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**AN EVALUATION OF THE PROFILE OF  
CHARACTERISTICS OF THE POPULATION OF STATE  
PATIENTS ADMITTED TO VALKENBERG HOSPITAL'S  
FORENSIC UNIT FROM DECEMBER 1964 TO MAY 1997**

**Arlene (Lane) Benjamin**

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**University of Cape Town  
Department of Psychology  
Faculty of Human Sciences  
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**Supervisor : Dr Colin Tredoux**

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## ABSTRACT

Forensic psychiatry is the mental health profession that deals with patients and problems related to both psychiatric and legal services. Due to the dual systems involved, it is not always clear who is serving what sector of the criminal population. Changes in provision of resources calls for ongoing evaluation of the patients being served. Before one can consider the kinds of changes that need to be made in terms of resources one needs to know what the population is.

This study provides a profile of the characteristics of State Patients admitted to Valkenberg Hospital's Forensic Unit. The aim is to provide alternatives for the care and treatment of individuals with mental illness who are involved in criminal activity. However it would appear necessary to explore some of the associated characteristics which have brought these individuals into psychiatric services in the first place.

This research, therefore, also explores the relationship that exists between mental disorder and crime in the patients at Valkenberg's forensic unit. The study examines patients admitted to psychiatric hospitals, and for what reasons, as well as what factors contribute to their length of stay or discharge. This relates to the concepts of risk assessment and dangerousness.

Patients selected for the research spanned an admission period from 1964 to 1997. The data for the period May 1997-May 1999 was gathered and analysed. Patients admitted to the forensic unit after May 1997 did not qualify for this study as they needed to be in the hospital for at least two years. The patient sample would have been observed and treated for a two year period. Data was gathered from information recorded in the hospital files. The data was collected using the archival research method.

This study gives an account of some of the demographic characteristics of patients admitted to Valkenberg's forensic unit. It was found that a high percentage of patients were charged with physically violent offences and diagnosed as schizophrenic. A high percentage of patients have been detained in hospital for 5 or more years which brings into questions the length of detention of mentally disordered offenders in hospital. A substantial number of patients were found to be psychotic and mentally stable. However, violent behaviour amongst the patients was prominent. High levels of physical violence in hospital were identified and can be one of the main causes for the ongoing detention of patients in hospital. It remains controversial as to who should be made responsible for managing violent behaviour amongst mentally disordered offenders. It was found that high numbers of patients had been experiencing vocational leave, thereby advancing towards potential for discharge. However, factors such as violent behaviour; problem behaviours e.g. aggression, sexual disinhibition and absconding; substance abuse; and family circumstance may influence the patient's potential for discharge from hospital.

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## INTRODUCTION AND LITERATURE REVIEW

Research in the area of forensic psychiatry has seen the emergence of a number of controversial issues. One of these has been the association between mental disorder and crime. Media attention given to mentally disordered patients and crime has been largely negative. An article in the Mail & Guardian (May 22-28, 1998) reporting on the “rehabilitated” patients who had claimed more victims after their release from Valkenberg Hospital, provides an example of the stereotypes of mental patients which could be perpetuated through the media. There are, however, real fears with regards to the release of mentally disordered patients, and out of these fears emerged a growing concern around the dangerousness of mentally disordered people. In South Africa, particularly the Western Cape, an exodus of state psychiatric mental health workers created large gaps in the system which is designed to assess, manage and treat mentally disordered patients. Staff losses form part of an overall health rationalisation and cost-cutting programme in order to modernise its approach to mental and psychiatric health care. The Western Cape based its rationalisation plans partially on a taskteam report finalised in 1998 (Mail & Guardian, May 22-28, 1998). The report did, however, warn that a movement towards community-care was being hampered by severe staff shortages and lack of resources. Herbst and Gunn (1991) too indicate that changes in the philosophy and organisation of psychiatric services during recent decades have been associated with a continuing decline of hospital beds. Concerns about de-institutionalisation of patients in order to keep up with international trends, seem to be leading to the reduction of hospital services and premature discharge rates of patients which ultimately could mean endangering the lives of patients and those in the community.

The issues around managing and treating mentally ill offenders fall into the area of forensic psychiatry. Forensic psychiatry can be defined as that part of psychiatry which deals with patients and problems and straddles both psychiatric and legal systems. The Forensic Mental Health Association (FMHA) in the Western Cape was formed in order “to advance psycho-legal practice, to lobby for services and resources and to protect the interests of patients” (Kaliski, 1998,1) Forensic psychiatric services in western countries tend to be autonomous and separate from general psychiatry. In North America for example two parallel forensic systems operate: one operates in prison hospitals and the other within forensic hospitals. The difficulty with forensic patients is that they cannot be transferred to the punitive structure of correctional services because as state patients, they are not convicted of a crime and therefore, cannot be held as prisoners. Patients within the forensic units do need specialised care.

Before one can consider the kinds of changes that need to be made in terms of resources one needs to know what the population is that we are dealing with. To date no adequate profile of the characteristics of State Patients admitted to Valkenberg Hospital's Forensic Unit has been provided. With the current trends in forensic mental health care, seeking alternatives for the care and treatment of individuals with mental illness, it would appear necessary to explore some of the associated characteristics which have brought these individuals into the confines of high security psychiatric services. Furthermore it is important to ascertain what are some of the factors involved in patients maintaining their status of confinement within high security wards. Following on from this, therefore, low risk and higher risk patients are defined in terms of dangerousness. Many researchers have referred to the concepts of risk and dangerousness and these will be further discussed later in the chapter.

The purpose of this chapter is to explore the background of existing work done in the area of forensic psychiatry. It will be looking at the relationship that exists between mental disorder and crime. Studies have been reviewed in order to gain a better understanding of forensic hospitalisation of these patients. The focus here lies in who is admitted to psychiatric hospitals and for what reasons as well as what factors contribute to their length of stay or discharge. Relating to this is the concept of risk assessment and dangerousness, which will be dealt with only briefly but has become a widely explored area in forensic psychiatry both internationally and in South Africa. A brief review of some international policies in dealing with forensic patients will be explored. Finally policies surrounding admission to the Valkenberg forensic unit will be addressed in order to understand what processes and what criteria need to be fulfilled in order for patients to be admitted to, given leave, or discharged from, the forensic unit at Valkenberg Hospital. The chapter concludes with the rationale and objectives for this study.

### **Mental Disorder and Crime**

Much research has gone into investigating the relationship between mental illness and crime. The strict provisions provided by policy makers surrounding the release and detention of forensic patients, suggests that psychiatric practice tends to rest on the assumption that the mentally ill group are a high risk group for criminality and furthermore, violent behaviour. In recent years there has emerged a consensus that a strong association exists between mental disorder and offending, particularly violent crimes (Hodgins 1993, Wessely, 1997, Wallace, Mullen, Burgess, Palmer, Ruschena & Browne, 1998) In contrast to this Monahan and Steadman in 1983 concluded that "there is no consistent evidence that true prevalence of criminal behaviour among former mental patients exceeds true prevalence of criminal behaviour among the general population" (Wessely 1998,8). The fact that a person is mentally ill may, however, predispose the individual towards criminality as in psychotic symptomatology but conversely, one should also

consider the aspect of mental illness which may inhibit criminal behaviour - for example catatonia. Therefore, according to Monahan and Steadman (1983) mental illness and criminality may not necessarily be linked.

In support of this argument is Zitrin, Hardesty, Burdock and Drossman (1976) who emphasise that the mentally ill do not necessarily commit fewer or more crimes than the general population. It seems therefore, that at this stage little distinction could be made between the mentally ill and the rest of the general population with regards to offending behaviour.

However, several mental health professionals dispute this opinion as it is felt that it does not correlate with what is observed in clinical practice. Take for example the study done by Humphreys et al. (1992) and Gibbens et al. (1986) where one could conclude very high rates of violent behaviour occurred in the community prior to hospitalisation. Taylor and Gunn (1984) also in their important studies of Brixton Prison found that of those remanded to prison, a high proportion often had a history of mental illness higher in comparison to the prevalence of mental illness in the community. Toch, Hans and Adams (1990) conducted research which examined the criminal, social and mental health backgrounds of emotionally disordered inmates and compared them with other offenders. They found that increased propensity for violence was associated with increased emotional disorder.

According to Wessely (1998) often these differences of opinion have arisen because of who is conducting the research. Criminologists who use large samples say one thing and psychiatrists with more clinical, detailed research using smaller samples say another. One solution to this would be to have large-scale population-based studies which would provide information on associations between offending and characteristics of mentally ill patients. As we can see this area is still widely debated and the empirical evidence does not seem to provide any definitive information about the relationship between mental illness and crime.

Several studies have compared certain characteristics of mentally disordered offenders and those of the general population and correlated these with offending behaviours. Some of these related characteristics will be discussed under the following sections.

### *Demographic characteristics and offending behaviour*

Many studies have focused on legal or the medical questions surrounding forensic psychiatry. Few have focused specifically on the relevant characteristics of the patients themselves.

In an attempt to fill this gap the famous Baxtrom study was done by Steadman and Coccozza (1974), and provides a comprehensive picture of the social-psychiatric- criminal backgrounds of the Baxtrom patients. One of the categories investigated was the social and demographic characteristics of the patients in the study. They found that a high proportion of the more dangerous patients never married and were largely unskilled and had reached low educational levels. Farrington (1981) too showed the effects of poverty, school failure, family history and childhood antisocial behaviour as being characteristics associated with offending behaviour.

Similar findings were made by Williams and Miller (1977) who conducted two studies investigating the role of forensic patients' personal characteristics in evaluations of dangerousness. Patients with a history of crime against persons and those with a poor educational background, low intelligence and limited occupational skills were perceived as being more dangerous than middle class patients who had not committed crimes against persons. Race did not appear to influence raters' perceptions of dangerousness. In the Baxtrom study age was another important variable which influenced the relationship between mental illness and offending (Steadman and Coccozza, 1974). The younger the patients were, the more likely they were to be seen as dangerous and in need of maximum secure facilities. The mean age of patients at Baxtrom was 51 years as compared with patients who were seen as less dangerous whose mean was 62 years.

Another very significant study was done more recently by Mason and Woods (1996). For the twenty year period under investigation by Mason and Woods (1996) the mean age on admission for all patients admitted to Ashworth Hospital was 30.35 years of age. A high number (71.5%) were admitted prior to the age of 30 years. Carstairs, the maximum security facility for Scotland and Northern Ireland, was the focus of a descriptive study of patients by Thomson, Bogue, Humphrey, Owens and Johnstone (1997). Their results showed that patients were on average 34 years old and had spent 9 years in psychiatric hospitals. Wallace et al (1998) in researching criminal offending and mental disorder found that men between 20 and 29 years were the most likely group of males to be convicted of offences. It seems that different studies have found different age groups represented in their samples and factors such as origin of patients and the general population age also need to be considered to make effective comparisons between sample groups.

In addition to these findings, Monahan and Steadman (1983) studied mentally ill offenders and offenders from the general population. They were matched for demographic characteristics and prior criminality, and they found no conclusive evidence that showed that criminal behaviour was more prevalent amongst the mentally ill than the general population when comparing demographic information. It seems that criminologists would suggest that the same characteristics apply to offending behaviour amongst the mentally ill as it would to the general population (Wessely, 1998)

The characteristics associated with offending behaviour are well known and seem to be consistent in many studies whether they are identifying mentally disordered populations or the general population. Consequently demographic characteristics such as age, educational background, marital status and so on are also important in the prediction of dangerousness of these patients as will be seen further on in this chapter.

