

Fall 2005

# The State of “Differentlyabled” People in the Western Cape, South Africa

Joshua Wade Paul  
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The State of “Differently Abled” People in the Western Cape, South Africa

Joshua Wade Paul

School for International Training

Fall 2005

## Table of Contents

<b>ACKNOWLEDGMENTS.....</b>	<b>4</b>
<b>ABSTRACT.....</b>	<b>5</b>
<b>(1) INTRODUCTION.....</b>	<b>6</b>
<b>(2) METHODS.....</b>	<b>7</b>
<b>(2.1) Research Design.....</b>	<b>7</b>
<b>(2.2) Interviews.....</b>	<b>8</b>
<b>(2.3) Meetings.....</b>	<b>9</b>
<b>(2.4) Visits.....</b>	<b>10</b>
<b>(2.5) Volunteering.....</b>	<b>11</b>
<b>(2.6) Legislation Review.....</b>	<b>12</b>
<b>(2.7) Literature Review.....</b>	<b>12</b>
<b>(2.8) Limitations of the Study.....</b>	<b>13</b>
<b>(3) ANALYSIS</b>	
<b>(3.1) Disability Context in the Western Cape.....</b>	<b>13</b>
<b>(3.1.1) Integrated National Disability Strategy.....</b>	<b>15</b>
<b>(3.1.2) Additional Healthcare Legislation Analysis.....</b>	<b>16</b>
<b>(3.2) EDUCATION.....</b>	<b>18</b>
<b>(3.2.1) The Need for Family Education.....</b>	<b>19</b>
<b>(3.2.2) Additional Educational Analysis.....</b>	<b>20</b>
<b>(3.3) TRANSPORTATION.....</b>	<b>20</b>
<b>(3.3.1) Additional Transportation Legislation Analysis.....</b>	<b>21</b>
<b>(3.4) EMPLOYMENT.....</b>	<b>22</b>
<b>(3.4.1) Additional Employment Equity Analysis.....</b>	<b>24</b>
<b>(3.5) HEALTHCARE.....</b>	<b>24</b>
<b>(3.5.1) Healthcare 2010.....</b>	<b>25</b>
<b>(3.5.2) Medication.....</b>	<b>27</b>
<b>(3.6) PUBLIC AWARENESS.....</b>	<b>29</b>
<b>(3.7) HUMAN RESOURCE DEVELOPMENT.....</b>	<b>30</b>
<b>(3.7.1) Additional Human Resource Development Legislation.....</b>	<b>30</b>

**(4) CONCLUSIONS.....31**  
**(4.1) Poor Legislation Implementation.....31**  
**(4.2) Funding.....32**  
**(4.3) Employment Equity Does Not Exist.....32**  
**(4.4) There is a Need for Significant Reform in Transportation.....33**  
**(4.5) The Situation is Better Now (2005), than is was Under Apartheid.....33**  
**(4.6) Are there Actually Resources Available?.....33**  
**(4.7) A Philosophical Change in the Outlook Concerning Disability.....34**  
**(5) WORKS CITED.....36**  
**(5.1) Secondary Sources.....36**  
**(5.2) Legislation.....37**  
**(5.3) Interviews.....38**  
**(5.4) Observations.....39**  
**(6) APPENDIX 1.....41**

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**ABSTRACT**

This project is a look into whether the current legislation and resources provided allow for the equality that is promised in the new constitution. I looked at legislation and community NGOs in order to establish what is being done in order to assure that people with disabilities have equal access to resources, including education, transportation, employment, healthcare, public awareness, and human resource development. In order to investigate these questions I worked with the Cape Mental Health Society and the Fountain House; I conducted interviews and observations looking at the community facilities of care. These community groups also provided insight into the translation of legislation to the people it is intended to serve. After I finished my research, I concluded that South Africa has progressive legislation when it comes to the actual laws being signed. However, these laws are ineffective and poorly implemented, thus creating a system of exclusion. As a result of poor implementation, resources are not being allocated to people with disabilities, thus people with disabilities are operating in a system that promotes exclusion. Additionally, the Healthcare 2010 policy is one that is supposed to increase the quality of care for people, based on community service, but people with disabilities are simply being removed from the hospitals and overloading into under funded community NGOs. Finally, I conclude that a complete shift, in terms of philosophy on disability, is needed in order to truly accomplish equality for people with disabilities.

**(1) INTRODUCTION-**

I began my trip to South Africa planning to research discrimination in the Cape Town context, but for reasons beyond my control I was unable to perform this research. However, I remember distinctly noticing that there was a lack of people with disabilities on the streets of Cape Town. When my project on discrimination fell apart it was this memory that I relied on to develop a new area of research. Why was it that I saw few people with disabilities on the streets of Cape Town?

I decided that disability in the Cape Town context would allow for me to combine not only my interest in discrimination, but also my own experience with people with disabilities. I believed that I could utilize my experience with my own parents, both of whom have a physical disability. I know from experiences with my family that discrimination exists everyday and a large part of this has to do with a lack of integration in schools and in the workplace. People simply do not interact with people with disabilities often, thus feel uncomfortable or don't know how to react when they encounter a person with a disability. Additionally, I will bring my experience of working with high school aged people with developmental disabilities.

Originally, I desired to look at both people with mental and physical disabilities in the Western Cape, but my advisor Jane Keen suggested that this might be too broad of a subject to cover in the time available. Although legislation generally encompasses both mental and physical disabilities, the barriers and the stigmas associated with each are very different.

All of these things have lead me to question, what is South Africa, the Western Cape specifically, doing to ensure that people with mental disabilities have equal access to resources? Is there legislation that truly represents the new constitution that promises equality for all of South Africa's citizens? If this legislation exists, how is it being implemented and is it having the desired effect upon the people of the Western Cape? What is being done in the community for people with disability? More importantly, if these things are not being addressed, is this a direct result of the other issues that South Africa is facing at the moment, including housing, HIV/Aids, unemployment and racial separation; or are all of these issues inter-related?

Throughout this paper I will make specific use of language when I refer to the disabled community. It is important to shift away from the labeling that occurs and eliminate the notion that people with disabilities are sick or a group of lesser standing or ability. So, when I refer to a person who utilizes mental health services, this person will be referred to as a *consumer*. This term indicates that this person has a mental disability, either intellectual or psychiatric, and utilizes mental health services. This terminology is something that I integrated into my daily speech as a result of working in the Fountain House. Additionally, I will use the specific wording *person with a disability*, instead of disabled person, handicapped person or sick person. A fundamental change in how the public addresses disability is pivotal to not only having a better understanding, but living in a more accepting manner. Also, to know that a disability does not control a person's life, they are a person first and that person has something that might be limiting or might not be. People with disabilities live incredible, productive, intellectual and happy lives despite having to take medication or not being able to run a marathon.

## **(2) METHOD-**

In order to investigate the state of people with mental disability in the Western Cape Province, I conducted research based on a social analysis/volunteer research design. I worked with the Cape Mental Health Society and volunteered at the Fountain House. For the purposes of this project I focused on mental disabilities, but make specific notes to legislation and situations which are not applicable to people with physical disabilities. However, I believe while focusing on mental disabilities, the vast majority of policy are supposed to be all inclusive of disability, thus is still an effective analysis of the state of disability as a whole. Whether these policies and legislation are actually all inclusive will be discussed later in this analysis.

