

**STATE PATIENTS WITH A LIFETIME SENTENCE: A CASE STUDY ON THE
TREATMENT AND CARE OF SUBSTANCE INDUCED PSYCHOTIC
OFFENDERS AT VALKENBERG PSYCHIATRIC HOSPITAL**

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CHAPTER ONE: INTRODUCTION

1.1 Introduction and motivation for research

According to South African law if an individual is suffering from mental illness at the time of the offense they are found to lack criminal responsibility and in need of treatment at a psychiatric hospital.¹ In the Western Cape the only psychiatric hospital that caters for these mentally disordered offenders is Valkenberg.² Valkenberg is involved with the total assessment of court referrals for mentally disordered offenders as well as the treatment, management and rehabilitation of these patients.³ Once admitted for treatment the individual is labelled as a state patient under the custody of the state for an indefinite period of time.⁴ The treatment of mentally disordered offenders is complicated by the high prevalence of substance abuse, which is an obstacle in regards to the rates of referral for substance-induced psychotic offenders at Valkenberg. The increase of substance abuse results in severe negative outcomes such as a higher prevalence of psychiatric disorders, crime, violence and family dysfunction.⁵ A large challenge in the Western Cape is the increase in methamphetamine (tik) abuse which has resulted in an increase in psychotic illness presenting for care, and has large repercussions for the already burdened mental healthcare system.⁶ Concern is raised regarding the link between substance abuse and aggression, with particular concern placed on the lack of available resources for effective treatment along with the lack of awareness around mental health.⁷

¹ Criminal Procedure Act 51 of 1977 S.78(1).

² Michelle Moore 'Forensic Psychiatry and Occupational Therapy' in Rosemary B. Crouch and Vivyan M. Alers (5th ed) *Occupational Therapy in Psychiatry and Mental Health* (2014) John Wiley & Sons. 106.

³ Tuviah Zabow 'Management of Mentally Ill Offenders in South Africa: The Assessment and Rehabilitation Program in Cape Town' (1981) 4(3) *International Journal of Law and Psychiatry* 449.

⁴ Criminal Procedure Act op cit (n1).

⁵ Dan J Stein et al 'Introduction: substance Use and Abuse in South Africa' edited by George F.R Ellis et al *Substance Use and Abuse in South Africa* (2012) UCT Press. 1.

⁶ Shandir Ramlagan and Karl Peltzer 'Epidemiology of Substance Use and Abuse in South Africa' edited by George F.R Ellis et al *Substance Use and Abuse in South Africa* (2012) UCT Press. 26.

⁷ Stein et al op cit (n5) 1.

This dissertation examines the treatment and care of substance-induced psychotic offenders at Valkenberg psychiatric hospital. These patients suffer from what is known as a comorbid disorder: a substance-abuse problem in combination with a mental disorder.⁸ The research aims to reveal whether there is a treatment model in place, and if so, how this is utilized. As it is a hospital it is questioned whether the emphasis on treatment lies on the patient's mental health or the crime that was committed. It will be explored whether there is a set standard of treatment for patients and whether there are set requirements needed for release. Is release granted according to low risk of relapse and recidivism or whether they are seen to be mentally stable? Lastly challenges around the treatment of comorbid forensic patients will be explored, focussing on how the current waiting period for observation in the Western Cape itself deem to be a problem for treatment?

With a population of eight million people and an area with a radius of around 800 kilometres, 35 per cent of the population at Valkenberg come from rural areas where psychiatric services are unavailable and where education about mental illness is lacking.⁹ Data from the South African Community Epidemiology Network on Drug Use (2017) found that Tik was the primary drug of abuse (32 per cent), followed by cannabis (28 per cent), alcohol (22 per cent), and other substances such as heroin and opiates (18 per cent) in the Western Cape.¹⁰ Most of the individuals arriving at the centres for substance abuse treatment were unemployed and only 69 per cent had completed secondary education.¹¹ This data suggests that individuals who are more likely to abuse drugs may lack knowledge around the effects of substances, especially the detrimental effects of tik abuse.

⁸ L Weich and W Pienaar 'Occurrence of Comorbid Substance Use Disorders among Acute Psychiatric Inpatients at Stikland Hospital in the Western Cape, South Africa' (2009) 12(3) *African Journal of Psychiatry* 213.

⁹ Sean Z Kaliski 'Risk Management During the Transition from Hospital to Community Care' (1997) 9 *International Review of Psychiatry* 253.

¹⁰ South African Community Epidemiology Network on Drug Use (SACENDU) 2017 (40) 5.

¹¹ *Ibid.*

One of the reasons that may explain the high prevalence (increasing over the last 10 years) of tik is that it is one of the cheapest drugs in the Western Cape.¹² In Cape Town the increase in individuals seeking treatment for tik abuse shows the most rapid increase of a specific drug ever noted in South Africa.¹³ The highest usage of tik was found in the poorer suburbs of Cape Town, where health service providers are unable to cope with the psychiatric manifestations of tik use. Of concern is the link between tik use and increased risk of mental illness, where health service providers in Cape Town were found to lack training in assessing drug-related psychosis.¹⁴ Of additional concern is the high prevalence of tik use amongst coloured and black communities where there is already a high level of violence, which can be made worse due to the effects of tik including onset of violent and risky behaviour.¹⁵

International research has found that there is a link between people suffering from a mental disorder and substance abuse disorders.¹⁶ Global statistics from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) found that between ‘seven per cent and 25 per cent of individuals presenting with a first episode of psychosis in different settings are reported to have substance/medication-induced psychotic disorder.’¹⁷ In South Africa specifically prevalence rates of comorbid substance abuse and mental illness were found to be 50 per cent.¹⁸ This dissertation is therefore motivated to investigate how the high prevalence of comorbid substance abuse and mental illness is a barrier to treatment at Valkenberg. It is critical to raise awareness around the burdens of disease as they ensure disastrous outcomes on society as a whole.

¹² Shandir Ramlagan et al ‘Epidemiology of Drug Abuse Treatment in South Africa’ (2010) 16(2) *South African Journal of Psychiatry* 44.

¹³ Andreas Plüddemann et al ‘Surge in Treatment Admissions Related to Methamphetamine Use in Cape Town, South Africa: Implications for Public Health’ (2008) 27(2) *Drug and Alcohol Review* 187.

¹⁴ Ibid 189.

¹⁵ Ibid 188.

¹⁶ Amanda Baker et al ‘Motivational Interviewing among Psychiatric in-Patients with Substance Use Disorders’ (2002) 106 *Acta Psychiatrica Scandinavica* 233.

¹⁷ American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 5th edition (2013) American Psychiatric Association.

¹⁸ Don Wilson et al ‘The Clinical Presentation of Substance-Related Disorder in South Africa’ edited by George F.R Ellis et al *Substance Use and Abuse in South Africa* (2012) UCT Press. 41.

Focus will be placed on how the staff determine whether an individual was psychotic at the time of the offense along with what treatment model is in place. The forensic setting in the hospital provides routine, structure and support by the staff. This is removed immediately upon release, and the individual is back in the former environment surrounded by temptations and opportunities and may relapse into past behaviours. In order to ensure that the individual does not take advantage of these temptations and opportunities family and/or social support is imperative.¹⁹ The study aims to bring awareness to the problem of limited awareness around mental health throughout the South African society and impact on service provision. In order to decrease the prevalence of substance-induced psychotic offenders it is crucial for society to be educated about mental disorders. Through this individuals are more likely to receive help and support at the onset of symptoms, which could decrease the likelihood of substance abuse and crime. The issue of substance abuse needs to be addressed in order to prevent these crimes from occurring.

In order to gain a better understanding of the treatment model for substance-induced psychotic offenders, empirical research was conducted for this dissertation. Interviews were conducted with staff members at Valkenberg who work directly with the state patient's treatment. Empirical research was utilized in order to better comprehend the treatment model along with the participants standpoint on the application of the treatment along with the challenges. The research is motivated by the high prevalence of substance abuse in poorer rural areas in the Western Cape and particularly substance abuse leading to crime and cases of substance induced psychosis.²⁰ This dissertation will evaluate the treatment model that is used at Valkenberg in order to better understand the challenges that the population faces in regard to rehabilitation.

¹⁹ Robin E Clark 'Family Support for Persons with Dual Disorders' (1996) 1966(2) *New Directions for Mental Health Services* 66.

²⁰ SACENDU op cit (n10) 5.

1.2 Valkenberg Psychiatric Hospital

Valkenberg works with the total assessment of forensic psychiatric patients in the Western Cape. The psychiatric hospital employs the use of a multidisciplinary team which refers to staff members from various fields within psychology working together with the mentally disordered offender. The team consists of psychiatrists, psychologists, social workers, occupational therapists and nursing staff.²¹ The multidisciplinary team work together to hold regular reviews of each patient, where assessments are conducted regarding the individuals mental state, compliance and participation in the programme along with level of contact with family or other support.²²

Valkenberg admits male patients from the age of 18 up to the age of 80 years old.²³ The hospital may observe female mentally disordered offenders but only admits male patients for treatment. It was estimated that 80 to 90 per cent of the population are people of color, mostly coming from extremely poor communities.²⁴ Most of the admitted patients have had numerous admissions to Valkenberg and have been tried on different medications due to the presence of prior mental health diagnosis.²⁵ The high prevalence of substance use disorders within the forensic population is a complicating factor since it has been found to result in severe chronic mental disorders.²⁶ These long-term illnesses include schizophrenia, schizoaffective disorder, bipolar mood disorder and intellectual disability.²⁷

The psychiatric hospital consists of a maximum secure unit, medium secure ward, low secure ward followed by a step-down unit on the premises. The maximum secure unit is meant to house 50 state patients, however, is currently at a capacity of 61, and has at

²¹ Kaliski op cit (n9).

²² Ibid 251.

²³ This presents data of Valkenberg provided by the participants as there is no other documented source.

²⁴ Personal interview with Participant 6 (P6), Valkenberg.

²⁵ Personal interview with Participant 2 (P2), Valkenberg.

²⁶ Ibid.

²⁷ Ibid.

times gone up to 70 patients.²⁸ These numbers emphasize the lack of available resources to treat these patients elsewhere, resulting in overcrowding in various cells. All patients who are sent to observation at Valkenberg start off in the maximum-secure unit before moving to less secure wards. This is based on their compliance to medicine, their mental health status along with the risk of violent behavior towards themselves and others. Officially observation cases are meant to take up 15 beds in the unit, however, due to the growing number of long-term patients the current number of observation cases is 10 at a time.²⁹ Once admitted to the hospital state patients remain in the maximum unit for an average of one to two years.³⁰ The aim during this period is to stabilize their individual symptoms with medication, before being moved down to the medium secure unit where therapy commences.

When a patient is moved from the maximum secure unit to medium secure ward, he is required to spend one month inside before being granted any benefits such as ground parole. This initial benefit allows the patient to walk around the hospital premises at certain times during the day. This strongly contradicts the push for deinstitutionalization as even patients who are doing well³¹ are kept inside of the premises. During this period patients may get more adapted to life inside of the hospital and get used to the set structure and rules. This can make it more difficult to adjust to the life outside once they are given the privileges such as leave. From the medium secure ward, the patient will be moved to low-secure ward where the individual will be trusted with periods of leave, which will increase in duration if they do not relapse.

If the individual has nowhere to go in the community, there is a 'step-down' ward. This ward functions as a home on the premises where 25 to 30 individuals at a time are seen as residents of the ward and are trusted to run it by themselves with very little

²⁸ Personal interview with P6 op cit (n24).

²⁹ Ibid.

³⁰ Ibid.

³¹ Interviewees referred to stable patients as being well, therefore this term will be used interchangeably throughout the dissertation.

supervision.³² Kaliski (1997) emphasizes the contradiction between society's push towards discharging patients and the reality of patients making Valkenberg a permanent home.³³ These patients can benefit from being permanently attached to the forensic unit, where they are allowed to spend various amounts of time in the community combined with regular returns to the unit for stabilization.³⁴ Valkenberg also houses 'night patients' who work and largely live outside the hospital by day but return to sleep inside of the hospital.³⁵ Remaining a state patient does not mean that they are not allowed leave, it merely means that they have to return to Valkenberg for check-ups or if they relapse. The argument is made that the longer someone remains a state patient with supervised care can improve the risks against future violence, re-offending and relapse.³⁶

Even though a patient may be sent on leave from Valkenberg they will initially be required to return to the psychiatric hospital for regular check-ups. If these leaves are successful meaning the patient does not relapse or commit crime the length of time in the community increases each time. Permanent discharge as a state patient rarely occurs due to relapse into substance abuse or crime.³⁷ The high rates of substance abuse increases the risk of relapse and Valkenberg works with a revolving door policy, where patients come in and out of the psychiatric hospital.³⁸ Therefore re-admission to Valkenberg is seen as a reality rather than failure. Kaliski explains how several risk factors for relapse are found within their population of state patients including 'history of repeated brief hospitalizations, chaotic or poor social supports, alcohol and substance abuse (and co-morbidity) and poor response or compliance with treatment.'³⁹ Valkenberg is unique in that it is the only psychiatric hospital that caters for a forensic population of offenders. As

³² Personal interview with Participant 3 (P3), Valkenberg.

³³ Kaliski op cit (n9) 252.

³⁴ Ibid.

³⁵ Ibid 253.

³⁶ Ibid 250.

³⁷ Ibid.

³⁸ Madeleine Duncan and Claire Prowse 'Occupational-Therapy for Anxiety, Somatic and Stressor-related Disorders' in Rosemary B. Crouch and Vivyan M. Alers (5th ed) *Occupational Therapy in Psychiatry and Mental Health* (2014) John Wiley & Sons. 375.

³⁹ Kaliski op cit (n9) 251.

the hospital is found to be over its max capacity combined with an ever-increasing substance abusing population the treatment model that is used within the hospital needs to be investigated.

1.3 Definitions

In South Africa there is debate over the definition of mental disorders,⁴⁰ therefore this dissertation will use the definition mental illness being: ‘A syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning.’⁴¹ For the purpose of this research this means that the individual was unable to control and regulate their behaviour due to the effect of substances.

Substance-induced psychosis is seen as a mental disorder and falls under the category of psychotic disorders within the DSM-5 (2013). According to the DSM-5 an individual can only be diagnosed with a substance-induced psychotic disorder if there is a presence of one or both of delusions and/or hallucinations.⁴² Delusions are characterized by fixed beliefs where persecutory delusions have been found to have the highest likelihood of resulting in criminal behaviour.⁴³ Hallucinations on the other hand are perception-like experiences that come about without an outside provocation.⁴⁴ They are involuntarily and vivid, making them seem like regular perceptions.⁴⁵ Two forms of hallucinations are possible: sensory and auditory hallucinations. Auditory hallucinations are found to be most common for substance-induced psychosis.⁴⁶ For substance-induced psychosis delusions

⁴⁰ Mental illness, mental disorder, mentally ill and mentally disabled will be used interchangeably throughout the dissertation.

⁴¹ American Psychiatric Association op cit (n17).

⁴² Ibid 110.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid 113.

⁴⁶ Ibid.

and/or hallucinations have to come about during or soon after intoxication, or during withdrawal of a substance. Substance-induced psychosis is differentiated from other psychotic disorders, as the ‘substance is judged to be etiologically related to the symptoms.’⁴⁷

DSM-5 (2013) provides evidence that the onset of psychosis depends on the type of substance that has been ingested. A state of psychosis may occur within minutes after taking cannabis, whereas long periods of alcohol abuse are usually required for psychosis to result from it.⁴⁸ The DSM-5 indicates that a sign of substance-induced psychosis is if there has been no prior history of psychotic episodes. These cases of substance-induced psychosis are found to have severely violent reactions.⁴⁹ In most cases the disability from the psychosis ends when the substance is removed.⁵⁰ However, for Tik the ‘psychotic features persist well beyond what the pharmacokinetics of the drug would suggest.’⁵¹

There are several factors that make it difficult to determine whether the individual was suffering from a state of substance-induced psychosis. One of the biggest challenges is when there is a long time period between the crime and the individual being screened for possible substance ingestion.⁵² Patients are likely to underreport or suppress ingesting substances if asked directly by the hospital staff, due to social stigma and criminal sanctions.⁵³ Ideally, appropriate screening of the factor’s indicative of a substance-induced psychosis should be available shortly after the crime is committed. However, due to the lack of resources available in the Western Cape this does not occur, making it difficult for the staff at Valkenberg to retrospectively determine whether the patient was suffering from substance-induced psychosis at the time of the offence.

⁴⁷ American Psychiatric Association op cit (n17).

⁴⁸ Ibid.

⁴⁹ Russil Durrant *An Introduction to Criminal Psychology* (2018) Routledge, Taylor & Francis Group. 92.

⁵⁰ Ibid.

⁵¹ Wilson et al op cit (n18) 41.

⁵² American Psychiatric Association op cit (n17).

⁵³ Glen P Davis et al ‘Substance Use and Duration of Untreated Psychosis in KwaZulu Natal, South Africa’ (2016) 22(1) *South African Journal of Psychiatry* 5.

1.4 Dissertation Structure

Chapter two of this dissertation will analyse the existing literature on international treatment models that are employed for both mentally disordered offenders, offenders who committed an offence under the influence of substances, and on forensic psychiatric patients. The three aforementioned topics were analysed separately, emphasizing the lack of research on comorbid forensic psychiatric patients. South African law and policies will be discussed in order to highlight the difficulties that Valkenberg faces in having to decide whether an individual had mental capacity at the time of the offence.

