explanation. The reason is that it has no evidence of advertising the top posts. It prefers to recruit persons on private and individual basis. This is therefore justification for the monopoly of power.

Midgely cites the different ways in which justification for power monopoly can be sought.[34] Firstly, cultural institutionalisation of beliefs of the agency. The Society's top structure could monopolise the power because it believes that it promotes the interests and provides for the needs of the blacks. Secondly, it may monopolise power because of its belief about the passivity of blacks and its own superior intellect and organisational abilities. These beliefs leave the blacks with neither influence nor opportuity to express their views. "Their powerlessness is

conveniently interpreted as passivity and indifference, but the real problem is the lack of opportunity for their direct involvement".[35] Consequently, they are victims of centralisation, bureaucracy, impersonal regulations and routines which are unresponsive to their needs. Chapter Six suggests ways of mobilising the black communities for self-help programmes and for active participation in decision making.

Value judgements are unavoidable in deciding who should benefit. This is why representation of all population groups is important in the middle and top management. The Society renders a diverse range of services, to several client groups and in different areas. The importance of needs depends on who is actually affected, which introduces a political dimension in the provision of human services. The top management is faced with different and pressing groups.

Another dimension of values in decision-making is that client values should be considered in programme planning. If the Society keeps on embarking upon programmes which are of no value to its clients, this is not an indication of a positive response to the clients' needs. Such programmes may not get community support and will ultimately die.

3.3 Problems in organisational processes and procedures

The macro and micro environmental constraints indicate that the Society is faced with unavoidable factors, namely:

- needs will always exceed resources

- value judgements inevitably affect prioritisation of

needs and distribution of resources

- resources will have to be distributed fairly amongst client groups

- services and their costs are never static

- innovations will have to come mainly from planned change and better and productive practices.[36]

This section examines the Society's evaluation and planning methods. Special attention is paid to goals and objectives set out and whether there is interrelationship between the two. Finally, the section examines the modes of planning employed by the Society and whether these are to the best benefit of all clients.

Professor Grover's study of some of the pressing needs for the mentally handicapped persons in the Western Cape identified the need for the development of mental health services for blacks.[37] The Cape Mental Health Society has long set this as its goal.[38] However, the objectives of the Society as reflected in its annual plan do not indicate any direction towards this goal, but are intended to maintain the existing programmes. However, there are indications of expanding services for the Coloured clientele. Therefore failure of the development of black services cannot be attributed to lack of funds but to other factors, for example, values of top management and non-representation of blacks at higher levels. The Society has to redistribute its resources and employ innovative plans which will effect the necessary change. Innovative plans refer to the planning of mental health programmes that are qualitatively different from the present ones.[39] Chapter Six provides and recommends a scheme of a programme that could be

used for the development of mental health services for blacks in the Western Cape.

The Society's planning process does not include the essential elements of development which could contribute to the advancement of black mental health services. These elements are hereby discussed according to the sequential steps of planning.[40]

- in forecasting, the Society only identified the need for the development of the services concerned but failed to decide on priorities and to allocate resources towards this need

- the existing tactics and methods employed in the provision of mental health services to blacks are not carefully evaluated so as to determine the extent of their success or failure in reaching organisational goals and reasons thereof

- policies and procedures have not been determined and their implications for services to blacks in particular have not been reviewed. In some cases, minor improvements which are incremental in nature have been effected. These are what can be referred to as "cosmetic changes". Policy planning would allow the Society to decide on the most appropriate approach

- resource allocation is done through an ad hoc approach, that is, programmes are not judged on their merits and not according to the relative importance of their services. There is much dependency on arbitrary decisions

- project planning and control does not establish the sequence of events that needs to be followed so as to ensure successful implementation of projects

- performance evaluation is superficial in that it is done without changing policies and strategies necessary for effecting change.

The evaluation process employed by the Society has some limiting implications on mental services for blacks. This process is retrospective, that is, it emphasises measurement of effort or input. This means that it is directly concerned with the past and has only an indirect tie with the future.[41] Input alone cannot tell how successful programmes are. It is also important to evaluate performance, that is, output in relation to social problems and needs; effectiveness, that is, the extent of penetration of the programme; efficiency, that is, how much the success has cost and whether the programme was the best way to attain the same result; finally, evaluation of the process, that is, why the programme has been successful or failed.[42]

Presently, the Society's programmes tend to be judged intuitively, through professional opinion and service statistics.

Chapter Six suggests a model of decision-making which is extended to include evaluation and planning, respectively.

3.4 Resource Allocation

This section examines the Society's resource allocation and its implications for the mental health services for blacks.

Table 14 in Chapter Three indicates that the Society allocates very limited resources to the black mental health services as compared with other population groups. An average of eleven percent is allocated to resources like staff members and programmes with an exception of time (hours) which rise up to twenty seven percent. Considering the environmental constraints surrounding black clients, the resources allocated are too limited.[43]

These figures indicate that the Society does not employ the criterion of equity, that is, distribution of benefits or services fairly amongst the deserving population groups. Coloureds (as defined in the Population Registration Act), are getting a bigger share. This has led to a very limited response to the mental health needs of blacks.

Resource allocation has an impact on how the organisation responds to the target clients' problems and needs. It is influenced by various factors like availability of resources, power distribution, value judgements, organisational pressure groups or orgsanisational interest groups and other dynamics.

4. IMPLICATIONS OF UNSATISFACTORY SOCIO-ECONOMIC AND POLITICAL CONDITIONS TO THE PEOPLE OF LANGA, NYANGA AND KHAYELITSHA

Various social, political and economic conditions of blacks in the three townships have been examined. These have been found to be putting blacks in a disadvantaged position. Most of these conditions are determined by apartheid.

A recent research study by Rai Turton in Soweto has found out that

the more disadvantaged people experience more stress than the advantaged people.[44] The social and economic measures used in the study were: family income and per capita income to measure poverty; the size of family homes and the number of persons per room or indwelling density were taken as measures of overcrowding; state expenditure within the different educational authorities, teacher qualifications and pupil/teacher ratios were used to measure inferior education; migrant labour, influx control, the positioning of townships far from places of work and the denial of permanent abode to urban blacks were considered to have negative effects on social support networks - the measure of social support took account of the size and quality of an individual's social network.

This study showed that there were correlations between social and economic measures and stressor scores. The table below shows the correlations.

