A Retrospective Analysis of Factors Used to Assess Fitness to Stand Trial in Adult Male Defendants Referred for Psychiatric Observation

By

Dr Candice Jacobson

Submitted to the University of Cape Town
In partial fulfilment of the requirements for the degree MMed Psychiatry
Faculty of Health Sciences
University of Cape Town

Date of submission: 14.12.2016

Supervisor: Professor Sean Kaliski
Department of Psychiatry and Mental Health
University of Cape Town

Table of Contents

Page

Declaration

I, Candice Jacobson, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the university to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signed: Signed by candidate

Date: 16.12.2016

Abstract

Background. A court orders a forensic observation of a defendant to determine a defendant's fitness to stand trial and/or ability to appreciate wrongfulness of action (criminal responsibility) at the time of the alleged offence. Fitness to stand trial is the focus of this review rather than criminal responsibility. In this instance, the court requests an expert to determine whether the defendant's current mental state would significantly impair his or her ability to participate meaningfully in his or her own trial. In South Africa, this process involves multiple assessments by a multidisciplinary forensic psychiatry team in a dedicated forensic psychiatry unit. However, at present no standardised format has been adopted for such an evaluation, the findings of which may have dire consequences for the individual being assessed. Furthermore, there is a paucity of current literature on fitness to stand trial evaluation.

Objectives. To establish whether fitness to stand trial is adequately assessed in the Western Cape, South Africa. A further objective is to establish whether mental illness is the sole factor that differentiates defendants fit to stand trial from those who are found not fit to stand trial, and whether defendants with mental illness are less likely to be asked the relevant questions to determine fitness to stand trial than those without mental illness.

Methods. A descriptive, retrospective review was conducted (via the application of a checklist) of clinical records of the last 100 male defendants' ≥18 years of age admitted to the Valkenberg Hospital Forensic Psychiatry Unit prior to March 2015.

Results. 30 defendants (30%) were found to have a psychiatric diagnosis. Of the 30 defendants, all were noted to have a serious mental illness (mostly psychotic disorder or cognitive impairment) and were found not fit to stand trial. Seventy (70%) of the defendants were found fit to stand trial by the expert panel. From the findings, it was noted that the forensic team asked and recorded the necessary factors to determine fitness to stand trial in 56% of the study population (based on frequency of responses: n = 894), with 32% of questions not appearing to have been addressed at all (especially those pertaining to role players in court and a defendant's understanding of his rights). Furthermore, various questions appeared to have been indirectly addressed in fewer than 50% of defendants. No significant difference was noted in how the forensic team conducted its assessments between those defendants found to have a serious mental illness and those without serious mental illness.

Conclusion. The results of the study suggest the need for a more in-depth review of the forensic evaluation process in the Western Cape to further ascertain the benefits of using a checklist during the evaluation process. Furthermore, additional research would assist in determining the factors contributing to a number of questions not having been addressed and the consequences thereof.

Key words: fitness to stand trial, competence to stand trial, evaluation, ethics, South Africa

Acknowledgements

I would like to express my sincere gratitude to my supervisor Prof Sean Kaliski, for his endless patience and continuous support throughout this labour-intensive MMed process. It has been a privilege to work with him and he has been a source of awe and inspiration throughout my time as a registrar.

My sincere thanks go to Mr Chris Fortuin, the senior administrative officer in the Valkenberg Forensic Psychiatry Unit. Without his helpfulness and efficiency, this project would not have been possible.

A special thank you to Ms Ushma Galal, the statistical consultant who assisted with my data analysis.

Last but not least, I would like to thank my family for their unwavering support throughout my academic career. I truly acknowledge not only how challenging it has been but also that I could not have achieved this without them.

List of Tables

Page

List of Figures

Chapter 1 Introduction and Literature Review

Introduction

The South African prison system is overcrowded.[1] Defendants awaiting forensic assessment and a court date regarding the outcome of the assessment further overwhelm the system. While undergoing forensic evaluation, a defendant may be held in a forensic psychiatry unit for up to 30 days (known as the '30-day observation period'), unless an extension is applied for and granted. Consequently, forensic psychiatry units are also overwhelmed, resulting in further delays in the legal system and a significant cost burden on the state.[2–4]

The forensic evaluation process in South Africa[5]

Fig. 1. outlines the process used to evaluate the fitness to stand trial of awaiting trial prisoners South Africa.

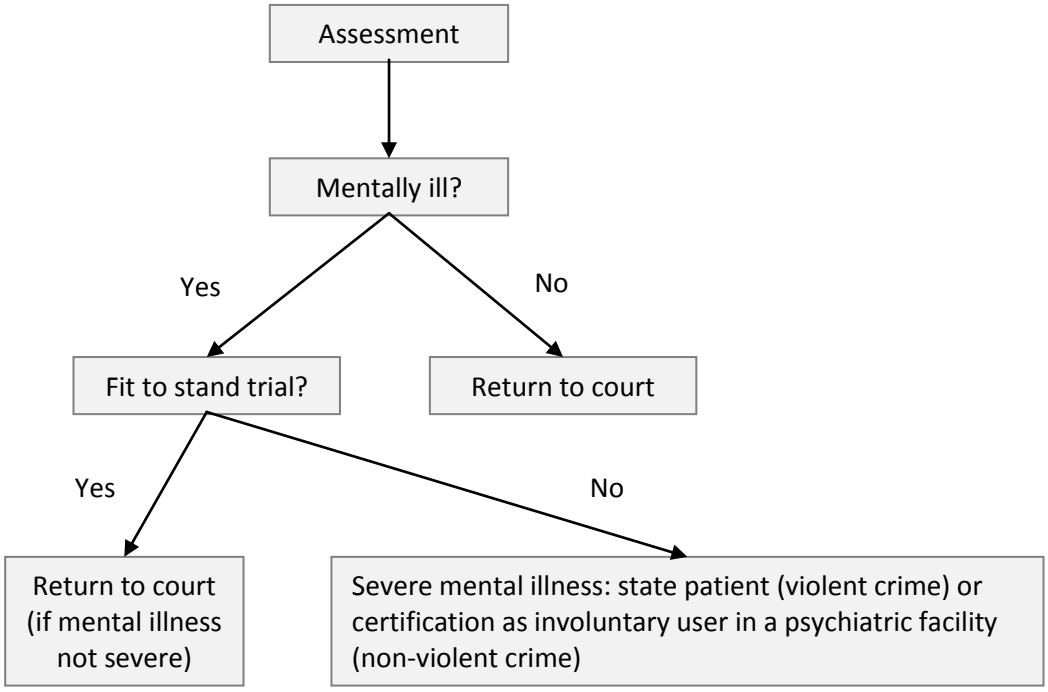


Fig. 1. Forensic evaluation process in South Africa

In South Africa when a defendant is referred by the court for a forensic observation, he or she undergoes multiple assessments by the multidisciplinary forensic psychiatry team (MDT), which usually includes psychiatrists, psychologists, social workers, occupational therapists and nursing staff, to determine whether a mental illness or defect, or other factor could have

an impact on fitness to stand trial (also referred to as competency to stand trial) and criminal responsibility.[5]

Fitness to stand trial is the focus of this review rather than criminal responsibility (see appendix III for useful definitions). It should also be noted that the MDT only makes a recommendation to the court regarding the fitness of the defendant to stand trial. Ultimately, however, determining competency to stand trial is a legal decision, although in most cases the court accepts the expert's findings.[6]

South Africa currently has 10 observation units.[7] This review examines the forensic observation process at Valkenberg Hospital's forensic psychiatry unit, which services the Western Cape and parts of the Northern Cape.

During the defendant's observation period, the MDT observes his/her behaviour, functioning and social interactions daily. A forensic psychiatry registrar conducts an in-depth interview with each defendant referred for observation. Prior to the interview, the registrar reviews all the relevant court documents pertaining to the case. At some point during the defendant's stay, additional information from family members may be sought. The case is then presented at a ward round with the forensic team where the findings and the individual's case is discussed further. In addition, the defendant is called into the team meeting to be interviewed by a consultant forensic psychiatrist. The final report to the court represents the consensus of the team.[5] No assessment scale/instrument is used to determine competency to stand trial; an entirely clinical approach is adopted**.**

In the United States (US), where most of the research in this field has been conducted, a number of tools have been developed over the past 40 years intended to address a defendant's competency to stand trial and to help standardise the process.[8]

These include informal checklists, self-report questionnaires, sentence-completion tasks and interview based techniques.[9] It is thought that use of such an instrument may improve efficiency and reduce subjectivity when conducting forensic assessments in South Africa. To date, little research has been conducted in South Africa on competency to stand trial. Furthermore, minimal change to the forensic system has occurred since the end of the apartheid era.[2]

As evident from the flow chart in Fig. 1, if found to have an active, severe mental illness (mostly refers to psychotic illness or cognitive impairment), the defendant is usually regarded as unfit to stand trial.[5] However, this may not stand true for all such defendants. No recent study exploring this question has been conducted in South Africa; particularly with regards to comparing competency between mentally ill and non-mentally ill defendants referred for forensic evaluation.

In the US, competency restoration programmes exist.[6] In the United Kingdom, a defendant with a mental disorder may be referred for psychiatric treatment to restore fitness to plead.[10] In South Africa, however, once a defendant is found unfit to stand trial, he or she is usually no longer afforded the opportunity to proceed to court. The defendant with a mental illness is either made a state patient indefinitely under section 42 of The Mental Health Care Act (MHCA) 17 of 2002 (reserved for violent crimes) based on a balance of probabilities or trial of fact (see appendix III for useful definitions), or referred to a psychiatric in-patient facility for involuntary psychiatric treatment under chapter V of the MHCA (reserved for non-violent crimes).[11] In certain instances, where the defendant develops a mental illness following the alleged crime and is expected to recover, or where the illness was found not to have affected the defendant's ability to appreciate the wrongfulness of his or her actions at the time of the alleged offence, he or she may be sent for treatment and then referred for a repeat forensic assessment thereafter.[5,12] However, this is the exception, rather than the rule. Assessment of fitness to stand trial can therefore lead to indefinite certification, and if not performed systematically, may result in an unethical use of psychiatry.[4,6,10,13] Without a programme in place to restore competency, the defendant is sometimes denied a fair trial.[2]

Furthermore, in the South African setting, defendants found not to have a mental illness/defect or other factor influencing competency to stand trial are sent back to court assuming fitness. However, such defendants may be totally ignorant of the court proceedings due to limited levels of education rather than mental illness.[2,4]

The above evidence questions the current competency assessment in South Africa, highlighting the need for a review of the process.

Literature Review

Objectives

1. To determine what data exists regarding evaluation of fitness to stand trial in South Africa and abroad.
2. To determine gaps in the evidence base and what research is required with regards to evaluating fitness to stand trial in South Africa.

Literature search strategy

A search of PubMed and PsychINFO was carried out as well as a search through Google Scholar for any recent publications. In addition, the broad legal database, LexisNexis, was scanned for additional relevant data. Other literature was accessed by searching the reference lists of key articles and via personal communication or supervisor recommendation. The original search was carried out in January 2014 and updated in September 2015. See appendix IV for a flow diagram of the search strategy used.