### **Substance Abuse**

Reference is often made to the relationship between alcohol, other drugs and serious offending. Substance abuse is an ongoing and increasing problem in today's society (Prins 1986). It is, therefore, an important characteristic to be looked at when studying the relationship between mental disorder and crime as it has a number of legal and health implications. These more specifically include discussions around the effects of these substances on criminal responsibility and recollection of these events afterwards.

Alcohol and other drugs will be discussed separately although it is clear that offenders may ingest both alcohol and another drug such as cannabis, making the separation between these two arbitrary.

In a study done by Thomas and McMurrin (1993) with Rampton Hospital patients, 18% were identified as having alcohol-related problems prior to admission and often a relationship between crime and alcohol abuse was found. Hodgins (1993) found alcohol was often associated with violent offences, and was an important precipitant of violent behaviour. An explanation of this is that due to the disinhibiting effects of alcohol, patients may become more aggressive and hostile.

Hodgins (1993) also found that psychotic men were less likely to have abused alcohol than non-psychotic people were. Prins (1986) suggests that psychotic patients may, however, chronically abuse alcohol in order to try and relieve themselves of the hallucinations or delusions such as voices. Prins (1986), Linquist

and Allebeck (1989) found that violence in schizophrenic patients increased with the abuse of alcohol or drugs as it could lead to unprovoked and unpredictable violent outbursts. It was found that alcoholics had a greater propensity to engage in arson, assault, reckless endangerment, and public order offences.

Prins also emphasizes that in some predisposed individuals only a very small quantity of the substance may have potentially lethal consequences. The connection between substance abuse and the types of offences committed (Prins 1986) is an important relationship to consider but cannot be seen as isolated variables without including other characteristics such as underlying diagnosis. For example Wallace et al. (1998) found that men with schizophrenia were significantly more likely to be convicted of offences if they had also received a diagnosis of substance abuse.

A substantial amount of literature is concerned with the relationship between drug abuse, addiction and criminal behaviour (Prins 1980). Mason & Woods (1996) studied a large number of patients who were also reported to have a drug problem alongside drinking problems. Mason and Woods (1996) found that in the patients who abuse drugs, the highest percentage of those use cannabis regularly as opposed to other forms of drugs.

Drug addicts were disproportionately involved in burglary and drug offences, including cannabis offences (Toch & Adams, 1990). Prins (1986) also found that few instances exist where drug abuse or addiction may lead to dangerous behaviour. If one takes cannabis for example which is a hallucinogen, it seems plausible to say that this drug would not necessarily facilitate dangerous or aggressive behaviour. Certain drugs combined with alcohol, however, may result in marked loss of control and increased aggressive impulses.

The relationship between alcohol, drugs and crime in mentally disordered populations remains complex. Changes in behaviour that may occur due to substance abuse may have adverse effects in some predisposed individuals and little effect on others. Some findings suggest that ingestion of even small amounts of alcohol or other drugs may be sufficient in provoking a very violent offence. In situations such as this very careful enquiries need to be made about the possible use or abuse of drugs and/or alcohol. Substance abuse in mentally disordered offenders needs to be discussed in conjunction with other factors such as the clinical diagnosis of the patient which follows in the next section.

### **Common Diagnoses associated with mentally disordered offenders**

The relationship between diagnosis, criminality and violence has also been a much-studied area. A diagnosis should not just be a psychiatric statement but should be descriptive in that it provides information needed about the cause, course, prognosis and choice of treatment of the individual.

Paranoid and other Schizophrenia were the **primary diagnoses** in the work done by Tardiff, Kenneth and Sweillam (1982). The next frequent diagnosis was psychotic organic brain syndrome associated with Korsakoff or other kinds of dementia.

Norton (1988) supports the finding that the most common diagnosis amongst a group he studied was paranoid schizophrenia. These included violent mentally ill offenders and forensic patients. The most common diagnosis amongst a non-violent control group of the same study was undifferentiated schizophrenia. Like Tardiff (1982) Norton (1988) found an organic disorder such as epilepsy to be the next most common diagnosis amongst those mentally disordered offenders.

Recent evidence according to Hodgins (1993) suggests major mental disorders such as schizophrenia, major affective and other psychotic disorders, are associated with violence. She found that people who have been diagnosed as schizophrenic tend to be more frequently involved in criminal activity or violence than people with affective or organic psychoses. Thomson et al. (1997) too found 70% of the patients at Carstairs Maximum secure facility had a principal diagnosis of schizophrenia. Psychotic symptoms continued to occur in many patients despite extensive treatment, and physical health problems were present in more than 50% of these patients. This research contradicted a previous finding by Menzies, Webster and Sepejak (1987) who suggested that offenders with a diagnosis of schizophrenia, manic-depression and other psychosis had less violent histories and fewer incarcerations than offenders without these diagnoses.

In the early significant study by Steadman and Coccozza (1974) it was found that diagnostically most of the Baxtrom patients were classified as schizophrenic. Two other diagnostic categories also formed a substantial portion of the patients: psychosis with psychopathic personality and psychosis with mental retardation. In a more recent large-scale study, Woods and Mason (1996) in their investigation of clinical diagnoses, they indicated that 60.6% of the admission group were diagnosed as personality disordered; 25.5% were diagnosed as paranoid schizophrenic. About 46.4% of patients were found to have been deluded or hallucinated on admission. Schizophrenia was found to be the next highest diagnosis.

From a first clinical description of high security hospital patients done by Taylor (1998) the association between psychiatric diagnosis and violence was examined. Schizophrenia was most commonly associated with violence against another person.

**Psychotic symptomatology** in schizophrenia and other psychotic disorders has become an important point of interest in researching mental disorder and crime. Link et al. (1992) concluded that mental patients are on average no more dangerous than non-patients. However, it has been proven in several studies which follow, that a strong connection exists between psychotic symptoms and violence. Patients with elevated psychotic symptoms tend to have higher rates of violent behaviour (Link et al. 1992).

Lanzcron (1965) and Virkunen (1974) studied 153 case records of patients including psychopaths committed to a state hospital on murder charges, and 74 schizophrenic violent offenders respectively. The psychopathic offender displayed antisocial behaviours such as empathic failure, a history of repeated violations of the law without remorse, callous and exploitative behaviour as defined by the Diagnostic and Statistical Manual of Mental Disorders or DSMIV (American Psychiatric Association, 1994). Homicidal or other violent offences were found to be a result of psychosis as characterised by symptoms such as delusions, hallucinations, disorganised speech or behaviour or catatonic behaviour described by the DSMIV (American Psychiatric Association, 1994). In the above-mentioned studies, Lanzcron (1965) and Virkunen (1974) found that hallucinations or delusions were present in 37% of the patients in both of these studies.

In another study done by Taylor (1988) more than 75% of those with a psychosis were recorded as being driven to offend by their delusions. However Planansky and Johnstone (1977) found only 59 of 205 offenders they studied were in the active phase of their illness at the time in which they had made homicidal threats or attacks.

Gibbens (1983) cited that 25% of offenders in his study were compelled by delusional phenomena to offend followed by quarrels, revenge or jealousy. This seems to be due to the fact that often people with whom the patient is quarrelling for example becomes incorporated into the delusional system or, as a consequence of a persecutory delusional system for example, the patient provokes the person and quarrelling occurs. Taylor and Gunn (1984) showed the association between psychosis and violent offending amongst men is higher than expected.

For the people with psychosis both positive and negative symptoms were highly likely to be present at the time of the offence, as were affective symptoms. The affective symptoms included flat affect or incongruent mood. In Taylor (1985) it was revealed that 90% of offenders reported positive psychotic symptoms but 40% reported the symptoms were a direct motivation for offending.

In trying to determine the relationship between specific diagnoses and offending in mentally disordered patients, often the picture is complicated by **multiple diagnoses**.

For specifically violent offenses, in a study done by Rapoport & Lassen (1965) for example, the highest number of arrests was recorded for ex-patients with diagnoses of personality disorder, alcoholism, drug abuse and schizophrenia. Similar findings by Cocozza et al. (1978) are suggested by the high arrest rates found amongst the combined diagnoses of alcoholism, drug abuse, personality disorder and paranoid schizophrenic states

Rasmussen and Levander (1996) also highlighted that institutionalised adults with a diagnosis of mental retardation tended to be more assaultive when multiple disorders were present.

From these results it would seem that people who have acquired a label of schizophrenia seem to appear more frequently in criminal or violent populations than do people with affective or organic psychoses. Offenders with a history of psychiatric treatment often have a violence history confined to the same time frame so psychiatric patients with chronic treatment histories tend to have chronic violence histories. As we track the course of mental health treatments over time, periods of serious emotional disorder consistently coincide with an increased propensity to violence. The pattern is significant because it suggests a connection between emotional problems and violence among seriously disturbed offenders (Toch et al. 1990).

### **Types of Offences committed by the mentally ill**

Random violence in general makes disturbed persons objects of fear, since it is the sort of violence that is exclusive to pathological offences. The media often associates these kinds of offences with mentally ill persons. These offences can without exception be ascribed to psychotic delusions or hallucinations or even substance abuse as mentioned previously (Hafner & Boker 1973). The offence may appear motiveless since the offender usually assigns private symbolic attributes to victims who happen to be available at the time of the offender's hallucinations or delusions.

In general it seems that in terms of the types of offences that are committed by mentally disordered patients, the data indicates that offenders with psychiatric histories more often stand convicted of murder, assault, rape and sodomy, implying that the degree of physical harm inflicted on victims is highest in this group. Substance abusers stand convicted more of burglary, indicating least physical damage to victims.

Hafner and Boker (1973) found motiveless offences usually occur among the mentally ill. Of 533 mentally ill offenders and very violent offenders about 20% of their crimes were rated as motiveless. Crimes which may appear motiveless and are often associated with mental handicap are arson and sexual offending. According to Turk (1989) mentally handicapped patients will not have the insight to conceptualise the very dangerous nature of arson for example. Prins (1986) describes it as one of the most dangerous of all offences as it is an offence which can be committed easily and several people can be injured unintentionally.

Domestic problems can provoke extremely violent reactions from mentally disordered individuals. The most consistent pattern Toch et al (1990) found in this study is that offenders with psychiatric histories are overrepresented in all categories of peculiar offensive behaviour. The pattern is a dramatic one given that many psychiatric patients demonstrate ineffectual or counterproductive behaviour, such as leaving behind incriminating evidence (10.9%), violent overkill where the offender continues to physically assault or mutilate the already dead victim, or other behaviour reflecting frenzied mental state (9.8%), and conduct one generally thinks symptomatic of mental disorder (7.8%). In 8.0% there was no plausible motivation for the offence while in 6.1% the offender could not recall his crime.

Maden et al. (1995) indicate from their results that 8% of the patients were admitted following homicide; 8% wounded/Grievous Bodily Harm; 19% violence against the person; 17% arson; 10% a sexually related offence. Further reported other behaviours which resulted in admission: 63% repeated assaults; 26% self harm; 26% fire-setting; 22% absconding; 19% sexually inappropriate behaviours; 18% life-threatening assaults and 15% threats to kill.

Similarly, Mason and Woods (1996) found the main types of offences patients were admitted for committing, were as a result of physical attacks on others (44.9%), followed by damage to property (17.8%) and other including burglary and trespassing (12.4%). A small number of patients (6.5%) were admitted following sexually inappropriate behaviour.

As can be seen, therefore, a high percentage of mentally disordered individuals are found to be assaultive towards other persons. Also the specific type of psychiatric disorder suffered by the patient, may also determine the kind of offence committed by the patient

### **Criminal History**

Popular stereotypes of mentally disordered patients encompass the view that the public needs to be protected from a frenzied, violent and at times the unpredictable criminally insane population who often have extensive criminal histories.