TABLE 23 : CORRELATIONS BETWEEN SOCIAL AND ECONOMIC MEASURE AND STRESSOR SCORES

MEASURES	CORRELATION
Family income	-0.17
Per capita income	-0.29
House size	-0.20
Indwelling capacity	0.41*
Formal education	-0.35
Occupational status	-0.28
Social support	-0.32

*This factor is positively related to stress levels. As the factor increases, so does the stress level. The remaining factors are inversely related to stress levels. As these factors decrease, so stress levels increase.

Source: Mental Health in Transition. OASSSA Second National Conference Proceeding. Research study by Rai Turton.

The social and economic measures mentioned above were not viewed as independent, but as tightly interlocking with other factors, forming a web of disadvantages.

From the above research study it can be concluded the blacks in Langa, Nyanga and Khayelitsha, who live under similar conditions, are targest of stress and are more prone to mental ill health. It can be further concluded that the present social, economic and political conditions in the townships have serious implications on their mental health. Most of these factors need to be attacked from a macro level. In other words these are structural problems which need intervention at a higher level.

Before the Society can deal with the existing problem of non-equity, it will have to address the various factors mentioned previously, for example, representation of all population groups at all levels, absence of which contributes to this problem. However, Chapter Six suggests a certain approach which could improve the Society's reponse to the mental health needs of blacks in the Western Cape.

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CHAPTER 6

TOWARDS A MORE APPROPRIATE MENTAL HEALTH SERVICE FOR BLACKS IN THE WESTERN CAPE

1. SUMMARY

The purpose of this study was to examine the response of the Cape Mental Health Society to the mental health needs of blacks in the Western Cape and mental health services for blacks. This has been done by identifying and analysing the existing services and ascertaining the shortfalls in service delivery. In addition, this chapter puts forth an alternative and/or additional framework to meet some of these shortfalls in the provision of these services. The framework is a simplified version drawn from models of management and planning of social services by different scholars, for example Knighton and Heidelman[1], Falk and Lee[2] and others.

The main issues highlighted throughout the previous chapters have confirmed the assumptions upon which this study is based. These include a response to mental health needs of blacks which is based on an irrational approach to planning, poor mental health services, emphasis on curative services and geographical and racial discrepancies in mental health provision. Another factor highlighted by the study is that there are micro (organisational) issues and macro (structural) issues which impinge on mental health service delivery for blacks. All these influence the mental health status of blacks in the Western Cape and consequently they

experience pressure from various forces. If an urgent response is not made to their mental health needs, such pressure could and does manifest itself in violent forms from both the macro and micro perspective.

The study has highlighted that the mental health services rendered by the Cape Mental Health Society are characterised by inadequacy, unavailability, inaccessibility and inappropriateness to the felt mental health needs of blacks. It has also been found that the Society provides services within the urban setting, and it neglects the rural areas. Rapid population growth of blacks in the Western Cape from Transkei and Ciskei has added more problems to the already limited mental health resources and to planning in general which must keep up the same pace.

The following sections provide detailed guidelines on how the Cape Mental Health Society and other relevant human service organisations could move towards an appropriate mental health service provision for blacks. If some of the recommendations cannot be implemented in the near future, there should be a move towards considering a long term strategy to address crucial areas of the organisation's response to mental health needs of blacks as not only the credibility of the organisation but also the survival of the Cape Mental Health Society would be affected.

2. RECOMMENDATIONS

Recommendations have been made within a framework of both micro and macro constraints.

2.1 Micro Environmental Constraints - Addressing Organisational Issues

Most organisational constraints emanate from the interpretation of the concept, mental health. The political nature of the problem of definition affects service provision and the response to mental health problems and needs. Chapter Two has provided the definition of mental health as a complete physical, mental and social well-being and not just the absence of disease. Chapter Five has provided certain indicators of development as prescribed by development theorists which could be used for the evaluation of mental health. All these should be included in the total development of mental health services for blacks and this must be done within their cultural context. The present clinically oriented services which are curative rather than preventive need to be improved.

2.1.1 Planning a programme to meet mental health needs of blacks in the Western Cape

Problems surrounding the provision of mental health service to blacks have been examined in Chapters Three, Four and Five. The Society has a further responsibility of making the necessary follow up. Figure Three below provides a schematic presentation of the steps which could be followed.

(continued over)

FIGURE 3 : SCHEMATIC PRESENTATION OF A FRAMEWORK FOR PLANNING A MENTAL HEALTH SERVICE FOR BLACKS

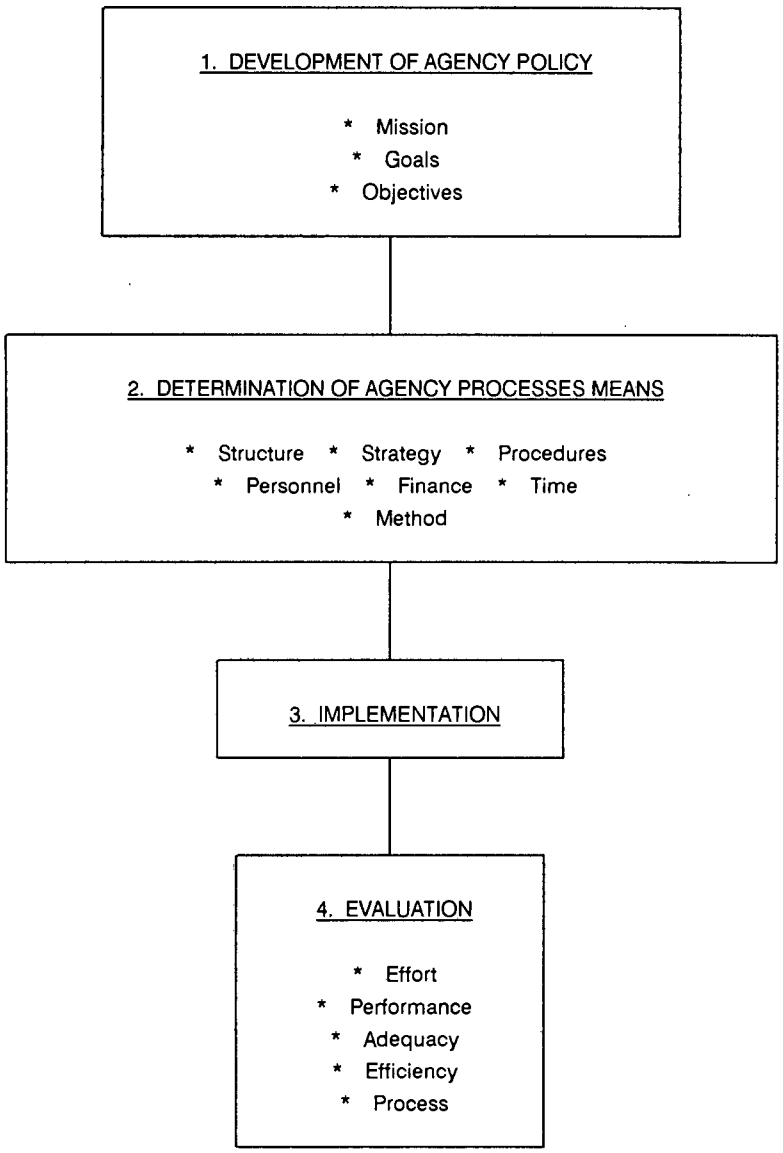

Figure Three depicts the different steps which the Society could take in improving its response to the mental health needs of blacks.