The following search terms and subject headings were used:

1. Competenc* to stand trial OR Fitness to stand trial OR fitness to plead
2. Evaluation
3. 1 AND 2
4. Ethics
5. 3 AND 4
6. South Africa
7. 5 AND 6

Inclusion criteria

1. English language.
2. Review or original articles studying competency to stand trial and related factors in South Africa and abroad.
3. Literature dating back to the 1960s due to both historical relevance and the current global dearth of literature on the topic.

Exclusion criteria

1. Foreign language literature.
2. Content pertaining to females and adolescents in the context of competency to stand trial.

Quality criteria

A dearth of good quality evidence is available relating to fitness to stand trial and the evaluation process thereof. Consequently, the search strategy included all relevant literature ranging from meta-analyses and systematic reviews to guidelines, books and even opinion pieces, as such articles provide an expert perspective on the topic in question.

Summary of the literature

Historical context

In South Africa, the 'special verdict' was instituted in 1891,[14] and it was the first time the justice system had made concessions for the mentally ill in criminal law. The defendant, although found guilty, was declared to have been insane at the time of committing the crime. The court then had the discretion to sentence the person to an appropriate detention facility.

In 1953, a South African case led to the formulation of the equivalent of the British M'Naghten rules.[14] This meant that a person would not be punishable for a crime if, at the time of committing the offence, they were suffering from a disease of the mind or mental defect interfering with the ability to determine the nature of their behaviour or appreciate wrongfulness or ability to control impulses.

Following the assassination of Prime Minister H. F. Verwoerd in 1964 by a man found to have paranoid schizophrenia, the Rumpff Commission was appointed in 1966 to inquire into responsibility in relation to 'mentally deranged persons and related matters'.[15] Based on the evidence from a vast number of psychologists, psychiatrists and lawyers, the commission's recommendations were incorporated into chapter 13 of the Criminal Procedures Act, 51 of 1977 (CPA), which is still in use today and forms the basis for referring a defendant to determine fitness to stand trial in South Africa.[5] Section 77 of the CPA addresses fitness to stand trial while section 78 addresses criminal responsibility.[16]

As mentioned previously, most of the research conducted on fitness to stand trial has taken place in the US. The origins of fitness to stand trial in the US, also known as adjudicative competence, are derived from nineteenth century English common law.[17] The current American construct of fitness to stand trial, however, was largely defined by the Supreme Court's landmark decision in the case of *Dusky vs. US*.[18] In this decision, the Supreme Court determined that to be fit to stand trial, the defendant must be able to consult with his or her lawyer rationally and that he or she should have an understanding of the proceedings against him or her:

'…the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him.'[19]

In 1993, Bonnie[20] expanded on the Dusky Criteria claiming that in addition to rational understanding, the defendant should demonstrate decisional competence. This refers to the ability to make decisions autonomously during the legal proceedings against the defendant.

In England and Wales, the origins of fitness to stand trial, also referred to as fitness to plead, can be traced back to the fourteenth century.[21] However, it was not until the eighteenth century, following the landmark case of *R vs. Pritchard,* that the construct of fitness to plead emerged.[21] The Pritchard Criteria were the result, and they have remained unchanged for more than 150 years. They are as follows: the ability to plead, to understand evidence, to understand the court proceedings, to instruct a lawyer and knowing that a juror can be challenged.[21] These criteria do not, however, consider decisional competence unlike the Dusky Criteria.

Resource drain

In many provinces in South Africa, waiting lists are lengthy to determine fitness to stand trial and criminal responsibility among defendants.[22,23] Consequently, delays occur in the criminal justice system as the defendant's trial cannot continue until the assessment has been performed. Time from charge to forensic observation may even be years, which makes the assessment particularly challenging in terms of establishing criminal responsibility as it refers to competency at the time of the alleged offence.[22]

In March 2010, the nationwide waiting list for forensic observation assessment in South Africa included 735 defendants for a total of 168 beds in 11 institutions.[23] One province recorded a waiting time of 15 months to observation.[23] Between April 2012 and March 2013, 197 defendants were referred for observation to Valkenberg Hospital Forensic Unit in Cape Town, South Africa, (per personal communication with Professor S. Kaliski, head of the Valkenberg Forensic Psychiatry Unit, Dec 2013). During the year, the waiting list for observation varied between 150–160 individuals due to inadequate beds for adequate turnover. The defendant could wait for up to one year to be admitted to Valkenberg for observation. The figures are currently standing at approximately 240 observation evaluations per annum with a minimum waiting time of approximately 9 months (per personal communication with Professor S. Kaliski, head of the Valkenberg Forensic Psychiatry Unit and Mr Chris Fortuin, senior administrative officer Valkenberg Forensic Psychiatry Unit, Sept 2015). The waiting time has since decreased slightly due to an increase in the number of observation beds from 15 to a minimum of 20 at any given time (per personal communication

Mr Chris Fortuin, senior administrative officer Valkenberg Forensic Psychiatry Unit, Sept 2015).

In 2013, the Forensic Mental Health Service database in the Western Cape had just over 800 state patients with at least 4 new state patients being admitted monthly.[2] Discharging a state patient is extremely laborious and time consuming with few community resources available to meet the stringent discharge criteria.

In mid-2016, the South African population stood at 55.91 million.[24] At a local meeting of the South African Society of Psychiatrists, South African Psychiatrist, Dr Eugene Allers, reported that as at March 2016, South Africa had 670 psychiatrists of whom approximately 40% work in state. Of the 40%, few are involved in forensic services, which further compounds the long delays in the observation process.

In addition to the burden of the forensic observation on resources and waiting times, the process also places a significant cost burden on the state. Prior to 2015, the cost per defendant for the required 30-day stay in hospital was reported to be R30 000.[20] In 2015, the cost of accommodating a defendant for observation stood at R3 622 per day, which equates to R108 660 per 30 days (per personal communication with Mr Chris Fortuin, senior administrative officer Valkenberg Forensic Psychiatry Unit, Sept 2015).

Despite the above evidence, the last identified study in South Africa exploring ways of addressing the burden of the fitness to stand trial assessment was conducted in 1996. Calitz et al.[25] developed a list of criteria to determine 'trialability' based on the opinions of 298 experts in the field, including judges, magistrates, advocates, forensic psychiatrists and psychologists. These experts were asked to complete a questionnaire on the subject and from the questionnaire, a list of the relevant criteria was drawn up. These criteria were then applied by means of a structured clinical interview to 100 observation cases at Oranje Hospital, Bloemfontein. The MDT evaluated the same 100 participants for trialability in the forensic unit. The results of the two evaluation procedures were then compared and marked similarities were noted. The researchers determined that the rating criteria were just as reliable as the MDT assessment. Therefore, they concluded that by applying this single rating method, both cost and time could be saved.[25] However, the criteria were not formally validated and the sample size was limited. While promising, the results of the study indicated the need for further research in this area before adopting the use of such criteria over an MDT assessment.

Further exploration into the use of specific criteria or other means of improving the evaluation process in South Africa has not been published to date.

In the US, it was noted that in 1998 and 2000, the estimated annual number of evaluations for fitness to stand trial for each year was approximately 50 000 (total population estimated to be 270 248 million) and 60 000 (total population estimated to be 281 421 906 million) respectively.[6] Another study reported that approximately 2% to 8% of all criminal defendants were referred for competency evaluation in the US. Of those referred, 10% to 30% were found incompetent to stand trial.[18] A more recent publication reported that in the Forensic Psychiatry Clinic of Bellevue Hospital in New York City, 1 200 to 1 500 defendants are evaluated annually for fitness to stand trial.[26]

The above highlights the significant burden the forensic assessment places on the forensic systems in both South Africa and the US and the limited research conducted in this field.

The evaluation process

No gold standard exists for evaluating fitness to stand trial, either in South Africa or abroad. As Mossman et al.[27] point out, this may be an issue when offering expert testimony in that the court may question the accuracy of the assessment. In addition, the ultimate finding of fit or not fit to stand trial carries significant consequences for the defendant.

In the US, a number of tools have been developed over the past 50 years intended to address a defendant's competency to stand trial and to help standardise the process.[8] These include checklists, self-report questionnaires, sentence-completion tasks and interview-based techniques.[9] In 1965 Robey[28] created a checklist to ensure that all the relevant legal and psychiatric questions were asked when assessing competency to stand trial. He has been credited with developing one of the first standard methods for competency assessments.[9] In 1971, Lipsett et al. went on to develop the competency screening instrument, a sentence-completion tool.[9] This was then complemented by the Competency to Stand Trial Assessment Instrument developed in 1973.[9] Since then a number of other assessment instruments have emerged. However, the degree to which these instruments are used varies state by state, with no standardised format existing for assessing competency.[6]

A number of studies conducted in the US have examined the various competency assessment instruments.[6, 9,18, 29, 30] One such review, conducted by Rogers and Johansson-Love[30] and published in 2009, examined three competency assessment tools regarding their relevance in aiding evidence-based practice when evaluating fitness to stand trial. The instruments

included the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA), the Evaluation of Competency to Stand Trial-Revised (ECST-R) and the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR). They concluded, in accordance with the American Academy of Psychiatry and Law Practice (AAPL) Guideline and other literature, that evidence-based practice cannot be achieved regarding fitness to stand trial assessments without integrating the use of standardised measures with clinical interview and other data obtained.[6, 9,30] In one of the few meta-analyses conducted in this field, Pirelli et al.[8] compared a number of competency instruments with the use of traditional psychological tools for evaluating fitness to stand trial. The specific competency instruments demonstrated a larger effect size, although they did report that this finding was based on limited data and recommended further research in this area.

Mossman et al.[27] attempted to quantify examiner accuracy when assessing fitness to stand trial by applying statistical methods. The findings, published in 2009, showed evaluators to be very accurate but, due to a number of study limitations, advised viewing this finding with caution.

Gowensmith et al.[31] noted that little research had been conducted on the reliability of field evaluators determining fitness to stand trial. Most of the research had focused on instrument reliability. Thus, between 2007 and 2008, they undertook to review 216 cases referred to determine competence to stand trial in Hawaii and being evaluated by 3 independent clinicians. The aim of the study was to examine the extent to which the evaluators were in agreement/disagreement regarding the defendant's competence to stand trial. They found that there was moderate agreement amongst the evaluators regarding competence. They suggested the use of instruments to evaluate fitness to stand trial to standardise the process, improve reliability among evaluators and enhance training. In contrast, a similar study undertaken by Murrie et al.[32] in 2008, which examined clinician variation in findings of competence to stand trial, found that the rates of incompetency varied considerably among evaluators (0% to 62%). They acknowledged that a number of explanations could account for this and recommended further research.

Ryba and Shealy[33] examined the role of research in creating change to the process of forensic evaluations determining competence to stand trial. This research followed the findings of another study in which it was evident that reports of competence to stand trial issued from a forensic hospital in the state of Alabama were not addressing all the key elements of competence as required by the statutes of the state. These findings were similar to

the results of other studies. The hospital involved conducted an internal review and implemented changes to its evaluation process. The effects of these changes, explored by Ryba and Shealy,[33] were found to have improved the evaluations conducted, thus highlighting the benefits of research on clinical practice. The long-term objective of this MMed project would be to effect a change in clinical practice in the Valkenberg Hospital forensic psychiatry unit should the findings of this review suggest the need.

