

Institutional victimisation in post-apartheid South Africa

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Objective. Institutionalisation of psychiatric patients was a prevalent treatment approach in the apartheid era of South Africa. Allegations of patient victimisation in the form of violence and abuse arose frequently during that time. From 1994 the process of democratisation introduced a strong human rights ethos. The post-apartheid Department of Health prioritised improvements in mental health care by recommending, *inter alia*, deinstitutionalisation and reintegration of patients into the community. Ten years later these interventions have proved difficult to institute and many patients are still hospitalised. The present study investigated whether currently hospitalised patients continue to experience violence and abuse.

Method. This was an exploratory naturalistic study in which both qualitative and quantitative data were collected by means of a questionnaire and individual interviews.

Results. Of the 127 patients who completed the study, more than 50% reported experiences of abuse. The main perpetrators were other patients, although violence on the part of staff was reported. Almost 44% of patients were frightened to stay in the hospital for treatment.

Conclusion. A balance is needed between provision of care and protection from danger, and respect for the individual liberty of those suffering from serious mental illness in our society.

A recent television programme¹ investigated patient care conditions in a well-known KwaZulu-Natal psychiatric hospital. Mistreatment of patients formed a large part of the criticisms raised in the programme. As with all investigative television features there was an element of sensationalism; nevertheless, the Minister of Health commented on the programme.² As scientists and clinicians we prefer our information to be delivered in a less dramatic manner, with evidence-based results. The qualitative and quantitative data from the present exploratory naturalistic study provide results that in part give credence to the television report.

During the apartheid years institutional patient abuse was frequently alluded to in South Africa,³ and often cited in the media, but little objective information was available.⁴ During that era institutional care was predominantly custodial and arranged along racial lines. With the arrival of democracy in South Africa in 1994, these allegations were finally investigated by the Committee on Mental Health and Substance Abuse in 1995, created by The National Department of Health (DOH). The allegations were supported³ (and Mental Health and Substance Abuse Committee – unpublished policy document submitted to the Department of Health, Gauteng, 1998), especially in psychiatric institutions.⁵

Hope for restitution accompanied the 1994 change to democracy, with its new culture of human rights advocacy. The DOH planned improved mental health by means of deinstitutionalisation, reintegration of previously institutionalised patients into community life, the incorporation of mental health into the primary health system, revision of the Mental Health Act and equitable reallocation of the available resources.^{6,7}

Deinstitutionalisation would have automatically dealt with many of the issues of institutional violence and abuse, but 10 years later the interventions proposed by the DOH have proved difficult to execute because of lack of community facilities, inadequate training and lack of funding.⁸⁻¹⁰ While hospitals that historically confined the mentally ill continue to have a large

residual population of chronic long-term patients, they now see an increasing number of acutely ill cases.^{9,10} (This increase has a complex aetiology based on factors such as closure of some general hospitals, increased demands on urban services because of the influx of people from rural areas, increased numbers of patients with psychiatric illness, and the HIV/AIDS epidemic.) Even if patients are discharged back into the community there is a high likelihood of readmittance because of relapse, hence the ongoing reports of patient abuse in the newspapers¹¹ and television.¹

Institutional violence and abuse, especially in psychiatric facilities, has a long and complex history.¹² The character of this violence is normally typified by patient hostility towards staff members. Incidents of this type have been well documented internationally and occur with extraordinary frequency, especially among nurses, who bear the brunt of the aggression.¹³ After staff members, fellow patients are probably the most common targets for assault by patients.¹⁴

However, there has been little formalised research to assess reports of institutional abuse of patients (hence the need for media reporting). In 1984 Sundram¹⁵ wrote that there was a scarcity of literature on this subject, and journal searches today continue to confirm this. Newbern¹⁶ attributed this dearth to reporting methods and disciplinary procedures. Most of the relevant research has been undertaken by the staff or treatment facilities; it relies on official ward recording of assaults¹² and almost certainly underestimates prevalence and type of incident.¹³ The hospitalisation experience of psychiatric patients is rarely canvassed.¹⁵ Patients in psychiatric institutions or hospitals are usually hospitalised against their wishes for care and treatment of their mental illness, providing an implicit message that they lack insight and understanding of what is best for them. It is erroneous, however, to assume that patients who need to be institutionalised are incapable of understanding their environments or what is happening to them.