The first step entails the development of

agency policy towards this end. It involves transformation of public policy as prescribed by the Mental Health Act (whose shortfalls have already been identified and analysed) into agency mission, goals and objectives. The Society needs to develop a sub-policy which should include how it defines mental health for blacks.

The agency mission is the overall goals of what the agency hopes to achieve. The Society's particular mission is to uplift the standard of living and to improve the quality of life of the mentally handicapped and psychiatrically ill persons and their families.

The goals seek to further development of the mission. Goals in the case of mental health provision could include the development of mental health services for blacks in the Western Cape; the development of responsive needs assessment techniques and improvement of programme development and implementation processes. All this should be done within the cultural context of blacks.

Objectives should be specific, measurable, time focused, realistic, that is, be formulated in relation to the environment and available resources. (That is why, later in the chapter, recommendations

have been made on how to increase resources by acknowledging those already existing in the black communities). They should also describe specific courses of action.

The second step of the framework consists of the development of agency means, that is, how the agency can or hopes to achieve the stated goals and objectives. This involves many aspects, for example the structure, the staff, funds, equipment, procedures, time, method and others.

Questions arising from the structure could be: does the present structure serve the full purpose of the agency which is service effectiveness and does it achieve the necessary consumers' need satisfaction? Are all the population groups served by the Society represented at all levels? Does the present structure allow or encourage community participation? If not, what alternative structures could be used to effect these goals?

Section 6.1 in Chapter Three has indicated that the estimated number of people who are psychiatrically ill in the three townships under study is 2 760. This number can assist in determining by ratio, i.e. social worker : clients, as to how many social workers will be needed to work in these areas. The management should find out

whether the present staff members need additional training and development; whether they possess the necessary skills, knowledge and expertise.

All the necessary changes need to be weighed against available funds. The agency planners should assess whether the funds are sufficient for the development of a welfare programme for blacks in the Western Cape. If not, they must devise means of accumulating funds. Since the state is not subsidising programmes and not social workers' salaries and administrative costs, proposals for such programmes should be efficiently written and well motivated. This can be done by using the available statistics, for example, the estimated number of clients who need service provision; waiting lists; the number of social workers who need to be employed as according to the approved social worker/clients ratio; transport needed, satellite offices needed. Since it is not easy to obtain land for building structures, the ordinary township four-roomed houses could be leased. Proposals to the private sector should be specific and to the point. It is advisable to include estimates of different programmes so as to allow prospective sponsors to choose their area of interest. Furthermore the devising of more appropriate fundraising methods for the different population groups served by

the Society, could prove fruitful.

The Society needs to consider whether the agency's equipment will be sufficient for implementation of the programme and if not, which type of physical resources need to be replaced or increased and by how much.

The additional aspects which need to be considered as a means for effecting change or development of mental health services for blacks include procedures, methods and time. Will the existing procedures apply to the new context of service provision? If not, what alternative procedures could enhance development? Do the present methods which are clinically oriented ensure service effectiveness? If not, what alternative methods could be used? Realisation of time factor is pertinent to all steps and actions taken.

Determination of means involves weighing the different alternatives and choosing those which are regarded as most efficient and most effective.

Programme planning for mental health services for blacks should be governed by five aspects cited in Chapter Five as problems in the existing service delivery. These are availability, adequacy, accessibility, accountability, effectiveness and

efficiency.

Availability of mental health services to black communities implied that these services must be readily available for utilisation by present and prospective mental health service consumers. This calls for preventive mental health programmes. Such programmes may include formation of mental health schemes with mental health committees and mental health workers for attacking mental health problems at grassroots levels. These committees and workers could help in lay counselling and early detection of mental health problems. This will accelerate the availability of mental health services.

Adequacy of mental health service for blacks implies that there should be a reasonably immediate response to requests of blacks for mental health facilities, especially for serious problems like sexual abuse of the mentally and psychiatrically ill and urgent needs like applications for special care facilities in respect of those clients who need hundred percent special care. These will not only address the problem of inadequacy of mental health services, but will assure the appropriate response of the Society to the mental health needs of blacks.

Accessibility implies that mental health services need to be decentralised and to

be located within reach of black people in the townships. This calls for the establishment of area offices for mental health workers and social workers. Accessibility of mental health services also means availability of services which address the urgent mental health needs of black which seem to be most materialistic in nature, e.g. sheltered employment, places of special care, training centres, pre-school facilities and after school care centres.

Accountability of the Society to its clientele calls for the former to find out from the latter as to whether their needs and expectations are being addressed and whether after programme implementation these have been satisfied. This revolves around the whole issue of the evaluation of output discussed in Chapter Five. Such accountability could promote the Society's appropriate responsiveness to the mental health needs of the blacks. This can be done by promoting community participation at the planning and decision making levels of the programme. This could also help in solving the problem cited earlier in this chapter of the interpretation of mental health in the cultural context of blacks.

If these could be implemented, the problem of effectiveness which addresses the question of the quality of services, will

be resolved. There will be improvement in the quality and response of the Society to the mental health needs of blacks.

Efficiency, on the other hand, will take care of means as measured against cost of these services.

The Society in all its means to effect change must consider preservation of the consumer values. This has been found to be very important in the consideration of the cultural perspective of mental health amongst blacks. This could be done by recognising and utilising indigenous resources like faith healers, witchdoctors, self-help and mutual aid groups.

If the Society could employ more realistic fundraising methods for the black communities additional to those mentioned in Chapter Three - the organisational profile - this could lead to more community members being able to make small contributions in the townships, organisation of afternoon concerts where school or church choirs could render musical items, and others. Membership drive could also draw a lot of funds from the black communities. The subscription is not more than six rand per annum. Blacks need to be informed about how to obtain such membership and of its good cause. Only eleven percent of the Society's state subsidy is for mental health

services for blacks. The Society needs to apply for an increase of this subsidy from the Department of Constitutional Development and Planning.