Chapter three outlines the research methodology that was employed during the research. Initially the research design will be explained, followed by a description of sample size and sampling plan. Data collection methods along with analytical strategy are then discussed. Lastly ethical considerations and limitations of the study are outlined.

Chapter four discusses the study's findings. The chapter discusses the prevalence of substance abuse in the forensic population and the overarching treatment model focussing on the role of the patient's family, concluding with challenges throughout the treatment including the effect of the waiting period before arriving at Valkenberg for observation.

The final chapter looks at the existing literature in comparison to the findings from the various interviews. The aim is to gather a full picture of how each participant contributes to the treatment of substance-induced psychotic offenders' along with the challenges they have to overcome. Lastly, recommendations will be suggested in regard to work needed in order to ensure state patients receive time and resources efficient treatment.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In South Africa neuropsychiatric disorders are ranked third in the national burden of disease.⁵⁴ In spite of mental illness linked with violence presenting as an issue in South Africa there is little research done on substance-induced psychotic offenders and how to treat them. Mental health care remains a low priority and is still underfunded with the National Department of Health allocating four per cent of its budget to mental health services.⁵⁵ International research has been conducted on various treatment approaches of mentally disabled patients, mentally disordered offenders and offenders committing a crime under the influence of substances.⁵⁶ This emphasizes the lack of research on specifically substance-induced psychotic offenders. A lack of research still remains regarding the definition of the most effective ‘content, shape and form of interventions’ that will help forensic patients with comorbid substance abuse and mental illness.⁵⁷ Additionally, there is a large gap in the literature about how the state and society deal with the mentally disordered offender upon release. International research focuses on the necessity of community-based care in order for the offender to stray away from relapsing into violence once they are released from psychiatric hospital. However, with the lack of resources allocated to mental health in the Western Cape this is a rarely a reality for forensic psychiatric patients.⁵⁸

⁵⁴ Christopher Paul Szabo et al ‘Mental Health Leadership and Patient Access to Care: a Public–Private Initiative in South Africa.’ (2017) 11(1) *International Journal of Mental Health Systems* 2.

⁵⁵ Ibid.

⁵⁶ Jennifer P Wisdom et al ‘Substance Use Disorder Among People With First-Episode Psychosis: A Systematic Review of Course and Treatment’ (2011) 62(9) *Psychiatric Services*.

⁵⁷ W James et al ‘A Group Intervention Which Assists Patients with Dual Diagnosis Reduce Their Drug Use: a Randomized Controlled Trial’ (2004) 34(6) *Psychological Medicine* 983.

⁵⁸ Y Zubi and P Connolly ‘Recollected Experiences of First Hospitalisation for Acute Psychosis among Persons Diagnosed with Schizophrenia in South Africa’ (2013) 19(3) *South African Journal of Psychiatry* 81.

Research has found that up to 80 per cent of all offenders abuse substances and are on substances at the time they commit the crime.⁵⁹ For the purpose of this research there is specific interest on the treatment of the substance-induced psychotic offender, specifically whether the focus during treatment is placed on reducing the risk of recidivism or stabilizing the mental health of the individual. Being a psychiatric hospital, Valkenberg revolves around treatment of forensic patients by mental health professionals, suggesting that addressing the criminal offence may be the last priority. Once the patient is released into the community support is necessary to ensure that the individual will not relapse. Due to the lack of knowledge throughout society, the final step of reintegration into society deems to be immensely difficult, as there is large stigma around mental disorders and substance induced violence.⁶⁰

2.2 Law and Policy

There are several laws and policies that are relevant in South Africa in terms of how to identify whether an individual lacked mental capacity at the time of the offense and what course of treatment the individual should receive. Initially, the individual will be arrested and serve time in prison whilst waiting for an observation space to be assessed at a psychiatric hospital.⁶¹ In the Western Cape this assessment regarding the individual's mental health and criminal capacity can only be done at Valkenberg hospital.⁶² If it is concluded that the individual lacked mental capacity according to the Criminal Procedure Act 51 of 1977 guidelines regarding the individuals treatment set out by the Mental Health Care Act 17 of 2002 should be followed.

Mental health care in South Africa is not only regulated by legislation. In regard to substance abuse and the implementation of treatment for mentally disordered offenders the National Mental Health Policy Framework and Strategic Plan (2013-2020) and the

⁵⁹ Sean Z Kaliski *Psycholegal Assessment in South Africa* (2006) Oxford University Press. 126.

⁶⁰ Zubi and Connolly op cit (n58) 81.

⁶¹ Criminal Procedure Act op cit (n1).

⁶² Mental Health Care Act 17 of 2002.

National Drug Masterplan (2013-2017) will be analysed. Lastly, the Prevention of and Treatment for Substance Abuse Act of 2008 will be discussed to emphasize the urge towards a decrease in substance abuse in the country. The proceeding sections will provide a brief summary of the relevant chapters within each Act and Policy. This will be done in order to highlight the potential difficulty in application within the forensic setting in the Western Cape due to the lack of available resources to treat the burden of disease.⁶³

2.2.1 Criminal Procedure Act 51 of 1977

If an individual was thought to not have had mental capacity at the time of the offence a defence of insanity may be raised. In order to determine mental capacity in South Africa the court looks to section 78 of the Criminal Procedure Act of 1977 which states that:

A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable-

- a) of appreciating the wrongfulness of his or her act or omission; or
- b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

shall not be criminally responsible for such act or omission.⁶⁴

Section 78 does not provide any formal definition of mental illness or mental defect.⁶⁵ Nonetheless, if the insanity defence is raised section 79 of the Act requires that the court must send the individual for observation at a psychiatric hospital for a period of 30 days at a time,⁶⁶ during which it is determined if the individual did or did not have mental capacity. No determination is however made on whether or not they were guilty of the crime.⁶⁷

Once the individual is designated a spot for observation the staff that carry out the assessment of the patient at the psychiatric hospital are required to submit a report to the

⁶³ Mental Health Care Act op cit (n62) 9.

⁶⁴ Criminal Procedure Act 51 of 1977 S.78(1).

⁶⁵ M Swanepoel 'Legal Aspects with Regard to Mentally Ill Offenders in South Africa' (2015) 18(1) *Potchefstroom Electronic Law Journal/Potchefstroomse Elektroniese Regsblad* 3248.

⁶⁶ Criminal Procedure Act op cit (n1) S.79(2(a)).

⁶⁷ Swanepoel op cit (n65) 3251.

court with their findings including: a diagnosis of the accused's mental condition and to which extent the mental condition affected their ability to 'appreciate the wrongfulness of the act.'⁶⁸ Determining mental capacity is in itself subjective because the decision is based purely on the accused's *ipse dixit*.⁶⁹ *Ipse dixit* refers to the accused making statements about their own mental capacity as circumstantial evidence without any proof. The psychiatric staff must retrospectively consider the available evidence of the individual's mental capacity to determine whether or not they are in need of psychiatric treatment. This can be a difficulty whilst assessing substance-induced psychotic offenders as individuals experience the substances differently, and individuals present psychotic symptoms differently. Additionally, if there is a long waiting period before observation the psychotic symptoms may have ameliorated.⁷⁰ The court requires input from the psychiatric hospital but ultimately it is the judge who makes the final decision as to whether the individual lacked criminal capacity.⁷¹ If it is concluded that the individual did not have criminal capacity they should receive treatment at a psychiatric facility, as set out by the Mental Health Care Act of 2002.⁷²

2.2.2 Mental Health Care Act 17 of 2002

Once the individual is found to have lacked mental capacity the Mental Health Care Act 17 of 2002 provides guidelines as to the course of treatment. The individual is now regarded as a State patient, which means that they are admitted for treatment for an indefinite period under the custody of the State.⁷³ Whilst waiting for the National Department of Health to issue an order of transfer to the forensic psychiatric hospital the patient is transferred to a prison where they are usually placed in remand detention.⁷⁴ Szabo

⁶⁸ Criminal Procedure Act op cit (n1) S.79(4(d)).

⁶⁹ Jonathan Burchell, *A Provocative Response to Subjectivity in the Criminal Law*, 2003 Acta Juridica 23 (2003) 28.

⁷⁰ American Psychiatric Association op cit (17).

⁷¹ Swanepoel op cit (n65) 3253.

⁷² Mental Health Care Act op cit (n62).

⁷³ Ibid S.41.

⁷⁴ Christopher Paul Szabo and Sean Zalman Kaliski 'Mental Health and the Law: A South African Perspective' (2017) 14(3) *BjPsych International* 70.

and Kaliski (2017) found that this process takes at least one month, but can be an even longer time period as the designated hospital does not have enough beds to house the patient.⁷⁵

Once a state patient has been admitted for treatment the Act specifies that periodic reviews must be done regarding the patient's mental health status. According to the Act the first review should take place six months after the date that treatment commenced, and every following 12 months.⁷⁶ This review should provide a description of the individuals current mental health status and specify plans for future treatment. The long time period between the reviews is largely due to the lack of personnel resources in the public health system in South Africa.⁷⁷ Nevertheless, in order to provide appropriate treatment, the periodic reviews are crucial.

During the course of treatment it is possible for the state patient, curator ad litem,⁷⁸ head of the health establishment, medical practitioner, spouse or a next of kin to apply to a judge (in chambers) for the discharge of a state patient.⁷⁹ This application needs to include reasons for the application, a report by a psychologist who treated the patient, history and prognosis of the patient's mental health status from the head of the health establishment along with a report from two mental health practitioners, one of which must be a psychiatrist. Even though the Act specifies the possibility of discharge it will be questioned how realistic this is in practice in regard to how many state patients get discharged from Valkenberg.

The Mental Health Care Act specifies clear guidelines for treatment, however mental health remains a low priority in practice and on the policy agenda in South Africa.⁸⁰ The South African Stress and Health Survey (2004) found that 30.3 per cent of South

⁷⁵ Szabo and Kaliski op cit (n74) 70.

⁷⁶ Op cit (n41)S.46(1).

⁷⁷ Op cit (n62) 9.

⁷⁸ A curator ad litem is a legal representative appointed by a court to represent the best interests of a person who lacks the mental capacity to make decisions for themselves

⁷⁹ Op cit (n1)S.47(1).

⁸⁰ Szabo and Kaliski op cit (n74) 70.

African adults had a lifetime prevalence of any mental disorder where individuals in the Western Cape had the highest prevalence in the entire country (39.4 per cent).⁸¹ Of concern is that this data is likely to be underreported as it does not include psychiatric disorders.⁸² Despite data emphasizing mental illness as a high burden of disease and a need for proper treatment facilities the reality of availability is different. There are 41 psychiatric inpatient units within general hospitals, providing a total of 2.8 beds per 100,000 people in the population.⁸³ In addition to this there are 23 mental hospitals providing a total of 18 beds per 100,000. These mental hospitals provide 56 per cent of mental health beds in the whole country.⁸⁴ Despite the high prevalence of mental disorders in South Africa there is a lack of available treatment, especially for individuals from poorer rural areas who are unable to access treatment.⁸⁵

With 56 per cent of the treatment bed being inside of hospitals there is less lack of community-based treatment facilities compared to inpatient units. It is critical to expand community-based treatment, to provide sustainable treatment so that individuals are less likely to relapse and have to go back to inpatient treatment. From 2002 to 2007 the Western Cape experienced a drastic 21 per cent decrease in available beds.⁸⁶ Additionally, data shows that the total number of human resources in the Department of Health's mental health facilities are 9.3 per 100,000 (0.28 psychiatrists, 0.45 medical doctors, 7.45 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists, 0.28 other health workers).⁸⁷ This data shows a clear lack of resources within the department of mental health, which effects the availability of treatment for psychiatric patients.

⁸¹ N Jacob and D Coetzee 'Mental Illness in the Western Cape Province, South Africa: A Review of the Burden of Disease and Healthcare Interventions' (2018) 108(3) *South African Medical Journal* 178.

⁸² Ibid.

⁸³ WHO and Department of Psychiatry and Mental Health, 'WHO-AIMS Report on Mental Health System in South Africa' (2007) 5.

⁸⁴ Ibid 26.

⁸⁵ Plüddemann et al op cit (n144)

⁸⁶ WHO and Department of Psychiatry and Mental Health op cit (n83) 13.

⁸⁷ Ibid 5.

2.2.3 The National Mental Health Policy Framework and Strategic Plan (2013-2020)

The National Mental Health Policy Framework and Strategic Plan (2013-2020) was formulated in order to promote the rights of mentally disordered people in South Africa.⁸⁸ The act strives towards rehabilitation of mentally disordered individuals but does not provide criteria for how this rehabilitation should occur. The Policy focusses on a ‘recovery model,’ which should provide ‘hope and restoration of a meaningful life’ where ‘recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.’⁸⁹

The Policy identifies factors such as poverty, violence, and substance abuse as having an effect on the likelihood of an individual developing a mental illness. The intention of the Policy is to endorse mental health from infancy to old age, through ‘effective promotion, prevention, treatment and rehabilitation interventions.’⁹⁰ Priority is placed on the necessity for community mental health services along with the need for family and care support. This could decrease the high burden of demand on mental health services. Obligation to educate the community about mental health is also identified. Work needed in the promotion of mental health awareness is made difficult by stigma, and years of work on community perception is necessary before successful implementation of the Policy can occur.⁹¹

The Policy considers the vast financial costs that need to be placed into the mental health sector in order to decrease the high prevalence of mentally disordered individuals throughout South Africa. According to the Policy the country spends more money by not treating mental illness than if they were to treat the issue properly.⁹² Individuals suffering

⁸⁸ The National Mental Health Policy Framework and Strategic Plan (2013-2020) 4.

⁸⁹ Ibid 8.

⁹⁰ Ibid 19.

⁹¹ Ibid

⁹² Ibid 13.

from a mental illness are likely to abuse substances, which has detrimental consequences including an 'increased risk for mental disorders, crime and violence and motor vehicle injuries.'⁹³ If the community is able to provide aid and support to the mentally disordered individual, they may be able to prevent and control symptoms from manifesting into aggression and violence. It is necessary to educate the community about the link between mental illness, substance abuse and crime in order to aim for a decrease in all burdens of diseases. In order to do so it is critical to discuss the impact of substance abuse on this population of mentally disordered offenders.

2.2.4 Prevention of and Treatment for Substance Abuse Act 70 of 2008

The treatment of mentally disordered offenders is complicated by the high prevalence of substance abuse within the population in the Western Cape.⁹⁴ South Africa is suffering from a large-scale substance abuse problem, and the country ranked 47th out of 189 countries in 2003 per capita per population, where individuals over the age of 15 drank seven litres of pure alcohol on average.⁹⁵ Even though this data is 15 years old, the increase in tik use throughout the past 10 years suggests that the prevalence has not decreased. Due to the high burden of disease The Prevention of and Treatment for Substance Abuse Act 70 of 2008 was promulgated to set out a list of aims, including deterring the onset of substance abuse and limiting the impact of the substances.⁹⁶ In order to do so facilities for prevention, early intervention, treatment, reintegration and after care services are needed. If there were readily available treatment centres it is suggested that individuals would be more willing to seek help. It is critical to make treatment available, especially in poorer rural areas where the level of substance abuse (especially tik) is found to be higher.⁹⁷

⁹³ The National Mental Health Policy Framework and Strategic Plan (2013-2020) 13.

⁹⁴ SACENDU op cit (n10) 5.

⁹⁵ WHO and Department of Psychiatry and Mental Health op cit (n83)

⁹⁶ Prevention of and Treatment for Substance Abuse Act 70 of 2008 S.1

⁹⁷ Plüddemann et al op cit (n144)

Illegal liquor vendors (shebeens) are largely found in informal settlements in South Africa where residents are more likely to report a current alcohol abuse problem than in other rural areas.⁹⁸ Since the Act aims for prevention through demand, harm and supply reduction it is suggested that alcohol use in these areas could decrease if the numbers of shebeens were reduced.⁹⁹ It was found that individuals in the lower socioeconomic areas were more likely to abuse the substance, emphasizing the need to implement the Policy especially in those areas. Demand, harm and supply reduction in unison will require community education about the detrimental effects of substance use, along with limiting the production and distribution of substances, followed by the use of criminal law to punish illicit drug use (such as cutting down the presence of shebeens).¹⁰⁰

2.2.5 National Drug Masterplan (2013-2017)

The National Drug Masterplan (2013-2017) follows the Prevention of and Treatment for Substance Abuse Act 70 of 2008, emphasizing the need for an improvement in policy as substance abuse has detrimental effects on the South African society as a whole.¹⁰¹ This is particularly critical in the lower socioeconomic areas. Throughout the above mentioned Act it was believed that supply reduction was necessary in order to combat substance abuse, however the prevalence of usage has not decreased.¹⁰² Contradictory to the Act the Masterplan defines prevention as an ongoing process, which empowers individuals to face the challenges of life events and transitions through producing and emphasizing conditions that promote healthy behaviour and lifestyle.¹⁰³ The three forms of reduction are described in more detail as demand reduction including educating potential users, making the substance undesirable, and imposing restrictions of

⁹⁸ Lawana, Nozuko, and Frederik Booyesen 'Decomposing Socioeconomic Inequalities in Alcohol Use by Men Living in South African Urban Informal Settlements' (2018) 18(993) *BMC Public Health* 1–9.