Humphreys et al. (1994) found that 16% of a sample of patients in their first episode of schizophrenia had committed an offence within the five-year period prior to their initial admission to hospital. Nearly half of these patients were clearly ill at the time of their offence, and a significant proportion were acting in response to psychotic symptoms. Their data suggested that patients with schizophrenia might commit a variety of offences even prior to their first hospital admission. They found that relatively few patients in their study received psychiatric treatment or were referred to psychiatric services, even if there was clear evidence that their offending was as a result of an abnormal mental state.

A high percentage (84.2%) of the patients studied by Mason and Woods (1996) had a previous criminal history. A significantly higher percentage had a juvenile or criminal record prior to their 17<sup>th</sup> birthday. The highest percentage had been previously convicted of the offence of theft or larceny. Burglary was another previous conviction which received a high rating.

Two final examples are the Baxtrom study where 51% of the patients had been previously convicted of a violent crime and their mean number of arrests was 3. Secondly, in the Carstairs Maximum secure facility about half of the patients were admitted following an offence and over 80% had a history of criminal activity (Thomson et al. 1997).

Although the stereotypical view of the mentally ill offender may not be an entirely accurate image, studies have indicated that patients often do have prior histories of criminal behaviour.

### **Antisocial Behaviour: Risk and Dangerousness**

Through the 1970s and early 1980s mental health professionals seemed to be primarily interested in the prediction of dangerousness in violent, mental patients (Cohen, D 1995). Some researchers such as

Monahan (1981) felt that these predictions were valid sometimes and others such as Steadman and Cocozza (1980) felt that psychiatrists and psychologists could not predict dangerousness accurately at all. Initially the research consisted largely of natural history experiments in which recidivism of discharged patients was assessed (Cohen 1995). Monahan (1984) suggests that later thinking should incorporate the development of techniques which include clinical material, situational items and varied populations to create statistical predictive techniques.

Much of this literature also debated arguments over whether schizophrenia was related to violent behaviour (Monahan 1992, Rice & Harris 1992). Their predictive studies looked at the development of statistical tables based on static variables such as the type of crime, age and sex of the victim, school records, age of onset, criminal behaviour and so on. Still, however, mental health professionals' ability to predict dangerousness is regarded with some skepticism. Hodgins (1993) felt that clinical "dynamic" factors needed to be included in predictive measures. Megargee (1976) also warned that personality and situational factors must be taken into account in assessing dangerousness.

Current knowledge about dangerousness and predicting violence is reviewed in an article by Newhill (1992). 'Dangerousness' is confined to danger to others. The traditional forensic definition of dangerousness typically refers to an individual's potential to do serious physical harm to another with the emphasis on violent acts against people. A more useful definition of danger to others implies a systems approach to the concept. Many authors have pointed out that dangerousness is not only an attribute of persons but of situations and environmental factors as well (Newhill, 1992; Hamilton 1982). It also includes impulsive and destructive behaviours (Hepworth 1982, Gunn 1982).

Research literature on risk assessment focus on different aspects of dangerousness and reach different conclusions with regards to predictive factors of dangerous behaviour.

Firstly there are studies which focus on aspects such as hostility, agitation, previous assaults, suspiciousness (Werner et al. 1984), history of violence (Menzies et al. 1981), forensic history (Menzies et al. 1981, Quinsey and Maguire 1986), social history (Jackson 1986), impulsive behaviour (Segal et al 1988), recent incidents, substance abuse and current offence as well as surrounding circumstances (Quinsey and Maguire 1986) These are all shown to indicate future patient dangerousness.

Secondly there are studies which include psychological factors such as violent fantasies, ruminations around the index offence, current mental health, mental health history, sexual behaviours (Marra et al.

1987), uncooperative behaviour, hostility, suspiciousness, impulsive behaviour (Werner et al. 1984) and other factors mentioned above. According to some researchers, psychological factors such as diagnosis, severity of disorder or personality traits, are poor predictors of dangerousness (Monahan, 1984; Halleck, 1986).

Hepworth (1982) a social worker at Broadmoor Hospital highlighted current mental health, current behaviours and attitudes, criminal history and social history as factors which should be taken into account when doing risk assessment

Pollock and Webster (1990) introduced a model of assessing patient dangerousness. The main areas highlighted as predictors were established patterns of violence, social history, anti-social value systems, underlying hostility, sadistic orientation, surrounding circumstances of the offence, drug and alcohol abuse, mental health history, suspicion, irritability, potential for change, current attitudes, motivation, socially acceptable values and goals and self attitudes.

From the kinds of research mentioned above, the best predictor of future violence seems to be previous violence (Monahan 1984). The probability of a patient committing a future crime increases with a history of previous criminal acts (Monahan, 1981). This is supported by Floud and Young (1981) One of the strongest predictors of future criminality and violence, in both the criminal and mentally ill populations, is the history of prior arrest or criminal conviction (Duckitt 1988; Williams and Miller 1966; Scott 1977; Bluglass and Bowden 1998; Tardiff and Sweillam 1982; Buchanan 1998).

The abuse of alcohol and drugs has been positively associated with criminal recidivism and violence (Berger & Gulevich, 1981; Gulevich & Bourne, 1970, Halleck, 1975, Menuck, 1983; Rasmussen & Levander 1996; Wallace et al. 1998). Mulvihill & Tumin (1969) suggest that alcohol and drugs act as secondary stimuli to violent acts, alongside primary personality economic and social factors. Most studies seem to show that substance misuse is a significant and important factor that increases the risk that a person with a mental disorder will be violent. (Swanson et al., 1990)

Demographic factors which best predict violence among the mentally disordered are the same as those used in predicting violence among non-disordered offender populations. Some of the factors looked at are age, gender, race, and social class. Males are far more likely to be arrested and convicted for criminal acts. Wallace suggests that research has shown that younger people (late teens to early twenties) are more likely to be involved in crime, including violence (1998). Research has shown that individuals who fall

into ethnic groups other than white are more likely to be arrested and convicted for criminal and violent crimes (Cohen 1991). Socioeconomic status is negatively associated with arrest and conviction rates, as well as reoffending.

Mulvey and Lidz (1984) suggest that a loose, chaotic crowded family environment is a context which is likely to precipitate violence and that lack of family support for the patient may be a key factor in determining the occurrence of violent behaviour as well as the likelihood that the person will return to hospital (Hafner & Boker 1973, Grubin 1997, Oates, 1997)

An extensive review of the literature on dangerousness and risk assessment highlighted a number of areas perceived as being relevant to the understanding of the relationship between mental disorder and risk. The literature on the relationship between mental disorder and dangerous behaviour is vast but more recent research seems to be able to more clearly define the circumstances in which mentally disordered people may behave dangerously (Reed 1997). For future research a closer look at the diagnostic variables and symptoms as well as perhaps the characteristics of the patients of high security units may be a step towards understanding the mechanisms behind the violent and dangerous behaviour. Exploring these factors would also provide valuable information as to which mentally ill patients are directed to maximum, medium and minimum secure units and which persons become incarcerated in correctional facilities.

### **Imprisonment and Hospitalisation of forensic patients**

The question is often asked about which offenders are referred to a psychiatric hospital and who is incarcerated in prison. It seems to be that those who are admitted to prison are considered to be unresponsive to treatment whereas the patients admitted to hospital are responsive to treatment or their condition can be prevented from deteriorating.

A system has been set up to divert the mentally ill and non-mentally ill offenders to the appropriate facilities by means of criteria and policies which will be discussed later in the chapter which looks at international trends related to mental health and law. However, due to lack of resources the system may not always be protecting the rights of these patients and some may end up being inappropriately placed. For example in the Western Cape in 1998 there was a backlog of patients awaiting admission to the psychiatric hospital but due to downscaling of staff and fewer beds in the wards, Pollsmoor Prison would only admit referrals from courts in the Peninsula. This meant that many patients would have to wait in police cells around the country until space could become available for them (FMHA 1998)

Hargeaves (1997) was concerned with the number of mentally ill people serving prison sentences. He identified prisoners with schizophrenia, affective disorders, delusional disorder and with a clear history of treatment need but who were unable to access hospital facilities due to lengthy transfer processes and limited secure provision. Gunn et al. (1994) established that psychiatric disorder is over-represented among the prison population and Lamb and Weinberger (1998) also acknowledge the urgency of the problem of mentally ill persons in prisons. Offenders studied in their research population generally had acute and chronic mental illness. The factors outlined in their study, explaining the causes for why mentally ill people are being placed in the criminal justice system rather than the mental health system, were lack of adequate community support, difficulty in gaining access to community treatment and societal attitudes.

Two main admission sources that have historically referred offenders to high security psychiatric services are the prisons and the courts. Because of the degrees of mental illness of these populations, those patients who are referred to hospitals require substantial ongoing care in facilities with varying levels of security.

#### Maximum Security

Snowden recognised that there was a group of patients who were not dangerous enough to warrant being restrained in a maximum security unit but who nevertheless were still in seclusion facilities or in special hospitals. They found that 59% of the patients in the special hospitals did not actually require detention under conditions of maximum security. The Review of Health and Social Services for mentally Disordered Offenders (Reed report- Dept of Health and the Home Office 1992) stressed that patients should be cared for in conditions of no greater security than is justified by the degree of danger they present to themselves or to others.

Maden et al., (1995) examined the treatment and security needs of special hospital patients' and there is some indication of the reason for admission and the offending behaviour of the mentally impaired within these establishments.

Shaw et al., (1994) studied the demographic, legal and clinical characteristics of patients from the Northwest region currently detained in maximum security facilities. Shaw et al. found that patients placed in the Special hospital group tended to have been currently aggressive, clinically impaired in daily living skills, currently demonstrating positive symptoms of mental illness, lacking insight into the mental illness, non-compliant with medication and having had alcohol-related problems prior to admission. They

were often actively psychotic and treatment resistant and these factors have been seen to be commonly associated with increased risk of violent behaviour and offending, justifying a stay in a maximum secure facility (Taylor 1985).

### Medium Security

Examination of a group of patients in a medium security ward seems to suggest that long stays are unavoidable (Kennedy et al., 1995). Patients who were placed in medium-secure wards tended to be slightly older, socially impaired and highly functionally impaired. They also seemed to be mostly non-offenders but more a chronically disordered population group. It was realised that a proportion of patients could not be discharged because they could not cope in the community. The characteristic of this population involved having a chronic psychiatric illness, being socially disadvantaged and isolated as well as having multiple coexisting disabilities e.g. Schizophrenia and cannabis abuse. Another example provided by Rasmussen and Levander (1996) indicates that psychotic symptoms were often the target for treatment, thereby suggesting that length of stay in a psychiatric institution is determined by the treatment need and not by the crime committed.

### Minimum Security

Mc Clintock and Evans (1995) conducted a study investigating the reasons for admission or transfer to a minimum secure ward and whether there were any differences between those with multiple admissions and those with single admissions. Most of the multiple admission group tended to be readmitted due to aggressive behaviour, Patients admitted to minimum secure units also tend to have long admissions as these units seem to be the bridging gap between maximum and medium secure units and community care.

Monahan, (1988) and Dell (1988) found that in mentally ill patients in Broadmoor, the course of their illness and their response to treatment determined the length of their stay in hospital. Inadequate supervision in the community were seen as factors which would result in mentally ill patients reoffending.

### Absconding

Absconding is a fact of psychiatric hospital life, and seems to be inevitable amongst the forensic population. Short (1995) examined the characteristics of absconders from an acute admission ward. She found that the absconders tended to be younger males, single, unemployed, compulsorily admitted and with a history of previous admissions. Episodes of absconding and the precipitating factors for absconding were seldom recorded in the medical notes. There did seem to be a relationship between absconders and diagnoses of affective disorders.