The third step is the implementation of programme plans. Staff members delivering the services need to know about the mission, goal and objectives. Community members need to be informed by their representatives at the planning and decision-making levels of each and every step taken in the programme development stage. During the implementation stage there may be a need to educate community members on the different roles to play in implementing the plans. Community participation promotes mutual understanding between the agency and its clientele. Community members may learn to appreciate the society's problems and could help in increasing its political, social and lobbying power against governmental inflicted constraints. Furthermore, with proper guidance and training, they increase the manpower.

The final stage involved evaluation of the programme. Although the overall evaluation of the programme comes at the end, continual evaluation should take place at all times and after every step taken. As the community members need to be included at the planning and decision stage, so as to enable them to express

their desires and needs, they must also be included in the evaluation stage so as to enable them to see the input and outcome of all their efforts. Such a feedback helps to educate the community members about their role in mental health programmes and it acts as motivation. Staff members responsible for the implementation of the programme should enable and reinforce community members to learn new experiences and to avoid repeating the same mistakes.

The main purpose for evaluation should always be borne in mind, that is, it is to determine whether the intended objectives were achieved, how well this was done and reasons for specific failure and successes. The Society was found to have a tendency to concentrate on input rather than output evaluation procedures. In addition to effort and performance evaluation, the Society needs to evaluate adequacy, that is, how successful the programme has been in meeting the total amount of the identified needs. Added to this is evaluation of efficiency which concentrates on evaluating the cost-effectiveness of the programme. Efficiency evaluation is concerned with devising various ways through which agency resources can be used so as to increase the success rate.

Finally, the Society should consider

evaluation of the process. This delves into the specification of the programme that influences its effect, for example, environmental constraints, time spent, attitudes of providers and consumers, etc.

In addition to the micro issues, the Society should also deal with macro issues which are discussed in the section below.

2.2 Macro Environmental constraints - Addressing Structural Issues

Macro environmental constraints affect the Cape Mental Health Society and other organisations in addressing structural issues. Organisations such as the Cape Mental Health Society and any interested groups working in black communities should be aware that mental health must be viewed within the broader contexts of the structural factors that influence development of individuals, families and communities. This must be a conscious and planned decision. If the human service organisations are unable to address structural issues for certain reasons they should clarify and indicate factors which preclude their involvement in the change process in South Africa. Human service organisations need to form lobbying groups with other interested bodies and should examine major issues which include an appropriate definition of mental health, approaches to welfare service and the urgency for social, economic and political change.

The Society needs to further facilitate and strengthen its operational linkages with other human service organisations. This will bring a number of resources

together, for example, knowledge and expertise, human resources, facilities, political influence, lobbying power and financial resources. The following aspects should also be considered:

2.2.1 Definition of Mental Health

There is a need for an appropriate definition of mental health. This concept must be defined in its holistic context. Such context should broaden the clinical and psychiatric focus to include community mental health care within a comprehensive framework.

2.2.2 Legislative and Administrative Interface

Human service organisations should consider analysing how social and public policy sets up bureaucratic machinery which hinders meeting of mental health needs. The Mental Health Act is, for example, highly bureaucratic in its implementation and this delays the identification and admission of mental health patients to institutions. Furthermore, the tri-cameral system delays human service delivery especially in those organisations which serve all population groups. The new governmental structure which allows for the establishment of the State Security Council and Joint Management Committees at different levels implies greater state control at community level.

The residual approach and its constraints and implications to welfare provision needs to be analysed with a view to explore the possibility of adopting the institutional approach to welfare provision.

Differentiation and privatisation of welfare services will perpetuate poverty and suffering of blacks. These are a threat to their mental health. There is an urgent need for the human service organisations to challenge the government's intention to differentiate and to privatise social services.

2.2.3 Lobby for increased welfare budget allocations

The government ought to provide a good financial backing to all those private organisations which take upon themselves to provide welfare services. However, the South African government is conservative and consequently does not see the mental health of black communities, nor their welfare, as high priority. Because blacks are not represented at parliamentary and/or cabinet level, budget allocations are influenced by partisanship. The focal point of the legislative agenda is defence and maintaining law and order so as to preserve the minority rights while neglecting and destroying the majority rights. The government will continue maintaining cleavages in resource

allocations. This is what apartheid, amongst other things, is all about. This is where mental health becomes politics. It is politics which decide who is to get what, when and how much.

In order to counteract this, the focal point of the organisation's agenda should be lobbying for change. Change in South Africa will not come as a present or a surprise from outside, but needs to be effected from within. the health of people in South Africa should be considered by the South African Government as priority in its legislative agenda. Health must encompass a state of complete physical, mental and social wellbeing and must not be considered as just an absence of disease. If such values are developed and upheld, the government will increase budget allocations for health and welfare.

2.2.4 Structures

Upper governmental and organisational structures do not have representation of blacks. The human service organisations should consider closing this gap. They need to develop their structures in such a way that decision making and planning is shared amongst all population groups. It is after they have done this that they can act as pressure groups to let the government do the same. Structures should be developed in such a way that

they can enhance full participation of blacks at all levels. Such structures will see to fair distribution of resources. This fair distribution should also cater for the forgotten rural areas so as to break the existing geographical discrimination.

3. CONCLUDING REMARKS

Recommendations made in the study should not be viewed as prescriptive and final, nor as being all inclusive and exhaustive. They are merely intended to stimulate thought and subsequent action by the Cape Mental Health Society and other similar human service organisations. All human service organisations need to be concerned with the development of people they serve. Concerned organisations who strive for service effectiveness and client satisfaction will find this study helpful in pursuing these goals. Human service organisations have to realise that they will be exposed to extreme pressure if they allow themselves to be used as instruments for certain political ideologies like, for example, apartheid.

This study revealed many avenues which offer a scope for further studies which will provide answers to the recommendations made concerning the role of the human service organisations in a society in transition.

******

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ANNEXURE 1

INTRODUCTION TO THE INTERVIEW SCHEDULES

My name is Thobeka Mangwana. I am a student at the University of Cape Town. I am presently doing my Master's Degree in Social Planning and Administration under the School of Social Work. As a partial fulfillment of my degree I am doing a research study on how the Cape Mental Health Society responds to the mental health problems and needs of blacks in the Western Cape.