In order to investigate my research questions I established a relationship with the Cape Mental Health Society (CMHS). This is one of the largest organizations dealing with psychiatric and intellectual disabilities in the Western Cape. Cape Mental Health Society has 16 projects under its umbrella of care. With the help of Carol Bosch and Rene Minnies, Social Workers at CMHS, I conducted interviews, project visits and attended meetings in order to establish a full picture of the range of services and possible

difficulties of operation that exist in the Western Cape context. I was under the supervision of Cape Mental Health Society, so all interviewees and organizations that I interacted with understood my role as a researcher in this context. Additionally, I was advised by Jane Keen, a social worker in Cape Town, South Africa. She facilitated this project and assisted in any problems that I encountered along the way. Additionally, Jane provided direction for my analysis.

The Cape Mental Health Society (CMHS) was established in 1913 and is a member of the national organization, the South African Federation for Mental Health. CMHS is one of the only organizations that provide services for people with mental disabilities in the Western Cape. CMHS receives government subsidy for some programs based on attendance and the range of service that the project provides. This subsidy varies from project to project.

Cape Mental Health has three goals for their consumers. (1) They hope to improve the quality of life for people with mental disabilities; (2) empower people to advocate for themselves; (3) involve family and community in the process (Orientation Presentation at CMHS, 11-11-2005).

As defined earlier in this work, the label of mental disability encompasses two types of disability, psychiatric and intellectual. CMHS covers a spectrum of diagnoses and a range of independence and function of its consumers (Cape Mental Health Orientation Presentation [11-11-2005]).

## **(2.1) Interviews-**

I interviewed Rene Minnies, a social worker at Cape Mental Health Society. Rene is in charge of the Rainbow Foundation at CMHS, thus is a main facilitator in the social model of care, Psycho-Social Rehabilitation (PSR). The Rainbow Foundation represents a set of support groups located in several communities which act as a therapeutic support for people with psychiatric disabilities. Additionally, Rene acts as an executive member of the Cape Consumer Advocacy Body (CCAB) and thus can speak to the push for self advocacy of the consumers in CMHS's facilities and resources.

Shamila Ownhouse is also a social worker at Cape Mental Health Society and works in the *Workshops Unlimited* project. This project acts to enable people with

mental disabilities with the appropriate skills to work and maintain positive work relationships. Additionally, Shamila Ownhouse is one of the founding members of the *Siyanceda* project which trains people with mental disabilities to work in the public work sphere. This is vital to my project, in that, an integral part of equality and access to resources is the availability of employment.

Gadija Koopman is the Deputy Policy Director for Cape Mental Health Society and spoke to me about legislation reform in the Western Cape. She spoke to the reform that has occurred since 1994 and the social policies that have been instituted as a result of the legislation. This interview was important to my research because Gadija Koopman was able to provide insight into the NGO response to government action and the role that NGOs are forced to play in a government system that provides incomplete care.

In order to gain first hand descriptions of the state of legislation reform and healthcare for people with disabilities I interviewed 3 guardians of CMHS consumers who take a primary caretaker role for their family member with a mental disability. Juleiga Harlem and Mymoema Meyer are the parents of people with schizophrenia and Geraldie Shess is the grandmother of a person with epilepsy. This was a productive experience based solely on the fact that I was able to speak with the guardians of consumers and hear about the difficulties that occur in daily life for people with disabilities.

In addition to people associated with Cape Mental Health Society, I was able to speak with Dr. Gates, the Head Psychologist in the Pre-Release Ward at Lentegeur Hospital and Western Cape Rehabilitation Center. This information was vital in my understanding of the internal working of a state hospital after the legislation and policy reform that has taken place. Additionally, the doctor spoke to the shortcomings that exist in staffing and the barriers of language.

## **(2.2) Meetings-**

In order to establish the issues that are truly facing people with mental disabilities I attended several meetings pertaining to activism in the disability community. The first of these meetings was a visit to the *Cape Consumer Advocacy Body*, partially facilitated

by Rene Minnies. This organization represents a means for the people with psychiatric disabilities to advocate for themselves and have a voice to define their own issues.

The Western Cape Network for Disability is an organization that is constructed of representatives from most of organizations that deal with disability, including physical, mental, communication and epilepsy. This organization represents a means to unite the disabled organizations of the Western Cape in order to work together on issues that pertain to all, such as availability and quality of medical resources, transportation, employment and education. This organization also represents, or at least is supposed to, a direct link to the Office on the Status of Disabled Persons, in the Deputy President's office.

I attended a Cape Mental Health Society advocacy planning meeting for people with intellectual disabilities. This meeting was attended by Carol Bosch and Rene Minnies, along with two other social workers from CMHS. This meeting was designed to plan a schedule for the possible implementation for an organization like CCAB (which only advocates on the behalf of people with psychiatric disabilities), but for people with intellectual disabilities. This is a difficult task in that people with intellectual disabilities who, at times, have more trouble verbalizing and comprehending, thus making advocacy on a large public scale a more complicated task. However, it is important to understand there is a spectrum of ability and people with intellectual disabilities need to possess the ability to speak for themselves, instead of "able" people always speaking for them. This meeting was set to define the main problems associated with starting an intellectual disability advocacy group and a timeframe for the possible implementation of this group. This was an important observation to make because the very reasons that a intellectual disability advocacy group would be difficult to start, are the same things that are guaranteed by the constitution and the very notion of equality, such as transportation and human resource development.

#### **(2.4) Visits-**

Another program under the Cape Mental Health Society umbrella of care are the special care homes, for children with intellectual disabilities. The *Erica Special Needs House*, in Mitchell's Plain, represents one of these projects. This visit provided an

abundance of information about the lack of funding and government support that these organizations are receiving, but also indicated the great strides that can be made when people with disabilities are given individual attention. Additionally, I gained a significant amount of insight into the influence that Europe has on the methods of social services, specifically with intellectual disabilities, and how these influences manifest themselves with a limited budget.

The Mitchell's Plain, Philippi and Guguletu Psycho-Social Rehabilitation groups represent entities within the Rainbow Foundation project. The Rainbow Foundation is run by Rene Minnies, utilizing several social workers within each of these communities in order to establish a therapeutic group within close proximity to the consumers' homes. These meetings provided me an opportunity to meet with consumers of CMHS and the Rainbow Foundation in order to better understand the issues facing people with psychiatric disability. Out of these meetings came the unanimous understanding that there is a need for family education, transportation and a sense of community.

Finally, I had the opportunity to visit the ComCare House and the Welcome House which represent a home for people with psychiatric disability, which still falls under the Cape Mental Health Umbrella of Care. The Welcome House is a social organization within ComCare which provides a facility for activities, so that people may leave their house and interact on a social level with their peers.

### **(2.5) Volunteering-**

In addition to these observations I volunteered at the Fountain House. The Fountain House is a work rehabilitation program, exclusively for people with psychiatric disabilities. This model of organization was established in the 1960's United States. It was designed to accommodate an influx of people with mental disability back into the community, who personally felt they needed some assistance in returning as functioning members of society.

This organization offers skills training in order to encourage companies to hire people with mental disabilities. Job training includes a range of skills including basic motor functioning tasks, like cutting paper, to higher levels of responsibility, like reception work (Coles, Tim, "A Day in the Life").