In conclusion admissions to a special hospital is a major life event as the stay can be so inordinately long in comparison with prison institutions where the length of incarceration is clearly specified. By and large the more seriously disturbed patients who are deemed high risk to the community tend to be admitted to these facilities. Another important issue highlighted by Cumella and Samson (1994) is the probability of offenders with mental impairment being inappropriately placed because of the scarcity of services for these individuals.

### **International trends in Mental Health and Law policies**

The changes within the relationship between mental health and law seem partly to have arisen due to a lack of mutual understanding of these professions. In practice a review done by Dr Reed (Department of Health and Home Affairs in the UK 1993) advocated that wherever possible a mentally disordered offender should receive care and treatment from services other than the criminal justice system. This involves identifying the mentally disordered offender at the point of arrest and if possible diverting the individual from a custodial remand to a place where further assessment or treatment can be obtained.

MacCulloch et al., (1994) presented an analysis of cases of those who had been reconvicted of a serious offence. Two main elements need to be taken into account: the safety of the public and the needs of the patient. Mental Health Review Tribunals are responsible for ensuring that patients are detained in hospital if the requirements of the MHA of 1983 are met in the UK. This means that the patient is seen to require treatment within the hospital due to a mental disorder, and that such treatment is necessary for the safety of both the patient and of others. It is not within their remit to consider the level of security required nor to prescribe specific treatment or management including periods of leave. MHRTs do, however, have the greater power to discharge

In Italy unlike the U.K, South Africa and Sweden, the institutions involved in the treatment of mentally ill offenders depend on the ministry of justice and not health. This led to several debates arising out of the Italian mental health law. Firstly a mentally ill offender would be committed to a judicial psychiatric hospital on the basis of the degree of danger he/she present to society. The type of mental disorder and severity of the psychopathology takes second place, thereby failing to acknowledge recurrent illness and long-term care. As a result many patients have been found to become chronically ill, as the main causes for their psychotic relapse lies in the home environment (Calabrese et al., 1990). Secondly there seems to be no therapeutic intervention at these institutions and they are run like prisons.

Similarly, in the USA it is suggested that the criminal act determines the length of the patient's stay in a forensic psychiatric unit. Some states in the USA have passed laws that a person who was found to be mentally disturbed when committing the offence will still be required to serve a period of imprisonment after he has regained his mental health (SA Law Commission 1995).

In Norway (Rasmussen & Levander 1996) there seems to be a suggestion that the relationship between the patient's length of stay and the symptoms of the patient indicates that the practice focuses on the treatment of the patient and not on the offence committed.

In Israel the aim of the institutionalisation of the mentally ill is mainly for treatment as defined in the Act of 1991(SA Law Commission 1995). "When an accused has stood trial and has been found guilty and the evidence has led the court to conclude that the accused was mentally disturbed at the time the crime was committed and thus should not be punished, and the accused is still mentally ill, the court is obliged to order that the accused be admitted to a mental hospital or should receive treatment as an out-patient" (SA Law Commission, 1995, 41). When a mentally ill offender is admitted to a mental hospital, leave and discharge power is vested in the hospital manager.

Policy in Canada indicates that a person found unfit to stand trial, be detained as a patient for an indefinite period. In 1993, however, it was stated that the detention of a patient should not extend the maximum period of imprisonment that would have been imposed on conviction (SA Law Commission 1995).

The issues raised within creating policies in this area have been related to management and treatment of these mentally disordered offenders. The clinical processes of assessment and treatment of mentally disordered offenders occur within what seems to be an unusually constraining administrative framework in the different countries. There does seem to be some suggestion that these frameworks arise from legislative and clinical practice which operate on out of date knowledge and ideas. This appears to have become an area of serious concern.

There also seems to be no mechanism for feedback to the legal system with regards to the outcome of their decisions for example in matters of transferring patients from prisons to special hospitals, thereby extending their period of incarceration without a time limit being given. As MacCulloch et al., (1994) also indicate, before any large scale changes can be made to Special hospitals, there is a need for an audit of

the patients currently within the system in order to explore the characteristics and situations of these patients.

### **South Africa: Mental Health and Legal Policies**

Some of the issues raised in the previous section have become an area of increasing concern in the South African context. The mentally disordered offender is placed in the hands of a structure which is essentially a system of support staffed by psychiatrists, psychologists, social workers etc. These are members of the caring professions. However, the offender is also given over to the agents of the criminal justice system: police officers, lawyers, judges etc.

The focus of this dissertation is specifically within the field of institutional forensic psychiatry and ventures on the population of institutionalised psychiatric patients known as State Patients. A State patient is a person detained in a psychiatric hospital because they have been found to be incompetent to stand trial due to mental illness or not guilty by reason of mental illness(SA Law Commission 1995).

A patient is declared a State patient by virtue of the criteria stated in Chapter 13 of the Criminal Procedure Act 51 of 1977 (CPA of 1977, 1998) and Chapter 4 of the Mental Health Act of 1973 (MHA of 1973) (SA Law Commission 1995).

According to the CPA of 1977 (1998) an individual may be declared a State patient if found to be:

- i) “not capable, by reason of mental illness, of understanding the proceedings or conducting a proper defence” (P. 62, Section 77(1), CPA, 1977).

Here an enquiry is made into the capacity of the accused to understand the proceedings so-as to be able to conduct a proper defense. The capacity to understand the trial can be raised at any stage of the proceedings (SA Law Commission 1995).

- ii) “incapable of appreciating the wrongfulness of his act or of acting in accordance with such appreciation” (P. 64, Section 78(1), CPA, 1977).

If a person suffers from a mental illness which renders him incapable of appreciating the wrongfulness of his act, the law acknowledges that a pathological impairment exists and responsibility for the offence becomes reduced or non-existent.

These issues may arise as a result of enquiries due to the nature of the offence, if the accused has a history of psychiatric treatment or behaves in an unusual manner during court proceedings (Zabow 1990).

Section 79 of the CPA describes how the accused should be examined. This entails that he be detained in a psychiatric hospital for 30 day's observation. In SA psychiatrists are formally required to report on the dangerousness of a State patient in several instances:

1. "The reports shall state where there is a likelihood of the patient committing serious acts of violence if he is not detained" (P. 28, Section 29(1)(b), MHA, 1973).

If a State patient has been charged with an offence involving serious violence, the psychiatrist is required to provide his/her personal view of the likelihood of the patient committing serious acts of violence if not detained in hospital.

2. A consideration of the State patient's dangerousness to self and/or to others is required on the form notifying the authorities of his escape from hospital.

3. "The superintendent of an institution or person in charge of any place in which a President's patient or mentally ill prisoner is being detained...shall transmit the report to the Minister together with his observations thereof" (P. 32, Section 35, MHA, 1973)

On the periodical report which he/she must submit to the Minister of Health, the psychiatrist is required to provide a summary of the course of the State patient with special reference to any symptoms indicating homicidal, suicidal or other dangerous behaviours.

The forensic unit at Valkenberg hospital consists of a multidisciplinary team of mental health professionals (psychiatrists, clinical psychologists, social workers, nursing staff and occupational therapists) who collect the relevant information necessary to formulate opinions expressed in the final court report (Zabow 1990).

Once the individual has been declared a State patient what happens to him/her i.e. detention, leave and discharge is governed by the rulings of Chapter 4 of the MHA (1973).

A formerly lengthy procedure for discharge of state patients was revised in the Third General Law Amendment Act (1993). An application for discharge is made directly to the judge in chambers. The judge may order that the patient be discharged conditionally or unconditionally or he be detained as a patient under a more appropriate section.

Dangerousness and risk assessment is, therefore, a recurrent theme in developing policy guidelines around the State patient. The psychiatric assessment and prediction of dangerousness is an integral and ongoing process which serves as a major determinant of the decisions of the conditions of the State patient's

detention. In order to develop an appropriate and effective tool for the prediction of dangerousness and risk assessment, one needs to have clarity about the kind of population with which one is dealing.

Certain guidelines were given to hospitals which emphasize the policy that Declaration as a state patient is not used as a punishment for a person. When the state patient's readiness for discharge is determined, it should not be evaluated against the charge laid against him but rather the clinical profile should be considered, and whether had there been no charge laid against the person, he would have been dischargeable. Discharge procedures no longer necessarily have to wait until a 2 or 4 year period of normality has passed (SA Law Commission 1995).

All State patients at Valkenberg are formally reviewed by the forensic team on a three monthly basis (Zabow 1990). An assessment is made of the stability of the State patient's psychiatric condition, and a social worker investigates possible resources within the community such as family circumstances which would be favourable for release.

A State Patient may be conditionally or unconditionally discharged but usually the former occurs. It may arise that it is felt that a State Patient no longer needs to be institutionalised but is unable to be discharged due to unfavourable home circumstances. In cases such as this the State Patient is reclassified to the appropriate patient status according to the section of the MHA (1973). If released the State Patient is usually on conditional discharge for a period of two years, and reports are submitted to the Minister of Health every six months (Section 38[a]). If these conditions are adhered to the patient is reclassified to unconditional discharge.

The purpose of conditional discharge is to help the patient become reintegrated into the community. The conditions stipulate that the patient reside at a specified address, and is compliant with medical and social supervision. The purpose is to guard against a relapse in mental health or antisocial behaviour which may recall the patient to hospital for further treatment.

The presence or absence of violence determines the manner in which a State patient's status is changed. State patients assessed as more dangerous or potentially more violent than fellow patients may not even be considered for discharge because of the nature of the original charge. In light of this it is important to understand that being given State patient status is a measure by which to "protect the public and provide for treatment" (Kruger 1980, p 208) and should not be seen as a punishment. Consequently the

development of various laws and policies and the practice thereof, should be carefully scrutinised in order to facilitate the most fair and ethical practice for both the State patient and the public.

### **Rationale for study**

This study investigates the characteristic profile of the entire forensic population at Valkenberg. Additionally the characteristics involved in admission and detention in hospital are looked at in an effort to describe who the mentally disordered offenders are; which patients are being admitted to hospital and to begin to understand why they are still being detained in the hospital.

More broadly in order to adequately be able to determine risk factors that are appropriate for assessing risk, one needs to be able to be clear about the kind of population with which one is dealing. In establishing who makes up the forensic patient population at Valkenberg Hospital and in providing a description of their characteristics, this research will also be able to help identify the needs of this population in terms of treatment and rehabilitation. The research will also be important in informing the kinds of facilities required within hospital, in the community and follow-up resources as well as playing an important role in the process of policy development within the changing health and criminal justice systems.

This kind of research is in the interest of four different sectors of society:

Firstly, the hospital may be provided with a better understanding of the population for whom staff are expected to provide treatment. In an ideal therapeutic milieu there would be a high staff/patient ratio. A unit with a large turnover of patients must have an enhanced complement of staff. The staff should not be withdrawn into other areas, making up deficiencies elsewhere. This clearly seems to be inevitable if we look at the number of restructuring processes which have occurred at Valkenberg Hospital within the last two years. Inadequate staff numbers will cause a unit to degenerate into a place of merely custodial function.

In order to provide an adequate service for patients, it is necessary to know what kinds of patients the service will be utilised by. Not many studies have provided information on actual characteristics of patients.

Equally important to characteristics of patients is the assessment of dangerousness. The assessment of a State patient's dangerousness will indicate the risk of harm he imposes on the staff, other patients and the

public should he escape. This determines the ward in which he is placed e.g. maximum security, secure, closed or open wards. This also determines the patient's suitability for movement between these different wards. A risk assessment will contribute towards decisions regarding the State patient's eligibility for privileges e.g. suitability for ground parole, permission to leave the hospital grounds, permission for leave (V/L) and discharge (D/C) from hospital (Cohen 1991), and comparisons of characteristics will be made between those patients who are given leave and those who are not in this study.