All the literature mentioned above is from the US. No recent studies have examined the role of competency screening instruments for determining fitness to stand trial in the South African setting. Furthermore, no published research explores the reliability and accuracy of clinical fitness to stand trial evaluations in South Africa to date.

The effect of mental illness on fitness to stand trial

A study conducted in South Africa by Kaliski, Boncherds and Williams[4] between 1996 and 1997 looked at the understanding and expectations of defendants referred to Valkenberg Hospital for 30-day observation regarding their charges and upcoming trial. They found that defendants had a good understanding of court procedure and wrongfulness. Mentally ill subjects differed only in their ability to distinguish between a guilty and a not guilty plea. However, the presence of mental illness was found to have a negative impact on competence to stand trial as well as criminal responsibility. To date no similar study has been replicated in South Africa.

Various international studies evaluating the role of mental illness in competency to stand trial have found that the presence of a psychiatric condition, in particular a psychotic illness, has a significant bearing on a defendant's fitness to stand trial.[6,29,34,35] One such study found that the presence of a psychotic disorder, or organic or intellectual disorders were strong predictors of incompetence when compared with demographic or criminal variables.[36]

A meta-analysis of competency to stand trial research found strong evidence to suggest that defendants with a psychotic disorder were eight times more likely to be found not fit to stand trial than those without a psychotic disorder diagnosis.[8] A more recent retrospective review directly explored the differences between those defendants found to be competent to stand trial and those found incompetent.[26] Their results showed psychotic symptoms to be inversely associated with fitness to stand trial. However, the sample size was small and the findings were based on the administration of the Brief Psychiatric Rating Scale which was not designed for this purpose.

In contrast to the above evidence, some literature suggests that defendants with mental illness, particularly psychosis, are not necessarily incompetent to stand trial.[37,38] However, as with the South African study cited above, the evidence is not robust and the research is outdated.

Ethical issues related to fitness to stand trial

Various ethical issues come to light when evaluating fitness to stand trial. Weinstein[13] highlights the fact that the competency assessment usually takes place before the defendant's trial, making the assessment really only a predictor of whether or not the individual will be able to participate in the trial. This suggests that although the defendant may be found competent/incompetent to stand trial at the time of the assessment, this could change at a later stage. In the South African context, however, the defendant is rarely offered a re-evaluation. The US offers competency restoration programmes and the United Kingdom allows a defendant with a mental disorder to be referred for psychiatric treatment to restore fitness to plead.[6,10] However, this may also lead to the involuntary detention and treatment of those awaiting trial with a resultant delay in their trial until such time as they are found to be competent.[39] Furthermore, it should be considered that referral for inpatient competency assessment temporarily deprives those defendants granted bail of their freedom while awaiting trial.[39]

In South Africa and abroad, the consequences of a competency assessment are a significant burden for the evaluator, especially if the nature of the crime is violent (for example, assault, murder, rape).[5,27] As mentioned previously, a defendant charged with a violent offence and found not fit to stand trial is likely to be made a state patient.[5] This involves indefinite certification in a state psychiatric facility. On the other hand, if such a defendant is found fit to stand trial, he or she may face a lengthy prison sentence if found guilty of the offence. Other countries (for example, certain states in the US) have the death penalty. Thus, competency to stand trial evaluation allows little room for evaluator error; yet this process is not standardised.

With the focus on integrating mental health patients into the community, there is a shortage of facilities to accommodate those patients who warrant longer-term institutional care. A recent South African study points out the possibility that charges are being laid against a person with mental illness by family members as a desperate attempt to seek help for their ill relative due to a completely overwhelmed mental health care system,[12] thereby unnecessarily burdening the forensic system. Similarly, in Canada the literature has suggested that the fitness to stand

trial evaluation is perhaps misused by psychiatrists to obtain treatment for defendants who would not otherwise gain access to psychiatric services.[40] However, a systematic review of the literature published in 2010 found evidence contradicting this hypothesis.[29]

The same South African study referred to above also found that the majority of defendants charged with a violent crime and referred for assessment were referred by their attorney due to being unable to consult with the defendant.[12] Of this group, 78% were ultimately found competent to stand trial. It was speculated that the referral may have been a tactical move by counsel in an attempt to defend a difficult case,[12] thus adding further burden to, and abusing an already overloaded forensic psychiatry and legal justice system. Another possible explanation is that defence attorneys are often overwhelmed. Consequently, they may refer a defendant for psychiatric evaluation in the hope of gaining time to prepare the case.

Other ethical considerations include the fact that evaluating fitness to stand trial conflicts with the traditional role of medical practitioners as defined by the Hippocratic Oath. When evaluating competence to stand trial, the primary goal is to aid the justice process as opposed to relieving the pain and suffering of others.[6] Furthermore, confidentiality is key to the usual physician-patient relationship, yet this is severely limited in the forensic setting.[6]

Identifying gaps in the evidence base

From a review of the literature available on fitness to stand trial, there is a clear need globally for further research in this field.

In South Africa in particular, insufficient evidence is available that explores the adequacy of the evaluation process. Research into methods of reducing the burden of the observation referral in terms of waiting times, trial delays and cost on the forensic system should be conducted. There is also a paucity of data evaluating the variables influencing fitness to stand trial among defendants. Furthermore, no studies address the ethical issues that arise as a result of the evaluation process.

While research into fitness to stand trial has been conducted internationally over the years, particularly in the US, there is a distinct lack of recent data. This is despite the resources consumed by evaluating competency to stand trial. For example, the only guideline on the subject was last published in 2007, the American Academy of Psychiatry and the Law (AAPL) Practice Guideline.[6] Also in 2007, Mackay[41] argued for the construct of fitness to plead in the United Kingdom to be reviewed as the Pritchard Criteria dictating competence do not include decisional capacity as the Dusky Criteria do in the US. Furthermore, the United

Kingdom lacked a guideline equivalent to the AAPL Practice Guideline and there appeared to be a lack of interest in developing an instrument to aid with the assessment of fitness to plead.[41] From the review of the literature, it appears that no significant progress has been in made in these areas since then.

Aims and objectives

The study aims to determine, via the application of a checklist, whether all the necessary questions pertaining to fitness to stand trial have been addressed and recorded by the forensic psychiatry team during a defendant's forensic evaluation performed at Valkenberg Hospital's forensic psychiatry unit. The checklist (see Appendix I) was based on the Competency Screening Tool (an established screening tool used to screen competency to stand trial) plus various checklists for assessing fitness to stand trial, and was adapted to the South African forensic setting.[5, 28, 42]

The following was hypothesised:

- A checklist is a useful tool to aid in determining fitness to stand trial.
- The forensic psychiatry team is more likely to find defendants with a history of severe mental illness not fit to stand trial.
- The assessment of defendants with severe mental illness does not differ significantly from those without mental illness in terms of fitness to stand trial.

The primary objective is to establish whether fitness to stand trial in the Western Cape is adequately assessed. A further objective is to establish whether mental illness is the sole factor differentiating defendants fit to stand trial from those who are found not fit to stand trial, and whether those defendants with mental illness are less likely to be asked the relevant questions to determine fitness to stand trial than those without mental illness.

References

1. Department of Correctional Services (RSA). Annual Report 2015/2016 [Internet]. Available from: http://www.dcs.gov.za/docs/ [Accessed 21 February 2017)].
2. Kaliski S. Does the insanity defence lead to an abuse of human rights? Afr J Psychiatry. 2012;15(2):83, 85, 87.
3. Kaliski S. Reinstitutionalization by stealth: the Forensic Mental Health Service is the new chronic system. Afr J Psychiatry. 2013;16(1):13–17.
4. Kaliski SZ, Borcherds M, Williams F. Defendants are clueless – The 30-day psychiatric observation. South African Med J. 1997;87(10):1351–1355.
5. Kaliski S. (ed.) Psycholegal Assessment in South Africa. 1st ed., Cape Town: Oxford University Press; 2006.
6. Mossman D, Noffsinger SG, Ash P et al. AAPL Practice Guideline for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law. United States; 2007;35(4 Suppl):S3-S72.
7. Janse van Rensburg B. The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector. South African J Psychiatry. 2012;18(3):133–148.
8. Pirelli G, Gottdiener WH, Zapf PA. A meta-analytic review of competency to stand trial research. Psychol Public Policy, Law. 2011;17(1):1–53.
9. Zapf PA, Viljoen JL. Issues and considerations regarding the use of assessment instruments in the evaluation of competency to stand trial. Behav Sci Law. 2003;21(3):351–367.
10. Exworthy T. Commentary: UK perspective on competency to stand trial. J Am Acad Psychiatry Law. 2006;34(4):466–471.
11. South African Government. Mental Health Care Act, 17 of 2002.
12. Schutte T, Subramaney U. "Single" v. "panel" appointed forensic mental observations: Is the referral process ethically justifiable? South African J Bioeth Law. 2013;6(2):64.

13. Weinstein HC. Psychiatry on trial: clinical and ethical problems in the psychiatric assessment of competency to stand trial. Ann N Y Acad Sci. (United States); 1980:347:12–19.

14. Kruger A (ed.). Mental health law in South Africa. Durban: Butterworth; 1980.

15. Rumpff Commission. Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters. Government Printer; 1967.

16. South African Government. Criminal Procedure Act, 51 of 1977.

17. Fitch WL. AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial: an American legal perspective. J Am Acad Psychiatry Law. 2007;35(4):509–513.

18. Dawes SE, Palmer BW, Jeste DV. Adjudicative competence. Curr Opin Psychiatry. 2008;21(5):490–494.

19. Dusky v. United States, 362 U.S. 402. 1960.

20. Bonnie RJ. Dusky v Drope. 1993;539–602.

21. Rogers TP, Blackwood NJ, Farnham F, et al. Fitness to plead and competence to stand trial: A systematic review of the constructs and their application. J Forens Psychiatry Psychol. Rogers, T. P. 2008;19(4):576–596.

22. Pillay AL. Competency to stand trial and criminal responsibility examinations: are there solutions to the extensive waiting list? South African J Psychol. 2014;44(1):48–59.

23. Mars M, Ramlall S, Kaliski S. Forensic telepsychiatry: a possible solution for South Africa? Afr J Psychiatry. 2012 Jul;15(4):244–247.

24. Statistics South Africa [Internet]. Available from: http://www.statssa.gov.za/ [Accessed 16 November 2016]

25. Calitz FJ, van Rensburg PH, Oosthuizen H, et al. Criteria for fitness to stand criminal trial. S Afr Med J. 1996;86(6 Suppl):734–737.

26. Lee E, Rosner R, Harmon R. Mental illness and legal fitness (competence) to stand trial in New York State: expert opinion and criminal defendants' psychiatric symptoms. J Forensic Sci. American Academy of Forensic Sciences; 2014 Jul;59(4):1008–1015.