The Fountain House deals exclusively with consumers that have psychiatric disabilities; of these consumers the vast majority are schizophrenic and bi-polar. It is important to note, that in mental health settings it is rare that a person can put their psychosis in a single box, most consumers suffer from multiple illnesses, some of which are derived from the primary illness or as a direct result of the stress associated with the principle diagnosis. Specific definitions and descriptions for schizophrenia and bipolar disorder can be found in Appendix 1.

### **(2.6) Legislation Review-**

In addition to observation and interviews I will be conducting an analysis of legislation reform that has occurred post-1994, specifically pertaining to disability. The legislation analysis will work in combination with the observations that I make at CMHS and additionally will be the main topic of several of my interviews. Some of the important legislation and social policy reform are the following acts and documents.

- The South African Constitution: Chapter 2, Section 9
- The Integrated National Disability Strategy: The White Paper, 1997
- The Employment Equity Act, 1998 (Act. No 55 of 1998)
- The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act. No. 4 of 2000).
- Healthcare 2010

### **(2.7) Literature Review-**

**Dube, Andrew (2005).** *The role and effectiveness of disability legislation in South Africa*  
This document represents a private organization's research on disability legislation that has occurred in South Africa. This document focuses on disability and lists healthcare

and anti-discrimination legislation and talks to policies that affect the lives of people with disabilities.

**Budlender, Geoff (2002). *Basic Needs: Enforcing Constitutional Rights***

Geoff Budlender is a South African political analyst. This article represents a critique of the legislation and judicial decisions which affect the constitutional rights of South Africans. This critique also includes an explanation of the rights that the constitution actually affords the people, and the time frame within which people can expect these rights to actually come to realization. This analysis looks at the Soobramoney judgment which represents a decision that changed or perhaps just enlightened people to the government's responsibility to supply healthcare.

**Prevalence of Disability in South Africa (2001). *South African Census***

This document serves as one of my main statistical reference documents. I used these numbers as the basis of my understanding of the context that exists for people with disabilities in the Western Cape. This document supplies statistical analysis on disability, including race, education, gender and socio-economic status.

**(2.8) Limitations of the Study-**

I would say the greatest limitation of this study was time. I feel as though I was able to conduct a thorough investigation, but only with one organization. While this is a large organization, in order to truly triangulate these issues I would require the time to interview government offices and understand, department by department, the issues that government identifies within the disability realm. Additionally, the purpose of this study was an overall analysis of the state of people with disabilities, but each of these issues could be addressed individually and should be in the future.

**(3) ANALYSIS:-**

**(3.1) Disability Context in the Western Cape-**

It is important to understand the context in which disability is operating and that it is in fact an indicator of "lesser-ness" in South Africa. It is important to understand what

exactly constitutes a disability and what are the numbers associated with this label. In the South African context numbers vary, but consistently remain in the neighborhood of 5-6% disability. This represents approximately 2,255,982 people in South Africa. Of these people, approximately 186,850 are from the Western Cape; the province in which my research will be focusing; focused in combination with national policies and their implementation provincially (South African Census, 2001).

Charlotte Vuyiswa-McClain (2002) asserts that there are in fact three-nations in South Africa. This notion was expressed in response to President Mbeki's 'two nations' speech, concerning the separation that still existed socially and economically in South Africa. Vuyiswa-McClain argues the separation exists because of the unacceptable state of economic and social exclusion. She cites a statistic that reports an 88% unemployment rate of people with disabilities (South African Census, 2001; Swartz and Schneider, 2004).

Within these numbers there are two main categories of disability in South Africa, the first being mental and the second physical. Within the label of mental disability there are two main categorizations, intellectual [developmental] and psychiatric. There is a wide range of physical disability, from paraplegia to blindness. The percentage breakdown is as follows: sight (32.1%), hearing (20.1%), communication (6.5%), physical (29.6%), intellectual (12.4), and emotional (15.7%) (South Africa Census, 2001).

It is accepted by most, including the government, that there is a large population of people who are disabled in one form or the other. I believe it to be important to look at the measures being taken by the South African government and the Western Cape Provincial government in order to create a better situation for people with disabilities within this country.

Gadija Koopman and by the *Executive Summary: The role and effectiveness of disability legislation in South Africa* cite specific legislation, that are principle documents in the promise of equality, for every person and make illegal discrimination based on gender, age, religion, language or disability.

The South African constitution is considered a progressive document which guarantees a country in which every person will have equal access to resources. In

Chapter 2, Section 9 the constitution defines and describes the term equality. “Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken” (South African Constitution, Chapter 2, Sec.9, 2).

**(3.1.1) *Integrated National Disability Policy: The White Paper, 1997***

A direct result of the identification of the inequalities being experienced by the disabled population is the *Integrated National Disability Strategy: White Paper* (1997). Within this document, published by the Deputy President’s Office, an acknowledgment of exclusion exists and subsequently how to eradicate this exclusion from the policies of South Africa. The White Paper identifies the exclusion that exists in the areas of education, healthcare, rehabilitation, barrier free access, transportation, communication, research, employment, human resource development, social security, housing and sport/recreation. In a speech to launch this plan, the Western Cape Premier called this an “enabling strategy that aims to ensure practical and visible change to the lives of people with disabilities at the grassroots level, especially in terms of economic empowerment” (Van Schalkwyk, 2002). All of the things that this policy hopes to encourage are things that were promised in the new constitution. Promises made in section nine guarantee an absence of discrimination and basic human rights for all the people of South Africa.

Additionally, the government paper acknowledges a fundamental problem in how disability is perceived by the public and by the treatment organizations. Use of the medical model creates a system in which people with disabilities are less than those people who are “normal” or well. In this context, the medical model represents the template for care of a person with a disability (The White Paper, 1997). This model would represent the standard treatment for a person, pre-White paper and pre-new legislation. The criticism, or result of the model, is that there is a system of dominance that is established, patient – doctor. The “abled” person taking care of the “sick or disabled” person also establishes an understanding of lesser-ness for the disabled person. Shelly Barry (1998), the former Media Officer for the Office on the Status of Disabled Persons, says that under apartheid the government used the “welfare approach” to helping

people with disabilities. She states that television commercials would play asking for donations to help primarily images of poor and homeless people with disabilities.

As an alternative to the medical model, the social model of care is being encouraged. This social model attempts to dissolve the dominance established in the medical model and utilizes the person in his or her own care and rehabilitation. This social model is based on the autonomy of the consumer in understanding their own best course of action, to sustain participation in the community in which they exist. The White paper (1997) acknowledges this new method of thinking and adopts it as a principle way to “help” people with disabilities. Principle to this model is the understanding that it is not the person that is disabled; it is the context or society that has insufficient means to address his or her own inaccessibility. Meaning it is not the wheelchair that is a disability; it is the stairs to the classroom. It is not the inability to speak that is the disability; it is the schools’ deficiency that they have not developed the means to alternatively communicate (The White Paper, 1997).

