

would need answering—what happened in other countries, including the EEC, and how serious were the risks to the public of the current situation. The view prevailing in the DHSS was that the risks from some of the practices which now went under the name of psychotherapy, and from practices of a similar kind under other names, were real and

very worrying, but were probably not susceptible to prevention by statute.

PROFESSOR MICHAEL SHEPHERD's paper (p. 166) was a searching criticism of the Report, with the conclusion that registration was pointless unless concerned with a well-defined field of work, effective in achieving its aims.

KENNETH RAWNSLEY

Correspondence

Mental health and apartheid—A case to answer?

DEAR SIR,

Over the last five years, the South African government has been accused of abusing Blacks in psychiatric institutions and also of involuntary psychiatric detention for political reasons. The charges have come from sources within South Africa (de Villiers, 1975), the British and European press (Deeley, 1975; Wästberg, 1976) and the World Health Organization (WHO, 1977); a *Lancet* editorial in 1977 expressed considerable concern. More recently, the American Psychiatric Association has published the findings of its committee which investigated the allegations (1979). The President of the APA wrote: 'the most powerful impression made on us was that the evils of apartheid do not stop at the hospital door' (Stone, 1979).

The WHO Report—a preliminary review of available information on mental health services in South Africa—first gave credence to various accusations of political abuse of psychiatry. The Report is an indictment of the South African government's policies in the organization of mental health services for Blacks; these are noted as inadequate not only in comparison to those provided for the white population but also in relation to the most elementary essential human needs and rights.

Moreover, there is collusion of interest between private companies and the State, as the care of chronic patients is handed over to private, profit-making companies. These companies make profit, using government subsidies; government spending through this arrangement is less than it would have to be if mental health care for Blacks were provided directly by the State Health Service.

The most disturbing aspect of the WHO Report is the claim that psychiatric facilities could be used for political and social control of Blacks. Legislation concerning the rehabilitation of pass law offenders (i.e. Blacks convicted for remaining in a white area without valid authorization) equates the non-observance of apartheid laws with mental disorder. The proclamation about rehabilitation institutions in the Bantu homelands was approved in 1975 and this

established institutions for 'rehabilitation', 'treatment' and 'training' of ordinary offenders against the pass regulations. The aims of the 'rehabilitation' procedures are defined in paragraph 5 of the proclamation, and they imply that any African who does not observe the laws of apartheid is mentally disturbed and in need of compulsory improvement of his 'physical, mental and moral condition'.

The APA Report confirmed most of the WHO allegations, finding evidence of bad medical care resulting in needless deaths, inadequate sanitation and deficient psychiatric treatment at most of the private psychiatric institutions for Blacks. On the other hand, there was no evidence that Blacks were confined in psychiatric hospitals for political reasons. The Americans were shown selected psychiatric institutions only, and their visit was arranged and coordinated by the South African Ministry of Health. They were prevented from visiting any State-controlled hospitals for Blacks. As the APA Report says: 'We were prevented from investigating a crucial link in the mental health service system'. In other words, the Committee was not in a position to deny or substantiate the allegations of political abuse of psychiatry.

Following the publication of the WHO Report and the *Lancet* editorial, Professor Gillis, of the Society of Psychiatrists of South Africa, denied the allegations and commented: 'it is unwarranted to tie the apartheid tin to the tail of the psychiatric cat, no matter how much of a pleasing din it makes' (Gillis, 1977). As Jablensky subsequently (1978) pointed out, Gillis had failed to address himself to the main issue raised in the WHO Report—whether to regard 'socially harmful policies in the areas of health' as a legitimate ethical concern or as 'frankly political issues'. Clearly, South African psychiatrists need to take stock of the situation, particularly following the APA Report.

The College has so far not commented on the South African issue, although it has spoken out courageously on similar issues—such as the Soviet misuse of psychiatry for political purposes. The College's silence is not only worrying but is likely to be interpreted as condoning what is happening in South Africa. I am sure there are many members, like myself, who feel that the College should speak out on

this issue. The implications of such a step are clear. The WHO Report and the *Lancet* editorial created international concern about ethical aspects of mental health practice in South Africa. Since the world's attention has been directed to these problems there has been some improvement in the situation (Stone, 1979).

At present the College (and other psychiatric institutions in the UK) has flourishing contacts with South African psychiatry, which only adds to the unease that many feel about the College's silence. Recent events, including the refusal of the South African Medical and Dental Council to proceed against doctors implicated in the death of Steve Biko, and the increasing number of doctors held as political prisoners or who have actually died in custody (Parkes, Ryan *et al.*, 1978) only strengthen the argument for the College to make its position clear on the very sensitive issue of mental health and apartheid.

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Approval under Section 28(2)

DEAR SIR

I was interested to read the item on page 141 of the issue of September 1980 in relation to the approval of medical practitioners under Section 28(2) of the Mental Health Act 1959.

The College seems to have taken upon itself the task of interpreting the law. I find these occasional statements from the College are regarded by the profession with the same degree of reverence as the children of Israel regarded the tablets of stone handed down from Mount Sinai, and they

tend to have the force and importance of law and are not regarded as mere advice. I am being reminded continually by my juniors as to how I should give ECT and what I can do and not do in relation to compulsory treatment. This latest piece of advice is part of the same series. I feel that College interpretations of the law are not going to be of much advantage to psychiatry, and it surprises me that the College should have taken this on.

The Mental Health Act was drawn up in relation to Section 28 on the basis of very good advice given by senior members of the old RMPA. Many of us had had years of experience of dealing with medical practitioners who were regarded by the local authorities as experts in psychiatry but who had no real training in psychiatry. These doctors spent a large part of their time going around towns certifying patients and sending them into mental hospitals. Very often their attempts at diagnosis were very misleading and inaccurate. At the time the Mental Health Act was passed (DHSS, 1960, Memorandum on Mental Health Act, 1959, pp. 11-12, para. 49), it was made abundantly clear that in the ideal situation the two doctors involved in compulsory procedures should be the patient's own general practitioner and the responsible medical officer who is going to look after the patient in the hospital. This is an ideal which really does its best to safeguard the liberty of the individual. We are departing from this ideal if we are going to condone the recognition under Section 28(2) of numbers of doctors who are neither going to be the patient's general practitioner nor the consultant who is responsible for the patient's treatment.

There is an additional factor that has emerged in recent years. Surprisingly the courts have chosen to recognize Section 28(2) as a distinction of some sort. It is not enough to be a consultant and to be well qualified: one has to be recognized under Section 28(2) as well. Only such a doctor will have his evidence accepted as valid by the average court of law. Only such a doctor is entrusted by the Court with the care of patients under Probation Orders. The College has decided that the criteria for appointment to the Hospital Practitioner grade should be the criteria for approval under Section 28. Basically this is two years full-time hospital experience in a specialty. I have had many juniors during the last 20 years who have spent two years in psychiatry and then decided for various reasons to leave the specialty. I would not consider that the great majority of these had sufficient expertise in psychiatry to merit appointment under Section 28. Again, this Hospital Practitioner grade is a rather doubtful entity. In my current issue of the *BMJ* I can find no advertisement for any appointment in this grade in any specialty. As a result, by default what will happen is that people who have been appointed as clinical assistants will be recommended for approval under Section 28.

If the College considers that there is a need in certain areas for approval of doctors under Section 28 it can only mean that there is a shortage of consultants in that area. It would be in the best interests of the profession if the College