27. Mossman D, Bowen MD, Vanness DJ, et al. Quantifying the accuracy of forensic examiners in the absence of a “gold standard”. Law Hum Behav. 2010;34(5):402–417.

28. Robey A. Criteria for competency to stand trial: a checklist for psychiatrists. Am J Psychiatry (United States); 1965 Dec;122(6):616–623.

29. Fogel M, Schiffman W. Ten Year Research Update (2001–2010): Evaluations for Competence to Stand Trial (Adjudicative Competence). Behav Sci law. 2013;31:165–191.

30. Rogers R, Johansson-Love J. Evaluating competency to stand trial with evidence-based practice. J Am Acad Psychiatry Law. 2009;37(4):450–460.

31. Gowensmith WN, Murrie DC, Boccaccini MT. Field reliability of competence to stand trial opinions: How often do evaluators agree, and what do judges decide when evaluators disagree? Law Hum Behav. 2012 Apr;36(2):130–139.

32. Murrie DC, Boccaccini MT, Zapf PA, et al. Clinician variation in findings of competence to stand trial. Psychol Public Policy, Law. American Psychological Association; 2008;14(3):177–193.

33. Ryba NL, Shealy RC. Narrowing the gap: How a research intervention influenced clinical forensic practice. J Forensic Psychol Pract. US: Haworth Press; 2007;7(1):19–36.

34. Stafford KP, Wygant DB. The role of competency to stand trial in mental health courts. Behav Sci Law. 2005;23(2):245–258.

35. James DV, Duffield G, Blizard R, Hamilton LW. Fitness to plead. A prospective study of the inter-relationships between expert opinion, legal criteria and specific symptomatology. Psychol Med. 2001 Jan;31(1):139–150.

36. Warren JI, Murrie DC, Stejskal W, et al. Opinion formation in evaluating the adjudicative competence and restorability of criminal defendants: a review of 8,000 evaluations. Behav Sci Law. 2006;24(2):113–132.

37. Roesch R, Eaves D, Sollner R, et al. Evaluating fitness to stand trial: a comparative analysis of fit and unfit defendants. Int J Law Psychiatry. 1981;4(1–2):145–157.

38. Ohayon MM, Crocker A, St-Onge B, et al. Fitness, responsibility, and judicially ordered assessments. Can J Psychiatry. 1998;43(5):491–495.

39. Hoge SK, Poythress N, Bonnie R, et al. Mentally ill and non-mentally ill defendants' abilities to understand information relevant to adjudication: A preliminary study. Bull Am Acad Psychiatry Law. 1996;24(2):187–197.

40. O'Shaughnessy RJ. AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial: a Canadian legal perspective. J Am Acad Psychiatry Law. 2007;35(4):505–508.

41. Mackay RD. AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial: an English legal perspective. J Am Acad Psychiatry Law. 2007;35(4):501–504.

42. Lipsitt PD, Lelos D, McGarry AL. Competency for trial: a screening instrument. Am J Psychiatry (United States); 1971 Jul;128(1):105–109.

Chapter 2 Publication-Ready Manuscript

Prepared for submission to the *South African Journal of Psychiatry*

A Retrospective Analysis of Factors Used to Assess Fitness to Stand Trial in Adult Male Defendants Referred for Psychiatric Observation

Department of Psychiatry and Mental Health

University of Cape Town

South Africa

Candice Jacobson, MBBCh (Wits), DCH (SA), DMH (SA), FC Psych (SA)

Correspondence: Dr CI Jacobson, Department of Psychiatry and Mental Health, UCT, Groote Schuur Hospital, Anzio Road, Observatory, Cape Town, 7925, South Africa

Telephone: +27 21 650 1641

Email: candyjacobson2003@yahoo.com

Abstract

Background. A court orders a forensic observation of a defendant to determine a defendant's fitness to stand trial and/or ability to appreciate wrongfulness of action (criminal responsibility) at the time of the alleged offence. Fitness to stand trial is the focus of this review rather than criminal responsibility. In this instance, the court requests an expert to determine whether the defendant's current mental state would significantly impair his or her ability to participate meaningfully in his own trial. In South Africa, this process involves multiple assessments by a multidisciplinary forensic psychiatry team in a dedicated forensic psychiatry unit. However, at present no standardised format has been adopted for such an evaluation, the findings of which may have dire consequences for the individual being assessed. Furthermore, there is a paucity of current literature on fitness to stand trial evaluation.

Objectives. To establish whether fitness to stand trial is adequately assessed in the Western Cape, South Africa. A further objective is to establish whether mental illness is the sole factor that differentiates defendants fit to stand trial from those who are found not fit to stand trial, and whether defendants with mental illness are less likely to be asked the relevant questions to determine fitness to stand trial than those without mental illness.

Methods. A descriptive, retrospective review was conducted (via the application of a checklist) of clinical records of the last 100 male defendants' ≥18 years of age admitted to the Valkenberg Hospital Forensic Psychiatry Unit prior to March 2015.

Results. 30 defendants (30%) were found to have a psychiatric diagnosis. Of the 30 defendants, all were noted to have a serious mental illness (usually psychotic disorder or cognitive impairment) and were found not fit to stand trial. Seventy (70%) of the defendants were found fit to stand trial by the expert panel. From the findings, it was noted that the forensic team asked and recorded the necessary factors to determine fitness to stand trial in 56% of the study population (based on frequency of responses: n = 894), with 32% of questions not appearing to have been addressed at all (especially those pertaining to role players in court and a defendant's understanding of his rights). Furthermore, various questions appeared to have been indirectly addressed in fewer than 50% of defendants. No significant difference was noted in how the forensic team conducted its assessments between those defendants found to have a serious mental illness and those without serious mental illness.

Conclusion. The results of the study suggest the need for a more in-depth review of the forensic evaluation process in the Western Cape to further ascertain the benefits of using a checklist during the evaluation process. Furthermore, additional research would assist in determining the factors contributing to a number of questions not having been addressed and the consequences thereof.

Key words: fitness to stand trial, competence to stand trial, evaluation, ethics, South Africa

Introduction

The South African prison system is overcrowded.[1] Defendants awaiting forensic assessment and a court date regarding the outcome of the assessment further overwhelm this system. While undergoing forensic evaluation, the defendant may be held in a forensic psychiatry unit for up to 30 days (known as the '30-day observation period'), unless an extension is applied for and granted. Consequently, forensic psychiatry units are overwhelmed, resulting in delays in the legal system and a significant cost burden on the state.[2–4]

The forensic evaluation process in South Africa[5]

Fig. 1. outlines the process used to evaluate the fitness to stand trial of awaiting trial prisoners South Africa.

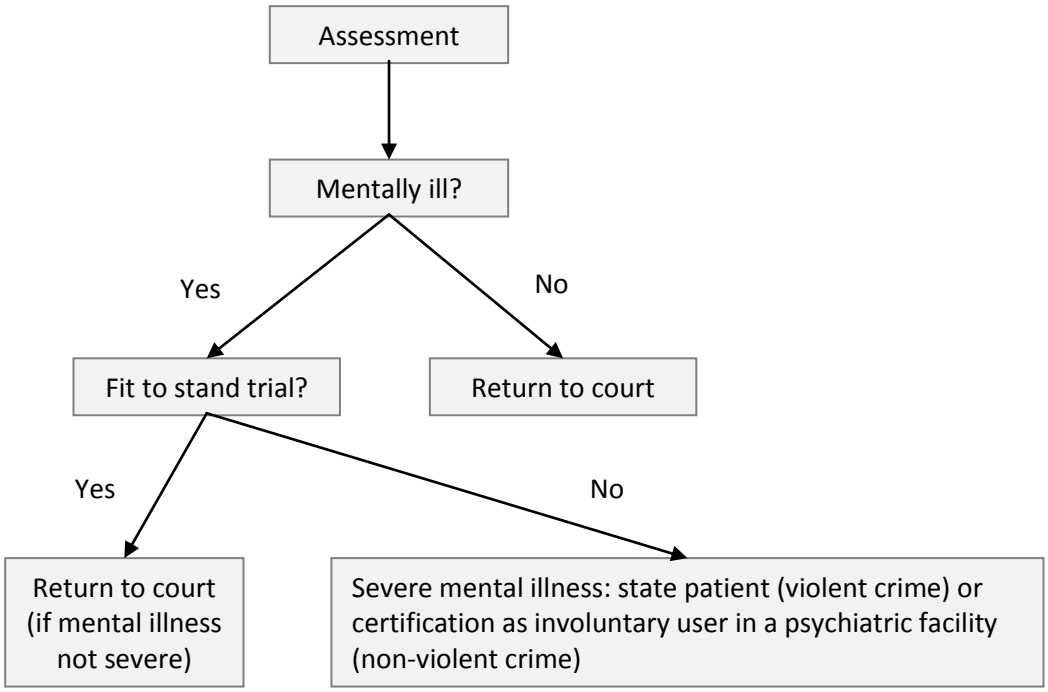


Fig. 1. Forensic evaluation process in South Africa

In South Africa, when a defendant is referred by the court for a forensic observation, he or she undergoes multiple assessments by the multidisciplinary forensic psychiatry team (MDT), which usually includes psychiatrists, psychologists, social workers, occupational therapists and nursing staff, to determine whether a mental illness or defect, or other factor could have an impact on fitness to stand trial (also known as competency to stand trial, and refers to current mental competence) and criminal responsibility (mental competence at the time of the alleged offence).[5] The focus of this review is fitness to stand trial rather than criminal responsibility (see appendix III for useful definitions).

South Africa currently has 10 observation units.[6] This review examines the forensic observation process at Valkenberg Hospital's forensic psychiatry unit, which services the Western Cape and parts of the Northern Cape.

During a defendant's observation assessment, the MDT observe his behaviour, functioning and social interactions daily. A forensic psychiatry registrar conducts an in-depth interview with each defendant. Prior to the interview, the registrar reviews the relevant court documents pertaining to the case. At some point during the defendant's stay, additional information from family members may be sought. The case is then presented at a ward round with the forensic team where the findings and the individual's case are discussed further. In addition, the defendant is called into the team meeting to be interviewed by a consultant forensic psychiatrist. The final report to the court represents the consensus of the team.[5] No assessment scale/instrument is used to determine competency to stand trial; an entirely clinical approach is adopted.

In the United States (US), where most of the research in this field has been conducted, a number of tools have been developed over the past 40 years intended to address a defendant's competency to stand trial and to help standardise the process.[7] These include informal checklists, self-report questionnaires, sentence-completion tasks and interview based techniques.[8] It is thought that the use of such an instrument may improve efficiency and reduce subjectivity when conducting forensic assessments in South Africa. To date, little research has been conducted in South Africa on competency to stand trial. Furthermore, there has been minimal change to the forensic system since the end of the apartheid era.[2]

As evident from the flow chart in Fig. 1., if found to have an active, severe mental illness (mostly refers to psychotic illness or cognitive impairment), the defendant is usually regarded as unfit to stand trial.[5] However, this may not stand true for all such defendants. No recent study exploring this question has been conducted in South Africa, particularly with regards to comparing competency between the mentally ill and non-mentally ill defendant referred for forensic evaluation.