Thabo Mbeki, then the Deputy President, gave a speech endorsing the White Paper, as a necessary document in the fight for equality, but also noted that this document is so inclusive that it is impossible to implement all at once. “Apart from the fact of the limitation imposed by the scarcity of resources available to all of us, the Paper envisages a revolutionary overhaul in our approach and our program of action (Thabo Mbeki, October 18, 1997). Thus, the Deputy President endorses the notion of mapping out priorities in the eventual equality of opportunities.

### **(3.1.2) Additional Equality Legislation Analysis**

The promise equal access to resources is the basis for the subsequent legislation, including the Employment Equity Act, 1998, which defines that no discrimination shall legally exist on the basis of disability. Additionally, this document defines a level of employment that is required; meaning a certain number of people with disabilities should be employed, within public and private sector organizations.

The Promotion of Equity and Prevention of Unfair Discrimination Act, 2000, like the name implies promotes a sense of fairness in all areas of life including education and employment. This legislation makes illegal “failing to eliminate obstacles that unfairly

limit or restrict persons with disabilities from enjoying equal opportunities or failing to take steps to reasonably accommodate the needs of such persons”.

Additionally, the South African government has established the *Office on the Status of Disabled Persons*, which is an office that is charged with making sure that the voices of disabled are heard and legislation is properly advocated. This office is also charged with encouraging awareness, public education and mainstreaming equality (The CapeGateWay. com).

The Mental Healthcare Act, 2002, (Act No. 17 of 2002) provides a specific list of rights of consumers and subsequently the requirements of caretakers thereof. This document lists efforts to be made in order to assure that consumers have to opportunity to the necessary amount of healthcare in order to assure their safety and safe rehabilitation. This document also calls for decision making boards to be established at all state mental disability facilities, in order to accurately assess the needs of people admitted into their care.

As a direct result of the White Paper and other anti-disability discrimination legislation derives a structural transition towards social model forms of care. The primary piece of social reform policy in this movement is the *Heath Care 2010* project. This legislation represents the government’s attempt to deal with healthcare in a more personal and efficient manner. Principle to this program is the implementation of a shift to 90% of care being transferred to community health organizations. Only 8% of care would be within a regional hospital and 2% would come from central or academic teaching hospitals. The 90-8-2 theory this stands to create more community care for people with disabilities and reduce the number of chronic disability beds in state hospitals, making more room for South Africa’s free primary care (Vernon de Vries, 2002).

For the purposes of the analysis of legislation and subsequent state of people with disabilities in the Western Cape, I will utilize the South African: *Integrated National Disability Strategy*. This document puts forward basic human rights that every person should have access to; these are things that people with disabilities should be entitled to. I will utilize several of these basic needs for equality in my analysis; (1)education;

(2)transport; (3) employment; (4)healthcare; (5)public awareness; (6)human resource development.

### **(3.2) EDUCATION FOR PEOPLE WITH DISABILITIES**

In an analysis of disability Andrew Dube state that “ a large portion of respondents felt blocked by their lack of education, opportunities and reasonable accommodation which impeded an upward move, and by the inability of management to conceptualise people with disabilities performing any other tasks other than those at junior level” (Dube, Andrew 2005). This includes all forms of disability and means that appropriate means are not being addressed in order to encourage or incorporate special needs people into main stream education. Shamila Ownhouse and Stephan Pretorious reiterated this fact with discussion about the hardships in obtaining employment, which I will discuss later. They state that people with disabilities, intellectual disabilities in this context, are kept in separate schools, if any schools at all, and expected to develop separately. This ultimately sets the disabled person up for being ostracized from the community at large.

There [Cape Town, South Africa], to find a school for disabled students, Matshedisho had to travel far from the city center. He found students of all developmental and skill levels together - whether they were blind or epileptic, mentally retarded or autistic. "They are isolated not only socially," he points out, "but physically as well. And the schools they go to don't prepare them to pursue higher education; they just learn handcrafts. The ones who make it to college are the standouts, and those whose disabilities are not considered severe. People diagnose them just by looking at them, and they think, 'Well, OK, you are not worth higher education (Gehram, Elizabeth, 2002).

This notion is supported by the 2001 South African census which states that only 3 percent of people in higher education are people with disabilities.

Upon visiting the Erica Special Care Center, a school for children with intellectual disabilities, I saw first hand the lack of funding that is allocated to people with disabilities in special education. This school had 30 children, all different intellectual disabilities and 3 staff members. One staff member was

in charge of 12 low functioning adults, also enrolled in the school. This school ran on a budget which derived in part from government subsidy and in part from R70 per month, per child, out of their disability grant.

This school utilized therapeutic methods derived from a German-South African exchange program. The Erica Special Care Center utilized methods such as a calm rooms and hanging toys from the ceiling in order to work on hand-eye training and grabbing things. Additionally, the school had one student, who was so low functioning and violent that she had to be kept separate from the rest of the students. Gwen Rosen, the director of the project, states that more progress has been made with the solitary child in a year, than the rest combined. This success simply hints to the strides in functioning that could be made with the proper funding and subsequent staff allocation.

### **(3.2.1) The Need for Family Education**

In addition to the need for equality in family education, it is a need for the mentally disabled community to have more extensive family training and education. In the Psycho-Social Rehabilitation groups, facilitated under the Rainbow Foundation, each of the members shared stories of how their family was making them feel inadequate because their families did not fully understand the side effects of anti-psychotics. These side effects are an increased appetite and a desire to sleep. When put together these symptoms can create a significant amount of weight gain. Each of the members expressed a great degree of stress in the animosity that has being experienced as a result of their families. While it is a positive situation in which these people can express this stress with a supportive group of their peers, it also identifies a problem with the incomplete or lack of education being done by the people who distribute medication.

The interviews that I conducted with the caretakers of CMHS consumers yielded a similar sentiment, in that they feel as though they have not been educated enough about their child's disability and medication.

### **(3.2.2) Additional Education Legislation Analysis**

The South African Schools Act, 2000, acknowledges the need for a policy that will allow for integration into educational structures. Andrew Dube (2005), from *Disability: Knowledge and Research*, claims that in the Eastern Cape, only .28% of people enrolled in education are disabled, whereas the disability level is approximately 17% for the population. He claims that these trends are similar across provincial lines. This represents a situation in which schools are not advocating for equal access to education, which from the beginning will act as a means to exclude people with disabilities from the work force in the future. From the very beginning, a large number of people with disabilities are being excluded from their very basic constitutional rights.

### **(3.3) TRANSPORTATION**

This issue represents a vital one for people of all disabilities because it is intimately tied to attending school, access work and basic facilities, such as the place in which medication is distributed or the community centers. This issue maybe more than any other is completely different, based on whether a person has a physical or mental disability. The implications of a physical disability make the task of traveling, especially on public transport, much more difficult. However, in my observations and interviews this issue is one that completely crippled the movement of organizations and individuals. In the *Western Cape Network on Disability* meeting a large percentage of the time was spent determining how to mobilize people with disabilities for an event designed to raise awareness about disability. The International Day for Disability on December 3<sup>rd</sup>, 2005 is supposed to represent a day for all of the Western Cape to come together despite any circumstance, but the same people who are supposed to be integrating back into the main stream are the ones having the hardest time attending. This difficulty is primarily a financial matter for people with mental disabilities, it being difficult to hire a taxi on a budget of R780 per month, the maximum disability grant available (Statistics comes from Department of Social Services and Poverty Alleviation). For people with physical disabilities it provides a different problem, in that, you must also find a way to transport your mobilization device, such as a wheelchair or crutches.