Decisions around discharge and leave from hospital have implications for the community which brings us to the second sector of society for whom this study would provide valuable information: the public. The public's perceptions of mentally disordered individuals would be further informed through challenging certain stereotypes if an adequate description of forensic patients can be produced. The public's fears around the mentally ill and mentally ill offenders may be refuted or justified through conclusions drawn from information gathered in research of this nature.

The movement to deinstitutionalise the mentally ill also carried with it the promise that treatment alternatives would be provided in the community. One reason given that chronic mental patients did not fare well in the community following release from the mental hospital is that the hospital invested little effort in preparing people for release. When one considers the high percentages of patients with past criminal histories, the high recidivism rates are not surprising given this lack of preparation. It is important to establish what resources are available to patients when they are released into the community whether it be for short or long-term leave or discharge. Their family circumstances and support structures would need to be investigated and this study would provide some information as to the characteristics and behaviours of patients who are released into the community and the situations into which they are released.

The prevalence of violence before hospitalisation has been used to indicate the fundamental relationship between mental disorder and violence and has informed the legal criteria for hospitalisation. Violent behaviour would be one of the reasons why disordered people are rejected out of the total disordered population for hospitalisation and are deemed unsuitable for discharge. It would be interesting to compare the rates of aggressive behaviour of the patient in hospital to that in the community. A comparison of where violent behaviour takes place is looked at in this study.

Thirdly, the government would be provided with information to guide their decisions around policies relating to state patients. It has already been pointed out that there are gaps in the systems which have

been put in place to manage and treat mentally disordered offenders. In the South African context reasons for the shortcomings of these systems have been related to the move towards more community care approaches and deinstitutionalisation which has meant the reduction of hospital services, limited staff and ultimately premature discharge of patients from institutions which can no longer care for them.

In evaluation of services, it is important to first have knowledge about the population for whom the services are being provided. Although the samples in most of these studies help to develop a picture of the mentally disordered individual who offends, they tend to be too small to allow any generalisations of offending behaviour; or the methodologies are so different that comparisons are difficult to make. There does seem to be a need for more population-based studies such as this to provide information on the association between mental disorder and offending.

Finally, this research is also in the interest of the state patient who may be detained indefinitely. This raises another controversial aspect of hospitalisation of these patients, which is the unlimited length of detention imposed on them. It is important that basic research should, therefore, have relevance to the containment of the mentally disordered offender within the hospital setting.

A strong association between mental disorder and offending has been described in the literature. Policy around the detention of mentally disordered offenders has been established with the view of not implementing punitive structures on mentally disordered individuals. The broader aim of this study, having gained knowledge about the characteristics of the State patients, is to secure appropriate treatment for the patient's illness in a humanitarian and therapeutic manner.

## METHODOLOGY

### Aim and Background

The Forensic Psychiatry Unit at Valkenberg Hospital is called upon to report on the triability and responsibility of individuals referred by the courts. It serves the Department of Justice for the Western Cape. The Forensic Psychiatry Unit is also responsible for the detention, treatment and follow-up of many State Patients from these areas.(Zabow 1981). State Patients are detained in the hospital because they have been found incompetent to stand trial due to mental illness or not guilty by reason of mental illness. As a result an ongoing evaluation of the patient's mental state and potential for dangerous behaviour occurs.

The primary aim of this research is to provide a descriptive analysis of the characteristics of the patients identified as State Patients. As evaluation of the patient's violence potential and risk assessment is ongoing, the subsidiary aim is to identify the factors which have determined the length of stay in hospital or the potential for discharge. This includes looking at the kinds of antisocial behaviour which have taken place over a period of two years from May 1997 to May 1999. Violent behaviour, in particular, is an important factor in extending hospitalisation as it influences assessment of risk. It is necessary to understand the profile of the patients and the types of behaviours of the patients before an adequate and appropriate risk assessment tool can be used.

This study also forms part of ongoing research where a database is being set up for the availability of information for further research opportunities on Forensic patients. It also forms part of a research project to establish the tools that need to be used to identify risk behaviours within Valkenberg's population of forensic patients and establish criteria for the assessment of dangerousness which is adapted to the South African population.

### Sample

A decision was taken to limit the population to the period extending from 1964 to 1997. This would therefore, exclude people who had been admitted after May 1997. This was necessary as the period of behaviour was being examined over the two year period from May 1997 to May 1999, and it would require that patients had been admitted for 2 years or more to qualify for the study.

**Table 1**  
**Number of patients in each ward in May 1999**

<b>WARD</b>	<b>Freq.(n)</b>
9 & 10	50
12	102
20	57
7	30

The total population number (N) was 239. Thirteen patients had to be discarded as they were on conditional discharge and were not in the hospital for all or most of the time period in which the patient's behaviour was being assessed.

Ward 20 is the most secure and contains potentially dangerous patients and prisoners (i.e. observation cases). Wards 9 & 10 were combined due to staff shortages and are medium secure wards. These wards contain patients who have been considered stable enough to be transferred from Ward 20 but do not function well enough to be placed in open wards. Ward 7 is a closed ward that houses low functioning long-term patients. Ward 12 is an open ward which prepares patients for discharge(usually by allowing them extended periods of leave and freedom of movement). It does also cater for chronic patients whose social circumstances are unsuitable for discharge. The patients are graded from High security risk through to low risk. Ward 20 is considered a Maximum Security Ward in terms of the Mental Health act. Low risk patients are eventually placed in Ward 12 (Appendix VI: Forensic Psychiatry Unit document 1999).

### **Rationale for Archival Method**

The archival method of data collection was used as it is the most practical if not the only method of obtaining information, through a retrospective review of patients' files. This method provides secondary information, consisting of data and other information collected by others and archived in some form. The files also provide a comprehensive description of the population of State patients which is the primary aim of the research.

The use of secondary information is often referred to as secondary analysis which means simply a further analysis of information that has been obtained and may address an issue quite different from that which prompted the original data collection. It involved the integration of information from several sources of data.

Files contain a large amount of information about the characteristics of the State Patients along several dimensions (sociodemographic, psychiatric, legal/criminological) including explicit evaluations of their dangerousness (past criminal histories, convictions, present charge, psychiatric diagnosis). A State patient file is opened as soon as a patient is admitted to the unit and circulates among the clinicians until the patient is conditionally discharged.

The file information is gathered from the admission interview and mental state examination (MSE), the social worker's reports, information from external authorities, official reports and communication which provides ongoing records of the course of the patients' stay in hospital.

Different clinicians have different styles. Therefore, the type and quality of information that is recorded will vary. One cannot assume that State Patient files contain all the variables which influence the clinician's views about dangerousness and deciding upon who would be granted leave or discharge. It is possible that clinicians may have evaluated State Patients as dangerous or been aware of some antisocial behaviours but this may not necessarily be explicitly recorded in the files. Another drawback of archival data is that records may be lost or destroyed or essential information inconsistently recorded, mislaid or illegible (Scott, 1990).

Inter-rater reliability was not used to test the reliability of the information gathered. However, it is likely that the data collected is reliable as the information was drawn from written perceived factual information. For example a note would be recorded whether a patient had been violent or not with the date when the incident may have happened, therefore, it seems unlikely that a very different interpretation of the data would be drawn from the files. It may not, however, be the most accurate method of gathering the information as the data is recorded by different sources and not all the information may be included in the files, depending on the subjective approach to record-keeping. However, record-keeping is important at VBH forensic wards. Staff are legally obligated to keep records of the patient's stay in hospital as these documents can be called to court at any time, therefore, it is expected that records are kept as accurately as possible. Consequently the archival research method was the most practical method of collecting the information. It is also the only way of accessing an extensive amount of information bearing in mind the limited time period and financial constraints. Limitations will be further discussed in the final chapter of this dissertation.

## Data Collection

As stated previously, the files contain an extensive amount of information about the patient gathered from several sources. This includes information about demographics, summaries of court proceedings, accounts of the alleged offence, criminal and psychiatric histories, family history, reviews of development, mental state examinations and ongoing reviews of patients with regard to progress and treatment, medication, recommendations and so forth.

Consequently, it was necessary to extract only key points for the purposes of this study. An example of the table of the data collection sheet can be found in Appendix I.

Firstly, demographic characteristics such as age, marital status, family circumstances and so on were gleaned from the files. These factors were important in development of the database although not all characteristics may necessarily have been used for this particular study. For example which court the patient may have been referred from or court case number may not have been considered useful for this study.

Secondly, clinical diagnosis was recorded as well as the type of offence allegedly committed by the patient.

Thirdly, the vacational leave (V/L) history was important to see how much time patients were spending physically in hospital wards in the period May 1997 to May 1999. It was also important to establish which patients had been considered by the staff to have discharge potential in this time. For purposes of the database it was also felt necessary to assess at what stage of the discharge process the applications for discharge of these patients were. In other words a record was kept of which patients were ready to have application made for discharge, who had been approved discharge or had been denied a request for discharge.

Fourthly, the mental state of the patient over the six month period from November 1998 to May 1999 was noted down to assess the stability of the patients over this period.

Fifthly, different forms of antisocial behaviour was observed and recorded in the files. These were important to extract, particularly as behaviours such as these may influence the patient's detention in hospital. Violent behaviour, whether it occurred within hospital or in the community, and substance abuse

were recorded. Other behaviours which were considered problematic such as sexual disinhibition or absconding were also considered in gathering the data.

Other significant events which may have had an effect on the patient, for example a parent dying in the two year period or a patient falling ill was recorded for the database. This may have provided some insight as to whether a patient's mental health had deteriorated or whether they had displayed problem behaviours around this time.

Finally, if there was an incidence of a previous criminal history, this too was recorded.

### **Procedure**

Ward staff were informed that the researcher would be visiting each ward for research purposes and had permission to do so from the forensic consultant. This meant that the researcher would need access to all the files of patients represented by that ward at the time of collecting the data. Not all patients would necessarily be physically present in the ward if they were on leave but their files would still be made available. The researcher would require time to go through each file and note down the variables relevant for purposes of this research. It took between 20-30 minutes to go through each file and extract the relevant information.

The justification for collection of this data was to provide information to compile a database or a special hospital case register which will continue to be maintained in future. There is an interest in the forensic team to see this research completed as the information will provide information for ongoing research on forensic patients at Valkenberg Hospital. The database will hold a wealth of information on four main areas of the patient's life history. For example, demographic variables including date of birth admission date, gender, ethnicity, place of origin and so on were recorded. There are also offence details such as type of offence committed and criminal history. There is information on the clinical details such as diagnosis and mental state. The fourth area is that relating to risk assessment and provides information on the patient's previous criminal history and antisocial behaviour. This is important in assessing a patient's potential for being granted leave, conditional discharge or appropriateness for transfer between different wards within the hospital.

Literature in the area of dangerousness and risk assessment provided guidelines regarding the types of information which ought to be included in identifying relevant variables

One cannot assess risk until one knows the population of patients being assessed. In the files no official recording of dangerousness may necessarily be found, however, written entries usually available on periodical reports recommend for conditional discharge, leave etc. and are influenced by the mental state and behaviour of the patients in the wards or in the community.

The data was captured using Microsoft Excel, and the data was analysed for descriptive statistics on the Excel 97 programme. Further statistical analyses and cross tabulations were done using SPSS and Epi Info.

## RESULTS

This chapter is divided into three sections. Firstly, a description of the characteristics of the patients will be reported. Secondly, the relationships between certain characteristics of these patients and their displays of violence and dangerous behaviour will be looked at in an effort to provide some discussion around dangerousness assessment and prediction of violence. Finally factors which determine the length of stay within hospital will be discussed, and the relationships between violence predictors and a patient's ongoing detention in hospital will be looked at. <sup>1</sup>

For the 33 year period of admissions, a sample of 239 patients have been selected for this study. The earliest admission for this sample occurred in 1964 and admission dates of patients to VBH forensic wards vary from then until 1997.