In the US, competency restoration programmes exist.[9] In the United Kingdom a defendant with a mental disorder may be referred for psychiatric treatment to restore fitness to plead.[10] In South Africa, once a defendant is found unfit to stand trial he or she is usually no longer afforded the opportunity to proceed to court. The defendant with a mental illness is either made a state patient indefinitely under section 42 of The Mental Health Care Act (MHCA)

17 of 2002 (reserved for violent crimes) based on a balance of probabilities or trial of fact or referred to a psychiatric inpatient facility for involuntary psychiatric treatment under chapter V of The MHCA (reserved for non-violent crimes).[11] In certain instances, where the defendant develops a mental illness following the alleged crime and is expected to recover, or where the illness was found not to have affected the defendant's ability to appreciate the wrongfulness of his or her actions at the time of the alleged offence, he or she may be sent for treatment and then referred for a repeat forensic assessment thereafter.[5,12] However, this is the exception, rather than the rule. Assessment of fitness to stand trial can thus lead to indefinite certification, and if not performed systematically may result in an unethical use of psychiatry.[3,9,10,13] Without a programme in place to restore competency the defendant is sometimes denied a fair trial.[2]

Also to be considered: in the South African setting those defendants found not to have a mental illness/defect or other factor influencing competency to stand trial are sent back to court assuming fitness. However, such defendants may be totally ignorant of the court proceedings due to limited levels of education rather than mental illness.[2,3]

The above evidence questions the current competency assessment in South Africa, highlighting the need for a review of the process.

This study aimed to determine, via the application of a checklist, whether all the necessary questions pertaining to fitness to stand trial are addressed and recorded by the forensic psychiatry team during a defendant's 30-day observation period with the primary objective of establishing whether fitness to stand trial in the Western Cape is adequately assessed. A further objective was to establish whether mental illness is the sole factor that differentiates between defendants fit to stand trial and those found not fit to stand trial, and further, if those defendants with mental illness are less likely to be asked the relevant questions to determine fitness to stand trial than those without mental illness.

Methods

Study design and sample characteristics

The study was conducted at Valkenberg Hospital Forensic Psychiatry Unit in Cape Town, Western Cape. It involved a retrospective review of clinical records of the last 100 male defendants' ≥18 years of age admitted to the unit for forensic observation prior to March 2015. Females were excluded as too few women are admitted to the unit, which precludes

meaningful comparisons. Adolescent defendants were also excluded as referred cases are usually managed through a different system.

A descriptive analysis was undertaken, via the application of a checklist, to determine whether all the necessary questions pertaining to fitness to stand trial were addressed by the forensic psychiatry team during the defendant's observation. The checklist (see Table 1.) was based on the Competency Screening Tool (an established screening tool used to screen competency to stand trial) plus various checklists for assessing fitness to stand trial, and was adapted to the South African forensic setting.[5,14,15] The data collected via the checklist was also used to establish whether mental illness was the sole factor differentiating defendants fit to stand trial from those found not fit to stand trial, and whether those defendants with mental illness were less likely than those without mental illness to be asked the relevant questions. In addition, the analysis included an examination of the profile of the defendants for greater understanding of the study population.

Data Source

Data were sourced from the admission register, the clinical notes made during the observation period and the final forensic observation report. Information collected regarding the profile of each defendant included demographic data (age, marital status, years of education, employment status at time of offence, and living situation at time of offence), psychiatric and substance use history, criminal history and the finding of the expert panel in terms of fit or not fit to stand trial (see appendix II). The checklist (see Table 1.) included questions to determine whether the defendant understands the nature of the charges against him and if his plea is logical. Also included were questions addressing the defendant's comprehension of the court proceedings as well as his appreciation of wrongfulness (what he understands about the charges and his role in the alleged crime). Each checklist question was given a score from 0 to 2, where 0 = no mention of the factor in the file; 1 = some (indirect) reference to the factor (e.g., insufficient reference to the factor in question); 2 = factor asked and answer recorded in the file.

Table 1. Fitness to stand trial checklist[2,14,15]

Question		Scores: 0 = no mention of factor at all in file; 1 = some (indirect) reference to factor; 2 = factor asked and answer recorded in file		
Charge and Plea				
1.	Does the defendant know what charge has been laid against him?	0	1	2
2.	How will the defendant plead, guilty or not guilty?	0	1	2
3.	Does the defendant understand the difference between a guilty and not guilty plea?	0	1	2
4.	Does the defendant understand what will happen if he is found guilty?	0	1	2
5.	Does the defendant understand what will happen if he is found not guilty?	0	1	2
Comprehension of Court Proceedings				
6.	Does the defendant know what a trial is?	0	1	2
7.	Does the defendant know his rights? (i.e., to trial, to be represented by legal counsel, to protection against self-incrimination)	0	1	2
8.	Does the defendant understand the role of a magistrate?	0	1	2
9.	Does the defendant understand the role of a prosecutor?	0	1	2
10.	Does the defendant understand the role of a defence lawyer?	0	1	2
11.	Does the defendant know what a defendant is?	0	1	2
12.	Does the defendant know what a witness is?	0	1	2
Appreciation of Wrongfulness (patient's account and quality thereof)				
13.	What does the defendant understand about the charge against him?	0	1	2
14.	Does the defendant think the alleged offence is wrong?	0	1	2

Question		Scores: 0 = no mention of factor at all in file; 1 = some (indirect) reference to factor; 2 = factor asked and answer recorded in file		
15.	What does the defendant understand about his stay in the observation unit?	0	1	2
16.	Does the defendant think he has a mental illness?	0	1	2
Total score each column				
Overall total				

Ethical considerations

Ethics approval for the study was granted by the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee. Institutional approval was granted by the Chief Executive Officer of Valkenberg Hospital and the Western Cape Health Research Committee. The study was conducted in accordance with the Declaration of Helsinki.[16] There was no direct contact with defendants at any stage of the research. The data was collected anonymously by allocating a number to each participant folder, thereby preserving confidentiality.

Data analysis

The data were analysed by the Department of Statistical Sciences at the University of Cape Town, using the latest version of SPSS statistical software. Data were categorised by fit to stand trial and not fit to stand trial. Descriptive analyses of the data were performed.

Summary statistics were estimated including means and standard deviations, medians and interquartile ranges for continuous variables; and frequencies and percentages for categorical variables. The data was also represented visually (using bar charts for categorical variables).

For univariate comparisons of categorical variables, chi-squared tests were used. For comparing numerical variables, correlations were applied.

Results

Demographic data

The mean age of the study population was 30 years (range 18 to 74; SD = 9.1). Most of the defendants were single (83%), had completed less than 12 years of education (range 1 to 14 years; mean = 8 years; SD = 2.5), were unemployed (85%) and were not living a vagrant lifestyle at the time of the alleged offence (85%).

Psychiatric data

Only 30 defendants (30%) were found to have a psychiatric diagnosis and all 30 of these defendants were noted to have a serious mental illness (psychotic disorder or cognitive impairment). However, despite this minority, 57% of the study population had received treatment for a psychiatric condition in the past. A history of substance misuse/abuse was prominent (89%), with cannabis emerging as the most frequently used substance (75%), followed by alcohol (64%), methamphetamine (61%) and methaquolone (59%). Most of the defendants were reported to have used a combination of these substances (14% – 1 substance; 11% – 2 substances; 33% – 3 substances; 31% – 4 substances).

Criminal data

Of the defendants' whose clinical records were reviewed 13% had undergone a prior forensic observation to determine fitness to stand trial. 43% had previously been charged. 60% were charged with a violent crime (e.g., rape, assault, sexual assault, murder, attempted murder).

Findings of the expert panel

The overwhelming majority (70%) of defendants were found to be fit to stand trial. Of the defendants diagnosed with serious mental illness (30%), all were found 'Not fit to stand trial'. A chi-square test was then performed which examined the relationship between the presence of serious mental illness and being found 'Not fit to stand trial'. The relationship between these variables was significant, x^2=86.4, df1, $p \leq 0.001$.

The relationship between the nature of the current charge and fitness to stand trial was also examined. Of those found fit to stand to stand trial, 49 (70%) had been charged with a violent crime (rape, assault, sexual assault, attempted murder, murder). In comparison, those found not fit to stand trial had largely been charged with a non-violent crime (n=19, 65.5%). The

relationship between fitness to stand trial and nature of the charge appears to be significant (x^2=9.6, df1, p ≤0.002). Refer to Fig. 2.

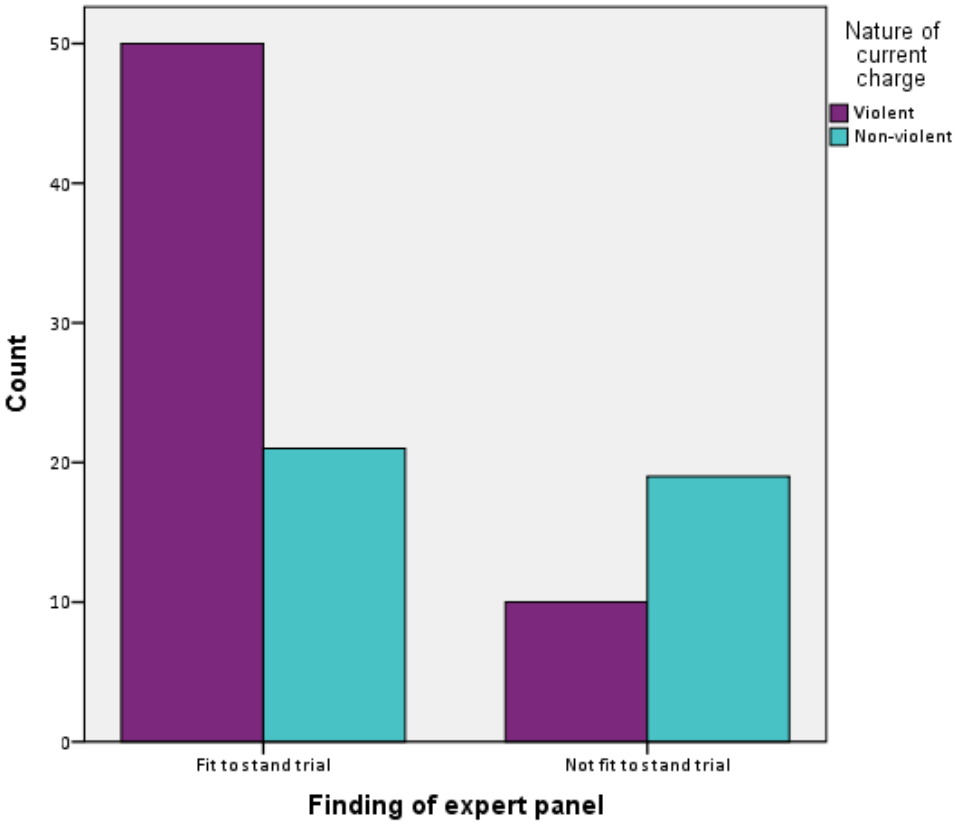


Fig. 2. Bar chart to show fitness to stand trial and nature of the charge

Checklist data

The checklist data refers to the data elicited from the implemented checklist (see Table 1.). It is evident that the forensic team asked and recorded the necessary factors for 56% of the study population (based on total number of factors asked and answers recorded: n = 894). However, the team did not appear to address certain questions (based on total number of factors with no mention at all in the file: n = 504, 32%).