Again, my interviews with the parents of the CMHS consumers yielded unanimous concerns as to the lack of transportation. These women state that there is no longer transportation to the state hospitals that they can use in case of a complication or breakdown of their family member with a mental disability. Michelle De Benedictis at the ComCare house echoes this sentiment and states that most of the families they are associated with have found it easier to stay home and deal with a psychotic episode. She states that when they are taken to the hospital the family must provide transport and they will subsequently be released to early, then animosity is created in the home because the family member is upset that they were taken to the hospital in the first place.

### **(3.3.1) Additional Transportation Legislation Analysis**

While transportation is a basic and vital issue for the organizations on the ground, it appears as though the government and provincial legislation are still in the planning stages of reform. The *National Land Transport Strategic Framework* focuses on a means to include people with disabilities in public transportation. On a positive note, this document does acknowledge the different areas that people with disabilities live in, thus makes acknowledgement of the common use of Mini-Bus taxis. This is important simply because it acknowledges areas that encompass much of the disabled population; areas that are less urban. However, a pivotal part of the Western Cape's plan is based on the use of *Dial-a-Ride*. These are buses that the government purchased, which will provide door to door service. These busses are state of the art including wheelchair lifts. These buses however are only for the use of people with physical disabilities, such that only people in wheelchairs can utilize this service. This represents the sentiments that Shamila Ownhouse, at Workshops Unlimited, shared when she referred to programs concerning disability. She states that she feels as though people are more willing to help physical disabilities because you can "see them". Mental disabilities are harder to help because you cannot see a psychiatric disability; you can't identify it just walking down the street. Rene Minnies states that the trains and minibuses are not always conducive to travel for the members of the CMHS with mental disability. A lack of access to affordable transport acts as another form of exclusion from a fully integrated existence and access to social structures. How are people with mental disabilities suppose to fully integrate

socially, if they cannot safely leave their house to maintain interaction in their community?

### **(3.4) EMPLOYMENT**

Employment is a problem all over South Africa, but is especially a problem in the disabled community. A report from the *Inter-Ministerial Committee for Poverty and Inequality* (1998) states that more than 30% of South Africa's workforce is currently unemployed. Unemployment of people with disability hovers around 88%. Shamila Ownhouse claims this to be the result, not only of poor education, but also the stigma associated with people with disabilities. She claims that the stigma is so far reaching that people will go to lengths not to hire people with disabilities.

Many barriers such as wide spread ignorance, fear and stereotypes have caused people with disabilities to be unfairly discriminated against in society and employment (The Code of Good Practice: Key Aspects of the Employment of People with Disabilities, 2002).

The Employment Equity Act, 1998, ensures that there is a penalty or incentive depending on your view point, for not hiring or hiring people with disabilities in your workforce. The legislation requires a certain percentage of your workers have disabilities. This is supposed to be enforced because the company will pay 1% of their total paycheck bill. This money can be reclaimed given the company meets the disability requirements, which is 4% of your workforce according to the act. Shamila Ownhouse and Stephan Pretorius claim that most companies would rather just pay the levy to the Department of Labor, than to bother hiring a person with disability.

In my interview with Shamila Ownhouse and Stephan Pretorius they said that there is a similar system in Germany, only differing in the fact that it is successful. In Germany, people pay a levy to encourage the employment of people with disabilities, but if they forfeit the funds it goes to a Department of Integration. This department will in turn use this money for programs and organizations that are promoting integration of people with disabilities.

Shamila Ownhouse works on the *Siyanceda* project, which as described above strives to place people with mental disabilities into the public work sphere. This project is the very spirit of integration, moving a disadvantaged group into the community to work with the community. In the first phase of the *Siyanceda* program, 23 of 40 participants are now successfully working in the public labor market. However, a very small percentage of this program comes from the government. More than 90% of the funding for this program comes from the charitable organization *Umsobomvu Projects*. Stephan Pretorious claims that they applied to the Department of Labor for subsidy and said it has been a “complete nightmare”. He states the Department of Labor simply doesn’t have the ability, at this point, to adapt their current procedures to allocate money to people with disabilities.

In my meeting with Gadija Koopman, she discussed a program in which the Western Cape Provincial government facilitated in order to promote the provincial strategy for integration of people with disabilities. Upon further research I identified this program as the *Provincial Co-ordination Forum*, which consisted of the Office on the Status of Disabled Persons, the *Inter-departmental Forum* and the *Western Cape Network on Disability*. This group was meant to establish the issues and the implementation of solution related to disability in the Western Cape (CapeGateway.com). She claims this committee originally met once a quarter in 2004 and now has been completely dissolved.

Despite the lack of government intervention the people of CMHS and the *Workshops Unlimited* are making progress, within their own organization, proving that people with mental disabilities have the capacity to perform as workers. The *Workshops Unlimited* has trained people in what they call Life Skills and Work Skills. These two areas represent what CMHS would define as requirements to be an effective worker. Shamila Ownhouse claims that the people who work well in these areas can come to the Workshop and become workers there. The Workshop signs outside-commercial contracts with a range of companies and subsequently employs their own members to perform the work. This work includes packing, folding, gluing and counting. These contracts serve to gain revenue for the project and for the people employed within it, as a subsidy to their disability grants.

Additionally, the Fountain House provides work rehabilitation for people with psychiatric disabilities. This project separates its members into 4 sections, including catering, administrative, paper making workshop and fundraising. These sections work to improve the social and work skills of the members. The Fountain House also offers skill training classes, in which people can come together and talk about interview skills and how to deal with problems in a job. Eventually, some of the members of Fountain House will be placed into jobs, or begin to work with the Workshops Unlimited project.

### **(3.4.1) Additional Employment Equity Legislation Analysis**

The Code of Good Practice: Key Aspects of the Employment of People with Disabilities. This code acts in supplement to the Employment Equity Act, 1998 and serves as a guide for employers to understand and utilize the Equity Act, in terms of serving people with disabilities. This act moves for the “reasonable” accommodation of people with disabilities and promotes the use of Affirmative Action methods, in order to empower a previously disadvantaged group. This code is cited by both Gadija Koopman and Andrew Dube, as an important supplement to understanding the Employment Equity Act of 1998. Businesses however, would still rather pay the levies, rather than make the appropriate modifications to business in order to accommodate people with disability. It is important to note that the issue of renovation in order to accommodate people with disabilities, is more of an issue for people with physical disability, simply because being able to enter the building is key to employment.

### **(3.5) HEALTHCARE**

South Africa provides free primary healthcare to all its citizens, including people with disabilities and those destitute and impoverished. However, the notion of primary healthcare does not mean that the government is required to supply all health care. Geoff Budlender, a South African analyst, claims that the South African government is not required to supply any healthcare, if it can possibly jeopardize the implementation of other policies or projects vital to the constitutional rights of others. When the new constitution was established, it was recognized that there was a large proportion of the population who were not receiving the rights guaranteed. So the stipulation of

“‘reasonable legislative measures, within available resources’ to achieve the ‘progressive realization’ of these rights” was included in the constitution (Budlender, Geoff, 2002).