⁹⁹ Ibid.

¹⁰⁰ Prevention of and Treatment for Substance Abuse Act 70 op cit (n96) S.3(1).

¹⁰¹ National Drug Masterplan (2013-2017) 2.

¹⁰² Ibid.

¹⁰³ Ibid 19.

the use of substances.¹⁰⁴ Supply reduction involves reducing the quantity of drugs.¹⁰⁵ Harm reduction focusses on individuals who have already started using and abusing substances, by providing them with treatment, care and ways to approach reintegration into society.¹⁰⁶

Overarchingly it is believed that the way to combat the substance abuse issue throughout South Africa is to decrease the availability of substances and illicit drugs. Nevertheless, this is made more difficult without community education and awareness about the effects of substances, especially in rural areas where usage is more prevalent.¹⁰⁷ Research has found that mentally disordered are more likely to abuse substances,¹⁰⁸ which is not only a barrier for implementation of treatment but is also seen as a contributing factor to the cause of violent behaviour.¹⁰⁹ Therefore the implementation of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 and the National Drug Masterplan (2013-2017) should serve as guidelines for how to decrease substance abuse throughout the country.

2.3 Complicating Factors: Substance Abuse, Mental Illness and Crime

Substance abuse can be seen as a predictive factor of violence. South Africa's homicide rates are at more than eight times the global average among males and five times among women, suggesting that the country is one of the most violent in the world.¹¹⁰ Persistent alcohol abuse has been found to enhance the risk of developing mental disorders and increases the likelihood of crime and violence.¹¹¹ It is critical to understand the link between substance abuse, mental illness and crime in order to explore what treatment

¹⁰⁴ National Drug Masterplan op cit (n101) 29.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Plüddemann et al op cit (n144)

¹⁰⁸ Dominique Morisano et al 'Co-Occurrence of Substance Use Disorders with Other Psychiatric Disorders: Implications for Treatment Services' (2014) 31(1) *Nordic Studies on Alcohol and Drugs* 11.

¹⁰⁹ Ibid

¹¹⁰ Ibid 103.

¹¹¹ Corrigan, Joanne, and Richard Matzopoulos 'Violence, Alcohol Misuse and Mental Health: Gaps in the Health System's Response' (2013) *South African Health Review* 103-115.

substance-induced psychotic offenders should receive. The proceeding sections explore the international research on the link between substance abuse, mental illness and crime revealing the lack of research regarding substance-induced psychotic offenders in the Western Cape.

2.3.1 Substance Abuse and Mental Illness

Alcohol remains the most widespread substance of abuse in South Africa with 38.7 per cent of the population using it regularly. However, for comorbid psychiatric patients alcohol is rarely the only substance of abuse.¹¹² In the Western Cape alcohol is usually not considered a substance of abuse since it is legal and a large part of the society use it.¹¹³ Therefore, individuals who present themselves in need of treatment will likely do so due to the usage of other substances in combination with alcohol. Nevertheless, alcohol abuse is still a problem in terms of potential violent symptoms as it is likely to result in enhanced psychiatric symptoms for the individual.¹¹⁴

Alcohol intoxication can result in a reduction in psychological efficiency and motor control.¹¹⁵ These symptoms can include impaired judgement, faulty attention, impaired muscle control, loss of restraint and self-control.¹¹⁶ Individuals may be unable to control impulses and to consider the future consequences of behaviour which can heighten the risk of criminal and violent behaviour.¹¹⁷ In the more severe cases of withdrawal alcoholic hallucinosis can occur, which is hard to distinguish from schizophrenia, since it usually involves auditory threatening hallucinations.¹¹⁸ Where intoxication leads to substance-induced psychosis it is critical to get a detailed history of whether or not the individual had

¹¹² Margaretha S Van Heerden et al 'Patterns of Substance Use in South Africa: Results from the South African Stress and Health Study' (2009) 99 *S Afr Med* 358.

¹¹³ Weich and Pienaar op cit (n8) 117.

¹¹⁴ Van Heerden et al op cit (n112)

¹¹⁵ Ibid

¹¹⁶ American Psychiatric Association op cit (n17).

¹¹⁷ Durrant op cit (n49) 277.

¹¹⁸ Ibid.

been abusing substances for a longer period of time.¹¹⁹ Since a high percentage of the South African population abuse alcohol it is important to consider the negative symptoms of the substance in combination to effects of other substances.

Various research has found a high comorbidity between substance use and mental illness.¹²⁰ Mentally ill individuals are more likely to use substances for various reasons including: trying to alleviate their symptoms with substances, substance abuse leading to mental illness, genetical predisposition to mental illness or substance use or lastly that they share a neural substrate.¹²¹ In Cape Town this link is especially present where Saban et al (2014) found that 90.5 per cent of individuals seeking substance abuse treatment at an inpatient clinic used drugs on a daily basis (including tik and/or cannabis).¹²² Following the report of substance use the study showed that 96 per cent of the patients had some form of psychopathology.¹²³ Since the patients were admitted at private centres focusing on reducing substance use the research did not focus on treating their mental illness. It is notable that the study took place at private clinics where the participants payed for their treatment. This data may therefore not be applicable to the entire Western Cape, especially in the rural areas where psychiatric treatment is less available or for individuals who cannot afford treatment.¹²⁴

Wisdom et al (2011) in a study exploring substance use disorders in people with first-episode psychosis in New York found that approximately one-half of people suffering from a first episode of psychosis had a history of cannabis abuse and one-third had a current cannabis disorder.¹²⁵ The link between cannabis use and psychosis is particularly worrying

¹¹⁹ Larissa Panieri Peter 'The Effects of Alcohol and Substances' in Sean Z Kaliski *Psycholegal Assessment in South Africa* (2006) Oxford University Press. 131.

¹²⁰ Amina Saban et al 'The Association between Psychopathology and Substance Use: Adolescent and Young Adult Substance Users in Inpatient Treatment in Cape Town, South Africa' (2014) 17 *Pan African Medical Journal* 2.

¹²¹ Ibid 1.

¹²² Ibid 2.

¹²³ Ibid.

¹²⁴ Plüddemann et al op cit (n144).

¹²⁵ Wisdom et al op cit (n56) 1007.

in South Africa after the legalization of private use of marijuana on the 18th of September 2018.¹²⁶ Ramlagan et al (2010) found that the amount of cannabis-psychosis has been increasing every year in South Africa since 2005.¹²⁷ This is worrying as cannabis use has been found to result in poor medication adherence, amplified severity and continuation of symptoms along with risk of relapse for patients suffering from psychotic symptoms.¹²⁸

In unison with Ramlagan et al (2010) a study from Pietermaritzburg in Kwazulu-Natal (2016) concluded that the rate of substance abuse amongst individuals receiving psychiatric treatment was higher than amongst the general population in South Africa.¹²⁹ The authors concluded that the high percentage of individuals with a serious mental illness (schizophrenia, bipolar disorder and schizoaffective disorder) who misused psychoactive substances showed the growing tendency of substance abuse in South Africa.¹³⁰ Providing further evidence of the rate of comorbidity of substance abuse and mental illness'.¹³¹ Of particular interest was their research on individuals who had no prior mental illness diagnosis yet became psychotic after using Tik.¹³² This is concerning in regards to the growing tendency of tik abuse, suggesting that there is a correlation between use and substance-induced psychosis.

If the individual suffered from long-term substance abuse international research suggests that both disorders should be treated simultaneously.¹³³ Morisano et al (2014) found that integrated treatment that approaches both substance abuse and the psychiatric

¹²⁶ Casey Quakenbush 'South Africa's Supreme Court Has Legalized the Private Use of Marijuana' 19 Sep. 2018, available at <http://time.com/5400271/south-africa-legalizes-marijuana-cannabis/>, accessed on 5 April 2019.

¹²⁷ Ramlagan et al op cit (n12) 45.

¹²⁸ J Edwards et al 'Randomized Controlled Trial of a Cannabis-Focused Intervention for Young People with First-Episode Psychosis' (2006) 114(2) *Acta Psychiatrica Scandinavica* 110.

¹²⁹ Davis et al op cit (n53) 5.

¹³⁰ Ibid.

¹³¹ Ibid 5.

¹³² Ibid 7.

¹³³ Kim T Mueser et al 'Psychosocial Interventions for Adults with Severe Mental Illnesses and Co-Occurring Substance Use Disorders: A Review of Specific Interventions' (2005) 1(2) *Journal of Dual Diagnosis* 58.

problem simultaneously had improved outcome.¹³⁴ Similarly, James et al (2004) found that using an integrated treatment model looking at the mental illness and substance abuse is effective for people with psychotic disorders and substance abuse.¹³⁵ South Africa approaches treatment of substance abuse and mental health separately.¹³⁶ Research has found that clinicians are likely to perceive substance abuse and mental health as two primary disorders, which interact and affect each other separately.¹³⁷ This results in individuals with both a substance abuse disorder and mental disorder having further difficulty in accessing appropriate treatment.

Similarly to Saban et al (2014), Weich and Pienaar (2009) found that there is no service in the Western Cape that adequately provides treatment for these individuals.¹³⁸ Looking at the prevalence of substance abuse in acute adult psychiatric inpatients at Stikland Hospital (one of three state acute psychiatric hospitals in the Western Cape) Weich and Pienaar (2009) found that most admissions for treatment were involuntary following violence committed by the patient.¹³⁹ This is particularly concerning as it suggests that not only is there a relationship between substance abuse and mental illness, but also substance abuse and mental illness increasing the risk of violent behaviour.

2.3.2 Substance and Mental Illness leading to increased risk of crime

The effects of alcohol, tik and cannabis are heterogeneous, however all ‘states of intoxication are accompanied by irritability, autonomic arousal and temporary cognitive impairment,’ which can lead to hostility and aggression.¹⁴⁰ Research has found that it may also increase the probability of attack behaviours and aggression.¹⁴¹ Tik has been found to

¹³⁴ Morisano et al op cit (n108) 13.

¹³⁵ James et al op cit (n57) 983.

¹³⁶ Weich and Pienaar op cit (n8) 214.

¹³⁷ Ibid.

¹³⁸ Ibid.

¹³⁹ Ibid 216.

¹⁴⁰ Andrew Johns ‘Substance Misuse: a Primary Risk and a Major Problem of Comorbidity’ (1997) 9 *International Review of Psychiatry* 234.

¹⁴¹ Michael C Gizzi and Patrick Gerkin ‘Methamphetamine Use and Criminal Behavior’ (2010) 54(6) *International Journal of Offender Therapy and Comparative Criminology* 918.

have a stronger correlation with violence than any other drug, as it impairs the ability to control aggressive behaviour to a greater extent.¹⁴² This is a particular concern for the Western Cape, especially in Cape Town, where 35 per cent of patients seeking treatment for addiction claimed that tik was their primary substance of abuse.¹⁴³ A study carried out in Cape Town found that individuals who had been using tik experienced the following symptoms: aggressive behaviour (74 per cent), followed by delusions (59 per cent) and hallucinations (57 per cent).¹⁴⁴ 30 per cent of these individuals had a combination of aggressive behaviours, paranoid thoughts and delusions.¹⁴⁵ Further research is needed on precisely how tik increases ones violent actions, nevertheless, the above-mentioned side effects are concerning as they indicate a link between tik abuse and violent criminal behaviours.

Emotion dysregulation, high levels of impulsivity along with feelings of paranoia has been found in tik abusers.¹⁴⁶ This combination further increases the likelihood of impulsive aggression, where tik abusers report difficulty in controlling their own behaviour.¹⁴⁷ This is supported by studies that found that 34.9 per cent of individuals committed violent acts under the influence of tik.¹⁴⁸ Feelings of paranoia explains why individuals under the influence of tik are likely to misinterpret people's emotions and experience hostile intentions to others.¹⁴⁹ Not only does tik abuse increase the likelihood of criminal and violent behaviours, research has also found that chronic use of tik has been proven to have resulted in the onset of psychosis, characterized by impulsivity and paranoia, and increases the risk of violence.¹⁵⁰ Gizzi and Gerkin (2010) found that Tik

¹⁴² Susan Malcolm-Smith et al 'Affective Neuroscience of Methamphetamine Abuse' edited by George F.R Ellis et al *Substance Use and Abuse in South Africa* (2012) UCT Press. 148

¹⁴³ Ibid.

¹⁴⁴ Andreas Plüddemann et al 'Monitoring the Prevalence of Methamphetamine-Related Presentations at Psychiatric Hospitals in Cape Town, South Africa.' (2013) 16(1) *African Journal of Psychiatry* 45.

¹⁴⁵ Ibid.

¹⁴⁶ Malcolm-Smith et al op cit (n142) 147.

¹⁴⁷ Ibid 148.

¹⁴⁸ Ibid.

¹⁴⁹ Ibid.

¹⁵⁰ Ira Sommers, and Deborah Baskin. 'Methamphetamine Use and Violence.' *Journal of Drug Issues*, vol. 36, no. 1, 2006, p.93.

users were more likely than other drug users to be drunk or high when they got arrested, had more extensive criminal records, and more likely to display aggressive and paranoid behaviours.¹⁵¹ Considering the increase of tik use, especially in rural areas of the Western Cape, it is critical to educate these communities about the effects of the substance in order to try and control the usage and limit the amount of cases that results in tik-induced psychosis.¹⁵²

Specifically for mentally disordered forensic psychiatric patients substance abuse should be seen as an important risk factor for violence and re-offending.¹⁵³ These patients are more likely to commit serious violent offences, where Pickard and Fazel (2013) found that three quarters of the population had charges of ‘violence against the person, burglary, criminal damage, robbery and sexual offences.’¹⁵⁴ This is supported by Soyka’s (2000) study which found that men with major mental disorders including paranoid states and psychosis were 2.5 times more likely to commit a crime than other men and four times more likely to commit a violent offense.¹⁵⁵

Not only does substance abuse within a mentally disordered population increase the risk of violence, it has several long-lasting consequences which should be seen as a target within treatment. The major issue is that the comorbid population is chronic and relapsing.¹⁵⁶ James et al (2004) found that the use of substances by people with psychosis has negative influences in terms of symptoms, length of illness and psychosocial adjustment.¹⁵⁷ There is a risk of lengthened psychosis, psychotic relapse, treatment

¹⁵¹ Gizzi and Gerkin op cit (n141) 933.

¹⁵² Plüddemann et al op cit (n144)

¹⁵³ Hanna Pickard and Seena Fazel ‘Substance Abuse as a Risk Factor for Violence in Mental Illness: Some Implications for Forensic Psychiatric Practice and Clinical Ethics’ (2013) 26 *Current Opinion in Psychiatry* 349.

¹⁵⁴ Ibid.

¹⁵⁵ Michael Soyka ‘Substance Misuse, Psychiatric Disorder and Violent and Disturbed Behaviour’ (2000) 176(4) *British Journal of Psychiatry* 347.

¹⁵⁶ Ibid.

¹⁵⁷ James et al op cit (n57) 983.

noncompliance, hospitalization, crime and imprisonment.¹⁵⁸ Morisano et al (2014) similarly found that these patients had overall worse physical health, less social functioning, more severe symptoms of both disorders, a heightened risk of homelessness and incarceration.¹⁵⁹ Soyka (2000) also found an increased risk for violence, hospitalisation and relapse rate along with non-adherence to medication.¹⁶⁰ Along with the increased risk of readmission to psychiatric hospitals, more positive symptoms of mental illness at follow up along with ‘lower rates of remission’ were found by Lambert et al (2005).¹⁶¹ This suggests that the substance abuse disorder needs to be targeted simultaneously with mental illness throughout treatment in order to decrease relapse.

2.4 Treatment Approaches to Substance-Induced Mentally Disordered Offenders

2.4.1 Introduction

The above-mentioned research shows a large prevalence of not only mental illness in South Africa and the Western Cape, but also a high prevalence of substances being abused by this population.¹⁶² Crime and violence being committed by mentally disordered individuals is complicated by the effects of substance abuse. It has been found to not only influence the level of violence but also the likelihood of criminal behaviour. Of worry is the increasing use of tik, combined with the high prevalence of cannabis and alcohol abuse throughout the Western Cape, and its effects on individual’s mental health.¹⁶³ As mental illness and substance abuse are treated separately in the Western Cape it is questioned what treatment is appropriate for this population.

The aim of treatment within the forensic setting is seen as ‘improving the patients mental state, physical health, social functioning, self-care and reducing aggressive

¹⁵⁸ James et al op cit (n57) 983.

¹⁵⁹ Morisano et al op cit (n108) 11.

¹⁶⁰ Soyka op cit (n155) 345.

¹⁶¹ M Lambert et al ‘The Impact of Substance Use Disorders on Clinical Outcome in 643 Patients with First-Episode Psychosis’ (2005) 112(2) *Acta Psychiatrica Scandinavica* 142.

¹⁶² Plüddemann op cit (n13).