Table 2. and Fig. 3. illustrate the extent to which the forensic team was noted to have asked the specific questions necessary to determine fitness to stand trial and recorded the defendants' responses in the file. The questions addressed particularly well (in >90% of defendants) included questions about charge, plea, wrongfulness and understanding of the reason for observation. In comparison, questions pertaining to verdict, role players in court, court proceedings and defendant rights appear to have been addressed in fewer than 50% of the study population or not at all.

Table 2. Checklist questions summarised in terms of factor asked and answer recorded

	n*
Does the defendant know what charge has been laid against him?	99
What does the defendant understand about the charge against him?	99
Does the defendant think the alleged offence is wrong?	98
What does the defendant understand about his stay in the observation unit?	92
How will the defendant plead, guilty or not guilty?	86
Does the defendant understand the role of a magistrate?	84
Does the defendant understand the role of a defence lawyer?	84
Does the defendant think he has a mental illness?	80
Does the defendant understand the difference between a guilty and not guilty plea?	67
Does the defendant understand the role of a prosecutor?	49
Does the defendant understand what will happen if he is found guilty?	47
Does the defendant understand what will happen if he is found not guilty?	5
Does the defendant know what a witness is?	4
Does the defendant know what a trial is?	0
Does the defendant know his rights?	0
Does the defendant know what a defendant is?	0

*n also represents the percentage as the sample size is 100

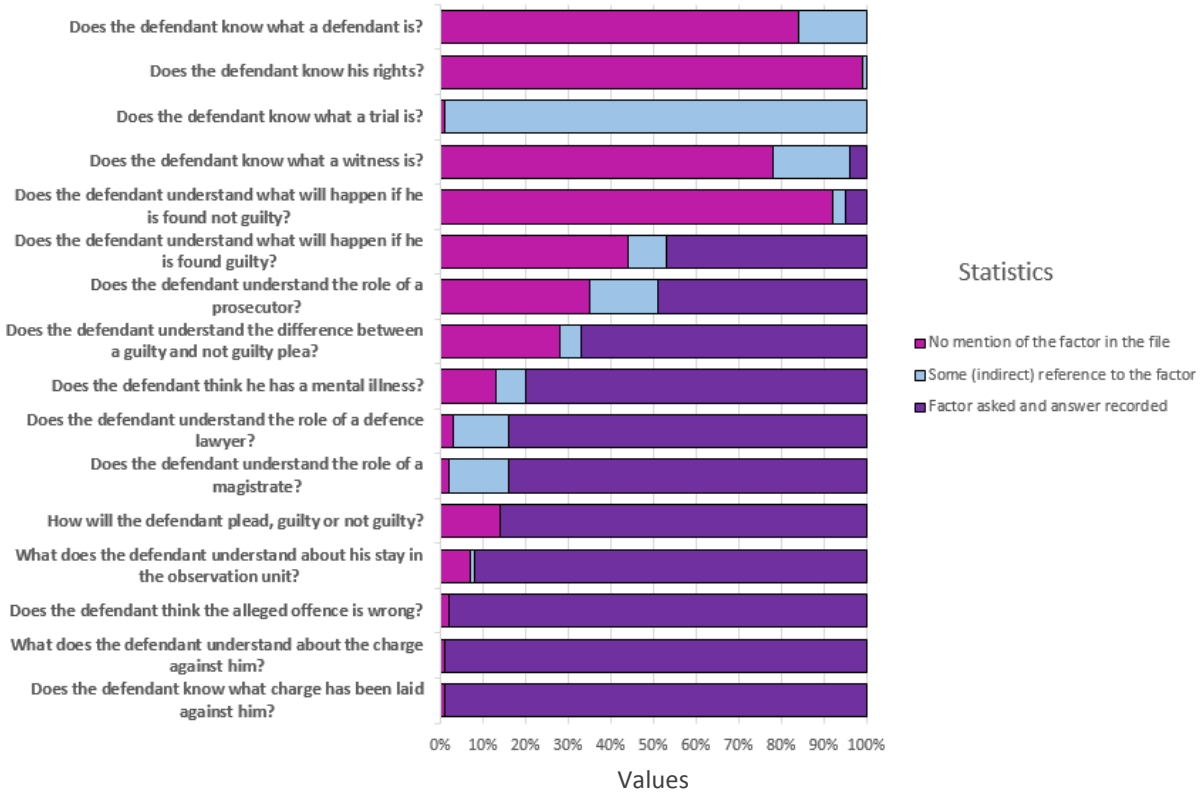


Fig. 3. Bar graph representing the extent to which the forensic team was noted to have asked the necessary questions to determine fitness to stand trial and recorded the defendants' responses in the file

There appear to be slight differences in the way the forensic team performed its assessments between defendants found to have a serious mental illness and those without serious mental illness as evidenced by Table 3. However, these differences were not thought to be of significance.

Table 3. Checklist questions: asked and answer recorded, comparing those with serious mental illness and those without

	With serious mental illness (N=30) n (%)	Without serious mental illness (N=70) n (%)
Does the defendant know what charge has been laid against him?	30 (100)	70 (100)
What does the defendant understand about the charge against him?	30 (100)	70 (100)
Does the defendant think the alleged offence is wrong?	30 (100)	68 (97)
What does the defendant understand about his stay in the observation unit?	29 (97)	63 (90)

	With serious mental illness (N=30) n (%)	Without serious mental illness (N=70) n (%)
How will the defendant plead, guilty or not guilty?	26 (87)	60 (86)
Does the defendant understand the role of a magistrate?	26 (87)	58 (83)
Does the defendant understand the role of a defence lawyer?	25 (84)	59 (84)
Does the defendant think he has a mental illness?	26 (87)	55 (76)
Does the defendant understand the difference between a guilty and not guilty plea?	17 (57)	50 (71)
Does the defendant understand the role of a prosecutor?	15 (50)	34 (49)
Does the defendant understand what will happen if he is found guilty?	13 (43)	34 (49)
Does the defendant understand what will happen if he is found not guilty?	2 (7)	3 (4)
Does the defendant know what a witness is?	0 (0)	4 (6)
Does the defendant know what a trial is?	0 (0)	0 (0)
Does the defendant know his rights?	0 (0)	0 (0)
Does the defendant know what a defendant is?	0 (0)	0 (0)

Discussion

As the results revealed, the forensic team asked and recorded the necessary questions in 56% of the cases, with 32% of questions not appearing to have been addressed at all. These results can possibly be accounted for by a number of factors; for example, the lack of a standardised format for evaluating fitness to stand trial and/or simple omissions or deficiencies in the current system. Another likely explanation is that after asking one or two questions it may have been evident that the accused lacked competency to stand trial, therefore eliminating the need for further questioning. Unfortunately, it is not possible to make significant comparisons to current literature due to the lack of similar studies both locally and abroad. However, one US study published in 2007 on fitness to stand trial evaluation was driven by the fact that there appeared to be missing data required by state statutes to determine fitness to stand trial.[17] This is in keeping with the above findings. The objectives of the aforementioned study were then to review the evaluation process following the implementation of training and standardisation of the interview and report formats. Significant improvements were noted. Therefore, based on the results of the latter study together with the findings of this review, the

use of a standard checklist appears to be a useful tool to aid in determining fitness to stand trial, as was hypothesised. Further research is required to validate such an instrument before it is implemented.

Further to the above findings, it was determined that certain questions did not appear to have been addressed at all by the forensic team, for example, the defendant's understanding of a trial, his rights or the role of a defendant and witness. Reasons for this are unclear due to the dearth of comparative studies. It can only be postulated that such questions are more abstract than concrete, making them difficult to address with a population that has a significant substance use history and a mean of 8 years of education (cognitive deficits may be present due to ongoing substance use and/or intellectual disability).

Another objective of the study was to explore the relationship between mental illness and fitness to stand trial. To this end the results were consistent with the findings in the literature.[7,8, 18] Those defendants noted to have serious mental illness (mostly psychotic illness or cognitive impairment) were usually found not fit to stand trial. The reasons behind this were not evaluated as part of this study. However, this finding may reflect that serious mental illness is automatically seen as a barrier to fitness to stand trial whether or not the defendant is able to understand the relevant questions required for such an assessment, as was pointed out in the study conducted locally by Kaliski, Borcherds and Williams,[3] who found that defendants had a good understanding of court procedure and wrongfulness, whether or not they suffered from serious mental illness. Mentally ill subjects differed only in their ability to distinguish between a guilty and a not guilty plea. However, the presence of mental illness was found to have a negative impact on both competence to stand trial and criminal responsibility.

A further study objective was to establish whether those found to be mentally ill were less likely to be asked the relevant questions than those without mental illness. As is evident in Table 3. the checklist results revealed only slight differences between those with severe mental illness and those without. These differences were not thought to be significant. Thus, the forensic team was noted to have operated fairly consistently irrespective of the presence or absence of serious mental illness. No literature is available for comparison.

Although not a study objective, it is interesting to note that only 30% of the study population was found to have a serious mental illness, yet 57% had received prior treatment for a psychiatric condition. One explanation for this would be that the defendants assessed as

having a serious mental illness were currently in remission (with the prior mental illness therefore not impacting on their fitness to stand trial). Furthermore, the study population had a significant history of substance use (89%), which may account for past treatment of mental illness (intoxication or substance induced mood or psychotic disorder now resolved). Also of interest is the finding of a significant relationship between fitness to stand trial and the violent nature of a crime, with violent offenders being found fit to stand trial in most instances. This finding is supported by the literature.[7,12,19] The explanation for this is unclear. Shutte and Subramaney speculated that the correlation between violent crime and fitness to stand trial found in their study may have been a tactical move by counsel in an attempt to defend a difficult case.[12] They also postulated that the relationship between non-violent acts and being found unfit to stand trial may have been as a result of authorities unnecessarily laying minor charges against the mentally ill who should rather be hospitalised. A further possibility is that those charged with violent offences are more likely to claim mental illness to avoid long prison sentences**.**

Study limitations

The retrospective nature of this study was a limitation as the data collected was limited to what had been recorded in the medical records and final forensic reports. Some questions pertaining to fitness to stand trial may have been addressed by the forensic team at some point during the defendant's observation but may not have been documented in the folder. Furthermore, information obtained from defendants may not always have been accurate or reliable, especially if a serious mental illness were present. Additional limitations include the study time period and sample size.

Conclusion

A fitness to stand trial determination carries significant ethical implications. Should a defendant be found not fit to stand trial, he or she potentially faces indefinite certification in a mental institution. Conversely, should the defendant be found fit to stand trial, a lengthy prison sentence may be the outcome. Both findings therefore carry significant consequences for the individual, which implies that the assessment process ought to be highly sensitive and specific. It is possible that without a more standardised format for evaluation, key factors may be missed and errors made with dire consequences.