The sample is described below according to the wards in which they were placed at the time the information was collected in May 1999. Ward populations have changed constantly as restructuring has had to take place due to the downscaling of beds in wards and shortage of staff.

The wards are still subject to change if further restructuring is to take place.

### 1) Number of patients in each ward

Each ward is suited to the security needs required for the patients being detained in these wards. A description of the wards follows.

**Table 2**  
**Number of patients in the wards in VBH in 1999**

WARD	Frequency (n)	Percent
9 & 10	50	20.9%
12	102	42.7%
20	57	23.8%
7	30	12.6%
Total (N)	239	100.0%

Ward 20 is a maximum secure ward catering for a maximum of 57 patients. Ward 10 is the medium secure ward, holding a maximum of 50 patients while ward 7 is a closed ward with 30 patients. Ward 12 is an open ward with a maximum of 102 patients. Transfers of patients between wards follow weekly reviews. Often the case will arise where a patient in the medium secure or open wards needs to be contained in Ward 20 due to some form of unacceptable behaviour.

About 90% of '30 day observations' are done at Valkenberg Hospital. Lentegeur Hospital is responsible for female assessments of state patients. Stikland Hospital seems to get non-serious charge referrals on an occasional basis. All the wards have more patients listed than their actual bed status allows. e.g. Ward 12 has 102 patients listed but physically is only able to ensure that about 40 are in the ward at any time.

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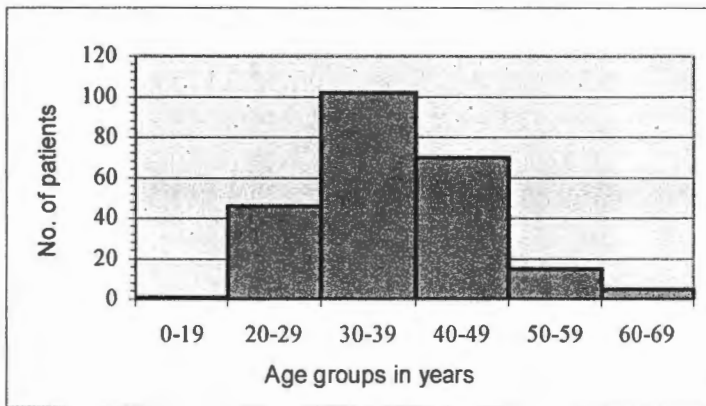
<sup>1</sup> Due to the voluminous nature of the raw data, it has not been included in this document. The raw data can, however, be obtained through Valkenberg Hospital's Forensic Unit, Private Bag X1, Observatory, 7925, Cape Town, South Africa

## **2) Demographic Profile of Patients**

### **Age of Patients**

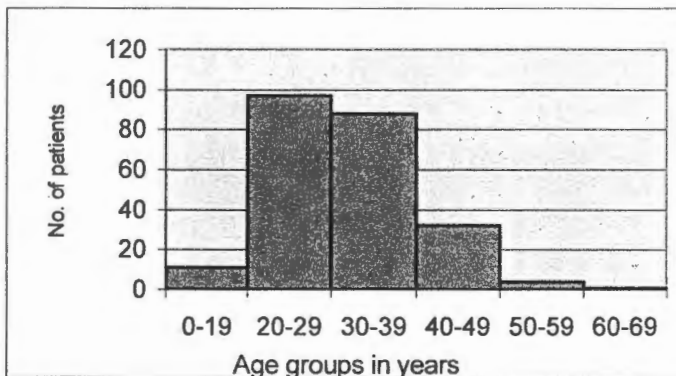
The ages of the patients were recorded to find out the current presentation of age groups of this population, and also the presentation of ages when patients were admitted into hospital.

**Figure 1: Current age distribution of patients**



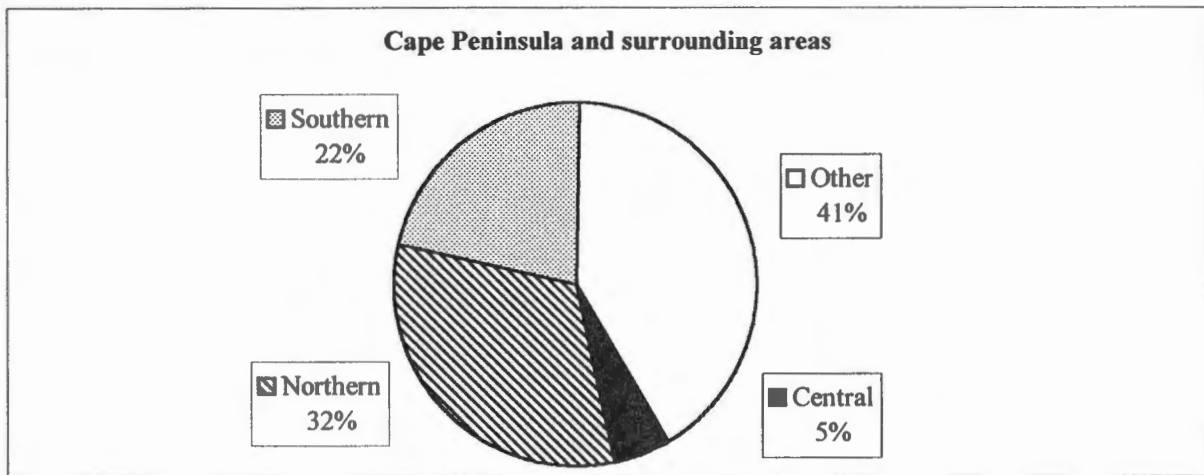
The exact dates of birth for six patients were not known. As a result an estimate of their current ages had been made and reported in the file in recent entries by staff members. The youngest patient was 17years and the oldest 67years. The mean age of the patients in the wards is 37.2 years with a standard deviation of 8.8.

**Figure 2: Ages on admission**



As the exact ages for 6 patients on admission was not known and therefore, not included in the above graph. 41.6% of the patients were admitted between the age 20-29years. The youngest age on admission was 17years and the oldest 64 years. The mean age on admission was 31.3years with a standard deviation of 9.0.

**Figure 3: Origin of Patients**



The Cape Town catchment area includes the southern, northern and central areas of the Cape Peninsula. The majority of the patients come from areas outside of the Cape Town area. For details of the origins of patients who come from areas in and outside of Cape Town, see Appendix II. A high percentage of patients have come from areas beyond the southern, northern and central Cape area. Some patients come from areas such as the West coast, Eastern Cape and Transkei.

Marital status of patients

Family life of the patients was looked at. Tables 1 & 2 identify the marital status and number of children of the patients respectively.

**Table 3**  
**Marital status of patients**

MARITAL	Frequency (n)	Percent
Divorced	20	8.4%
Married	31	13.0%
Single	185	77.4 %
Widowed	3	1.3%
Total (N)	239	100.0%

Patients who have children

**Table 4**  
**Number of children**

<b>CHILDREN</b>	<b>Frequency (n)</b>	<b>Percent</b>
0	154	64.4%
1	26	10.9%
2	33	13.8%
3	14	5.9%
4	8	3.3%
5	4	1.7%
<b>Total (N)</b>	<b>239</b>	<b>100.0%</b>

The majority of the patients are single (77.4%, 185/239). 13% (31/239) of these patients are married. This includes common-law marriages. 64.4% (154/239) of patients have no children.

Legal categories under which patients are classified

The legal categories are explained below.

**Table 5**  
**Legal categories under which patients are admitted**

<b>SECTION</b>	<b>Frequency (n)</b>	<b>Percent</b>
19	20	8.4%
28	202	84.5%
4	17	7.1%
<b>Total (N)</b>	<b>239</b>	<b>100.0%</b>

From the hospital records it was found that the highest number of patients 202 (84.5%) were admitted under section 28 of the Mental Health Act, which stipulates conditions around termination of detention in respect of people who are detained on a charge of murder or some other charge involving serious violence. Much fewer patients 20 (8.4%) were classified under section 19, meaning that they have been civilly committed and only 17 patients (7.1%) were section 4, which applies to patients detained for non-violent charges. (See Appendix VII for further explanation of the sections.)

Types of charges patients are admitted for

Forensic patients are admitted to hospital following being charged for committing their offences or other offensive behaviours with which they may not necessarily have been charged.

**Table 6**  
**Offences committed by patients**

<b>CHARGE</b>	<b>Frequency (n)</b>	<b>Percent</b>
Physically Violent	134	56.1%
Sexually Violent	48	20.1%
Non-violent	28	11.7%
Other	29	12.1%
<b>Total (N)</b>	<b>239</b>	<b>100.0%</b>

When examining the kinds of charges for which patients are admitted to hospital, the most frequent charges are those of physical violence (134/239 cases, 56.1%). These kinds of charges included murder, attempted murder, assault and arson. The next main charge is that of sexual violence (48/239 cases, 20.1%). These offences included rape, attempted rape, indecent assault and sodomy. This is followed by a number of other events leading to admission to hospital (29/239, 12.1%). Non-violent offences (28/239, 11.7%) included theft, malicious damage to property where behaviour may have been violent but not towards a person or persons. Other reasons for admission include charges such as intimidation, threats of violence, trespassing, crimen injuria or drunken driving as well as no charge at all in cases where patients are admitted due to relapse, bizarre behaviour in the community, absconding from hospital and so on. Appendix III provides a complete table of each charge.

Diagnoses given to patients

The clinical diagnoses of patients as recorded in the files, is shown below.

**Table 7**  
**Diagnoses of Patients**

<b>DIAGNOSIS</b>	<b>Frequency (n)</b>	<b>Percent</b>
Bipolar Affective Disorder	40	16.7%
Schizophrenia	137	57.3%
Schizoaffective	27	11.3%
Organic Disorders	30	12.6%
Other	5	2.1%
<b>Total (N)</b>	<b>239</b>	<b>100.0%</b>

The majority of patients (137/239, 57.3%) have a diagnosis of schizophrenia. Bipolar Affective Disorder (BPAD) is a diagnosis given to 40/239 (16.7%) patients. Organic Disorders form the next highest set of diagnoses (30/239, 12.6%). These include mental handicap, epilepsy, Neurosyphillis, Huntington's disease and dementia. Other disorders were psychotic disorders such as Brief Psychotic disorder and Delusional disorder. For further details of the diagnoses given to patients see the table on Appendix IV.

The relationship between charge and diagnosis received

The literature often describes a relationship between violent behaviour and the type of diagnoses given to patients, therefore table 7 looks at the relationship between charge and diagnosis.

**Table 8**  
**Relationship between charge and diagnosis**

DIAGNOSIS	CHARGE (n)				Total
	Physically Violent <sup>(a)n</sup>	Sexually Violent <sup>(b)n</sup>	Non-violent <sup>(c)n</sup>	Other <sup>(d)n</sup>	
Bipolar Affective Disorder	18	11	4	7	40
Schizophrenia	79	20	19	19	137
Schizoaffective	15	8	2	2	27
Organic Disorders	17	9	3	1	30
Other	5	0	0	0	5
Total (N)	134	48	28	29	239

There is no significant relationship between diagnosis and charge ( $\chi^2=15.55$ ;  $df=12$ ;  $p=0.21$ ). Of the 239 patients 134 committed physically violent offences and 48 committed sexually violent offences.

Previous criminal histories of patients

Previous studies have shown that criminal history is a significant area of research in patients who display violent behaviour. The incidences of criminal activity of offenders were included in this study to see how significantly past criminality features in mentally disordered offenders.