¹⁶³ Ibid.

behaviour along with promoting coping skills.’¹⁶⁴ A second aim is to protect the community by ensuring that the patient will not relapse into substance abuse and commit crime. The aim is to discharge them into their environments and to limit the rate of relapse.¹⁶⁵ The research that exists around the treatment of mentally ill offenders and the substance induced offender falls outside of this research which is the treatment of the substance-induced psychotic offender. Nevertheless, there is indication that various forms of treatment that can be used including use of medication, psychoeducation, occupational therapy, motivational interviewing and cognitive behavioural therapy. These therapies should be put into individualized treatment programs focusing on the individual’s symptoms and psychosocial problems.¹⁶⁶

2.4.2 Medication for stabilization

If the state patient presents with a mental disorder and severe symptoms during observation the initial step will be to get the patient to comply to medication in order to stabilize him.¹⁶⁷ This is especially critical for psychotic individuals because the hospital staff are unable to control the individuals otherwise. Clozapine, which is an antipsychotic medicine, has become a popular form of treatment as it effectively improves symptoms for forensic patients with psychosis and reduces rates of violence.¹⁶⁸ It is said to be superior to other antipsychotics as it decreases stay in hospital, increases rate of medication adherence and can achieve symptomatic remission if provided at early stages of psychosis.¹⁶⁹

¹⁶⁴ Moore op cit (n2) 107.

¹⁶⁵ Louise Farnworth and Jaime P Muñoz ‘An Occupational and Rehabilitation Perspective for Institutional Practice’ (2009) 32(3) *Psychiatric Rehabilitation Journal* 195.

¹⁶⁶ Sheilagh Hodgins and Rüdiger Müller-Isberner *Violence, Crime and Mentally Disordered Offenders: Concepts and Methods for Effective Treatment and Prevention*: John Wiley & Sons (2008). 15.

¹⁶⁷ James Vess ‘Development and Implementation of a Functional Skills Measure for Forensic Psychiatric Inpatients’ (2001) 12(3) *Journal of Forensic Psychiatry* 593.

¹⁶⁸ Adam Martin et al ‘Clozapine Use in a Forensic Population in a New South Wales Prison Hospital’ (2008) 42(2) *Australian & New Zealand Journal of Psychiatry* 141.

¹⁶⁹ Kristen Thien et al ‘Clozapine Use in Early Psychosis.’ (2018) 199 *Schizophrenia Research* 374.

However, both substance abuse and mental illness can complicate the individuals understanding of the need for medication and the need for compliance.¹⁷⁰ Zubi and Connolly (2013) in a study looking at patients experience of first-time hospitalization for acute psychosis at a psychiatric hospital in South Africa found that all participants expressed extreme dislike of having to take medication.¹⁷¹ These bad experiences could have been caused by the illness itself or other factors including poor understanding of the illness. Kaliski (1997) found that most patients at Valkenberg lack insight into their disorder, and are to varying degrees forced to adhere to medication and submit to treatment.¹⁷² Non-adherence of medication has a high correlation with substance abuse and higher risks of reoffending.¹⁷³ It is therefore important to educate the patient about their comorbid disorder in order to promote adherence, which can be done through psychoeducation.¹⁷⁴ Nevertheless medication cannot stand on its own as a form of treatment for mentally disordered offenders, and is only seen as the first step in controlling psychotic symptoms prior to commencing of therapeutic treatment.¹⁷⁵

2.4.3 Psychoeducation and the Family

As previously mentioned, it is likely that forensic state patients along with their family's lack insight into the illness. Without understanding of the disorder, they are unable to benefit from treatment as they do not see the need for it, therefore once they are stabilized a second step in the treatment is seen to be psychoeducation. Psychoeducation aims to provide information about the mental illness, need for medication and treatment, and explores various individual ways to prevent relapse.¹⁷⁶ For the patient to move forward with treatment he must accept the mental disorder, recognize the attributable symptoms and behaviour and be aware of external situations' that can influence his violent

¹⁷⁰ Zubi and Connolly op cit (n58) 81.

¹⁷¹ Zubi and Connolly op cit (n58) 83.

¹⁷² Kaliski op cit (n9) 249.

¹⁷³ Pickard and Fazel op cit (n153) 352.

¹⁷⁴ Ibid.

¹⁷⁵ Zubi and Connolly op cit (n58) 83.

¹⁷⁶ Edwards et al op cit (n128) 111.

behaviour.¹⁷⁷ Explaining the mental illness and substance abuse disorder and how it leads to substance-induced psychosis along with the consequences of this is beneficial in aiming to decrease the rate of relapse.¹⁷⁸

Psychoeducation usually occurs in group settings and focusses on both the patient and his family. Family involvement has been found to largely decrease the rate of relapse for the psychiatric patient.¹⁷⁹ Psychoeducation for the purpose of this research focuses on teaching the patient and his family information about the effects of substance use on mental illness and strategies that are available for behaviour management.¹⁸⁰ Family involvement for people with dual disorders is usually linked to a better course of treatment,¹⁸¹ where recovery is not seen as a reality without a 'supportive system.'¹⁸² On the other hand if the patient comes from an unstable family this has been found to increase the rate of relapse for comorbid patients.¹⁸³ Therefore there isn't a clear consensus as to whether family involvement is critical, since it depends on the individuals circumstances.

During the initial meeting with the family it is critical for the social worker to get an understanding of the family dynamics, in order to determine the best course of treatment for the individual patients. During this initial meeting the social worker will also gather collateral¹⁸⁴ from the family about the patient.¹⁸⁵ It is useful to hear the family's version of the story in order to compare it to how the patient is presenting in the hospital. For cases of substance-induced psychosis the collateral from the family is critical, as the family will be able to recall how the person was prior to the psychotic symptoms. The family plays a

¹⁷⁷ Kaliski op cit (n9) 254.

¹⁷⁸ Clark op cit (n19) 71.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid 72.

¹⁸¹ Mueser et al op cit (n133) 66.

¹⁸² Clark op cit (n19) 75.

¹⁸³ Ibid 70.

¹⁸⁴ Collateral refers to family sharing what they know about the patient, how they usually act, and any relevant information in order to determine what happened at the time of the offence.

¹⁸⁵ Moore op cit (n2) 108.

key role in gathering information about the patient as they are usually the ones who know the patient best.

Even though the family is seen to play an integral part in the mentally disordered offenders treatment process, family involvement is not always a reality. In a lot of the cases family members were the victims of the violence committed by the state patient.¹⁸⁶ This can be an obstacle as they may be reluctant to commence therapy and unwilling to have contact with the patient.¹⁸⁷ Psychoeducation is critical in these cases for the family to understand that the patient was mentally unwell at the time of the offence and was not responsible for their actions. Valkenberg caters for the entire Western Cape, and families may simply be unable to travel the long distances to visit their family member in the hospital. Or if the patient comes from a poorer area, which research shows they are likely to do, the family may not have the financial means to travel.¹⁸⁸ Therefore one obstacle to treatment may be the ability for family involvement during the state patient's treatment at Valkenberg.

2.4.4 Occupational Therapy

Being admitted (usually involuntarily) to a psychiatric hospital for an indefinite period of time can result in a loss of autonomy.¹⁸⁹ The patients are in a controlled environment within the psychiatric hospital where there may be a lack of meaningful opportunities for work and/or education. This has been found to result in extreme feelings of anger, frustration and anxiety.¹⁹⁰ Comorbid mentally disordered offenders are already more likely to suffer from an inability to manage anger, anxiety and conflict resolution,

¹⁸⁶ Soyka op cit (n155) 345.

¹⁸⁷ Ibid.

¹⁸⁸ Karl Peltzer and Nancy Phaswana-Mafuya 'Drug Use Among Youth and Adults in a Population Based Survey in South Africa' 2018 24(0) *South African Journal of Psychiatry* 1.

¹⁸⁹ Zubi and Connolly op cit (n58) 82.

¹⁹⁰ Ibid.

which has been found to escalate within the controlled hospital setting.¹⁹¹ Additionally, the loss of habit and routine can have harmful effects on the individual's health. In order to give the patient a sense of self within the hospital occupational therapy is useful in promoting and providing meaningful occupations to give the patient a sense of purpose.¹⁹²

Due to the above-mentioned complicating factors of the comorbid forensic (including prevalence of substance abuse) psychiatric population occupational therapy has been found to be important in the rehabilitation of mentally disordered offenders.¹⁹³ The therapy encourages the individual to take responsibility and become an active part of the treatment process.¹⁹⁴ By taking responsibility the hope is to improve independence and promoting a sense of choice.¹⁹⁵ The overall aim of occupational therapy is found to improve cognitive skills, communication, motivation, role performance, self-esteem, and affect.¹⁹⁶ Large focus is placed on improving awareness of self and others, inspiring appropriate responses, improving understanding, life skills and social skills.¹⁹⁷ By promoting social skills research has found that patients successfully reduce recidivism.¹⁹⁸ In combination the aim is to improve communication, conflict management, problem solving, and money handling.¹⁹⁹ Comorbid forensic psychiatric patients receive a disability grant if the multidisciplinary deems it fit for them to be put on leave from the hospital.²⁰⁰ Social skills training in combination with family training and appropriate medication adherence has seen success in rehabilitation.²⁰¹

¹⁹¹ Zubi and Connolly op cit (n58) 110.

¹⁹² Farnworth and Muñoz op cit (n165) 196.

¹⁹³ Edward A S Duncan et al 'Research Priorities in Forensic Occupational Therapy' (2003) 66(2) *British Journal of Occupational Therapy* 55.

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

¹⁹⁶ Moore op cit (n2) 108.

¹⁹⁷ Ibid 111.

¹⁹⁸ Danielle Hitch et al 'Occupational Therapy in Forensic Psychiatry: Recent Developments in Our Understandings (2007–2013)' (2015) 79(4) *British Journal of Occupational Therapy* 202.

¹⁹⁹ Moore op cit (n2) 112.

²⁰⁰ Western Cape Government 'Disability Grants.' 21 Nov. 2018, available at www.westerncape.gov.za/service/disability-grants, accessed on 5 April 2019.

²⁰¹ Marnie E Rice and Grant T Harris 'The Treatment of Mentally Disordered Offenders' (1997) 3(1) *Psychology, Public Policy, and Law* 139.

2.4.5 Motivational Interviewing

In order for the state patient to comply to treatment he needs to accept the need for change and have a certain level of motivation to do so.²⁰² This is a large obstacle if the individual does not have knowledge about the mental disorder or does not see the need for change. Motivational interviewing aims to increase inherent motivation through individual or group therapy. This therapy has seen success in decreasing substance abuse.²⁰³ Decreasing substance abuse is critical for the forensic population in Valkenberg, as it is an overall challenge in treatment and leads to a higher likelihood of relapse.²⁰⁴ Kavanagh et al (2004) found that the motivational interviewing showed success as an initial intervention and could drastically decrease patients substance use below baseline levels.²⁰⁵ Similarly, Chanut et al (2005) found that motivational interviewing can improve treatment adherence for dual disordered psychiatric patients.²⁰⁶ Additionally, patients suffering from psychosis were more likely to comply to medication after motivational interviewing.²⁰⁷ Of significance was the finding that motivational interviewing, in combination with active support from the community, had the ability to increase attendance rates at psychiatric outpatient centres.²⁰⁸ Utilization of community resources could therefore lower the rate of relapse within the comorbid population.

In contrast, Baker et al (2002) concluded that motivational interviewing did not significantly enhance the patient's willingness to participate in substance abuse treatment. Reasons for the failure of motivational interviewing in certain studies may include the severity of substance abuse in the population and high rate of readmission.²⁰⁹ Due to the

²⁰² Florence Chanut et al 'Motivational Interviewing and Clinical Psychiatry' (2005) 50(9) *The Canadian Journal of Psychiatry* 548.

²⁰³ Michelle Cleary et al 'Psychosocial Treatments for People with Co-Occurring Severe Mental Illness and Substance Misuse: Systematic Review' (2008) 65(2) *Journal of Advanced Nursing* 238.

²⁰⁴ James et al op cit (n57) 983.

²⁰⁵ Ibid.

²⁰⁶ Chanut et al op cit (n202) 549.

²⁰⁷ Ibid.

²⁰⁸ Ibid.

²⁰⁹ Kavanagh et al op cit (n193) 238.

above mentioned research on the high prevalence of substance abuse in the Western Cape it still remains whether the success of the international research on motivational interviewing applies to the South African context.²¹⁰ Nevertheless, motivational interviewing has shown success in a decrease of substance abuse for forensic populations along with an increased willingness to participate in treatment.

2.4.6 Cognitive Behavioural Therapy

As mentioned above there are several complicating factors for treatment of comorbid substance abuse and mentally disordered offenders including their aggressive behaviours and lack of impulse control.²¹¹ These behaviours (along with other behaviours associated to the mental disorder) need to be controlled in order for the individual to receive treatment. Cognitive Behavioural Therapy aims to do this through a correction of the negative thoughts, feelings and actions by promoting alternative ways of coping and encouragement of treatment adherence.²¹² The therapy revolves around the patient understanding the link between mental state and substance abuse, understanding why they use substances and the effects of it, along with training to avoid future vulnerable situations which may result in substance abuse.²¹³ The above mentioned research indicates that a large emphasis of treatment needs to initially lie on the individuals substance abuse problem, before trying to treat the mental illness. The above-mentioned studies indicate that cognitive behavioural therapy cannot successfully be employed on its own to help and treat mentally disordered individuals with a comorbid substance abuse disorder. There is indication that the therapies need to be used in unison with each other, further supporting the hypothesis that substance-induced psychotic offenders are a difficult population of offenders to treat.²¹⁴

²¹⁰ Plüddemann et al op cit (n144).

²¹¹ Zubi and Connolly op cit (n58) 82.

²¹² Cleary et al op cit (n203) 241.

²¹³ Joy M Schmitz et al 'Cognitive-Behavioural Treatment of Bipolar Disorder and Substance Abuse: A Preliminary Randomized Study' (2002) 1(1) *Addictive Disorders & Their Treatment* 19.

²¹⁴ Farooq Naeem et al 'Cognitive Behaviour Therapy for Schizophrenia in Patients with Mild to Moderate Substance Misuse Problems' (2005) 34(4) *Cognitive Behaviour Therapy* 214.

2.4.7 Combination of therapies

From research on the above mentioned therapies the general push was to use a combination of therapies for comorbid substance abusers with mental illness.²¹⁵ Medication adherence is a critical initial step to stabilize the patients psychotic symptoms, which has been found to be aided by cognitive behavioural therapy.²¹⁶ This combination was found to also improve mood symptoms,²¹⁷ however did not have any effect on the level of substance abuse.²¹⁸ Similarly, Naeem et al (2005) concluded that cognitive behavioural therapy did not result in a change in substance use or mental state.²¹⁹ The study suggests that a combination of pharmacotherapy and psychotherapy could be beneficial in treating comorbid patients. However, as mentioned the population is troubled by the high prevalence of substance abuse, which needs to be targeted in order to ensure a better treatment outcome on mental health.²²⁰

Motivational interviewing in combination with cognitive behavioural therapy was found to not only improve the patient's rate of substance abuse but also improve their mental state.²²¹ Baker et al (2006) showed that individuals who received cognitive behavioural therapy and motivational interviewing in unison had short-term improvements on substance use.²²² And for individuals with psychosis it also had a positive effect on general functioning.²²³ Barrowclough et al (2001) similarly found that integrating motivational interviewing, cognitive behavioural therapy and family intervention led to

²¹⁵ Naeem et al op cit (n214).

²¹⁶ Ibid.

²¹⁷ Ibid.

²¹⁸ Ibid.

²¹⁹ Ibid 214.

²²⁰ SACENDU op cit (n10) 5.

²²¹ Cleary et al op cit (n203).

²²² Amanda Baker et al 'Cognitive-Behavioural Therapy for Substance Use Disorders in People with Psychotic Disorders' (2006) 188(5) *British Journal of Psychiatry* 446.

²²³ Ibid.

significant improvement in patients level of functioning.²²⁴ The study further emphasizes the need for individual treatment programs according to the patients mental state but also the need for integrated treatment in term of substance abuse and mental health.

The above-mentioned research indicates the success of a combination of therapies for comorbid psychiatric patients. It is concluded that there is no set agreement of one treatment model that can be used, and the studies show success in different areas of treatment for the population groups. The above-mentioned research highlights the gap within the research on mentally disordered offenders, as it largely focusses on substance abuse and mental illness but does not take criminal behaviour into consideration. Furthermore, the research is largely conducted internationally, therefore it is questioned how the various treatment approaches can be used within the Western Cape population due to a difference in resource and treatment availability.

2.4.8 Complicating factors for treatment: Risk Assessment, Institutionalization and lack of available resources

International research shows that several challenges can arise during the treatment of substance-induced mentally disordered offenders including the risk assessment prior to release, effect of institutionalization and the availability of resources in the Western Cape.²²⁵ Prior to release from the psychiatric hospital the multidisciplinary team is required to weigh up the levels of risk of the individual reoffending and/or relapsing. However, risk assessment is not a precise science and future mental states and conduct can never be foreseen with certainty.²²⁶ Studies show that both psychiatrists and psychologist's predictions of future violence were wrong for two out of three patients.²²⁷ As mentioned, substance abuse can increase the risk of repeat offending by as much as 50 per cent.

²²⁴ Christine Barrowclough et al 'Randomized Controlled Trial of Motivational Interviewing, Cognitive Behavior Therapy, and Family Intervention for Patients With Comorbid Schizophrenia and Substance Use Disorders' (2001) 158 (10) *American Journal of Psychiatry* 1710.