I wish to thank you for allowing me to have an interview with you. I will briefly explain to you what the study entails so that you have an idea of what my expectations are from you.

The aims of the study are:

- to describe the organisational and community contexts within which mental health problems and needs are being dealt with

- to identify major environmental constraints which impinge on mental health service provision at macro- and micro levels

- to focus on different perceptions of mental health/illness

- to develop ideas on how to improve mental health care to blacks in the Western Cape

- to highlight the controversy surrounding the environmental impact on the quality of life of blacks with specific reference to their mental health and the extremely limited potential of private human service organisations in coping with this impact

- to assist in designing a framework for the planning of mental health service for blacks in the Western Cape.

The study arose from the assumptions that:

- mental health services are characterised by inadequacy and inaccessibility

- mental health services are administered on racial and geographical lines

- the trend followed by mental health programmes is an irrational response to the mental health problems and needs of blacks

- problems surrounding mental health provision are underlined by the exclusion of the cultural context in which blacks define mental illness.

The above assumptions necessitate the need to examine mental health provision in the South African context. The knowledge of how you define mental health and how you perceive mental health problems and needs and mental health service provision will form the basis of the interview.

The following aspects are taken into serious consideration:

- maintaining anonymity of interviewees, where necessary

- maintaining confidentiality of information provided by individual interviewees, where necessary

- the right not to respond to certain topics to which the interviewee may feel sensitive

- use of information gathered for study purposes only.

Once more I wish to thank you for your assistance and co-operation in anticipation.

ANNEXURE 2

INTERVIEW SCHEDULE FOR COMMUNITY LEADERS

1. **Definition of Mental Health/Illness**

1.1 Could you please define, in your own words, the following terms:

- mental health
- mental illness
- poverty
- unemployment.

1.2 What do you think causes each of the above?

2. **Mental Health Needs, Problems and Services**

2.1 Which do you think are the most pressing mental health problems / needs experienced by blacks in the Western Cape?

2.2 What do you think are the causes of these problems?

2.3 What mental health services do you think are appropriate in dealing with these problems?

2.4 Are there any other services which you think could help in alleviating mental health problems / needs?

3. Indigenous Healers

3.1 Do you know of any indigenous healers in your area and other areas?

3.2 Do you think that people are making use of their services? Motivate your answer.

3.3 What type of services do the indigenous healers, e.g. faith healers, witchdoctors and herbalists, offer to the people?

4. The Cape Mental Health Society

4.1 Do you know the Cape Mental Health Society?

4.2 If yes, how did you get to know this organisation?

4.3 Do you know of any services that it renders to the community?

4.4 If yes, what are these services and how do people receive these services?

4.5 What do you think about the services rendered by this organisation?

5. **Other Service Organisations**

5.1 What other service organisations render mental health care to the people in the township?

5.2 What services do they offer?

6. **General**

Are there any other aspects, not covered above that you would like us to discuss?

ANNEXURE 3

INTERVIEW SCHEDULE FOR SERVICE PROVIDERS

1. **Organisational Involvement**

   1.1 What is the name of your organisation?

   1.2 What services does it offer?

   1.3 Is it in any way involved in the rendering of mental health service?

   1.4 If yes, how?

   1.5 If not, what do you do when a case of a psychiatric or mental client is referred to you?

2. **Mental Health Problems / Needs and Services**

   2.1 What do you understand by the term mental health / illness?

   2.2 How would you define mental illness?

   2.3 What do you think are the pressing mental health problems or needs?

   2.4 What do you think are the main causes of these problems?

2.5 Whom do you think suffers from these problems?

2.6 Is there anybody that you think would gain from these problems?

2.7 What are the current programmes dealing with the problems?

2.8 What do these programmes hope to achieve?

2.90 How are these programmes monitored and evaluated?

2.10 Do you think that the quality of life of blacks has an impact on their mental health? Motivate.

2.11 How do you define poverty?

2.12 How do you define unemployment?

2.13 Which services do you think need to be included in mental health care?

3. **Indigenous Healers**

3.1 Do you come across any of your clients who receive therapy from the indigenous healers?

3.2 Do you think that such therapy should be incoporated in your treatment programmes? Motivate your answer.

3.3 Have you visited any of the indigenous healers?

3.4 If not, do you plan to do so in future?

4. **Funding**

4.1 Is your organisation subsidised by the state; or

4.2 by the private enterprise; or

4.3 other?

5. **Agency Linkages**

5.1 Are there any formal linkages between your agency and the Cape Mental Health Society?

5.2 Are there any informal ones?

5.3 Do you find these useful?

6. **Constraints**

6.1 What do you perceive as major constraints in mental health service delivery?

6.2 What do you think could be done to remedy the situation?

7. **General**

Are there any aspects not covered by the interview that you would like to discuss?

ANNEXURE 4

INTERVIEW SCHEDULE FOR SERVICE CONSUMERS

1. **Mental Illness**

   1.1 How do you define mental illness?

   1.2 What do you think are the causes of mental illness?

   1.3 Do you think psychiatrists can cure all mental illnesses amongst blacks? If not, why?

   1.4 Most of the blacks, whether they are in receipt of the "western" psychiatric and other related treatment, will still go to indigenous healers. True/false. Motivate.

   1.5 Do you think that the mental health treatment process should incorporate indigenous healers? Motivate your answer.

2. **Services**

   2.1 Whch organisations have you approached for mental health services?

   2.2 Where are the structures situated?

   2.3 Was the assistance readily available?

2.4 If not, what do you think was the reason?

2.5 Did the services provided, if any, coincide with your expectations? Motivate.

2.6 What kind of mental health services do you think are needed in the black townships?

3. The Cape Mental Health Society

3.1 How did you know about this organisation?

3.2 What type of services did you need when you approached the organisation?

3.3 Was the service readily available?

3.4 If not, how long did you have to wait?

3.5 What were your expectations when you approached the organisation?

3.6 Are you aware of any other services rendered by the Society in the townships?

3.7 What do you think the Society can do so as to improve its service delivery to blacks?

4. General

4.1 How do you define poverty?

4.2 How do you define unemployment?

4.3 Do you think that the above have an impact on mental health of blacks? Motivate your answer.

4.4 Is there anything not covered above that you would like us to discuss?

ANNEXURE 5

INTERVIEW SCHEDULE FOR THE CAPE MENTAL HEALTH SOCIETY STAFF MEMBERS

1. **Management of the Organisation**

   1.1 The Organisational Structure

   1.2 The Committee

   1.3 Black Representation

   1.4 Goal setting, goal conflict, goal displacement, priority setting

   1.5 Policy making

   1.6 Planning and analysis with particular reference to the model used, resource planning and distribution, client analysis, programme analysis