The remainder of this article relates to a study by Lucas and Stevenson¹⁷ carried out at a Gauteng psychiatric institution to investigate patients' experiences of violence and abuse.

Method

Participants

Participants were recruited from 4 wards of a specialised psychiatric hospital – 2 locked male wards, 1 open male ward

and 1 open female ward (on a typical day the male:female ratio of patients at the hospital was approximately 3:1, reflecting gender trends seen in all Gauteng psychiatric hospitals).¹⁸ Each ward has a capacity for 40 patients and all patients who were in the ward at the time of data collection were invited to participate. The female ward was not functioning at full capacity.

As patients were asked about their experiences of abuse while still under the care of the psychiatric institution, the situation held the potential for retribution. Patients tend to suffer silently and may be treated unfairly if it becomes known that they have complained of mistreatment. Therefore, no attempt was made to verify or refute the information given, no names of alleged perpetrators were requested, and no collaborating information from hospital records or files was sought.

Measuring tool

The participants were patients typical of South African psychiatric hospitals,⁸ and generally level of education and socioeconomic status were low. Therefore, a simple questionnaire was developed to gather information. Patients were asked if they had been hit while in the ward, and if so, how often, by whom, and whether it was reported. If the answer was yes they were asked who they had reported to, and if anything had been done. This set of questions was essentially repeated when asking about sexual assault. Patients were then asked if they had been verbally insulted or threatened by staff members. Provision was made for patients to comment on their overall hospital experience, including their sense of personal safety.

Procedure

No prior warning was given to ward staff that the research was going to be undertaken. This was done in an attempt to capture a realistic evaluation of violence and abuse in the wards. The purpose of the study was explained to each patient in his or her preferred language. The researchers were permanent staff members who were familiar to the patients but not working on the selected wards where interviews were conducted. After patients had given informed voluntary consent to participate, a researcher interviewed each subject individually in a room separate from the general ward. All consenting patients from each ward were interviewed on the same day. Participants could choose to fill in the form themselves (it was written in

English), or the questions were verbally presented in Afrikaans or a vernacular language by two of the researchers who then completed the questionnaires verbatim on the subject's behalf.

The researchers offered no preconceived definitions of the terms 'violence' and 'abuse' as this research was concerned primarily with the subjective experiences of the patients rather than an objective outsider evaluation. Consequently, the interviewers listened to the participants and documented the reports without criticism. If an incident was reported it was assumed to represent objectionable behaviour from the patient's perspective. In using this more qualitative approach it was expected that the incidents described by the patients would be better understood by the researchers.¹⁹

Ethics approval for both studies was given by the Committee for Research on Human Subjects (Medical) at the University of the Witwatersrand. There was a hospital ombudsman available if any patient wished to report an incident for further enquiry. It was not the aim of the researchers to 'point fingers' or identify perpetrators, but merely to allow the patients to express their experiences in a non-judgemental environment.

Results

Thirty-six, 40 and 32 patients were recruited from the male wards and 22 patients from the female ward, giving a total of 130 participants. A minority of patients were missing from the wards for various reasons, including attending occupational therapy or being on parole in the hospital grounds. Only 1 patient declined to participate, but the results for 2 patients were excluded because of florid delusional beliefs. The only identification was the ward number on each response (which indirectly indicated the gender of the patient).