²²⁵ Ibid

²²⁶ Pickard and Fazel op cit (n153) 350.

²²⁷ Rice and Harris op cit (n201) 133.

²²⁸ Additionally, non-adherence to medication increases the risk of violence. Distinct emphasis needs to be placed on risk factors for recidivism throughout treatment, as risk of relapse is found to be highest during the first time the patient leaves the hospital.²²⁹ The reintroduction of previous cues and contexts from past use in the community can influence relapse and recidivism, which the multidisciplinary team cannot foresee.

The multidisciplinary team in the psychiatric hospital need to compare the risk of letting the patient out on leave with the risk of the patient becoming institutionalized after spending long periods of time constrained inside of the hospital premises.²³⁰ Institutionalization is defined as the patient spending extended length and time of treatment constrained in the hospital, making reintegration into society more challenging due to long periods of inactivity and a ‘loss of contact with the rest of the world.’²³¹ This in turn results in detachment, submissiveness and furthered loss of autonomy and individuality.²³² The sense of hopelessness impedes adjustment back into society as patients become adapt to life inside the psychiatric hospital and develop a dependency on the structured life.²³³ At Valkenberg institutionalization can be seen as an obstacle since the population consists of individuals who have committed a serious crime whilst suffering from mental illness and substance abuse.²³⁴ The treatment process therefore may require an extended period before the patient is allowed leave. Therefore, it will be questioned whether a certain level of institutionalization is inevitable for state patients at Valkenberg.

In order to decrease relapse and institutionalization the community and family support is crucial once the patient is granted leave.²³⁵ Research suggests that integrating

²²⁸ Pickard and Fazel op cit (n153) 352.

²²⁹ Ibid.

²³⁰ Kobie Zietsman and Daleen Casteleijn ‘Care, Treatment and Rehabilitation Programmes for Large Numbers of Long-Term Mental Health Care Users’ in Rosemary B. Crouch and Vivyan M. Alers (5th ed) *Occupational Therapy in Psychiatry and Mental Health* (2014) John Wiley & Sons. 150.

²³¹ Moore op cit (n2) 109.

²³² Zietsman and Casteleijn op cit (n230) 150.

²³³ Ibid.

²³⁴ Refer to information provided by participants throughout the interviews.

²³⁵ Ibid.

primary mental healthcare and promoting community-based services is necessary for the individual to reintegrate into society.²³⁶ If strong community-based services were available to the entire population it is highly plausible that the burden of disease around mental illness would decrease.²³⁷ However, the availability of this is lacking in the Western Cape, especially for individuals living in poorer rural areas.²³⁸ Rehabilitation centres within the South African community are not readily available and empowering the community to be able to deal with forensic patients' needs work.²³⁹ Zubi and Connolly (2013) found that prior to their first admission patients already had a negative perception of psychiatric hospitals in South Africa.²⁴⁰ The community needs to be educated about mental disorders, substance abuse along with psychiatric hospitals to not only decrease the stigma around both burdens of disease, but also increase the likelihood of individuals seeking medical help prior to an offence being committed..

2.5 Conclusion

From the research discussed above it is clear that there is no support for any one model of treatment for substance-induced psychotic offenders. Certain features from the treatment of mentally disordered individuals who abuse substances shows the positive impact of a combination of treatment. This combination includes the use of medication, psychoeducation, occupational therapy, motivational interviewing, cognitive behavioural therapy. It is necessary to consider that the research is mostly conducted internationally and does not take into account the forensic population consisting of mentally disordered population that abuse substances and have committed a crime.

The research indicates the large obstacle of substance abuse within the population, which is worrying when considering the high prevalence of substance abuse in the Western

²³⁶ Jacob and Coetzee op cit (n81) 178.

²³⁷ Ibid.

²³⁸ Moore op cit (n2) 112.

²³⁹ Ibid.

²⁴⁰ Zubi and Connolly op cit (n58) 83.

Cape. This is further exacerbated by the lack of available treatment where less than 5% of the population with substance abuse disorders in the Western Cape access treatment.²⁴¹ Due to the high rate of substance abuse within this forensic population large focus needs to be placed on preventing the individuals from relapsing into substance abuse as this has been found to increase the likelihood of psychosis and recidivism.²⁴² There is a lack of research on forensic comorbid psychiatric patients (especially substance-induced psychotic offenders) in the Western Cape that are receiving treatment. In order to understand the issues around treatment of state patients in the Western Cape it is necessary to explore the treatment model that is employed at Valkenberg, as it is the only place which provides this treatment for state patients.

²⁴¹ Bronwyn Myers et al 'Substance Abuse Treatment Engagement, Completion and Short-Term Outcomes in the Western Cape Province, South Africa: Findings from the Service Quality Measures Initiative' (2018) 185 *Drug and Alcohol Dependence* 278.

²⁴² Ibid.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This research aims to establish what treatment model is employed at Valkenberg for substance-induced psychotic offenders. As previously mentioned, the high prevalence of substance abuse by mentally disordered individuals increases the likelihood of violence and is a barrier to treatment.²⁴³ Barriers such as lack of awareness and resources in the Western Cape have been found to effect the treatment of substance-induced psychotic offenders.²⁴⁴ Of concern is the higher population of individuals from lower income areas in the Western Cape suffering from substance abuse and mental illness, which can act as a barrier to access of treatment.²⁴⁵ The above mentioned literature research shows large variance in the different studies and settings. There is a need to carry out a study at Valkenberg, as it is the only psychiatric hospital in the Western Cape that treats state patients, in order to analyse the extent of the problem of treatment for substance-induced psychotic offenders. In order to explore the treatment model used at Valkenberg interviews were conducted with staff members who are involved in the direct treatment of forensic psychiatric patients inside the hospital. These people have expertise and experience working with substance-induced psychotic offenders. This chapter will outline the research methodology that was used, the sampling strategy, analytical strategy, ethical considerations and the limitations of the research.

3.2 Research Design

This study used a qualitative research design. The interviewer asked the open-ended questions²⁴⁶ and recorded the findings in order to later evaluate it.²⁴⁷ Through this approach it was possible to later analyse the findings through thematic analysis. By using this

²⁴³ Myers op cit (n241).

²⁴⁴ Plüddemann op cit (n13).

²⁴⁵ Peltzer and Phaswana-Mafuya op cit (n188).

²⁴⁶ See Appendix 1.

²⁴⁷ Earl Babbie, *The Practice of Social Research* 12th edition (2010) Wadsworth Cengage Learning. 274.

research approach, it was possible to gather first-hand knowledge from the participants and allowed for leeway in the way that the information was gathered. The research aimed to gather information from participants who have had experience with working with forensic psychiatric patients in order to understand the treatment of substance-induced psychotic offenders along with the challenges that the multidisciplinary team face during this treatment period.

This research focusses entirely on gaining insight from staff members at Valkenberg who play a role in the treatment process of forensic psychiatric patients, in particular for substance-induced psychotic offenders. In order to gain access to the relevant participants purposeful sampling was used because it allowed the researcher to identify and select ‘information-rich cases,’²⁴⁸ in other words, individuals that are ‘especially knowledgeable about or experienced with a phenomenon of interest.’²⁴⁹ Participants who had done work with the forensic psychiatric patients at Valkenberg were identified and selected. Following purposeful sampling a snowball sampling technique was used. Snowball sampling involves the researcher recognising a few key members of the target population and asking those for contact information for further members of the target population.²⁵⁰ This is known as the ‘snowball effect’ where the population keeps growing. In order to gather a full understanding of the treatment model that is employed at Valkenberg the researcher interviewed a member within each role of the multidisciplinary team. This included a forensic psychiatrist, psychologist, occupational therapist, social worker and a nursing staff. In total the researcher interviewed six staff members involved in the treatment of forensic psychiatric patients at Valkenberg.

²⁴⁸ Lawrence A Palinkas et al ‘Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research’ (2015) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 534.

²⁴⁹ Ibid.

²⁵⁰ Chaim Noy ‘Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research’ (2008) 11(4) *International Journal of Social Research Methodology* 330.

Invitation emails²⁵¹ including an information sheet²⁵² were sent to the participants prior to the interviews. These emails highlighted background information for the research along with the aim and goals of the study. They were also informed that the findings of the research would be used in an LLM minor dissertation in order to fulfil a master's degree at the University of Cape Town. Each participant was told that they would receive a final copy of the research upon completion. Once the participants responded to the email either via email or a telephone call a suitable time to conduct the interview was decided upon. Each interview was conducted in the participants individual offices at Valkenberg. Prior to the commencement of the interview each participant was handed the information sheet again along with a consent form.²⁵³ This consent form stressed that their participation was voluntary, that they had the right to leave the interview at any point, and that they agreed for the interview to be recorded.

3.3 Data Collection Method

Participants were interviewed face to face on the premises of Valkenberg in the participants personal offices. It was beneficial to conduct the interviews face to face as it was possible to interpret the participants body language and build a personal relationship with the participants. Standardised open-ended interviews were conducted so that the participants were able to reveal as much information as desired and allowed for greater variance in responses. The interviews included general questions such as: 'Can you talk to me generally about the population of patients at Valkenberg?' and 'Can you talk to me about the treatment model that is in place and used at Valkenberg?' Participants were asked about the use of medication throughout the treatment, whether they had experienced any challenges, and the role of the family through the treatment and what aspect of the treatment they found to be most important in terms of a patient being put on leave. There was also a question about their experience of the waiting period in terms of the number of referrals

²⁵¹ See Appendix 2.

²⁵² See Appendix 3.

²⁵³ See Appendix 4.

for substance-induced psychotic offenders at Valkenberg. All participants received the same questions in the same order, making analysis easier as the datasets could be compared. The length of each interview varied from 45 minutes to one hour. All of the interviews were conducted between January and March 2019. All interviews were audio-recorded with the permission of the participants using the researcher's phone. Each interview was transcribed verbatim and analysed for common themes. Finally, the researcher drew conclusions about the treatment model of substance-induced psychotic offenders considering the relevant literature compared to the findings from the study.

3.4 Ethical Considerations

Ethical clearance was obtained from the Law Faculty at University of Cape Town, the Faculty of Health Sciences at University of Cape Town along with the Western Cape Government.²⁵⁴ Participants were promised confidentiality and so the consent form that was signed prior to the commencement of the interviews highlighted that the participants identity would remain confidential. Throughout the discussion section in Chapter Four each participant will be identified with participation numbers, namely participant one to participant six. The interview recordings and transcript were kept in a password protected file on the researcher's laptop in order to control that no one else could access the data. This data will be kept for a maximum of one year if the researcher sees the need to reopen the recordings and transcripts.

3.5 Limitations

Throughout the interviews the researcher could identify two limitations of the study. Firstly, the sample size could be seen as a limitation since it was quite small. Yet, from the researcher's perspective this number was sufficient as it included member of each role in the multidisciplinary team working with forensic psychiatric patients. After the six

²⁵⁴ See Appendix 5, 6 and 7.

interviews the researcher found that saturation had been reached, where no new information was provided by participants. Additionally, the participants who agreed to participate in the study had been employed at Valkenberg for a length of minimum one year up to 30 years. Therefore, the participants can be seen to have had vast experience working within the field.

Although research on one facility ran the risk of limited generalizability Valkenberg is the only psychiatric hospital in the Western Cape that works with these offenders. It was rather seen as beneficial as it further exemplified the lack of resources available for treatment of state patients within the Western Cape. Secondly, the aim of this study was to gather a wholesome picture of the treatment model used at Valkenberg for substance-induced psychotic offenders. Even though participants were asked primarily about the treatment of substance-induced psychotic offenders some participants spoke about the overall treatment of all patients in the forensic unit. Valkenberg also caters for other mentally disordered offenders with diagnosis such as schizophrenia, bipolar mood disorder, schizoaffective disorder et cetera.²⁵⁵ It is therefore possible that some of their responses relate more to the general population rather than specifically for substance-induced psychotic offenders. If the study were to be conducted again this would therefore have to be specified more clearly in the questions.

²⁵⁵ Information provided from personal interviews at Valkenberg hospital.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

Throughout the interviews with staff members involved in the multidisciplinary team it was possible to gather a picture of how the psychiatric hospital approaches the treatment of substance-induced psychotic offenders. This chapter presents findings from the interviews and discusses key themes that emerged including the prevalence of substance abuse in the population, the treatment model used, the role of the family, effects of the waiting period prior to admission and lastly the overarching challenges around treatment. These key themes are analysed in comparison to existing themes in the literature in order to discuss the complexity of the treatment of substance-induced psychotic offenders and the challenges that are involved.

4.2 Substance abuse

As discussed above substance abuse deems to be a large problem for comorbid forensic patients and has been found to have a large link with violence and crime.²⁵⁶ It is common for individuals in South Africa to begin abusing substances at an early age, where research found that youth began using alcohol between the age of ten and 12, and cannabis was used starting between the ages of 11 and 12.²⁵⁷ Additionally, there is an ever-growing increase in people who abuse tik starting from the age of ten years old, especially in rural areas of the Western Cape.²⁵⁸ At Valkenberg participants claimed that 60 to 70 per cent of the population have a comorbid substance abuse disorder.²⁵⁹ Participant 1 (P1) claimed that these numbers were as high as at least 95 per cent stating that ‘it’s quite exceptional to find

²⁵⁶ Pickard and Fazel op cit (n153).

²⁵⁷ Ramlagan op cit (n6) 40.

²⁵⁸ Plüddemann et al op cit (n144) 187.

²⁵⁹ Personal interview with Participant 4 (P4), Valkenberg.

someone who doesn't have one.²⁶⁰ Out of the people that are admitted to the forensic unit at Valkenberg a huge percentage have had a long history of substance abuse.²⁶¹ Due to the high presence of substance abuse it is difficult for the multidisciplinary team to distinguish whether the symptoms are related to the substances or mental illness.²⁶² It can be difficult to establish whether the substances caused psychosis themselves, whether the mental illness caused psychosis or whether it was a combination of the two. This makes it difficult for the staff to establish whether the focus of the treatment needs to begin with controlling substance abuse or ameliorating the mental disorder symptoms.

When asked about what substances were most prevalently used all participants mentioned alcohol, cannabis and Tik. Alcohol was found to be used by almost every patient at Valkenberg. The worst cases of alcohol use were found in patients that came from rural areas, which participants described as having a high rate of Fetal Alcohol Syndrome.²⁶³ There were reported cases where alcohol resulted in psychosis which in turn led to violence and crime being committed. Nevertheless, it was mentioned that it was very unlikely for a patient to only be using one substance and that alcohol wasn't seen by the participants as the main issue in regard to violence and substance-induced psychosis.

Despite the fact that alcohol is also a substance of abuse it was not regarded as such by the participants. This supports the research throughout the Western Cape which found that alcohol isn't seen as the substance of abuse for individuals seeking treatment as it is legal and used by most of the society.²⁶⁴ However, as participants explained cases of alcohol-induced psychosis the substance should still be regarded as problematic as it still influences the treatment for patients at Valkenberg. In combination with alcohol, cannabis was mentioned as the most prevalent substance of abuse.²⁶⁵ P1 noted that almost all of the

²⁶⁰ Personal Interview with Participant 1 (P1), Valkenberg.

²⁶¹ Personal Interview with P3 op cit (n32).

²⁶² Ibid.

²⁶³ Personal Interview with Participant 5 (P5), Valkenberg.

²⁶⁴ Weich and Pienaar op cit (n8) 117.

²⁶⁵ Personal interview with P2 op cit (n25).

patients started smoking cannabis in their teens. Several participants mentioned that for patients with chronic psychiatric illness, who are on constant medication, only a very small amount of cannabis is needed to get ‘really really ill.’²⁶⁶ The substance abuse in itself was said to speed up or even cause relapse.²⁶⁷ Even though participants explained the presence of alcohol and cannabis use in the population, their concern was placed on the rise in patients abusing tik.

Tik use has increased drastically throughout the past years in the Western Cape, and has become the primary substance of abuse for individuals seeking treatment, replacing alcohol and overtaking cannabis.²⁶⁸ This is particularly concerning in the forensic setting as tik has been found to increase risk of violent behaviour and psychosis.²⁶⁹ At Valkenberg tik use has drastically increased in numbers over the last years with an estimated 30-40 per cent of the patients having smoked it.²⁷⁰ P1 claimed that following a tik binge it was more likely for patients to use cannabis or Mandrax to bring them down.²⁷¹ Tik was mentioned as causing ‘enormously exaggerated reactions in patients’²⁷² and could ‘make people crazy.’²⁷³

As mentioned by Ramlagan et al (2010) the Western Cape has seen a drastic increase in Tik.²⁷⁴ This resulted in an increase in referrals to Valkenberg after tik-induced psychosis resulted in individuals committing crime. P1 stated: ‘In fact, it's because of the tik epidemic that our psychiatric or mental services can't cope anymore. They are just flooding everywhere.’²⁷⁵ Participant 5 (P5) noted that these referral numbers are only expected to increase:

²⁶⁶ Personal interview with P2 op cit (n25).

²⁶⁷ Personal interview with P4 op cit (n259).

²⁶⁸ Van Heerden et al op cit (n112) 359.

²⁶⁹ Plüddemann et al op cit (n13) 45.

²⁷⁰ Personal interview with P1 op cit (n260).

²⁷¹ Ibid.