According to Geoff Budlender (and Gadija Koopman agrees with this notion), the Soobramoney law suit gave the government the legal ability to place a hierarchy on their resources and deny one person or group their right to equality, in order to fulfill another. This notion becomes important when talking about funding in all of the areas mentioned in this analysis. The government must make a choice, especially in healthcare, as to who will receive the resources. This relates back to Thabo Mbeki’s comments, pertaining to having to decide on a hierarchy of importance in terms of steps to be taken for people with disabilities. In that, there are a limited number of resources for all, thus must pick and choose. However, the interconnectedness of all these issues, means that one missing piece, creates a situation in which it is hard to reach equality in the others. For example, if you can get people with disabilities jobs, it doesn’t matter if they are unable to get there because of a lack of accessible transport. Or if you can find companies willing to hire people with disabilities, it makes no difference if there are not sufficient funds allocated to the education, from a primary level, of people with disabilities.

### **(3.5.1) *Healthcare 2010***

The step toward better healthcare that the government took, or tried to take was the *Healthcare 2010* plan. As I discussed previously this document promises more efficient and effective healthcare by moving 90% of services into the community, leaving fewer services required of state hospitals, thus allowing for more technology in the hospitals and more specialized care. This plan includes a cut down on the number of beds located in hospitals, including the number of long term beds in the psychiatric wards; also limiting the number of beds in the psychiatric wards for temporary mental breakdown.

I had the opportunity to speak with Dr. Gates, the head Psychologist at the Pre-Discharge Ward in Lentegeur Hospital, and he bluntly stated that there are several problems with the system at present. He claimed that at this point, because of a lack of beds, people are forced out of the more severe ward and moved to the pre-discharge ward as a result. Additionally, because of this lack of beds, there are a number of people who

are released before they should be in order to make room for the more severe people. These people are then moved back into the communities while possibly still experiencing extreme symptoms.

*The Western Cape: Annual Performance Plan for the Department of Health (2004/2005)* speaks to the changes that will occur as a direct result of the Healthcare 2010 policy. The document states that by 2010 there will be a decrease in chronic disability beds, primarily intellectual disabilities, from 2235 to 1457. To do this there will be a decrease of 114 beds per year, until 2010 (Western Cape, Annual Performance Plan, Department of Health 2004/2005).

Shamila Ownhouse, Gadija Koopman, and Rene Minnies all agree with the notion that this movement seems a bit absurd when considering the effects. This movement forces 90% of the consumers into the community, possibly before they are ready, and overloads the already overwhelmed community staffs, without increasing the amount of government subsidy. This results in more people, but the same amount of money.

Healthcare 2010 also promises step-down care; this ideally is similar to the set-up at Lenteguur Hospital in which a person would ideally be placed in a more severe ward, and then moved to a pre-release ward, and then return to a community organization or home. However, as shown by the comments made by Dr. Gates, it is obvious that this is not happening. In a proposal written by Gadija Koopman, she establishes a plan that would utilize trained caretakers and provide home care until the consumer was actually ready to return to the community care centers. This proposal was given to the Western Cape Department of Health and returned with a very positive response and intense interest. However, she states that they asked her to cut the proposed budget in half for the project. She had proposed a budget of R70, 000 per 3 months. Gadija Koopman states the program would be impossible on a budget of only R35, 000. I proposed the notion that this seems almost to be a form of sabotage, a sabotage of progress. She expressed interest in my phrasing and told me that she will start using the word more often in this context. The notion of government sabotage, intentional or not, is representative of the frustration that NGOs feel when they attempt to facilitate programs to effect real change.

Additionally, resources in the state and community facilities are still lacking when it comes to the area of language barriers. Both Dr. Gates and Rene Minnies talked of the fact that there is a definite language barrier between the facilitators of care and the patients. Dr. Gates claims that there is a lot of psychosis that is missed as a direct result of the limited number of Xhosa translators. Rene Minnies runs the Rainbow Foundation group in Guguletu and claims that language is a barrier. Rene is Afrikaans and English speaking, as are many of the workers at Cape Mental Health Society, with only 3 social workers that can speak Xhosa. This could possibly be tied back to a legacy of the apartheid educational system, thus creating a lack of Xhosa speakers in higher education. Steven Sityo, a Xhosa speaking Social Worker from CMHS, claims that language is a problem. He also supports the notion that is a direct legacy of apartheid, with few Xhosa speakers in higher education.

### **(3.5.2) Medication**

Medication is a significant issue for people with mental illness. Medication can be a life saver in terms of balancing a person's moods and symptoms, but as stated above can also have side effects which can create undue stress. However in talking to the guardians of the consumers from CMHS, I heard that one complaint of the state healthcare system is the distribution of medication. Again tied to the transport issue, their family members must take a taxi to the hospital to pick up their medication, and then must wait in line with the general population for hours at a time in order to receive their medication. Medication in South Africa is free for people on disability grants, so their only expense is the time and money for transport. However, the guardians say that this causes a lot of anxiety for their family members, in that, some of their disabilities do not make waiting in line an easy task. But, my question on the administering of medication did in fact spark a conversation as to the benefits of waiting in line with the general population and whether this act eliminates possible stigma. Personally, I believe that this contributes to the stigma a great deal. I definitely believe that there is a need for integration. I believe there is also a need, possibly unfairly, for the disabled community to distance themselves from the "sick" label and perhaps waiting in line at a hospital is not

the best way to accomplish this. This however is possibly another area for future research and analysis.

An additional issue around medication is the distribution to people with psychosis or psychosis derived from HIV/Aids; what is called 'early onset psychosis'. Dolder, Patterson and Jeste (2004) state that it is known that late stage HIV and early stage Aids can cause psychosis. This psychosis can present itself in many ways but can look similar to schizophrenia and/or severe mood fluctuations. Michelle De Benedictis at the ComCare House states that the South African government is refusing people with psychosis Aids anti-retro-virals. She states that the government will not give medication to people with psychosis as a direct result of their poor adherence to medication. This sentiment is grounded in the sense that there is a fear that a person with psychosis, living independently might fail to adhere to a medication schedule. The Treatment Advocacy Center, in a briefing paper, states that the primary reason that schizophrenics will not take their medication is an absence of acknowledgement of their disorder or problem (Treatment Advocacy Center, 2004).

The fear (on the part of government) of non committal to a medication regiment is a legitimate fear, seeing as there is a need for a 90% commitment needed for Aids anti retro viral medication to be effective (Morna Cornell, Lecture 9-23-2005). However, this policy seems drastic, short sided and counter productive, especially in the case of consumers living in places similar to the ComCare House, in that, not only are they living in an assistance home that could advocate for timely medication consumption, but also it is a policy of places like the ComCare House, that even if a consumer is feeling well, they must continue their prescribed medication to remain in the home.

### **(3.6) PUBLIC AWARENESS**

Public awareness is an issue that directly ties to most of these issues including employment, education and healthcare. The ignorance that the population has concerning disability is what creates a sort of otherness. One example of the need for public awareness is the project started by Cape Mental Health Society called Sexually Abused Victim Empowerment (S.A.V.E.). This program is designed to assist people with intellectual disorders who have been sexually assaulted or raped by care takers, members

of the family, or in cases of random acts. Gadija Koopman states that before this program these cases were not even taken to court and people would not be charged, because police and courts did not know how to deal with people who had intellectual disabilities.