Incidence of abuse

The questionnaire was well understood by the patients. Of the 127 who completed the questionnaire, 52.8% ($N = 67$) reported that they had been physically abused. The number of physical assaults reported per patient ranged from a single incident to more than 6 separate events. Sexual abuse was reported by 18.9% ($N = 24$) of the total sample of patients, and verbal abuse by 37% ($N = 47$) of the total sample.

When the specific abusive interaction was investigated in the subgroup of 67 physically abused patients, it was found that patient-on-patient physical ill-treatment was reported by 38.8%

($N = 26$), staff-on-patient physical ill-treatment by 28.4% ($N = 19$), and both patient-on-patient and staff-on-patient ill-treatment by 32.8% ($N = 22$). In 19 of the 24 incidents of sexual abuse a fellow patient had been the perpetrator. However, in 4 incidents the perpetrator had been a staff member, and in 1 case the subject had been abused by both a patient and a staff member.

There was a significant co-occurrence between all types of abuse. Of those patients who had been physically ill-treated, 32.8% ($N = 22$) had also been sexually assaulted ($\chi^2 = 17.98$, $df = 1$, $p < 0.000$) and 56.7% ($N = 38$) had been verbally abused ($\chi^2 = 23.63$, $df = 1$, $p < 0.000$). Females were more frequently exposed to physical assault than males. On average women reported being hit 1.77 times during their hospitalisation and men 1.38 times ($f = 10.25$, $df = 1$, 125 , $p < 0.002$), but there were no significant gender differences for sexual and verbal abuse ($f = 0.251$, $df = 1$, 125 , $p > 0.05$; $f = 0.302$, $df = 1$, 125 , $p > 0.05$; $f = 1.074$, $df = 1$, 125 , $p > 0.05$).

Patient interpretation of abuse

When interpreting the concept of abuse patients appeared to include all incidents of aggression. Based on descriptions of those who commented on specific forms of violence, it appeared that most patient-on-patient physical abuse involved fist-fighting and kicking. When the perpetrator was a staff member, being pushed roughly predominated. However, 1 patient reported being beaten around the ears by a staff member, and 3 described being strangled by staff, 1 with a towel. Therefore, the high reported incidence of violence undoubtedly included minor skirmishes that may be unavoidable within the context of the institution, as well as more severe violations.

Patients were given the opportunity to comment on the specific form of verbal abuse they were subjected to by staff. The verbal abuse was mainly in the form of threats (for example, the patient being told to behave or s/he would be secluded), insults (for instance, the patient being told that s/he was crazy), or ridicule (such as for a physical deformity).

Reporting abuse

Subjects were asked if they reported physical or sexual abuse. Of the 67 patients who experienced physical abuse, 47.8% (N

= 32) had reported the experience but only 22.4% ($N = 15$) had their complaints acknowledged. Similarly, 41.7% ($N = 10$) of the subjects reporting sexual abuse informed the hospital authorities about it but there had been a response in only 12.5% of cases ($N = 3$). Patients generally reported this abuse to nursing staff and doctors, but 2 patients reported to the hospital ombudsman and the hospital superintendent respectively. Three sexually abused patients chose to report to a family member, a friend, and telephonically to the police.

Consequences of reporting the abuse

Less than half of the patients who reported physical abuse got any response ($N = 13$). One patient mentioned that the perpetrator (presumably a patient) was put in a seclusion room, but another commented on the futility of reporting abuse perpetrated by staff to other staff members. It was somewhat satisfying to note that the patient who reported directly to the hospital ombudsman did get a satisfactory response.

Patient perception of their hospital stay

Although many patients reported being satisfied with their treatment at the hospital, 12.6% of the total sample ($N = 16$) specifically commented that they wanted to go home, and 37% ($N = 47$) of the total 127 subjects responded that they were afraid to stay in the hospital. One patient wrote: 'This is my first time. I might die here and [my] family will not know.'