²⁷² Personal interview with P2 op cit (n25).

²⁷³ Personal interview with P1 op cit (n260).

²⁷⁴ Ramlagan et al op cit (n12) 43.

²⁷⁵ Ibid.

‘It’s becoming more and more difficult because of the amount of substances that we have, the amount of people who are becoming sick because of substances... You know people use drugs once and they are unwell for the rest of their lives...we’re not coping now with the amount of people that we have to see, so I can’t even anticipate what is going to happen in the future. And as long their substances the trend is just going to go up and up and up.’²⁷⁶

All participants placed large emphasis on the disastrous effects of substance abuse within the forensic population. As it was very unlikely for patients not to have had a history of substance abuse, the link between substance abuse and mental illness was seen to go ‘hand in hand.’²⁷⁷ It was suggested that substance abuse is a large obstacle throughout the treatment process with little hope that there will be an improvement. Not only does it influence the large number of referrals to Valkenberg, it is also the reason for the large rate of relapse for the patients.

4.3 Treatment model

Valkenberg works with a biopsychosocial model implemented by the multidisciplinary team. After the patient has been stabilized with medication (usually implemented by the nursing staff) in the maximum secure unit, they are moved down the medium secure where focus on therapy commences. Participant 4 (P4) claimed patients stay an average of six months to a year in medium secure before moving to low secure, where the push is for them to be sent out into the community. In most cases the individual is too unstable whilst spending time in the maximum secure ward, therefore it is rare for the individuals to receive therapy at this stage. Starting in medium secure the multidisciplinary team start playing a bigger role in the treatment and rehabilitation of the patients in terms of implementation of various forms of therapy.

²⁷⁶ Personal interview with P5 op cit (n263).

²⁷⁷ Personal interview with P6 op cit (n24).

Five staff members make up the multidisciplinary team at Valkenberg including a psychiatrist, psychologist, social worker, occupational therapist and nursing staff.²⁷⁸ Valkenberg distinguishes between ‘panel’ and ‘single’ cases. Panel cases are for the more serious crimes such as murder, rape, aggravated assault etc whereas single cases are said to be for the more ‘petty cases’ such as theft.²⁷⁹ For panel cases two psychiatrists will consult on the case to determine whether the person needs to become a state patient.²⁸⁰ Throughout the treatment the multidisciplinary team work together to decide what treatment is necessary and best for each patient.²⁸¹ Even though each area of work may have their own treatment model, for example occupational therapy having a different one compared to social work, participants concurred that team work is necessary. ‘I don’t think you can go without medication, but you also can’t go without therapy, and group work, and family work, they all go hand in hand.’²⁸²

All participants had similar views regarding the aim of treatment for forensic patients at Valkenberg, with a strong push to promote the patients independence and autonomy.²⁸³ Even though the patients are constrained within a forensic setting, the participants strive for the patients to have a good quality of life.²⁸⁴ P3 explained: ‘It’s a two-way street. We’ve got to treat our clients like normal people. We’ve got to help, not just to advocate for them, but help them to be agents of change. To advocate for themselves, to actually take an active role in their life.’²⁸⁵ Staff still try to emphasize that they have some control and say in their own life even though the patients are going through treatment.²⁸⁶ P4 articulated that the ‘framework is recovery, it is about allowing the patient to have a voice in their treatment, it is also about accepting that recovery doesn’t mean the

²⁷⁸ Personal interview with P1 op cit (n260).

²⁷⁹ Personal interview with P5 op cit (n263).

²⁸⁰ Ibid.

²⁸¹ Ibid.

²⁸² Ibid.

²⁸³ Personal Interview with P3 op cit (n32), and P4 op cit (n259).

²⁸⁴ Personal interview with P4 op cit (n259).

²⁸⁵ Personal Interview with P3 op cit (n32).

²⁸⁶ Ibid.

exclusion of symptoms but the capacity to accept that they have limitations and still have a good quality of life.’²⁸⁷

The initial stage of treatment for patients is the introduction of medication, ensuring that the correct medication is used to stabilize the patients mental disorder symptoms. Clozapine is used regularly as an antipsychotic, and some patients may be treated with mood stabilizers or anticonvulsants.²⁸⁸ Participant 2 (P2) stated that patients at Valkenberg could be ‘put on some of the most potent medication available.’²⁸⁹ This referred to cases of serious mental illness. Mood stabilizers are employed for mania, irritation, aggression and impulsivity.²⁹⁰ In certain cases injectable forms of medication will be used to ensure that the patient in fact takes the medication.²⁹¹ Additionally, they will sedate patients if they find it necessary, for example if they get involved in fights.²⁹² It is not unusual that the initial medication does not work, therefore they may be required to change the type or dose of the patients medication through the treatment.²⁹³ Many patients have had a long course of mental illness, been tried on several medications, and may have even become resistant. During the initial stages of treatment, it may take a longer period of time before they find the right fit of medication for the patient.

Several studies found that medication nonadherence is common for comorbid forensic patients.²⁹⁴ There is a clear link between medication adherence and psychoeducation. Part of the treatment includes engaging with the patient ‘around why there’s a need for medication... It's about them understanding their illness, what are their symptoms related to the illness and the purpose of different medications.’²⁹⁵ If the patient does not understand the illness, and the necessity for medication it is highly likely that they

²⁸⁷ Personal interview with P4 op cit (n259).

²⁸⁸ Personal interview with P1 op cit (n260).

²⁸⁹ Personal interview with P2 op cit (n25).

²⁹⁰ Ibid.

²⁹¹ Ibid.

²⁹² Ibid.

²⁹³ Personal Interview with P3 op cit (n32).

²⁹⁴ Pickard and Fazel op cit (n153) 352.

²⁹⁵ Personal Interview with P3 op cit (n32).

will not comply with the treatment. The multidisciplinary team stress the need for the patient to continue taking the medication, which is not possible unless the individual understands the need to take the need to do so, even if their apparent symptoms ameliorate. Therefore, an initial step in the treatment is to communicate with the patient and assist them to make ‘the link that the medication is actually helping to keep them well in most cases.’²⁹⁶ Patients need to take ownership of their illness and the fact that they need to take medication in order to create a new sense of self.

Psychoeducation focusses on educating the patient about the mental illness, substance abuse disorder and the necessity to take medication. The family²⁹⁷ will also receive psychoeducation in order to understand what it means for the individual to be a state patient and what their rehabilitation will be going forward.²⁹⁸ P6 claimed that if the families were informed about mental illness they would be able to attend to the ‘problem as soon as it’s there.’²⁹⁹ In South Africa mental illness is not prioritized, with four per cent of the National Department of Health’s budget being allocated to mental health services.³⁰⁰ However, the reality is that a lot of the inhabitants suffer from various disorders. Education is needed around the topic in order for families to be able to pick up symptoms of mental illness at an early stage. This is critical for the patient to get the appropriate treatment before the disorder’s symptoms escalates and the individual commits a crime.³⁰¹ The family is also often asked to administer medication when the patient is on leave, which is why they receive psychoeducation about the medications and the necessity of complying with it.³⁰²

The patient and his family at Valkenberg can be seen to receive psychoeducation in the form of two ways. Firstly, in the form of prevention, where it is hoped that education

²⁹⁶ Ibid.

²⁹⁷ Throughout the interviews the participants stressed that ‘family’ involvement referred to anyone close to the participant that was willing to care for them. Therefore, it did not always refer to the patient’s direct family and could refer to a patient’s friends for example.

²⁹⁸ Personal interview with P5 op cit (n263).

²⁹⁹ Personal interview with P6 op cit (n24).

³⁰⁰ Szabo et al op cit (n54) 2.

³⁰¹ Edwards et al op cit (n128) 111.

³⁰² Personal interview with P1 op cit (n260) and P5 op cit (263).

about substance abuse and mental illness will improve the family's ability to pick up and tend to symptoms. Secondly, psychoeducation at Valkenberg focuses on response or lack thereof, trying to improve the availability of mental health services for the family and patient once the individual is put on leave. These two forms of psychoeducation in unison aim to improve the general awareness and understanding of mental illness and substance abuse along with the need for compliance to treatment.

Once the patient's symptoms have stabilized and they are adhering to medication other therapies are then implemented. The multidisciplinary team needs to work together to create an individual treatment program for the patients. No patient will present with the same symptoms and needs; therefore, the multidisciplinary team needs to identify what treatment regimen will benefit the individual's needs the most. Lack of motivation is common for comorbid forensic patients; and motivational interviewing is found to play a large part in getting the patient to comply to treatment. As mentioned, motivational interviewing is necessary to inspire the individual to wanting to change and not using substances in the future.³⁰³ This is especially crucial for substance-induced psychotic offenders undergoing treatment, as it can prevent relapse and recidivism once they are put on leave. The participants agreed that treatment is not possible without the patient's motivation to change.

P1 explains how motivational interviewing encourages the patient to move from the precontemplative to contemplative stage. Precontemplative was referred to as 'they haven't given it a thought or they don't, even if you reflect to them what a problem it is, they deny it's a problem. So, they're in that phase where they are not interested at all in giving up or undergoing rehabilitation.'³⁰⁴ The aim is to move them to the contemplative stage where 'they accept that actually substances are not only causing them to relapse, it's not only using up their money and not only is it influencing the way they behave, but it's

³⁰³ Cleary et al op cit (n203)

³⁰⁴ Personal interview with P1 op cit (n260).

actually impeding their rehabilitation.³⁰⁵ The patient needs to accept the mental illness and substance abuse disorder in order to work on both. Following acceptance of the problem there needs to be a motivation to change the past behaviour, otherwise the patient will be unable to change their current mental state and substance abuse disorder.

Valkenberg has a dual diagnosis program where they treat the substance abuse problem jointly with the mental illness. The multidisciplinary agreed that treatment of the substance abuse problem are necessary due to the effects of continued substance use including a higher risk of relapse and recidivism. Substance abuse groups are run in a group setting and are co-facilitated by the psychologist and occupational therapist.³⁰⁶ Motivation to change is required for this to be successful. In order to join the group, the patient agree to regular screening and are required to provide regular urine samples.³⁰⁷ These urine samples are especially useful if the patient has been out on leave, in order to monitor whether the individual abused substances in that period. These urine samples provide a form of control as the multidisciplinary team is unable to supervise the patient's actions once he has been sent out on leave. It is seen as the easiest way to control whether or not the patient used substances.

Participants agreed that it was very likely for patients to relapse into substance abuse during periods of leave. This supports the need for urine tests once the patient comes back to the hospital. If one of these tests turns out positive for substances, then benefits such as going out for ground parole or leave will be forfeited. In order to keep track of whether patients have been using substances Valkenberg has a substance abuse register where they will take note if someone's test turns out positive.³⁰⁸ Where the patient continuously falls back into substance abuse the multidisciplinary team can notice and identify the needs for more focus on the treatment of the substance abuse disorder. Of

³⁰⁵ Ibid.

³⁰⁶ Personal interview with P1 op cit (n260).

³⁰⁷ Ibid.

³⁰⁸ Ibid.

concern was the finding that individuals were reportedly more likely to stop adhering to medication when they were out on leave. Reasons for this is that substances were used, they forgot to take the medication or did not feel the need to do so.³⁰⁹ The participants agreed that medication adherence along with abstinence are crucial for the patients to have a better chance of rehabilitation.

In order to change prior habits of substance abuse Valkenberg focusses on the necessity to provide the patients with a new sense of self. This is done through occupational therapy, which has been found to give comorbid patients a sense of purpose. Participants found that by providing the patient with an occupation their self-esteem is likely to increase. The hope is for the patient to learn life skills to be able to live independently and function in the community.³¹⁰ Through this it is more likely for the patient to be able to sustain a new life for themselves without going back to prior habits including substance abuse and criminal behaviour.

Occupational therapy commences with looking at ‘the person, environment that they’re in and environment they’re going to and the occupations they have to engage with.’³¹¹ Due to the population of patients at Valkenberg it may not be possible for the individual to maintain a job in the community because they are too unwell to do so. Additionally, the stigma around mental health may result in the individual not receiving a job as employers may not want to hire someone who has spent time in a psychiatric hospital. The patients that are allowed leave without being able to sustain a job are provided with a disability grant from the government. However, occupational therapy also looks at ways for the individual to utilize their leisure time more efficiently and constructively.³¹² Valkenberg offers various creative groups like pottery, mosaic, and art/drawing in order to allow the patients to have a way to express their emotions through art. These groups also

³⁰⁹ Personal interview with P6 op cit (n24).

³¹⁰ Personal Interview with P3 op cit (n32).

³¹¹ Ibid.

³¹² Ibid.

allow the opportunity for the patient to find new hobbies that they could continue with in the community. These new interests will benefit the patient as they are provided with a sense of self and allows them to spend their time more efficiently within the hospital. In order for the patient to maintain a stable life within the community and not relapse into past behaviour the occupational therapist focusses on getting the patient skilled. This could be in terms of a learnership and ‘basically trying to upskill them in order to make them more eligible for work.’³¹³ Through this process the patient will hopefully identify the occupations that will keep them well and provide them with motivation and purpose to change their behaviour.³¹⁴ Nevertheless it needs to be mentioned that not all patients are well enough to maintain a job, therefore the multidisciplinary team work to provide the patients with various opportunities to spend their time more ‘productively.’³¹⁵

Similarly, to the above-mentioned international research on treatment models all participants agreed that both medication and therapy are necessary. What was of interest was the urge for focusing on therapy rather than increasing medication if a patient deemed difficult. This was summarized by P4 who mentioned:

‘So, medication is important to stabilize a patient, but I think that the other therapies are vital in maintaining stability... the first point of call is really to sit down and find out what has changed in their lives, in their environment socially in terms of relationships, in terms of employment, all of those things, before you increase medication.’³¹⁶

All participants exemplified the need to cooperate together as a multidisciplinary team in order to ensure the best suited treatment for individual patients. Focussing on treatment prior to increasing medication was seen positively as it exemplifies the extensive work the multidisciplinary team do trying to rehabilitate the patient. Understanding why a patient relapsed rather than jumping to medication is more likely to result in sustainable improvement rather than short term relief of symptoms by medication.

³¹³ Personal Interview with P3 op cit (n32).

³¹⁴ Ibid.

³¹⁵ Personal interview with P1 op cit (n260).

³¹⁶ Personal interview with P4 op cit (n259).

When asked about the treatment model that was in place at Valkenberg most participants focused on the pathway of treatment and did not emphasize the necessity to talk to the patients about the crime they had committed. In order to talk to the patients about the crime they would need them to engage with the offending behaviour. It was emphasized that most patients at Valkenberg are not stable enough to work through their offending or may not even remember the event due to the effects of psychosis. In the rare cases where the patient was well enough a psychologist would work through the offending behaviour from the medium ward onwards.³¹⁷ Working on anger management, life skills, conflict resolution, problem solving, and harm reduction were also mentioned as important aspects of treatment. However, these were usually not related to the criminal offence itself, rather in cases where patients would act violently within the hospital.³¹⁸ It was therefore suggested that a lot of the patients are unable to work through their criminal offence. This is of particular interest in terms of the possibility of the patients committing future criminal behaviour. It is questioned how the individual will understand that their criminal behaviour was wrong if they are not confronted with it throughout treatment?

4.4 Family

Throughout the treatment process the patient's family play a large role, even starting prior to the patient's admittance to Valkenberg. Initially the social worker will contact the patients family in order to gather collateral³¹⁹, which influences whether the multidisciplinary decide to make someone a state patient or not.³²⁰ Through this interaction they are able to gather an initial picture of how the person was at home and are able to compare this to how the patient presents during observation. If the patient was very well at

³¹⁷ Ibid.

³¹⁸ Rice and Harris op cit (n201) 142.

³¹⁹ This collateral included any information the family was willing to reveal about the patient. Including prior substance abuse, whether they had previously received psychiatric help, were on medication along with anything significant that may have happened throughout their childhood.

³²⁰ Personal interview with P5 op cit (n263).

the time of observation at Valkenberg, talking to the family is especially critical to gather more information about the patient in order to understand why they were thought to be mentally disordered at the time of the offence.³²¹ The interaction with the family will be conducted mostly by the social worker, followed by the occupational therapist.

Building up the family relationship is the initial starting point, especially if the crime was committed towards the family member or close relative.³²² Getting the family to cooperate in therapy may be a challenge either because they are unwilling to do so or especially if they were the victim of the crime committed by the patient. Family non-involvement will affect the patient's rehabilitation, where participants revealed how patients with no family support or lack thereof were more likely to be depressed. Therefore, the initial approach may be to get the family to cooperate.³²³ Social work in relation to the family looks at 'the patient, how they fit into their family, how the family fits into the community and how community fits into society.'³²⁴ During the initial meeting with the family the aim is to get a full history of the patient 'from childhood, how was the patient as a child, their educational history, employment history, substance history etc.'³²⁵ Gathering this information aids the multidisciplinary team in deciding further course of treatment, as it provides a 'bigger picture.'³²⁶

The second meeting with the family at Valkenberg takes place during the ward rounds.³²⁷ These ward rounds take place every week, where the multidisciplinary team see an average of ten patients at a time.³²⁸ This is the first time that the family meets every member of the multidisciplinary team that is involved with the patient's course of treatment. Each member of the multidisciplinary team explains their role in the treatment

³²¹ Personal interview with P2 op cit (n25).