The results of the study highlight certain deficiencies in the current observation assessment performed in the Western Cape; however, the findings are not conclusive. Therefore, based on

the dearth of research on this subject, the significance of the study findings and the ethical consequences of a fitness to stand trial evaluation, further research in this area is recommended.

References

1. Department of Correctional Services (RSA). Annual Report 2015/2016 [Internet]. Available from: http://www.dcs.gov.za/docs/ [Accessed 21 February 2017)].
2. Kaliski S. Does the insanity defence lead to an abuse of human rights? Afr J Psychiatry. 2012;15(2):83, 85, 87.
3. Kaliski SZ, Borcherds M, Williams F. Defendants are clueless – The 30-day psychiatric observation. South African Med J. 1997;87(10):1351–1355.
4. Kaliski S. Reinstitutionalization by stealth: the Forensic Mental Health Service is the new chronic system. Afr J Psychiatry. 2013;16(1):13–17.
5. Kalilski S (ed.) Psycholegal Assessment in South Africa. 1st ed., Cape Town: Oxford University Press; 2006.
6. Janse van Rensburg B. The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) position statements on psychiatric care in the public sector. South African J Psychiatry. 2012;18(3):133–148.
7. Pirelli G, Gottdiener WH, Zapf P a. A meta-analytic review of competency to stand trial research. Psychol Public Policy, Law. 2011;17(1):1–53.
8. Zapf PA, Viljoen JL. Issues and considerations regarding the use of assessment instruments in the evaluation of competency to stand trial. Behav Sci Law. 2003;21(3):351–367.
9. Mossman D, Noffsinger SG, Ash P, et al. AAPL Practice Guideline for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law. United States; 2007;35(4 Suppl):S3–S72.
10. Exworthy T. Commentary: UK perspective on competency to stand trial. J Am Acad Psychiatry Law. 2006;34(4):466–471.
11. South African Government. Mental Health Care Act, 17 of 2002.

12. Schutte T, Subramaney U. “Single” v. “panel” appointed forensic mental observations: Is the referral process ethically justifiable? South African J Bioeth Law. 2013;6(2):64.

13. Weinstein HC. Psychiatry on trial: clinical and ethical problems in the psychiatric assessment of competency to stand trial. Ann N Y Acad Sci. (United States); 1980;347:12–19.

14. Robey A. Criteria for competency to stand trial: a checklist for psychiatrists. Am J Psychiatry (United States); 1965 Dec;122(6):616–623.

15. Lipsitt PD, Lelos D, McGarry AL. Competency for trial: a screening instrument. Am J Psychiatry (United States); 1971 Jul;128(1):105–109.

16. Association WM. WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects. 2013.

17. Ryba NL, Shealy RC. Narrowing the gap: How a research intervention influenced clinical forensic practice. J Forensic Psychol Pract. US: Haworth Press; 2007;7(1):19–36.

18. Murrie DC, Boccaccini MT, Zapf PA, etal. Clinician variation in findings of competence to stand trial. Psychol Public Policy, Law. American Psychological Association; 2008;14(3):177–193.

19. Fogel M, Schiffman W. Ten Year Research Update (2001–2010): Evaluations for Competence to Stand Trial (Adjudicative Competence). Behav Sci law. 2013;31:165–191.

Appendices

Appendix I

Fitness to stand trial checklist[1–3]

Question		Scores: 0 = no mention of factor at all in file; 1 = some (indirect) reference to factor; 2 = factor asked and answer recorded in file		
Charge and Plea				
1.	Does the defendant know what charge has been laid against him?	0	1	2
2.	How will the defendant plead, guilty or not guilty?	0	1	2
3.	Does the defendant understand the difference between a guilty and not guilty plea?	0	1	2
4.	Does the defendant understand what will happen if he is found guilty?	0	1	2
5.	Does the defendant understand what will happen if he is found not guilty?	0	1	2
Comprehension of Court Proceedings				
6.	Does the defendant know what a trial is?	0	1	2
7.	Does the defendant know his rights? (i.e., to trial, to be represented by legal counsel, to protection against self-incrimination)	0	1	2
8.	Does the defendant understand the role of a magistrate?	0	1	2
9.	Does the defendant understand the role of a prosecutor?	0	1	2
10.	Does the defendant understand the role of a defence lawyer?	0	1	2
11.	Does the defendant know what a defendant is?	0	1	2
12.	Does the defendant know what a witness is?	0	1	2

Question		Scores: 0 = no mention of factor at all in file; 1 = some (indirect) reference to factor; 2 = factor asked and answer recorded in file		
Appreciation of Wrongfulness (patient's account and quality thereof)				
13.	What does the defendant understand about the charge against him?	0	1	2
14.	Does the defendant think the alleged offence is wrong?	0	1	2
15.	What does the defendant understand about his stay in the observation unit?	0	1	2
16.	Does the defendant think he has a mental illness?	0	1	2
Total score each column				
Overall total				

Appendix II

Checklist for additional data collected

Demographic data at time of alleged offence	
Age	
Number of years of education	
Marital status	
Employment	
Vagrant lifestyle	
Psychiatric data	
Presence of psychiatric diagnosis?	
If yes to above presence of serious mental illness?	
Past psychiatric admission and/or treatment received?	
History of substance misuse?	
If yes to above what substances? (cannabis, methaquolone, methamphetamine, alcohol, other)	
Criminal data	
Prior forensic history (prior assessment, conviction)?	
Nature of current charge (violent versus non-violent)	
Finding of expert panel	
Fit to stand trial or not fit to stand trial?	

Appendix III

Definitions

In South Africa defendants are referred for a forensic assessment by the court to assess one or more of the following:

Fitness to stand trial (current competence)

This is dealt with in section 77 of the Criminal Procedures Act (CPA). [4] At any stage the court may order an enquiry into the defendant's mental competency at the time of the trial 'if it appears...that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence.'[4] That is, the court is requesting that an expert determine whether or not the defendant's current mental state significantly impairs his ability to stand trial.[1]

Criminal responsibility (past competence)

In contrast to the above this is a retrospective appraisal of the defendant's mental state at the time of the alleged offense.[1] Should the individual be found incapable of appreciating the wrongfulness of his/her actions at the time of the alleged offence or incapable of acting in accordance with the appreciation of wrongfulness, as dealt with in section 78(1) of the CPA he or she would not be held responsible for his/her actions (insanity defence).[1,4]

Presence of any psychiatric or psychological factors relevant to the case

The forensic assessment may be ordered by the court at any stage during a trial. The need usually arises when the defendant's mental state or behaviour in court comes into question or there is evidence to suggest that at the time of the alleged offence the defendant was affected by mental illness, defect or other factors.[1]

Other important terms to understand in relation to the forensic assessment include:

State patient

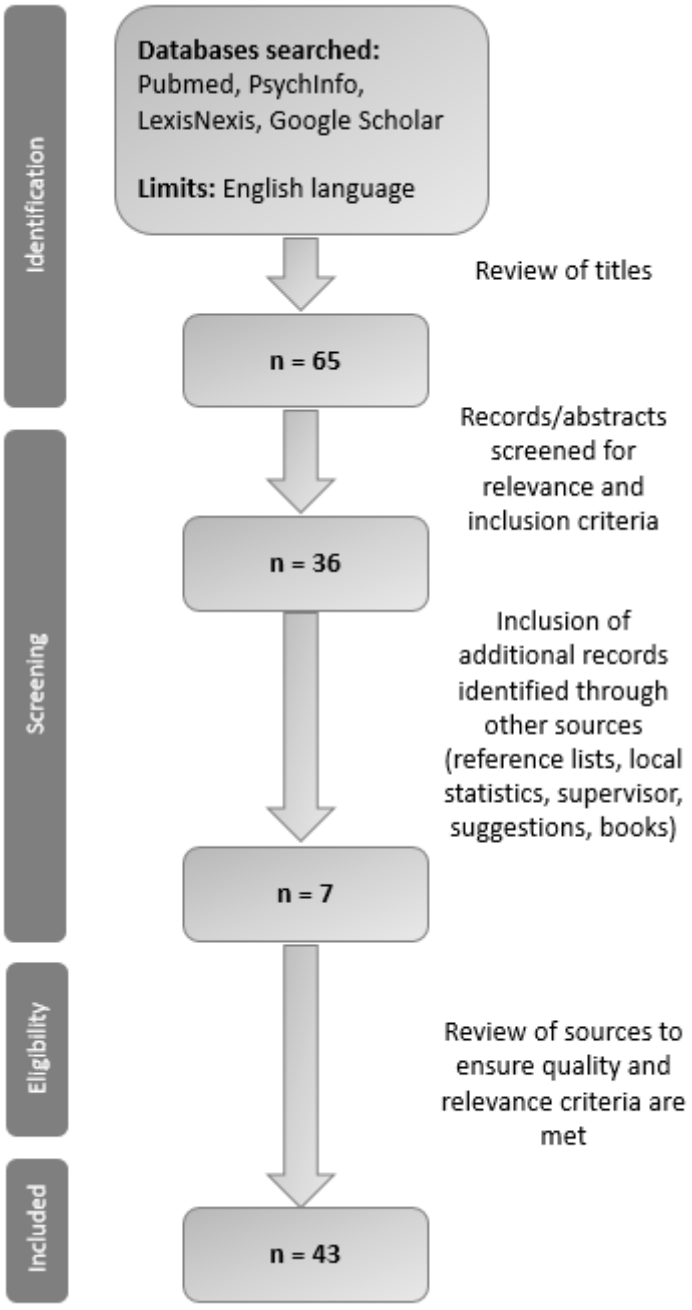
Is usually a defendant with a charge of violent crime who has undergone a forensic assessment and been found unfit to stand trial and/or not criminally responsible due to serious mental illness.[1] He/she is then referred to a forensic psychiatry unit for indefinite hospitalization as a state patient.

References

1. Kaliski S (ed.). Psycholegal Assessment in South Africa. 1st ed. Cape Town: Oxford University Press; 2006.
2. Robey A. Criteria for competency to stand trial: a checklist for psychiatrists. Am J Psychiatry (United States); 1965 Dec;122(6):616–623.
3. Lipsitt PD, Lelos D, McGarry AL. Competency for trial: a screening instrument. Am J Psychiatry (United States); 1971 Jul;128(1):105–109.
4. South African Government. Criminal Procedure Act, 51 of 1977.

Appendix IV

Flow chart of research strategy



Appendix V

Faculty Research Ethics Committee Approval Letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492 • Facsimile [021] 406 6411
Email: Sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

24 February 2015

HREC/REF: 776/2014

Prof S Kallski
Psychiatry & Mental Health
Valkenberg Hospital
Liesbeeck Parkway
Observatory

Dear Prof Kallski

Project Title: A RETROSPECTIVE ANALYSIS OF FACTORS USED TO ASSESS FITNESS TO STAND TRIAL IN DEFENDANTS REFERRED FOR PSYCHIATRIC OBSERVATION (MMeD-candidate Dr C Jacobson)

Thank you for your response letter, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year until the 28 February 2016.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

We acknowledge that the following student:-Dr C Jacobson is also involved in this project.