This program works with police, the courts and the victims in order to create a forum in which a victim can testify and implicate her alleged perpetrator. Victims work closely with expert witnesses, psychologists from the Western Cape, who assist in making clear and understanding the testimony of the victim.

Since the implementation of this program, courts are not only beginning to take alleged perpetrators to trial, but intellectual disability cases now have the same conviction rate as the rest of South Africa. Additionally, S.A.V.E., which only exists in the Western Cape, is starting to serve all provinces and has a waiting list for the next year. The courts in the Western Cape now refuse to begin a case dealing with a sexual assault or rape of a person with an intellectual disability, without the intervention of the S.A.V.E. expert testimony. Despite all this, Gadija Koopman states that the S.A.V.E. program still receives no government subsidy. All of the operational funds must be raised by the Cape Mental Health Society.

The Office on the Status of Disabled Persons (OSDP) is in charge of raising issues with government and ensuring that disability continues to be a priority in legislation and discourse. Additionally this office, located in the Deputy President's office, is responsible for utilizing resources to ensure that public education is generated. The OSDP did create six documentaries about people with disabilities to air on public television and educate South Africans as to the state of people with disabilities. However, these films only aired once, and were never shown again, except at international film festivals (Barry, Shelley, 1998). The fact that it occurred is not clear to me, my research has not yielded whether this is a lack of concern, funding or time, but again is an area that further research might be conducted.

The OSDP hopes to eventually create a set of short documentaries to air on public television in hopes of again educating people to the daily lives of people with disabilities, but as far as I have found this has not yet occurred (Barry, Shelley, 1998). These documentaries, at least how they are described, might be more exposed to the general

public and thus be more effective in their message of acceptance and understanding. Again, as far as I have seen, these have not been created, as of yet.

### **(3.7) HUMAN RESOURCE DEVELOPMENT**

The Integrated National Disability Strategy defines ‘human resource development’ as ‘a process which prepares the people of the disabled community to contribute in the economy, in the workplace and in the community’. It suggests programs like vocational rehabilitation, physical and mental rehabilitation and work skills training.

When I asked Shamila Ownhouse and Gadija Koopman if South Africa had a program similar to the one that exists in the United States, they answered no. In the United States vocational rehabilitation consists of funding modification so people with disabilities can return to work including supplying computers, making a business more handicap accessible, supplying important equipment or supplying extra training.

In the Department of Health’s Annual Performance Plan (2004/2005) they make reference to the effect of illness or disability on a person social capital.

Long term illness or disability in particular, may result in an inability to continue with gainful employment, it also results in the inability for individuals to participate in social and community activities, with the subsequent loss of human and social capital (p19, Department of Health, Annual Performance Plan 2004/2005).

This document goes on to state that if the society in which these ill or people with disabilities live institute programs that encourage a community and participation, people will experience lower levels of poverty as a result of their illness or disability. Acknowledging this, there is still a lack of sufficient programs to eliminate the 88% unemployment of people with disabilities and the subsequent loss of “human and social capital”.

#### **(3.7.1) Additional Human Resource Development Legislation**

The Skills Development Act, 1998 represents in part the very desire of the Integrated National Disability Strategy, in that it provides money and learnerships to people with previously disadvantaged backgrounds. However, of the people who

participated in these learner-ships, only 0.1% were disabled in 2003/2004, which was an increase from 2002/2003 (Dube, Andrew, 2005).

Additionally, Andrew Dube states that there has been approximately R18, 272,600 made available to National Skills Funds and National Student Financial Aid Scheme, for the purpose of administering scholarships to people with disabilities.

These allocated funds seem to primarily benefit the younger generations of people with disabilities, leaving the older generation of disabled unaffected. However, improving the education and resources of the younger disabled population could have its benefits in that you are not only educating more people with disabilities, but also more young blacks which will bring more diversity into higher education and employment in the future.

#### **(4) CONCLUSIONS-**

I have drawn several conclusions based on the review of legislation, interviews and observations I have made since beginning this project.

##### **(4.1) *Poor Legislation Implementation***

The first of these is an identification of a consensus that South Africa does possess progressive legislation and laws to promote the equality of people with disabilities, in the Western Cape specifically. Strategies like the *Integrated National Disability Strategy* represent a conscious effort to include people with disabilities as an important consideration of every conversation and in every government organization. However, I believe that it is obvious that the problem does not lie in the legislation, but in the poor implementation thereof. Given the progressive nature of the legislation, in a perfect world, without the history and legacy of the apartheid state and unlimited funding, there is no reason that people with disabilities could not enjoy the full benefits of absolute equality. South Africa is not a perfect place thus has alternative problems which apparently create a situation in which the government cannot focus on solving a single problem, which sometimes means the exclusion of disability from policy reform.

Projects like Healthcare 2010 appear to be in parallel with the direction in which the social model of care seemed to be heading, but in actuality is a step backwards for

quality and availability of care for people with disability; however it seems to be a step forward for people who only need primary healthcare, because of an increase in sophistication and resources. The general population, excluding people with disabilities, is receiving more focused care, but chronic problems like mental disability are being moved aside and not being allocated additional funding.

#### **(4.2) *Funding***

Funding in and of itself is another issue. Implementation can obviously not occur without properly allocated funds. It takes money and effort to make programs work, it takes properly designed infrastructures of management and this seems to be lacking in the actual government intervention. Gadija Koopman's home healthcare proposal, which was accepted but subsequently asked to cut the budget in half, leads me to believe, to a certain point, the government is sabotaging the efforts of the disabled community. As I described above, when government attempts to cut the minimal budget, of a drastically needed proposal, in half, something is wrong. This was a project which was going to rectify one of the greater problems of the Healthcare 2010 policy, but its life was ended because of funding. Additionally, programs like S.A.V.E. are receiving no government subsidy, even though they are supplying a service that is giving raped people with intellectual disabilities a voice. Additionally, the judicial system refuses to go to trial, unless there is the intervention of this program. The other 8 provinces are now utilizing this service, only available in the Western Cape.

#### **(4.3) *Employment Equity Does Not Exist***

Employment also raises an issue in which people of the disabled community will never reach full integration until employment equality is established. People will continue to stigmatize people with disabilities and consider them the "other", until interaction is achieved in an everyday context. The Employment Equity Act claims that the goal of 4% employment of people with disabilities, which make sense logically given that the percentage of people with disabilities generally sits around 6% and the inherent nature of disability means that a certain percentage are not going to be able to work, based solely on extreme disability, however this is why disability grants exist. At this

point, it is estimated that there is less than 1% participation in the economy (Dube, Andrew, 2005). Until policies put forward by legislation are actually enforced, such as levies and penalties for not hiring people with disabilities, integration will not occur and will simply perpetuate poverty and non acceptance. This effects const for the government also, in that, as long as disability unemployment remains around 88%, those people will all be receiving disability grants every month.

**(4.4) *There is a need for Significant Reform in Transportation***

People with disability are not being adequate represented when it comes to transportation reform. An acknowledgment of the special needs of all people with disabilities, not just people in wheelchairs, needs to be made. Programs like *Dial-A-Ride* are a step in the right direction, but exclude the vast majority of people with special transportation needs. An acknowledgement needs to be made concerning the expenses that are incurred by families and consumers in order to retrieve medication and emergency visits, especially since these expenses come from a minimal disability grant, in most cases. Social integration is not possible until a person with a disability has access to all the things that a person without a disability has access too. Meaning a person with a disability should have the ability to travel with ease around the city and utilize all of its services.