³²² Personal interview with P4 op cit (n259).

³²³ Personal interview with P5 op cit (n263).

³²⁴ Ibid.

³²⁵ Ibid.

³²⁶ Ibid.

³²⁷ Ibid.

³²⁸ Ibid.

in order for the family to have a broad understanding of the process.³²⁹ The family members are then able to reveal more information about the patient, primarily to ‘compare the patient’s behaviour from home compared to in the ward.’³³⁰ They are able to see if the patient has gone through any improvement. After this meeting the forthcoming treatment depends on the individual’s needs.³³¹

From the interviews it became apparent that the role of the family intensifies once the patient is put on leave into the community. Many families may feel strain with the individual coming back home, therefore monthly family/caregiver support groups are available at Valkenberg during the treatment process.³³² Family members will meet other patients’ families and are able to share their experiences. There was large disagreement amongst interviewees about whether a family’s cooperation was required for the patient to be sent out on leave, which can be due to the participants coming from different fields of research. The first three participants suggested that in order to send a patient out on leave, they would have to be sent back to their family in the community. P3 maintained: ‘If the families don't want to take them, we have nowhere else to send them to. Because the law says we got to send them to family. But if the families you know are not willing to take them and you know the patient is not completely well also, we don't have another place to send them to, then we got to keep them in hospital.’³³³ This was strongly disputed by P4 who asserted:

‘At one stage we were under the impression that the law states in south Africa that they have to go to family. We subsequently found out that that is not the case. They actually can go out on their own. It’s something we actually figured out not so long ago which is really horrifying. Because always, one of the criteria was the family had to take the patients and be the custodians. But actually, there is nowhere in black and white that it actually says that.’³³⁴

³²⁹ Ibid.

³³⁰ Personal interview with P5 op cit (n263).

³³¹ Ibid.

³³² Personal interview with P4 op cit (n259).

³³³ Personal Interview with P3 op cit (n32).

³³⁴ Personal interview with P4 op cit (n259).

It is striking to find such contradiction as to the role of the family in regard to the patient being able to leave the hospital as it may have affected their approach to designating leave to patients without a family. P2 contended that ‘That’s what our law requires from us is that the patient’s family or loved ones... has to become involved and will probably be relied upon and eventually to start taking the patient out of the hospital when they need to go on leave.’ This was further supported by P3, ‘We’ve got to send these patients back to these families... some of the families might be quite toxic for them.’³³⁵ However, ‘conflictual family relationships are a high-risk factor for relapse.’³³⁶

Therefore, sending a patient back to their family should be seen as an ideal situation however their ability to facilitate reintegration into the community ‘really is dependent on the health, mental health, the social health of the family, the level of insight, awareness, and intelligence of the family.’³³⁷ If the patient is doing well they should still be allowed to leave Valkenberg even if there is no family involvement. Ideally the multidisciplinary team would hope for good family support as this has been found to assist in rehabilitation, facilitates process of upskilling and can make ‘such a big difference.’³³⁸ Even though family involvement was largely believed to be crucial for a patient to be sent on leave, several participants mentioned that families may want nothing to do with the patient. This was especially the case if the crime was committed against the family resulting in the patient being sent to Valkenberg feeling like a ‘relief’ for them.³³⁹ Even if the social worker is able to work with the family in order to build up the relations, family involvement is not a reality for many of the patients at Valkenberg. As the hospital caters for the entire Western Cape a lot of families are unable to get involved due to the long distance between their home and the hospital. Since a large percentage of the population come from poorer rural areas in the Western Cape families may not have the financial means to travel to

³³⁵ Personal Interview with P3 op cit (n32).

³³⁶ Personal interview with P4 op cit (n259).

³³⁷ Personal Interview with P3 op cit (n32).

³³⁸ Ibid.

³³⁹ Personal interview with P6 op cit (n24).

Valkenberg to visit the patient. Therefore, even if the family does want to get involved in the treatment there may be various barriers hindering this process.

4.5 Waiting period

Due to the limited resources that the Department of Health in the Western Cape contributes to the mental health sector, there was interest in whether the waiting period for substance-induced psychotic offenders' referrals to Valkenberg impacted the course of treatment. All participants agreed on the current numbers on the waiting list being at least 200 or more waiting to come to Valkenberg for an observation.³⁴⁰ This transfers to one to two years on average that a person has to spend in prison, usually in remand detention, before they even arrive at Valkenberg for observation.³⁴¹ The standard of living in remand detention cells has been described as 'inhumane' where overcrowding can be as high as 246% and the transmission of HIV, tuberculosis and other illnesses is more likely than in other cells.³⁴² Evidence suggests that spending time in remand detention has detrimental effects on individuals mental health, drastically increasing levels of depression along with suicide risk.³⁴³

The length of the waiting period along with the standard of living in remand detention in South Africa is of particular concern for state patients waiting to be observed at Valkenberg. As Valkenberg is only able to cater for ten observation cases at a time, the waiting period gets longer and longer with the increase of substance-induced psychotic offenders and mentally disordered offenders committing a crime. During this period the offender is spending time in a prison filled with substances whilst merely waiting for a bed at Valkenberg.³⁴⁴ The disastrous effects of the waiting period was summarized by P5 stating:

³⁴⁰ Personal interview with P2 op cit (n25) and P3 op cit (n32) and P5 op cit (n263).

³⁴¹ Personal interview with P1 op cit (n260) and P4 op cit (n259) and P2 op cit (n25).

³⁴² Jeremy Gordin and Ingrid Cloete 'Imprisoned before Being Found Guilty: Remand Detainees in South Africa' (2012) 80 *University of Cincinnati Law Review* 1170.

³⁴³ Ibid 1171.

³⁴⁴ Personal interview with P4 op cit (n259) and P2 op cit (n25).

‘Of the patients that we see for forensic observations, only 25 per cent become state patients. So, its 75 per cent of people waiting in prison for observation, and most of those are substance-induced psychosis. I don’t think it’s fair on the patients... So, they’re completely fine after the arrest, but they still have to wait because now they’ve been put on the waiting list...I also don’t think it’s fair to our unwell patients because they’re sitting in prison and it’s not the best environment for them, they’re not getting their medication, or the treatment that they need.’³⁴⁵

Tuviah Zabow’s (1981) case study of Valkenberg found that at the time only 105 out of 1,047 (21.1 per cent) patients that were referred to Valkenberg for observation in fact became state patients.³⁴⁶ Almost 40 years later this problem has only seemed to have become worse. Szabo and Kaliski (2017) claimed that the waiting period is at least one month, however the reality is that it is between one to two years.³⁴⁷ There needs to be a large push towards getting these patients observed prior to the two years they have to spend in prison, however this cannot be done without more resource allocation to do so.

After having spent an average of two years in prison, it is extremely difficult for the multidisciplinary team to establish whether the individual had mental capacity at the time of the offence. All participants believe that the waiting period is unfair to the patients. When they arrive at the hospital it is their job to ‘try to put it all together in retrospect.’³⁴⁸ In cases of substance-induced psychosis the multidisciplinary team sits in a position where two years later a ‘completely well person’ sits in front of them,³⁴⁹ and what options do they have in these cases? P4 showed frustration in these cases and found it to be a ‘tricky, tricky situation’ as they don’t want to make completely well individuals into state patients.

Several cases represented the problem of the waiting period in terms of substance-induced psychotic offenders including a case of an individual who himself convinced the multidisciplinary team that he was suffering from psychotic episodes due to substances. He didn’t have any psychiatric history, but a long history of Tik and cannabis use, which

³⁴⁵ Personal interview with P5 op cit (n263).

³⁴⁶ Zabow op cit (n3) 453.

³⁴⁷ Szabo and Kaliski op cit (n74) 70.

³⁴⁸ Personal interview with P1 op cit (n260).

³⁴⁹ Personal interview with P2 op cit (n25).

resulted in him hearing voices and believing that he was put under surveillance by the community.³⁵⁰ These psychotic symptoms carried on until he finally stopped abusing Tik, and then found himself presenting at Valkenberg as a completely healthy individual in need of no medication.³⁵¹ It was unsurprising to find that each participant told similar stories of similar cases. In conclusion, it was found that the waiting period had a disastrous outcome on the number of referrals of individuals who were healthy yet deemed state patients as it was suspected that they didn't have mental capacity at the time of the crime.

P2 felt that 'the waiting period is absolutely atrocious... it's actually like a human rights infringement.'³⁵² Similarly, P4 felt that 'it's a travesty of justice.'³⁵³ Even though each participant felt that the waiting period had detrimental effects on the patient's life and course of treatment there was little consensus as to how it could be improved. P2 idealized the possibility of the observation being done straight after the offense in order to achieve a better assessment,³⁵⁴ however P5 stated that there are not enough available beds to do more observations and found that there was 'nothing more' they could really do.³⁵⁵ P4 debated the possibility of diversion programs for the less severe crimes so that they do not need to go to Valkenberg and wait two years for observation due to a petty crime committed under psychosis. Additionally, it was found that members in the multidisciplinary team urge for a change in law and policy so that the duration spent at Valkenberg should commensurate with the degree of violence of the offence.³⁵⁶ Serious offences like murder or rape should result in the patient being in the psychiatric hospital for a 'stipulated period that the courts decide on' compared to a shorter period until their symptoms have been treated if it was a petty crime.³⁵⁷ Nevertheless, the options that were presented in hope of changing the long

³⁵⁰ Ibid.

³⁵¹ Personal interview with P2 op cit (n25).

³⁵² Ibid.

³⁵³ Personal interview with P4 op cit (n259).

³⁵⁴ Personal interview with P2 op cit (n25).

³⁵⁵ Personal interview with P5 op cit (n263).

³⁵⁶ Personal interview with P4 op cit (n259).

³⁵⁷ Ibid.

waiting period are impossible to employ due to the lack of resources available throughout the Western Cape and at Valkenberg in terms of treatment possibilities for state patients.

4.6 Challenges

Each participant placed great emphasis on the numerous challenges that the multidisciplinary team face both in regard to their ability to implement treatment and due to the lack of motivation for treatment from the patients. P1 explained how research on psychosocial rehabilitation of substance abuse found that ‘whatever model you used didn’t work. Did not work... I think it's quite depressing, that's what I think. In actual fact the minority of these guys actually end up being abstinent, the minority.’³⁵⁸ All participants talked about the challenges around motivation and getting the patients to accept that ‘there’s a problem’ as none of the patients are in therapy by choice.³⁵⁹ Due to the stigma around mental health the patients are raised in a society where ‘mental illness is a condition that people don’t really accept.’³⁶⁰ Without the motivation to change past behaviour it is extremely likely for the patient to relapse into substance abuse followed by a higher possibility of recidivism.

4.6.1 Relapse

Relapse was found to be a large sub-theme under the larger picture of challenges. Each participant reported that relapse into substance abuse is extremely likely for the people at Valkenberg. Due to the nature of mental illness and substance abuse Valkenberg is seen to have a revolving door policy. P4 echoed findings in the literature on the high likelihood of relapse for the forensic patients by stating that the multidisciplinary team were likely to send a patient out on leave, even though they expected them to come back to the hospital due to a relapse.³⁶¹ Reasons for relapse at Valkenberg included the

³⁵⁸ Personal interview with P1 op cit (n260).

³⁵⁹ Ibid.

³⁶⁰ Personal interview with P6 op cit (n24).

³⁶¹ Personal interview with P4 op cit (n259).

individual using substances whilst on leave, not adhering to medication or committing another criminal act. P3 talked ‘casually’ about relapse being ‘expected, common and the nature of the beast, the nature of the illness, it’s the nature of the substance related problems.’³⁶² Each participant could recall several cases of patients going out on leave and coming back having relapsed into substance abuse or in a state of psychosis again. In this instance the multidisciplinary team have to sit down and implement the treatment from the beginning, including stabilization on medication and back into therapy. Unless the patient is able to live in society without using substances, he will come in and out for treatment at Valkenberg.

4.6.2 Administrative Challenges

The challenges surrounding administration and lack of resources are significant. For patients who are allowed ground parole³⁶³ participants explained that there are not enough resources in place for them to use their time constructively. For those who spend most of their time inside the premises the government is not likely to provide them with a disability grant, however this limits the likelihood of the multidisciplinary team allowing them to go out on leave as they do not have the finances or resources to be outside. Difficulties arise in trying to get the patients employed, as some of the patients are only allowed to leave the hospital on one day during the week and one day during the weekend. This limits the amounts of work places they can approach drastically. It was not surprising to find that overcrowding is a large issue within the hospital where a ward that has 38 beds regularly has between 50-58 patients in it.³⁶⁴ All participants made it evident that they struggle to implement successful treatment due to the lack of available resources in terms of available space and patients beds in the hospital, lack of financial resources along with human resources in terms of staff members.

³⁶² Personal Interview with P3 op cit (n32).

³⁶³ Ground parole refers to patients being able to walk around certain areas of the hospital grounds at certain periods of the day

³⁶⁴ Personal Interview with P3 op cit (n32).

Throughout the interviews each participant emphasized the push towards letting patients out on leave in a timely fashion in order to prevent institutionalization. Every participant explained that most patients are put on leave, however very few are actually discharged from being state patients: 'Discharge is almost an impossible thing in our system, but leave is not an impossible thing and they often go on leave very very early actually in comparison to people who would have just gone through the criminal justice system.'³⁶⁵ Being made a state patient was referred to as a 'life sentence' since the hospital becomes the custodian of the patient even when they are out on leave.³⁶⁶ Unconditional or conditional leave can be granted to individuals who have had numerous successful leaves. With conditional discharge the individual will still be required to go back to the hospital if he relapses. The process of applying for discharge is time intensive for the hospital staff, therefore it is more likely for an individual to be put on leave and not discharge. The Mental Health Care Act refers to the possibility of applying for discharge of a state patient, however from the participant's responses the reality of this going through is minimal and will take several years.³⁶⁷

In order for a patient to be sent out on leave the multidisciplinary team is required to determine the level of risk. Under risk assessment the multidisciplinary team takes into account the offence that was committed, community circumstances, medication adherence and likelihood of relapse into substance abuse and mental illness. Risk assessment can never be an exact science, therefore there is always a level of risk and uncertainty when the patient is being sent out on leave.³⁶⁸ P6 claimed that 'we are successful in the hospital, but we don't know if we open the doors what's going to happen.'³⁶⁹

Even though every participant mentioned the push towards leave, institutionalization was brought up as an overarching challenge. Patients at Valkenberg live with a set structure and everyday routine and rely on the multidisciplinary team to provide

³⁶⁵ Ibid.

³⁶⁶ Personal interview with P6 op cit (n24).

³⁶⁷ Criminal Procedure Act op cit (n1) S.47(1).

³⁶⁸ Pickard and Fazel op cit (n153) 350.

³⁶⁹ Personal interview with P6 op cit (n24).

them with medication and therapy. This can result in the patients getting used to being told what to do and when to do it.³⁷⁰ Some patients, especially those from very impoverished backgrounds, may prefer life inside of the hospital as it provides them with shelter and meals three times a day. If the patient is granted leave, there are no halfway homes or shelters for patients to go to if their family are unwilling to take them back. Due to this P4 claims that South Africa in fact does not accommodate for deinstitutionalization.³⁷¹

The overall issue of a lack of resources and the reality of institutionalization was summarized by an interviewee:

‘Providing a quality of life within the constraints of living in a hospital I think that needs to be improved upon. This is home. You have a group of men that literally are stunted in every single way... they lose their sense of self, they lose their sense of dignity, they don't have relationships, they don't live a normal life and they are stable. You might have the philosophy, you might talk the recovery model in your treatment, but the reality is that you can't actually facilitate it to its natural end because of all the systemic problems. I think for me it's the acceptance that these patients aren't deinstitutionalized, that were actually developing a chronic system again, but the infrastructure is not supporting the reality. so, there's like an almost pretence that oh no you know were reintegrating our patients into the community but were not because we don't have the capacity to do that...We do have success stories, but you know it's not enough.’³⁷²

For the individuals who make Valkenberg a permanent home there needs to be an improvement in resource allocation. Some patients may be so unwell that they will never be released into society, and this needs to be accepted and does not mean that they should have a bad quality of life within the constraints of the psychiatric hospital. Furthermore, this is not a sign of failure from the multidisciplinary team, it simply means that they need more resources in order to be able to provide these individuals with a good standard of life. For the more severely violent and psychotic patients it may merely be the reality.

³⁷⁰ Ibid.

³⁷¹ Personal interview with P4 op cit (n259).

³⁷² Ibid.

4.7 Conclusion

This chapter has conveyed the views of the participants in order to gain a better understanding of the approach towards treatment of substance-induced psychotic offenders at Valkenberg psychiatric hospital. In terms of the treatment model employed all participants placed great focus on the challenges that they are faced with both in terms of available resources and due to the population of patients they work with. Implementation challenges, including the lack of resources, were highlighted along with various challenges from regarding the patients' health. Nevertheless, none of the interviewees suggested a way to improve treatment unless mental health services are allocated more resources.