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence.

Yours sincerely

Signed by candidate

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Hrec/ref:776/2014

Appendix VI

Western Cape Health Research Committee Approval Letter

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6657 fax: +27 21 483 9895
3rd Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP50_190
ENQUIRIES: Ms Charlene Roderick

University of Cape Town
Anzio Road
Observatory
Cape Town
7935
For attention: Dr Candice Jacobson and Prof Sean Kaliski

Re: A RETROSPECTIVE ANALYSIS OF FACTORS USED TO ASSESS FITNESS TO STAND TRIAL IN DEFENDANTS REFERRED FOR PSYCHIATRIC OBSERVATION.

Thank you for submitting your proposal to undertake the above mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Valkenberg Hospital	**C Dean**	**Contact No: 021 440 3160**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure V) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Signed by candidate

DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 18/05/2015
CC

Appendix VII

South African Journal of Psychiatry Author Guidelines

INSTRUCTIONS TO AUTHORS

ISSN 1608-9685 ***printed version***
ISSN 2078-6786 ***online version***

Scope and editorial policy

All articles undergo peer review before being considered suitable for publication in the journal. The peer review process is handled and recorded via an online editorial system. After a manuscript is submitted via the online system by a researcher, the editor-in-chief screens the manuscript and rejects unsuitable or poor-quality manuscripts at this point. Articles deemed appropriate for peer review are sent to 2–3 reviewers selected by the editor–in–chief and/or deputy editors. Reviewers are invited if they are experienced researchers and suitably knowledgeable on the topic of the manuscript.

Following acceptance to perform the review, the reviewers are furnished with a copy of the manuscript and the journal's peer review guidelines, to which they are asked to adhere. The identity of the authors and their affiliation details are blanked out to ensure a blind review.

Reviewers are asked to complete the review within 4 weeks. Reviewers submit their reports via the online editorial system with a recommendation. The editor-in-chief collates the review reports and makes a decision on the status of the paper. Manuscripts may be: accepted (subject to minor or no revisions); declined; returned to the authors for revision (to address all reviewer comments in detail, with the possibility of resending for peer review depending on the nature of the reviewer comments); or invited for re-submission altogether.

Authors are not made aware of the identity of a reviewer (double-blind approach) unless sound justification or transparency requires for disclosure. The editor-in-chief has final decision on the acceptance or rejection of all manuscripts. The editor-in-chief considers the adequacy of each reviewer's report for a particular manuscript and obtains additional review reports when required. Members of the editorial board may be called upon to make additional recommendations. Reviewers are assigned a rating based on the quality of their review, which is entered into the online system for future reference.

Focus and Scope

The SAJP is a quarterly general psychiatric journal. It carries research articles and letters, editorials, clinical practice and other medical articles and personal opinion, South African health-related news, obituaries, general correspondence, and classified advertisements.

Journal sections: Editorials, Regular Articles, Opinion, Case Reports, Guidelines, Position Statements, Book reviews and Letters

Manuscript format and layout

AUTHORSHIP

Named authors must consent to publication. Authorship should be based on substantial contribution to: (i) conception, design, analysis and interpretation of data; (ii) drafting or critical revision for important intellectual content; and (iii) approval of the version to be published. These conditions must all be met (uniform requirements for manuscripts submitted to biomedical journals; refer to www.icmje.org).

CONFLICT OF INTEREST

Authors must declare all sources of support for the research and any association with a product or subject that may constitute conflict of interest.

RESEARCH ETHICS COMMITTEE APPROVAL

Provide evidence of Research Ethics Committee approval of the research where relevant.

PROTECTION OF PATIENT'S RIGHTS TO PRIVACY

Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives informed written consent for publication. The patient should be shown the manuscript to be published. Refer to www.icmje.org.

ETHNIC AND RACIAL CLASSIFICATION

References to ethnic and racial classification must provide the rationale for this.

MANUSCRIPTS

Shorter items are more likely to be accepted for publication, owing to space constraints and reader preferences.

Original articles usually not exceeding 3 000 words, with up to 6 tables or illustrations, are observations or research of relevance to psychiatry. References should be limited to only those that are relevant and pertinent to the article. Please provide a structured abstract not exceeding 250 words, with the following recommended headings, if applicable: Background, Objectives, Methods, Results, and Conclusion.

Scientific letters/short reports, which include case reports, side effects of drugs and brief or negative research findings should preferably be 1500 words or less, with 1 table or illustration and references limited to only those that are relevant and pertinent to the article. Please provide an accompanying abstract not exceeding 150 words.

Editorials, Opinions, etc. are welcomed and are usually about 1000 words in length. They will usually be subjected to the SAJP peer review process.

Review articles will be considered when they make a significant contribution to the field of psychiatry.

Letters to the editor, for publication, should be about 400 words with only one illustration or table, and must include a correspondence address. They may be subjected to the peer review process and their eventual placement is at the discretion of the editorial team.

Obituaries should be about 400 words and may be accompanied by a photograph.

Manuscript preparation

Refer to articles in recent issues for the presentation of headings and subheadings. If in doubt, refer to 'uniform requirements' – www.icmje.org.

Manuscripts must be provided in **UK English**.

Qualifications, affiliations and contact details of ALL authors must be provided in the manuscript and in the online submission process.

Abbreviations should be spelt out when first used and thereafter used consistently, e.g. 'intravenous (IV)' or 'Department of Health (DoH)'. Generally, they should be avoided in the title of the article.

Scientific measurements must be expressed in SI units except: blood pressure (mmHg) and haemoglobin (g/dl). Litres is denoted with a lowercase 'l' e.g. 'ml' for millilitres). Units should be preceded by a space (except for%), e.g. '40 kg' and '20 cm' but '50%'. Greater/smaller than

signs (> and <) should be placed immediately preceding the relevant number, i.e. 'women > 40 years of age'. The same applies to ± and °, i.e. '35±6' and '19°C'.

Numbers should be written as grouped per thousand–units, i.e. 4 000, 22 160...

Quotes should be placed in single quotation marks: i.e. The respondent stated: '...'

Round **brackets** (parentheses) should be used, as opposed to square brackets, which are reserved for denoting concentrations or insertions in direct quotes.

General formatting

The manuscript must be in Microsoft Word or RTF document format. Text must be single–spaced, in 12–point Times New Roman font, and contain no unnecessary formatting (such as text in boxes, with the exception of Tables).

ILLUSTRATIONS AND TABLES

If tables or illustrations submitted have been published elsewhere, the author(s) should provide consent to republication obtained from the copyright holder.

Tables may be embedded in the manuscript file or provided as 'supplementary files'. They must be numbered in Arabic numerals (1,2,3...) and referred to consecutively in the text (e.g. 'Table 1'). Tables should be constructed carefully and simply for intelligible data representation. Unnecessarily complicated tables are strongly discouraged. Tables must be cell–based (i.e. not constructed with text boxes or tabs), and accompanied by a concise title and column headings. Footnotes must be indicated with consecutive use of the following symbols: * † ‡ § ¶ || then ** †† ‡‡ etc.

Figures must be numbered in Arabic numerals and referred to in the text e.g. '(Fig. 1)'. Figure legends: Fig. 1. 'Title...'

All illustrations/figures/graphs must be of **high resolution/quality**: 300 dpi or more is preferable but images must not be resized to increase resolution. Unformatted and uncompressed images must be attached as 'supplementary files' upon submission (not embedded in the accompanying manuscript). TIFF and PNG formats are preferable; JPEG and PDF formats are accepted, but authors must be wary of image compression. Illustrations and graphs prepared in Microsoft PowerPoint or Excel must be accompanied by the original workbook.

REFERENCES

Authors must verify references from the original sources. Only complete, correctly formatted reference lists will be accepted. Reference lists must be generated manually and **not** with the use of reference manager software.

Citations should be inserted in the text as superscript numbers between square brackets, e.g. These regulations are endorsed by the World Health Organization,[2] and others.[3,4–6]

All references should be listed at the end of the article in numerical order of appearance in the **Vancouver style** (not alphabetical order). Approved abbreviations of journal titles must be used; see the List of Journals in Index Medicus.

Names and initials of all authors should be given; if there are more than six authors, the first three names should be given followed by et al. First and last page, volume and issue numbers should be given.

Journal references:

Price NC, Jacobs NN, Roberts DA, et al. Importance of asking about glaucoma. Stat Med 1998;289(1):350–355. [http://dx.doi.org/10.1000/hgjr.182] [PMID: 2764753]

Book references:

Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworth, 1975:96–101.

Chapter/section in a book: Weinstein L, Swartz MN. Pathogenic Properties of Invading Microorganisms. In: Sodeman WA jun, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974:457–472.

Internet references:

World Health Organization. The World Health Report 2002 – Reducing Risks, Promoting Healthy Life. Geneva: World Health Organization, 2002. http://www.who.int/whr/2002 (accessed 16 January 2010).

Other references (e.g. reports) should follow the same format: Author(s). Title. Publisher place: publisher name, year; pages.

Cited manuscripts that have been accepted but not yet published can be included as references followed by '(in press)'.

Unpublished observations and personal communications in the text must not appear in the reference list. The full name of the source person must be provided for personal communications e.g. '...(Prof. Michael Jones, personal communication)'.

PROOFS

A PDF proof of an article may be sent to the corresponding author before publication to resolve remaining queries. At that stage, only typographical changes are permitted; the corresponding author is required, having conferred with his/her co–authors, to reply within 2 working days in order for the article to be published in the issue for which it has been scheduled.

CHANGES OF ADDRESS

Please notify the Editorial Department of any contact detail changes, including email, to facilitate communication.

CPD POINTS

Authors can earn up to 15 CPD CEUs for published articles. Certificates may be requested after publication of the article.

CHARGES

There is no charge for the publication of manuscripts.

Manuscripts submission

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

1. Named authors consent to publication and meet the requirements of authorship as set out by the journal.
2. The submission has not been previously published, nor is it before another journal for consideration.
3. The text complies with the stylistic and bibliographic requirements in Author Guidelines.

4. The manuscript is in Microsoft Word or RTF document format. The text is single–spaced, in 12–point Times New Roman font, and contains no unnecessary formatting.
5. Illustrations/figures are high resolution/quality (not compressed) and in an acceptable format (preferably TIFF or PNG). These must be submitted as 'supplementary files' (not in the manuscript).
6. For illustrations/figures or tables that have been published elsewhere, the author has obtained written consent to republication from the copyright holder.
7. Where possible, references are accompanied by a digital object identifier (DOI) and PubMed ID (PMID)/PubMed Central ID (PMCID).
8. An abstract has been included where applicable.
9. The research was approved by a Research Ethics Committee (if applicable)
10. Any conflict of interest (or competing interests) is indicated by the author(s).

Article submissions:

Registration and login are required to submit items online and to check the status of current submissions.

Health & Medical Publishing Group
South African Journal of Psychiatry, 28 Main Road, Rondebosch, Cape Town, Western Cape Province, ZA, 7700, +27 21 681 7000

e-Mail

publishing@hmpg.co.za