**(4.5) *The Situation is Better Now (2005), than it was Under Apartheid***

In several conversations I had with the staff of Cape Mental Health Society, it was stated that things are progressing and are getting better because after the current legislation reform, people with disabilities have the right to these services. They are entitled by the constitution and the subsequent policies and legislation to access all the public resources that South Africa has to offer, despite having a disability. The disabled community must now fight for what is rightfully theirs. I believe that the disabled community has the right to appropriate funding for programs that were suggested by the government. I believe that organizations like Cape Mental Health Society deserve to be rewarded for the excellent level at which they are performing, such as creating a home for mental disability and establishing ground breaking programs like S.A.V.E.

**(4.6) *Are there Actually Resources Available?***

The question must be asked, in a country that is battling with a huge unemployment, HIV/Aids, housing and racial separation, can it really appropriately deal with an issue such as disability. Are there resources available to deal with all of these issues with the inclusion of disability? Gadija Koopman states that she has heard the Minister of Health in the Western Cape make claims that he is trying to address the wide variety of problems with in the medical profession but he can't please everyone. She claims this is a legitimate argument, until they publish the medical spending every year and they are under their proposed budget. Additionally, as cited above, Thabo Mbeki also makes the claim that there are not the resources to give people with disabilities all the rights they are promised immediately.

While I believe that in the current state of affairs the Health Minister's reasoning is understandable, after doing this research I believe that what is needed is an absolute shift in philosophy in addressing disability. I believe, at this point, disability is looked at as one problem, and thus the subsequent solutions are designed to deal specifically with people with disabilities. However, I believe that this problem is complexly intertwined in all the reasons that the health minister is claiming that he can not help the disabled community. Mental disability is partially a result of poor pre-natal care, family abuse, drugs, deprivation and lack of basic needs; all of these things are intertwined in the housing, employment and racial separation in the townships. The lack of education also plays a role in mental illness.

**(4.7) *A Philosophical Change on the Outlook Concerning Disability***

I argue that in order to better serve the people with disabilities in the Western Cape, a shift in philosophy is in order. There is a need for a transition from identifying disability as *just another problem*, to identifying it as a direct result of the already existing problems in South Africa. Thus when trying to assist the disabled community to come out of the *disadvantaged label*, you are not solving a problem, but instead rectifying a wrong. You are rectifying a situation that occurred because of a nation's history. This issue, in terms of reconciliation of the legacies of apartheid, can be looked

at as vital and as important as any other. This is not to say that disability should not be looked at as an independent issue, but must be looked at as a direct result of other problems. This change in philosophy could lead to a better understanding of disability and create a situation in which people are more accepting of allocating funds towards disability causes. Additionally a situation in which every time reform occurs in one of the major areas above, money is also allocated to people with disabilities.

Additionally, this change in philosophy could simply bring the issue of disability into the consciousness of the decision makers in the Western Cape. I feel that because, at this point, disability is looked at as one of many independent issues, it is easy to forget or exclude it from conversations concerning change. However, if it were to be looked at as an issue that derives from the other major problems, it could be more easily interjected into every conversation on legislation and budget allocation reform

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- 30) The National Land Transport Strategic Framework, 2000
  
- 31) The Mental Healthcare Act, 2002 (Act No. 17 of 2002)

**(5.3) Interviews-**

- 32) Dr. Gates, Lentegur Hospital and Western Cape Rehabilitation Center (November 21, 2005): Problems that Exist in the State Hospital Setting

- 33) Juleiga, Harlem, Mymoema, Meyer & Geraldie, Shess (Guardians of CMHS consumers) (November 24, 2005): Caretaker Perspective on the State of Assistance in the Western Cape
- 34) Koopman, Gadija (November 30, 2005): Cape Mental Health Society Policy and South African Disability Legislation
- 35) Minnies, Rene (November 17, 2005): Psycho-Social Rehabilitation
- 36) Ownhouse, Shamila (November 29, 2005): Employment and Work Skills Training
- 37) Pretorious, Stephan (November 29, 2005): Employment and Work Skills Training
- 38) Sityo, Steven (September 21, 2005) Project Visit Day.

#### **(5.4) Observations-**

- 39) Cape Consumer Advocacy Body (November 14, 2005). Meeting at the Fountain House.
- 40) Western Cape Network for Disability (November 15, 2005). Meeting at Reable Center, Athlone, Cape Town.
- 41) Advocacy Planning Meeting for Intellectual Disabilities (November 17, 2005) Meeting at Cape Mental Health Society.
- 42) Erica Special Needs House (November 21, 2005) Observation at Mitchell's Plain House.

- 43) Mitchell's Plain Psycho- Social Rehabilitation Group (November 21, 2005)
- 44) Phillipi Psycho-Social Rehabilitation Group (November 21, 2005)
- 45) Guguletu Psycho- Social Rehabilitation Group (November 21, 2005)
- 46) ComCare House and Welcome House (November 16, 2005)
- 47) Fountain House (November 11-December 2, 2005)
- 48) Workshops Unlimited and the Siyanceda Project (November 29, 2005)

## APPENDIX 1

Schizophrenia is an Axis I psychiatric disability. Generally the onset of symptoms will occur between the ages of 15 and 35. There are two types of symptoms associated with schizophrenia, 'positive' and 'negative'. The 'positive' symptoms that are added to the person, such as voices, delusions, false senses of smell and touch. 'Negative' symptoms are things that are taken away from the person, such as motivation or concentration.

There are multiple possible causes for schizophrenia, including birth defects, genetic make-up, stress, family problems, childhood deprivation or abuse and drugs.

If a person were to be deprived or avoid treatment there could be several effects. Suicide rates are extremely high in schizophrenics, as well as a possible increase in severity of symptoms (The Royal College of Psychiatrists, 2004).

Bipolar disorder is also an Axis I psychiatric disability. This disability consists of major mood fluctuation, from mania to depression. Mania or a manic episode consists of increased energy, a feeling of euphoria, an inability to concentrate and denial of disorder. Depressive episodes consist of lack of positive attitude, extreme guilt, sleep too much or none at all, chronic pain, and helplessness. These symptoms will generally work in a cycle, such that a person will go from a relatively normal state into a mania, then into a depression. The timeframe of these cycles varies from person to person.

Similar to schizophrenia there is a consensus that bipolar disorder has no specific cause, but instead is due to a combination of multiple factors. These factors include birth defects, genetics and environment. The current accepted treatment for bipolar disorder is a mood stabilizer to be taken consistently, not only when experiencing mania or depression. Medication acts to somewhat prevent severe fluctuations in mood (Spearing, Melissa, 2003).

Again it is important to note while schizophrenia and bipolar disorder are the two most common psychiatric diagnoses at Cape Mental Health and Fountain House, this is not the only disability that the Western Cape is dealing with. Additionally, there are a wide range of intellectual [developmental] disabilities that Cape Mental Health Society also advocates for. This is an important distinction because every disability has a different stigma attached and creates different difficulties in different areas of life.