**Table 9**  
**Previous criminal histories of patients**

Previous Criminal History	Frequency (n)	Percent
N	165	69.0%
Y	74	31.0%
Total (N)	239	100.0%

A low percentage of the patients (31% , 74/239) have recorded criminal histories prior to the present offence. For the patients who had a criminal history, the mean number of past offences is 1.7 with a standard deviation of 0.98. Offences committed most often prior to the present offence were theft and assault.

Mental State of patients over the 6 month period (November 1998 to May 1999)

The patients are reviewed every three months and a Mental State Examination (MSE) is done as part of the assessment. Over the six month period from November 1998 to May 1999, at least two mental state examinations would have been done and the patients mental state is taken from these. The mental state examinations are important in determining further treatment and management of the patient for example in changing medication or granting vocational leave (V/L). A comparison of MSE and V/L is done in the third section of the chapter.

**Table 10**  
**Mental state of patients**

MSE (Nov 1998-May 1999)	Frequency (n)	Percent
Apsychotic	108	45.2%
Demented	10	4.2%
Mentally Handicapped	22	9.2%
Psychotic	99	41.4%
Total (N)	239	100.0%

The mental states of the patients were assessed over the last 6 months and the current mental state showed that 99/239 were psychotic and 108/239 apsyhotic. 10/239 were assessed as demented and 22/239 patients were mentally handicapped. Psychosis cannot be assessed where below average intelligence is present given the criteria for mental retardation and Psychotic disorders according to the DSMIV (American Psychiatric Association, 1994). For example the psychotic person may not be able to function to his/her full potential and he/she may be perceived as having below average intelligence. Psychotic symptoms such as thought disorder may inhibit the person's ability to communicate intelligently and impair concentration and perceptual abilities.

Number of patients who abuse substances : cannabis, alcohol, mandrax

Information was gathered with regard to the patients' alcohol and drug usage. The cumulative title of 'substance abuse' was given to those patients who abused any of the three substances.

**Table 11**  
**Prevalence of substance abuse amongst patients**

	Substance Abuse		Cannabis Abuse		Mandrax Abuse		Alcohol Abuse	
	Freq (a)n	%	Freq (b)n	%	Freq (c)n	%	Freq (d)n	%
N	140	58.6	162	67.8	223	93.3	189	79.1
Y	99	41.4	77	32.2	16	6.7	50	20.9
<b>Total (N)</b>	<b>239</b>	<b>100.0</b>	<b>239</b>	<b>100.0</b>	<b>239</b>	<b>100.0</b>	<b>239</b>	<b>100.0</b>

Abuse of alcohol, cannabis and mandrax was assessed and 41.4% of the patients were found to abuse substances. 20.9% of the patients were found to be abusing alcohol and 32.2% were abusing cannabis while 6.7% abuse mandrax.

Number of patients granted leave from November 1998-May 1999

Rehabilitating patients depends on allowing patients trial periods of leave in the community. Initially patients are granted periods of week-end leave only. With time and further assessment these periods are lengthened. Eventually some are allowed extended periods of leave for 1-3 months.

**Table 12**

**Number of patients who have been on leave over the 6 month period (November 1998-May 1999)**

Vacational Leave(V/L)	Frequency (n)	Percent
N	97	40.6%
Y	142	59.4%
Total (N)	239	100.0%

*Amount of leave given to patients from May 1997-May 1999*

**Table 13**

**Length of leave given to patients**

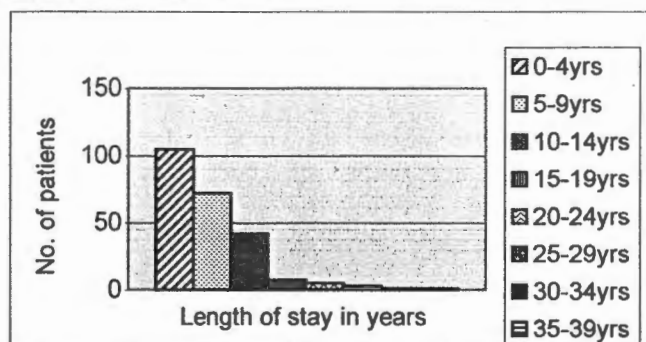
LENGTH V/L	Freq. (n)	Percent	Cum.
None	64	26.8%	26.8%
Weekends	38	15.9%	42.7%
1 Month	68	28.5%	71.2%
3 Months	26	10.9%	82.1%
6 Months	15	6.3%	88.4%
1 Year	28	11.7%	100.0%
Total (N)	239	100.0%	

Most patients were granted leave. 28.5% of the patients granted leave, have received 1 month leaves. 28 patients (11.7%) received extended leave up to a year with regular check-ups by the hospital.

*Length of stay in hospital since admission*

The length of the patient’s stay in hospital is significant in that forensic patients are admitted to hospital indefinitely. This raises questions as to what factors influence the decisions to keep patients detained in hospital. Procedures with regard to discharge are lengthy and are further explained in the literature review chapter. The following presentation of length of hospital detention in Fig. 4 has been rounded to the nearest year values.

**Figure 4: Length of hospital detention**



The shortest length of stay was 2 years and the longest detention in hospital was 35 years. The mean length of stay in hospital was 7.0 years with a standard deviation of 5.51.

### 3. Predictors of Violence

Some of the following factors have been considered to be important in predicting future dangerous behaviour. Comparisons were made between violent and other problem behaviours displayed by patients and these factors.

#### Number of patients who displayed violent behaviour over the last two years and place where violence occurred

Some patients have been reported to display violent behaviour. Violence towards another person(s) is considered dangerous behaviour and the patient is therefore, considered to be a threat to others to some degree or another. This will then have implications for whether the patients are given further leave or are potentially dischargeable. Sometimes patients need to be transferred to a more secure ward due to violent behaviour or if on leave they may need to be returned to hospital.

**Table 14**  
**Incidence of violent behaviour**

<b>VIOLENCE</b>	<b>Frequency (n)</b>	<b>Percent</b>
N	138	57.7%
Y	101	42.3%
Total (N)	239	100.0%

**Table 15**  
**Place where violence occurred**

<b>PLACE OF VIOLENCE</b>	<b>Frequency (n)</b>	<b>Percent</b>
Community	25	10.5%
Hospital	41	17.2%
Hospital & Community	34	14.2%
No violence	139	58.2%
Total (N)	239	100.0%

42.3% of the patients displayed violent behaviour. 17.2% of the violence took place in hospital.

#### Eligibility for discharge approval from hospital and comparison of approval of discharge of patients who displayed violent behaviour

When patients are observed in hospital, regular reviews take place in which their potential for discharge (D/C) is discussed.

**Table 16**  
**Discharge approval of patients**

<b>DISCHARGE APPROVAL</b>	<b>Frequency (n)</b>	<b>Percent</b>
N	155	64.9%
Y	84	35.1%
Total (N)	239	100.0%

The majority of patients (64.9%) have not been approved discharge.

Problem behaviours displayed by patients

Often inappropriate behaviour occurs in the hospital setting. Other unacceptable behaviours were also recorded which were not seen as physically or sexually violent behaviours. These patients would require seclusion or transfer to another ward or would be considered ineligible for leave due to behaviour which was considered unacceptable.

**Table 17**  
**Problem behaviours displayed by patients**

<b>PROBLEM BEHAVIOURS</b>	<b>Frequency (n)</b>	<b>Percent</b>
ABSCONDED	35	26.1%
AGGRESSION	61	45.5%
SELF MUTILATION	1	0.7%
SEXUAL MISBEHAVIOUR	30	22.4%
SMOKES MEDICATION	1	0.7%
STEALING	1	0.7%
ATT. SUICIDE	1	0.7%
VICTIM OF ASSAULT	4	3.0%
Total (N)	134	100.0%

Of the 134 problem behaviours displayed by patients in the last two years, 45.5% of these behaviours involved aggression which meant verbal aggression towards staff or other patients or being overly argumentative. This verbal aggression occurred in 61/239 patients (25.5%). One patient attempted suicide while another self-mutilated.

Sexual misbehaviours were noted but it is not easy to determine whether consent was given freely when sexual behaviour occurs between patients. The sexual misbehaviours have also included incidences of sexual disinhibition towards staff members. This occurred in 30/239 (12.5%) patients. 22.4% of all other behaviours involved sexual misbehaviour.

Patients who absconded from hospital was another form of problem behaviour included which made up 26.1% of all behaviours and occurred in 12.6% (30/239) of the patients.

Relationship between substance abuse and violent behaviour

Substance abuse has often been a predictive variable in assessing dangerousness. Reports on substance abuse are made after self-admission of patients or observations of staff members. Substance abuse may occur in and outside of hospital.

**Table 18**

**Relationship between substance abuse and violence**

SUBSTANCE ABUSE	VIOLENCE (n)		Total
	N ( <sup>a</sup> n)	Y ( <sup>b</sup> n)	
N	92	48	140
Y	46	53	99
Total (N)	138	101	239

**Table 19**

**Relationship between cannabis abuse and violence**

CANNABIS	VIOLENCE (n)		Total
	Y ( <sup>a</sup> n)	N ( <sup>b</sup> n)	
Y	45	32	77
N	56	106	162
Total (N)	101	138	239

**Table 20**

**Relationship between alcohol abuse and violence**

ALCOHOL	VIOLENCE (n)		TOTAL
	Y ( <sup>a</sup> n)	N ( <sup>b</sup> n)	
Y	28	22	50
N	73	116	187
Total (N)	101	138	239

The relationship between substance abuse and violence is significant ( $\chi^2=8.77$ ;  $p=0.003$ ). Those who do not abuse substances are twice as likely to be non-violent according to the odds ratio (Odds ratio=2.21;  $CI_{95}$ ). 53/99 patients who are violent abuse substances. 58.4% of those who abuse cannabis were violent as compared with 56% of the alcohol abusers who were reportedly violent.

Relationship between diagnosis and violent behaviour and the relationship between current MSE and violent behaviour

The relationship between the violent behaviour displayed by patients and their given diagnoses was looked at.

**Table 21**

**Relationship between diagnosis and violence**

DIAGNOSIS	VIOLENCE (n)		Total
	N ( <sup>a</sup> n)	Y ( <sup>b</sup> n)	
Bipolar Affective Disorder	26	14	40
Schizophrenia	85	52	137
Schizoaffective	10	17	27
Organic Disorders	14	16	30
Other	3	2	5
Total (N)	138	101	239

The relationship between diagnosis and violence is significant ( $\chi^2=8.16$ ;  $p= 0.09$ ;  $df=4$ ). Patients with a diagnosis of schizophrenia displayed the most incidences of violent behaviour (52/101; 51.2%).

**Table 22**  
**Relationship between Mental state and violent behaviour**

MSE (Nov 1998- May 1999)	VIOLENCE (n)		Total
	Y ( <sup>a</sup> n)	N ( <sup>b</sup> n)	
Psychotic	58	41	99
Apsychotic	26	82	108
Total (N)	84	123	207

There is a significant relationship between violence and psychosis ( $\chi^2=25.39$ ;  $p=0.0000005$ ). Of 108 apsychoic patients 26 were violent. Of 99 psychotic patients 58 were non-violent. Psychotic patients are, therefore 2.4 times more likely to be violent than apsychoic patients. There was a tendency for violence to be associated with diagnosis. Of the 99 patients who were psychotic in the 6 month period (November 1998-May 1999), 69 had a diagnosis of schizophrenia.

The relationship between marital status and violent behaviour

The relationship between marital status and violence is looked at in Table 23. Marital status has been reduced to 'single' and 'married' status only.

**Table 23**  
**Relationship between marital status and violence**

MARITAL	VIOLENCE (n)		Total
	Y ( <sup>a</sup> n)	N ( <sup>b</sup> n)	
Single	76	109	185
Married	14	17	31
Total (N)	90	126	216

There is no significant relationship between marital status and violent behaviour ( $\chi^2=0.18$ ;  $p=0.67$ ).