Discussion

It is known that widespread abuse occurred in South African institutions in the past. Sadly, the present research indicates that physical, sexual and verbal abuse of hospitalised patients continues. While those inflicting abuse were primarily other patients, it is disturbing that a significant proportion of the staff were reportedly implicated. Physical assault was the most common violation experienced, but a large proportion of these patients experienced verbal abuse as well. It could be argued that abused patients provoked this abuse as the trend was for the same patient to experience a variety of assaults. While this may be true it in no way exonerates the perpetrators, especially when the latter were the purported caregivers. Patients appeared to be acutely aware of being abused and were sensitive to what could perhaps be considered minor skirmishes. Approximately 50% of those experiencing abuse reported it, but less than half of the reports were responded to, and only one-

quarter of the reported incidences of sexual abuse received a response.

Formal disciplinary measures were in force at the hospital and an ombudsman was available for patient complaints, but few staff members were formally disciplined as patients were often too apprehensive to lodge an official complaint. This apparent lack of interest or care with regard to patient complaints is worrying and requires further exploration. Where there was a response to patient complaints, the specific outcome or level of patient satisfaction in this regard were not investigated in the present study, and neither were the reasons for abuse.

Explanations for abuse are undoubtedly complex and may include any or all of the following considerations.

1. Individual perceptions of what constitutes abusive behaviour differ. For instance it has been suggested that minor verbal threats and mistreatment are regular occurrences in chronic care hospitals and are unavoidable within the context of efficient functioning of such hospitals.¹⁵

2. Psychiatric nursing is considered stressful and staff often experience burnout. Levert *et al.*²⁰ measured burnout in South African psychiatric nurses and found that 54.9% of their sample were experiencing high levels of emotional exhaustion, 45% depersonalisation and 93.4% low feelings of personal accomplishment. These levels are higher than those cited internationally.

3. In the current social milieu in South Africa intolerance of others is mediated through violence, and hospital staff members are not excluded from exposure to pervasive domestic and criminal hostilities. They have no special powers to deal with such experiences²¹ and the impact contributes to a sense of helplessness in nurses and a failure to cope with their work demands.^{4,21}

4. Overcrowded institutions, lack of structured activities, mixing of chronic care patients with the acutely ill, power relationships between patients and staff, and language, cultural and ethnic communication confusions are factors known to cause reactive unexpected outbursts of violence in psychiatric patients, who are then blamed for their behaviour.^{4,15,22} All these factors were present at the study hospital and no doubt contributed to the ongoing level of violence and abuse.

The benefits and limitations of deinstitutionalisation have been well documented.^{8,23,24} Initially the discharge process in South

Africa tended to be unco-ordinated, with patients lost to follow-up or readmitted.^{25,26} Although this process is being improved,^{26,27} the South African health service remains unsatisfactorily equipped to treat those with severe mental illness.^{7,8,10,28,30}

Furthermore, professional staff, and patients and their families have expressed concern about deinstitutionalisation.^{10,31,32} It is not clear whether the reason for wanting patients to remain hospitalised is based on a wish by families to limit the burden placed on them by psychiatric illness, or a belief that treatment is still better at hospitals than at community clinics. It is also possible that when life is generally onerous because of poverty, unemployment and hardship, and psychiatric illness makes it more so, free board and lodging in an institution seems preferable,³¹ especially when community halfway house and hostel facilities are a scarce resource.³³ Professionals have raised major concerns about the viability of discharging patients into a community mental health care service staffed at 10% of estimated norms (A J Flisher – paper presented at the First Regional Congress of Social Psychiatry in Africa, Johannesburg, 22 - 26 March 2004).

South Africa cannot return to the large psychiatric asylums of the late 19th century as preferred treatment for those with serious mental illness. Yet discharge into an ill-prepared community is no better and there are patients who will always need specialist care. Surely significant constitutional changes to human rights in South Africa must include a balance between provision of care and protection from danger, with respect for individual liberty of those suffering from serious mental illness in our society?

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