   1.7 Decision-making

   1.8 Evaluation Design

   1.9 Accountability

   1.10 Management Information System

2. **Service Delivery**

2.1 Description of services according to the various departments

2.2 Problem identification and definition

2.3 Problem analysis

2.4 Needs assessment

2.5 Types of needs

2.6 Probable causes of the mental health needs and problems

2.7 Levels of needs

2.8 Measurement of needs

2.9 Monitoring of services

2.10 Types of facilities

2.11 Local participation

2.12 Programme monitoring, implementation

2.13 Staffing

2.14 Service models used

3. **Funds**

3.1 State funding

3.2 Public funding - methods and problems in fundraising

3.3 Distribution and allocation

3.4 Budgeting

3.5 Income and expenditure for the current year

4. **Organisational Linkages**

4.1 Formal

4.2 Informal

4.3 Usefulness

4.4 Problems

5. **Constraints in Service Delivery**

5.1 Organisational or micro constraints

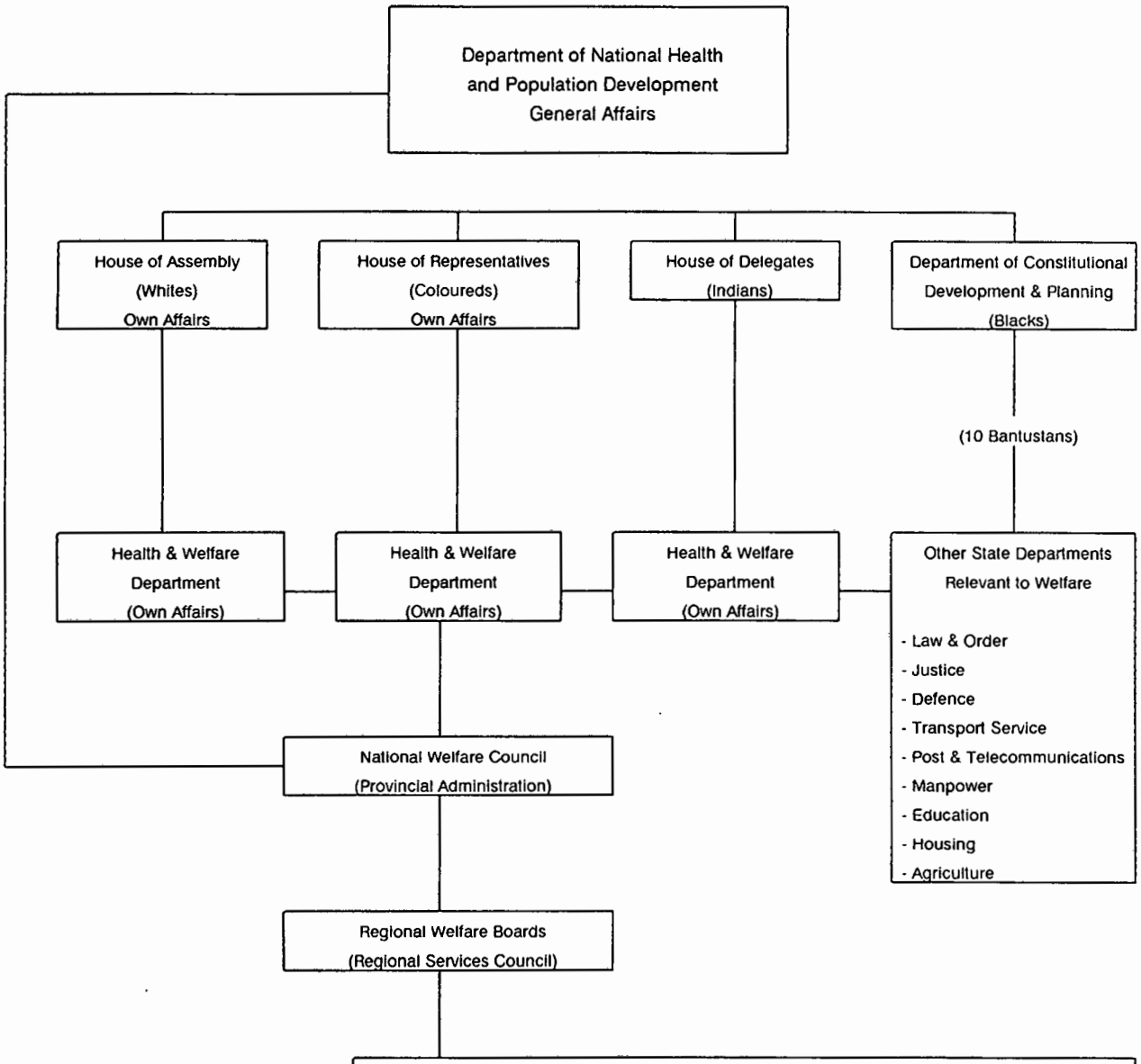
5.2 Environmental or macro constraints

6. **General**

Any other matter not covered above.

ANNEXURE 6

SCHEMATIC PRESENTATION OF THE WELFARE STRUCTURES IN SOUTH AFRICA



Governed by:

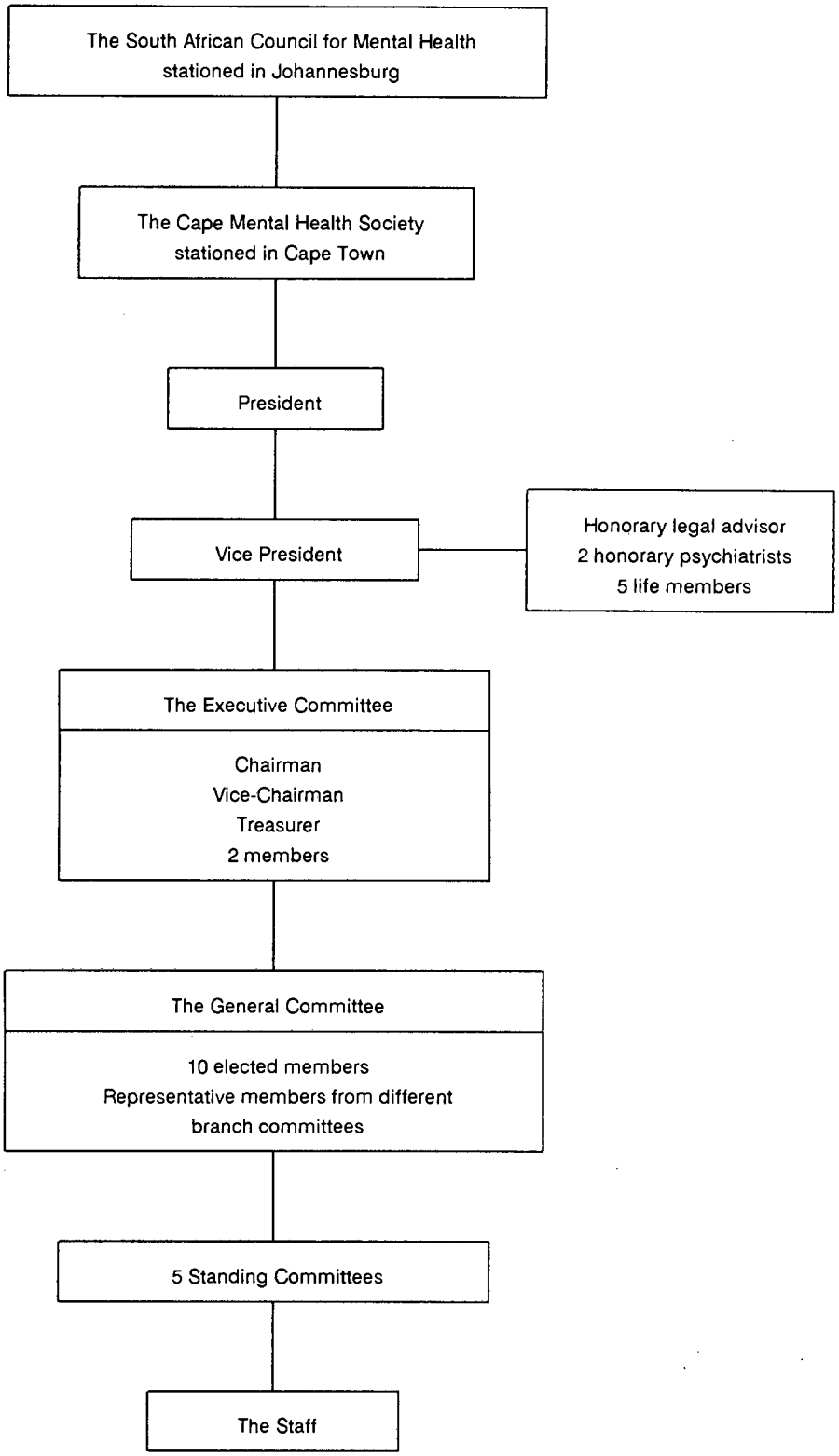
- National Welfare Act No 100 of 1978
- Fundraising Act No 110 of 1978
- Social and Associated Workers Act No 107 of 1978 (and Mental Health Act for mental health services)

Private Welfare Services

- human service organisations e.g. Cape Mental Health Society
- community and/or fundraising organisations e.g. Community Chest
- private bodies or persons rendering specific services e.g. old age homes
- agricultural, mining or commercial undertakings, offering social services to employees e.g. Foundation for Agricultural Community Development
- social workers in private practice