The resource and administrative challenges create difficulties with the mental health care system's ability to implement proper treatment. The waiting period was found to be unique for the Western Cape as it is a result of a lack of available resources for treatment. It is significant that the previously mentioned international research largely focussed on individuals who are able to access treatment, which is not a reality for the poorer communities in the Western Cape due to a lack of resources. The waiting period before an individual arrives for observation at Valkenberg was a large obstacle making the work for the multidisciplinary team more time invasive and difficult. The staff have to take into account the effects of time spent in remand detention in regard to the individual's mental health. Due to the 'inhumane' standards in remand detention it is highly plausible that their mental health will have deteriorated. In addition to the effect of prison the multidisciplinary team need to retrospectively examine whether the individual had mental capacity at the time of the offence. As the psychotic symptoms may have ameliorated this is an extreme obstacle for the staff as they rely on information provided by family members and/or people that witnessed the crime.

Of deep concern are the individuals who arrive at Valkenberg after up to two years in remand detention in prison who in fact present themselves as completely healthy.³⁷³ Even though these individuals should be released back into the community swiftly, it is impossible for the multidisciplinary team to reverse the process of them being labelled a state patient.³⁷⁴ They therefore have to keep them within the hospital for at least one year. Not only is this seen as a violation of the patient's rights, it is also a waste of resources as it takes up a bed within the hospital. Even if they were able to release a larger number of patients there are not enough resources within the community to support reintegration. There is a need for community support and aid in order for the individual to be able to return to a life staying away from substances and crime. It is believed this will only be a reality after the communities in the Western Cape understand the burden of disease that substance abuse and mental illness linked to crime has on their society.

In terms of challenges with the population that the multidisciplinary team work with it was emphasized that an initial difficulty is getting the patient and his family to understand the mental illness and the need for treatment. This problem is amplified when patients are not motivated to comply with treatment. If they do not understand the need for medication, they are very unlikely to comply with it. Psychiatric medications need to be taken throughout the individual's entire life and a dose cannot be skipped. If the patient were to be put on leave the multidisciplinary team need to ensure that they will continue to adhere to the medication. With the high prevalence of substance abuse there is a high rate of relapse and the hospital works with a revolving door. It is not uncommon for patients to come back to Valkenberg as they stop taking medication while on leave or fall back into substance abuse.³⁷⁵ In order for a patient to be rehabilitated they need to restrain from taking substances and comply to treatment, yet this is extremely difficult in the communities they come from due to the high overall prevalence of substance abuse.

³⁷³ Personal interview with P5 op cit (n263).

³⁷⁴ Personal interview with P6 op cit (n24).

³⁷⁵ Personal interview with P1 op cit (n260).

The following chapter will summarize the findings from all of the research presented in previous chapters in order to show the need for improvements in resource allocation to see an overall improvement in the treatment approach towards substance-induced psychotic offenders. The previously presented research has found that there will not be an improvement in the numbers of substance-induced psychotic offenders unless the rate of substance abuse by mentally disordered individuals decreases throughout the Western Cape. Recommendations in terms of how to move forward will also be presented throughout the chapter.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

The treatment of mentally disordered offenders and substance-induced psychotic offenders in particular deems to be a problem in the Western Cape. As explained above a reason for the large prevalence of mentally disordered offenders is due to the high presence of substance abuse throughout the country along with the lack of emphasis on the awareness and improvement of mental health. Mental illness has been found to have a high overlap with substance abuse, which exacerbates the symptoms and has a higher likelihood of resulting in violent behaviour.

Families and the community lack knowledge and awareness around mental health due to stigma. This is especially critical for the poorer rural areas in the Western Cape, as a large percentage of the state patients in need of treatment at Valkenberg come from these areas. It is necessary for the community to understand and accept mental illness in order to prevent individuals being admitted to psychiatric hospital's after years of prolonged illness. This has found to result in poorer illness outcomes. Additionally, it has been found that individuals suffering from mental illness use substances to alleviate their symptoms. Increasing mental health awareness throughout the community will be necessary in order to decrease the rate of crimes being committed by comorbid forensic psychiatric patients.

Due to the lack of resources available throughout the mental health sector large challenges exist regarding the treatment of the population. Initial symptoms of mental illness are not picked up by the individual or their family members as they lack the education to do so. The waiting period was seen as an impossible hurdle to overcome in regard to implementation of appropriate treatment for state patients. As a result of the waiting period severely ill individuals are not receiving appropriate and timely treatment in prison. Additionally, healthy individuals are spending unnecessary time in prison which is a clear violation of their rights. The waiting period is seen as a serious violation in terms of the treatment that should be designated to mentally ill offenders. Individuals are required

to receive treatment after the offense, rather than two years later. The implementation of treatment is made harder for the multidisciplinary team as they have to determine whether the individual had mental capacity retrospectively, taking into account the effects that two years in remand detention will have had on the individual's health.

The international research mentioned above emphasizes the need for a combination of treatment for comorbid mentally disordered offenders. Even though patients will require individual treatment the above-mentioned research has found that no one treatment can stand on its own. Medication may stabilize the patient's symptoms; however, therapy and family involvement will hopefully ensure the stabilization and reintegration of the patient into society. There is a need for further research to be done on how to treat substance-induced mentally disordered, especially in the South African context where a large percentage of this population comes from rural areas.

5.1 Recommendations

Literature and empirical research found a need for an increase in resource allocation into the mental health sector throughout South Africa. Participants interviewed stressed the numerous challenges faced trying to implement a treatment model for mentally disordered offenders, and specific challenges in regard to substance-induced psychotic offenders. They stressed several ways in which they could improve the implementation of treatment, yet none of these are realistic without heightened resources along with awareness throughout the community. This chapter provides several recommendations for necessary measures that need be followed in order to hope for a decrease in the numbers of referrals to Valkenberg. It is also hoped that the community's education on mental illness improves.

Previously mentioned research stressed the lack of available resources throughout South Africa within the Mental Health sector. With the high rate of crime being committed by mentally ill individuals under the influence of substances it is crucial to accept the need

for more awareness and education throughout society. This could be a reality if there was heightened resource allocation. Education throughout the community is hoped to decrease the prevalence of negative stigma. Finally, when the individual is released into the community there is a need for increased community centres and availability of halfway houses. This could increase the numbers of individuals released from Valkenberg as participants mentioned that one reason to deny leave was if the individual had nowhere to go to.

In order to decrease the challenging waiting period, it is essential for more resources including an increase in available beds for observation and treatment to be allocated to Valkenberg. Respondents made it clear that this lengthy period will not decrease unless the hospital is able to provide more beds and staff members to observe cases. There has been a decrease in available beds for observation cases due to an increase in admitted patients spending longer periods of time within the maximum secure ward in Valkenberg. There is a need to increase the available beds for observation in hope to decrease the length of the waiting period. Decreasing the waiting period is essential for those who are misdiagnosed and healthy in prison and for those who are very ill and spend time in prison worsening their symptoms of mental disorder.

Participants said it was unlikely for patients to be admitted to Valkenberg without a long history of substance abuse. Decreasing the high rate of substance abuse throughout the community is therefore essential. This is especially necessary with the ever-increasing rate of Tik use. It is of particular concern that individuals with no prior mental illness can become psychotic after single use of tik. Education about the effect of substances, in particular for tik, is required and should be stressed in impoverished areas throughout the Western Cape where the rate of abuse is highest.

The purpose of this research was to analyse the treatment and care of comorbid mentally ill offenders, with emphasis placed on substance-induced psychotic offenders. The aim was to stress whether there is one sole approach that can result in successful

rehabilitation for comorbid forensic psychiatric patients. Through the empirical research it became clear that a major challenge is the lack of resources available for treatment. The increase in rate of substance abuse, with particular concern placed on tik, along with high rates of crime committed by comorbid patients indicated the need for awareness around the problem. Not only does substance abuse increase the risk of crime, it also increases the risk of more violent crime being committed. Even though treatment is done on a case by case basis it was rare for patients to not have a history of substance abuse. It was evident that the treatment of substance-induced psychotic offenders was complicated by the substance abuse in itself. Therefore, it is suggested that educating the community (especially impoverished areas) about the effects of substance abuse in hope to decrease the rate of substance abuse could improve the treatment of state patients at Valkenberg. Ultimately there needs to be an increase in available resources, especially an increase in available beds for observation cases, at Valkenberg in order for the multidisciplinary team to be able to ensure appropriate treatment for state patients. there is also a need for an increase in community resources in order to ensure that the recommendations and aims, including a decrease in the burden of disease around substance abuse and mental illness, set out in the Mental Health Care Act and National Mental Health Policy Framework and Strategic Plan (2013-2020) can be become a reality.

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Appendix 1

Open-Ended Interview Questions for Staff Members at Valkenberg

- Can you talk to me generally about the population of patients at Valkenberg?
- How long, on average, is a patient admitted for treatment?
- Can you talk to me about the treatment model that is in place and used at Valkenberg?
- What do you think is the most important aspect of the model, with regards to a patient being released?
- Have you experienced any challenges throughout the treatment process?
- What is your experience with the waiting period in terms of the number of referrals for substance-induced psychotic offenders?
- What is your approach towards therapeutic medication during the treatment process?
- What role does the patients family have regarding the treatment of state patients?
- Is there anything else you think my questions haven't covered? That you would like to add?

Appendix 2

Project: A Case Study on the Rehabilitation Model used for Substance-Induced Psychotic Offenders at Valkenberg Hospital

Kelley Moulton

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Ida Kagnes

Phone: 071 359 1445
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Hello, my name is Ida and I am conducting research towards a Masters Degree. You are invited to take part in this study. Please read this Information Sheet in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

What does the research involve?

The aim of the study is to explore the rehabilitation model that is in place for substance-induced psychotic offenders at Valkenberg. The research focuses on what rehabilitation methods are employed from time of observation to release.

You will be asked to participate in an interview containing several questions revolving around rehabilitation focussing on therapy sessions. Please read this explanatory statement in full to understand the details of the study, after which you will be asked to give consent. The interview will take approximately one hour.

Why were you chosen for this research?

You were chosen to participate in this research as it is specifically focused on the staff that work with substance-induced psychotic patients at Valkenberg. Emphasis was placed on contacting staff that work with patients through various parts of their rehabilitation process.

Consenting to participate in the project and withdrawing from the research

This study is completely voluntary, and you are under no obligation to participate. If you do plan to participate, you will need to give consent before completing the interview. With this consent, you will be agreeing to take part in the study and have the data from your interview used in a master's Dissertation. You may withdraw at any time before or during the interview.

Possible benefits and risks to participants

Through your participation in the study, you will benefit in contributing to the existing body of knowledge within the field. If the participants wish, they may opt to receive a fact sheet or links with more information about substance-induced psychotic offenders. There are no known physical or psychological risks in taking part in this study.

Confidentiality/Anonymity

The interview consists of eight open-ended questions, with an estimated time of one hour on average. The interview will be recorded and then transcribed afterwards. You will be able to leave

the interview at any time. In addition, you will be able to go through the interview at the end and remove any undesired information. If I decide to use something that you said as a direct quote, I will email this to you in order to get reassurance that you are certain with publishing this information. If it becomes apparent that your voice is too strong and comes out through the interview, this interview will be removed in order to ensure your privacy. No parties outside of the researchers will have access to the contact information that was gathered in order to make initial contact with you.

Storage of data

The data will be stored on a secure computer. The data will be kept for 10 years, after which it will be disposed of in accordance to the University of Cape Town policy and regulations.

Results

The results will be available in thesis form and should be expected sometime at the start of the year 2019. If participants wish to view these results, they may request access to the results via the student researcher, Ida Kagnes, in which they will receive a research brief with the findings of the current study.

Concerns About The Study

If you have *concerns about the research, its risks and benefits or about your rights as a research participant in this study*, you may contact the Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen.

Phone Number: 021 650 3080

Email: lamize.viljoen@uct.ac.za.

Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator:
Room 6.28, Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.

THANK YOU FOR YOUR TIME

Appendix 3

Information Sheet Valkenberg

My research will be looking at the treatment model that is in place at Valkenberg, and how it is utilized with substance-induced psychotic offenders. Substance-induced psychotic offenders pose an issue throughout South African society, with a lack of capacity and facilities available for treatment. Understanding the treatment model in place for substance-induced psychotic offenders at Valkenberg can promote the implementation of the Mental Health Policy to decrease substance abuse and crime.

By researching substance-induced psychotic offenders I aim to raise awareness about mental health throughout the South African society. In order to decrease the prevalence of substance-induced psychotic offenders it is crucial for society to be educated about mental disorders. The issue of substance abuse needs to be addressed in order to prevent these crimes from occurring, I therefore strive towards promoting a decrease in substance abuse throughout the country.

I want to understand how the staff at Valkenberg, who work with the treatment of substance-induced psychotic offenders approach the treatment model that is in place. I would like to get an understanding about how the model is put in place, and how the staff contribute towards treatment. In order to get a complete understanding of the treatment model it is crucial to get experts perspectives on how the model works.

Appendix 4

CONSENT FORM for Staff Members at Valkenberg

To whom it May Concern,

My name is Ida Kagnes and I am conducting research towards a Master's degree in Law at the University of Cape Town. I am researching the treatment model used at Valkenberg for substance-induced psychotic offenders and would like to invite you to participate in the project.

Information about the research project:

My research will be looking at the treatment model that is in place at Valkenberg, and how it is utilized with substance-induced psychotic offenders. Substance-induced psychotic offenders pose an issue throughout South African society, with a lack of capacity and facilities available for treatment. My study therefore aims to analyze how the treatment model used at Valkenberg is employed. Understanding the treatment model in place for substance-induced psychotic offenders at Valkenberg can promote the implementation of the Mental Health Policy to decrease substance abuse and crime.

Please understand that your participation is voluntary, and you are not required to participate. If you choose not to participate, there will be no negative consequence. You will be free to leave the research project at any time and can do so without negative consequence. However, I would be grateful if you would assist me by allowing me to interview you.

The interview consists of eight open-ended questions, with an estimated time of one hour on average. The interview will be recorded and then transcribed afterwards. You will be able to leave the interview at any time. In addition, you will be able to go through the interview at the end and remove any undesired information. If I decide to use something that you said as a direct quote, I will email this to you in order to get reassurance that you are certain with publishing this information. If it becomes apparent that your voice is too strong and comes out through the interview, this interview will be removed in order to ensure your privacy. I will send you a copy of my final research project upon completion.

The data will be stored anonymously on a password-protected file on my laptop throughout and at the end of the research project.

'If you have concerns about the research, its risks and benefits or about your rights as a research participant in this study, you may contact the Law Faculty Research Ethics Committee Administrator, Mrs. Lamize Viljoen, at 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.28 Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.'

Date & Time, Signature: _____

Appendix 5



Faculty of Law

Research Ethics Committee

Private Bag X3 ▪ Rondebosch ▪ 7701 ▪ South Africa
 Room 6.29 ▪ Kramer Building ▪ Middle Campus
 Tel: +27 021 650 3080 Fax: +27 021 650 5660 Fax2Email : 086 572 1093
 E-mail: lamize.viljoen@uct.ac.za
 Internet: www.law.uct.ac.za

08 August 2018

Ms Ida Kagnes – KGNIDA001
 c/o Department of Public Law
 Level 6, Faculty of Law
 Kramer Law Building, UCT

Contact information

Tele/s: 0713591445,

Email: idaakagnes@gmail.com or KGNIDA001@myuct.ac.za

Dear Ms Kagnes

Re: Clearance Process Report for L0090-2018: “A Case Study on the Rehabilitation Model used for Substance-Induced Psychotic Offenders at Valkenberg Hospital”

Thank you for your revised application submitted. The Law Faculty's Research Ethics Committee very much appreciates the considerable effort put into the documentation.

This study has been carefully considered and confirm that all ethical issues have been adequately addressed.

Ethics clearance is hereby granted as of 06 August 2018 for a period of 12 months and is subject to renewal for another 12 months.

Please note that any material changes to the proposal will need to be cleared as an amendment.

Please do quote reference number above on all communication to the committee.

With best wishes,

Signature Removed

pp

MR THIYANE DUDA
REVIEWER: REC LAW FACULTY

cc: Dr K Mout (Supervisor: PBL Dept, UCT)

Appendix 6



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



Room E53-46 Old Main Building
Groota Schuur Hospital
Observatory 7925
Telephone [021] 406 6626
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

25 October 2018

HREC REF: 673/2018

Dr K Mout
Gender Health & Justice Unit
Falmouth Building

Dear Dr K Mout

PROJECT TITLE: A CASE STUDY ON THE TREATMENT AND CARE MODEL USED FOR SUBSTANCE-INDUCED PSYCHOTIC OFFENDERS AT VALKENBERG HOSPITAL (Masters Candidate - I. Kagnes)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

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 30 October 2019.

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.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval, where necessary, before the research may occur.

The HREC acknowledge that the student, Ida Kagnes will also be involved in this study.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC: 673/2018

Appendix 7



Health impact assessment
 Health research sub-directorate
 Health.Research@westerncape.gov.za
 tel: +27 21 483 0866; fax: +27 21 483 9895
 5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.copegateway.gov.za

REFERENCE: WC_201808_036
 ENQUIRIES: Dr Sabela Petros

University of Cape Town
 Anzio Road
 Observatory
 Cape Town
 7925

For attention: Ms Ida Kagnes

Re: **Case Study on the Rehabilitation Model Used for Substance-Induced Psychotic Offenders and Valkenberg Hospital.**

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

Prof Sean Kaliski

021 826 5865

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. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion date* which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

Signature Removed

MS A VAN DEN BERG

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 2018/12/13.