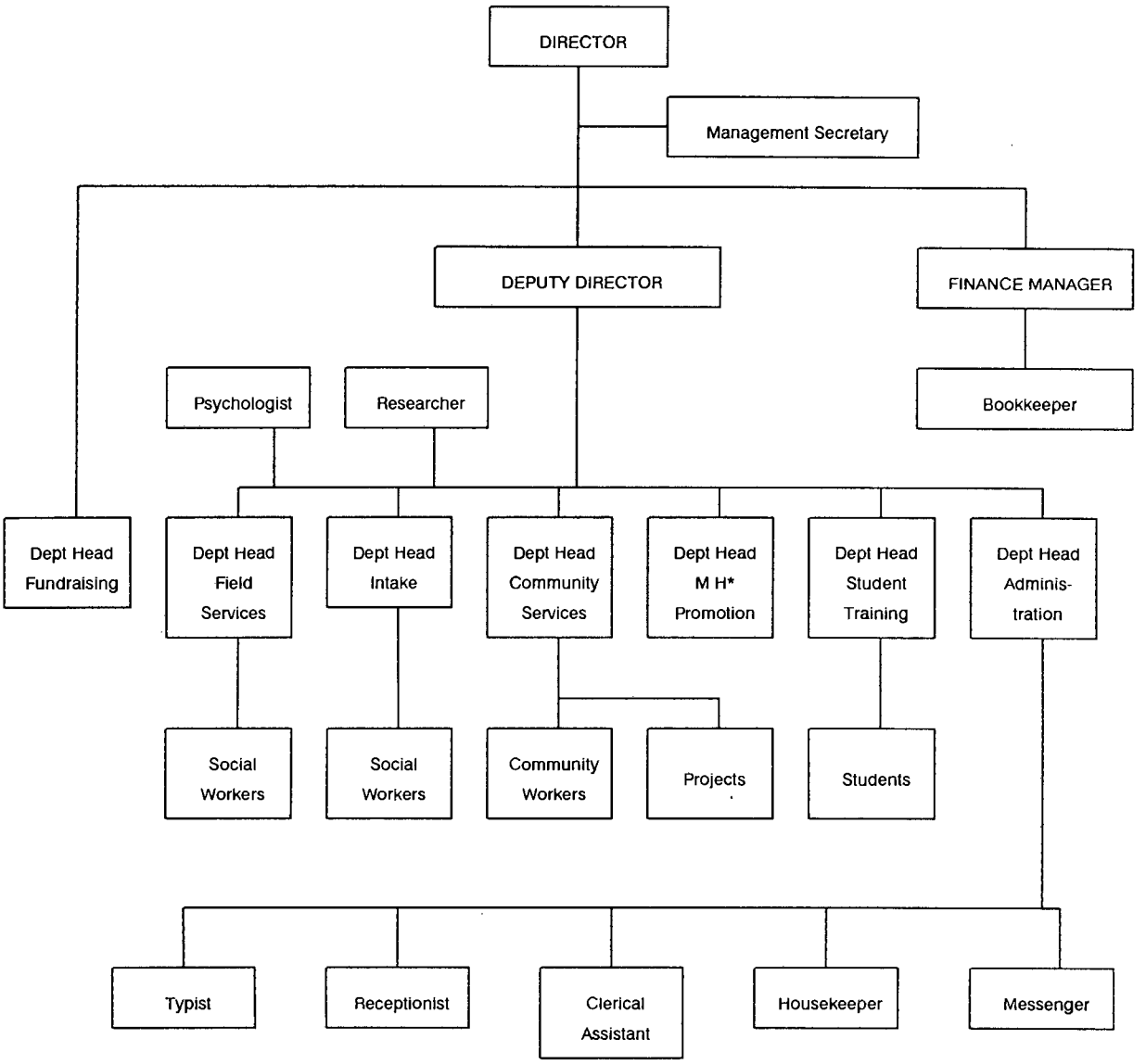
ANNEXURE 7

NON-STATUTORY STRUCTURE OF THE CAPE MENTAL HEALTH SOCIETY



ANNEXURE 8

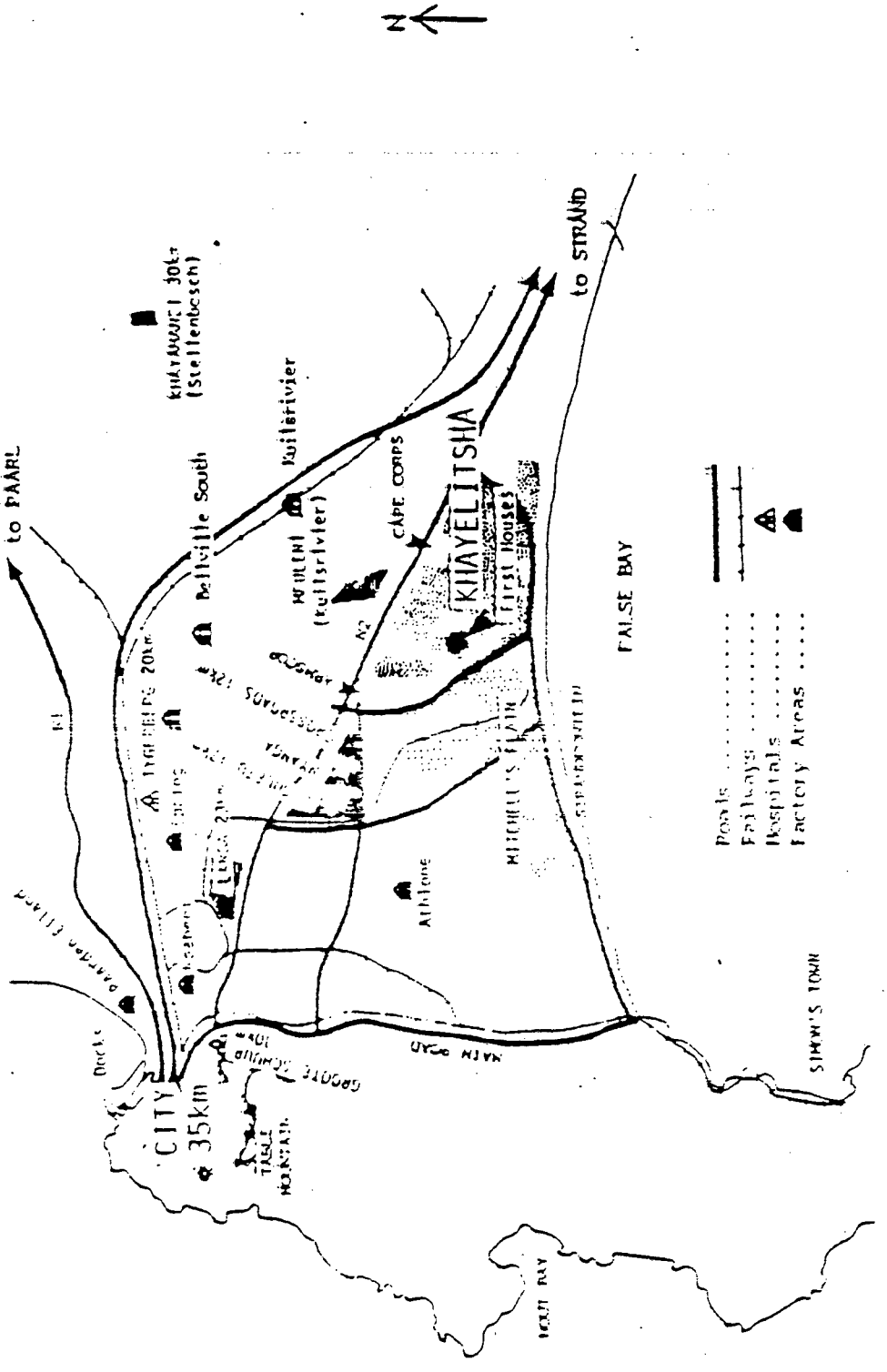
THE ORGANISATIONAL STRUCTURE OF THE CAPE MENTAL HEALTH SOCIETY



*MH : Mental Health

ANNEXURE 9

THE MAP OF THE CAPE PENINSULA



ANNEXURE 10

POLITICAL STRUCTURES PARALLEL TO THE NATIONAL SECURITY MANAGEMENT SYSTEM (FOR ENSURING STATE CONTROL)

<table>
<tr><td>Parallel Political Structures</td><td>National Security Management System</td></tr>
<tr><td colspan="2">Executive State President
Cabinet</td></tr>
<tr><td colspan="2">Permanent Cabinet Committees</td></tr>
<tr><td>Economic Social Constitutional</td><td>State Security Council</td></tr>
<tr><td>Tricameral Parliament
House of Assembly | House of Representatives | House of Delegates
Departmental Heads</td><td>Working Committee</td></tr>
<tr><td>Government Departments</td><td>Secretariat</td></tr>
<tr><td rowspan="2">Provincial Administrators</td><td>Intelligence | Commissions | Strategy | Administration</td></tr>
<tr><td>Interdepartmental Committees</td></tr>
<tr><td rowspan="2">Regional Services Council</td><td>Joint Management Committees (JMC's)</td></tr>
<tr><td>Semkom: Constitutional, Economic, Social | Gikkom: Joint Intelligence | Komkom: Commissions</td></tr>
<tr><td rowspan="3">Primary Local Authorities</td><td>Sub-Joint Management Committees</td></tr>
<tr><td>Mini-Joint Management Committees</td></tr>
<tr><td>Local-Joint Management Committees</td></tr>
</table>

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"Let us talk whilst there is still some time. What a wonderful land God has bequeathed to us and what a wonderful land it will be when we are South Africans together, when black and white will walk together towards the future of a united South Africa, with a more just society, more open, where people matter as children of God."

Archbishop Desmond Tutu
Tribute : September 1988