Comparisons between family circumstances and violence

The patients' family social circumstances relates to support structure and examines whether the individuals in the family or significant others are supportive of present and future management of the patient. 'Good family circumstances' indicates that the family is supportive and stable. 'Reasonable' relates to there being at least one family member who is involved in the patient's rehabilitation and who provides fairly consistent support. 'Poor circumstances' is defined by those families who are unsupportive or chaotic due to conflictual environments or substance abuse by family members for example, and are therefore, considered unstable and inappropriate for involvement in patient's rehabilitation (See Appendix V). For the purposes of trying to understand the relationship between family circumstances and violent behaviour, 'good family circumstances' have been combined with 'reasonable' as there is a suggestion of some form of support, and 'not good' has included 'poor circumstances' or 'no contact'.

**Table 24****Relationship between family circumstance and violence**

FAMILY CIRCUMSTANCE	VIOLENCE (n)		Total	Percent	Cum
	N ( <sup>a</sup> n)	Y ( <sup>b</sup> n)			
GOOD	79	44	123	51.5%	51.5%
NOT GOOD	59	57	116	48.5%	100.0%
Total (N)	138	101	239	100.0%	

As can be seen from the results in Appendix V, a high number of patients come from poor family circumstances (95/239, 39.7%) as opposed to only 48/239 (20.1%) of the patients who come from good, supportive families, and have these environments to go back to in considering potential return to the community. The relationship between family circumstance and violence is significant ( $\chi^2=8.40$ ;  $p=0.04$ ;  $df=3$ ). Those from good family circumstances are half as likely as those from 'not good' family circumstances to exhibit violent behaviour (Odds ratio=1.73;  $CI_{.95}=1.00; 3.01$ ).

**4. Ongoing detention of patients in hospital**

A number of factors influence the decision to detain in or discharge a patient from hospital. The tabulated results may provide some insight as to why patients are being detained in hospital and for how long. Some of these factors are looked at in an effort to understand how decisions are made around the detention of a patient in relation to some of the characteristics which have been reported.

*Comparison of relationship between MSE and whether leave has been granted*

As stated before regular reviews determine future treatment of the patient which includes granting V/L. This is assessed partly by the mental state of the patient.

**Table 25****Relationship between mental state (MSE) and granting leave (V/L) to patients**

MSE	V/L (n)		Total
	N ( <sup>a</sup> n)	Y ( <sup>b</sup> n)	
Apsychotic	22	86	108
Demented	5	5	10
Mentally Handicapped	8	14	22
Psychotic	62	37	99
Total (N)	97	142	239

The relationship between MSE and V/L is significant ( $\chi^2=38.78$ ;  $p=0.00000002$ ;  $df=3$ ). The patient's mental state influences decisions around granting leave. 62/99 psychotic patients were not granted leave and 86/108 apsychoic patients were granted leave.

*Number of patients who have been violent in the two year period (May 1997-May 1999) and who are eligible for discharge*

Violence will invariably influence the patient's eligibility for discharge and this is looked at in the following table.

**Table 26****Relationship between violent behaviour and discharge approval**

DISCHARGE APPROVAL	VIOLENCE (n)		Total
	N ( <sup>a</sup> n)	Y ( <sup>b</sup> n)	
N	73	82	155
Y	65	19	84
Total (N)	138	101	239

A cross-tabulation of discharge approval and violent behaviour shows that there is a significant relationship between violent behaviour and disapproval of discharge ( $\chi^2=20.39$ ;  $P= 0.000006$ ). Approval of discharge of patients is related to non-violent behaviour of patients. However, it is important to note that 52.9% of the violent patients were also not approved discharge.

**Table 27****Relationship between Discharge approval and Charge**

CHARGE	DISCHARGE APPROVAL (n)		TOTAL
	Y ( <sup>a</sup> n)	N ( <sup>b</sup> n)	
Physically Violent	45	90	134
Sexually Violent	15	33	48
Non-violent	13	15	28
Other	12	17	29
Total (N)	84	155	239

67.6% of those charged with physically and sexually violent offences have not been considered dischargeable. Only 46.4% of patients charged with non-violent offences have been considered dischargeable.

## DISCUSSION

The Forensic unit at Valkenberg Hospital serves a geographical area with a radius of over 1 200 kilometres. About 35% of patients come from rural areas where there is no or little access to psychiatric services. Some patients come from as far as Knysna, Ladysmith, Bethlehem and Bedfordview. Beyond the Cape Town catchment area, services that are available are few, and have a limited capacity to deal with the amount of work needed to be done.

Most of the patients in the present sample were aged from 20-39 years on their admission to hospital. This result differs from findings in the UK by Woods and Mason (1996 & 1998) where a higher number of patients were admitted to hospital during their teenage years. The majority of the patients are currently from 30 to 39 years of age, and this finding correlates with those from other studies done in forensic psychiatric units in the UK and USA.

According to Gunn and Taylor (1993), just as early family factors play a role in the prediction of the onset or prevalence of offending, later family factors may predict the desistance from offending behaviour. For example it is often believed that male offending decreases after marriage, and Gunn and Taylor have provided some evidence of this (1993). There is a clear tendency for mentally disordered patients at Valkenberg's forensic unit to have offended and have 'single' status. 85.8% of patients in this study were either single or divorced while 13.0% were married.

Criminal behaviour is a socially determined phenomenon. Criminal patterns differ from place to place, often closely linked to cultural values, and also vary from one sector of society to another.

Where mentally disordered persons are concerned, there has been controversy around the concept of criminality. In order to establish patterns or trends within the mentally disordered population, the type of mental illness needs to be diagnosed. In terms of diagnoses in this study, there was a spectrum from affective disorders, psychotic disorders to organic disorders. As in many studies reviewed in the literature review chapter, schizophrenia was the most common diagnosis given to patients. 57.3% of the patients were diagnosed schizophrenic while 11.3% of the patients were diagnosed as having schizoaffective disorder. Organic Disorders made up 12.6% of the diagnoses given with mental handicap forming 6.6% of these patients. 16.7% of the patients were diagnosed as having Bipolar Affective Disorder.

Having briefly discussed the demographic characteristics of the patients admitted to Valkenberg's forensic unit, this discussion will continue as follows. The type of offences committed by patients will be reported

and discussed in order to establish the level of violent crime for which patients are admitted. The length of stay in hospital will be discussed as it is not only the stigma attached to being admitted to a psychiatric hospital but also the length of detention which is an important aspect needing to be addressed in managing and treating mentally disordered offenders. The patient's detention in hospital is determined by the admission and discharge policies which were discussed in a previous chapter. The influence of these policies on patient's eligibility for vocational leave and eventual discharge will then be discussed. The patient's progression in hospital needs to be outlined and discussed in order to see how these policies are practically put in place in the hospital. Consequently the process of management, treatment and what factors influence the patient's placement, detention in and release from hospital will also be discussed. This includes discussion around behaviour in hospital such as violence, problematic behaviour, substance abuse to family circumstances and appropriate future placement of the patient. All these factors could have a positive or negative effect on the hospital staff's perception of the discharge potential of the patient. The strengths and limitations of the study will then be discussed and finally recommendations for future research and further points to consider will be raised.

Admission to the Forensic unit in particular, is a significant event in a patient's life. When a person is declared a State patient by the court, the patient is managed in a psychiatric hospital for which there is no specified sentence for patients. Their stay in hospital is usually longer than that of the average psychiatric patient, and special conditions are applicable to these patients, depending on the legal category under which patients are classified. 84.5% of the patients were classified under section 28 which stipulates conditions around a charge of violence.

It was found that 56.1% of the patients were admitted following committal of physically violent offences. It is worth noting that many patients have been admitted for taking the life of or attempting to take the life of another. 76.2% of the patients have committed violent offences with the majority being charged with physically violent offences. 79 cases of assault, 49 cases of murder, 22 cases of rape and 15 cases of indecent assault have been recorded amongst some of the violent offences committed by patients. This may imply that mentally disordered offenders do have a criminal disposition. On the other hand this may have implications for whether mentally disordered patients' ability to plan and execute these acts is quite developed or related to symptom-driven behaviour which needs further investigation. A high number of these patients were diagnosed as schizophrenic with a high incidence of physically violent offences committed. One wonders whether the symptoms for people with psychotic illness become the most important predictor in precipitating offending behaviour. Although past studies abroad and this study have shown a relationship between schizophrenia and violent offending, it is important to note that no psychotic person acts completely independently of his/her environment or personality. For example a patient may kill his mother because he believes she is spreading distressing rumours about him. In this situation, whether his

belief was true or not, there would be a range of different potential responses available to the patient. Therefore, something else in his internal or external environment must have contributed to his choice of such a physically violent option.

56.7% of patients with organic disorders were charged with physically violent offences. This includes, among others, two patients who suffered personality disorder due to frontal lobe head injuries and mentally handicapped patients. The mentally handicapped (6.6%) should not be placed in one category as their capacity to understand and control their environment lies on a continuum.

The next highest group of offences with which patients were charged, was sexually violent offences. 20.1% of patients at Valkenberg's forensic unit were charged with sexually violent offences while in a study abroad done by Maden et al., (1995), it was found that very few patients were admitted due to a sexually-related offence. Thus it may be that South Africa has an unusually high rate of incidences of sexual violence amongst mentally disordered patients. This would correspond to the high rates of sexual violence including sexual assault and rape which occurs in the general South African population. .

Some 31.0% of the patients in this study have already had contact with the criminal justice system, and there is a record of previous criminal history for charges such as theft and assault. As state patients, they are not convicted of a crime and therefore, cannot be held as prisoners. They are seen to be patients in need of specialised care and, therefore, cannot be transferred to Correctional services where the period of detention is predetermined and finite. The results show that more than half (56%) of the patients have been in hospital for 5 or more years. The forensic unit has patients who have been there for up to 35 years.

The maintenance of large numbers of patients in hospital appears to be hampered by the undetermined length of detention of these patients and also the hospital's inability to release patients to the community due to discharge policies. In other words while patients remain in hospital indefinitely, new patients are being admitted on an ongoing basis, and at the same time the hospital is not able to easily discharge patients whom they consider stabilised and dischargeable. This results in the hospital staff's reduced ability to care for numbers of patients who are being continuously increased and far exceeds Valkenberg Hospital staff's capacity.

The staff team regularly reviews all patients. This is done formally on a three-monthly basis. Recommendations as to further management, possible transfer or discharge are made and discussed with the patient. 35.1% of the patients have been found to be dischargeable by the hospital staff team. The

process of discharge, however, is lengthy particularly in cases where the patients committed serious crimes. 23% of those considered dischargeable have displayed violent behaviour over the two year period from May 1997-May 1999. Prior to being considered for discharge, periods of vocational leave from hospital have to be granted to assess how the patient copes in the community.

Interestingly, a high percentage (59.4%) of patients have already had opportunities for vocational leave over the 6 month period (November 1998-May 1999) while 73.2% have been given vocational leave between May 1997-May 1999. This would indicate that 13.8% were no longer granted vocational leave later over the 6 month period. Reasons for this could be relapse, displays of violence or other problem behaviours which changed their eligibility for vocational leave. Over the two year period (May 1997-May 1999) the majority of patients spent 1 month or more out of hospital. Because of the problem of overcrowding in hospital, an effective way of dealing with these problems may have been to increase possibilities for vocational leave. Therefore, one has to consider whether perhaps leave has had to be granted due to the limited bed facilities to create spaces for more acute cases or relapses. The transition from inpatient hospital care to vocational leave in the community care is an uncertain period as strategies to reduce previously indicated risk factors need to be applied in the community. For example patients may not comply with medication, and the family may have difficulty monitoring medication when the patient is on vocational leave. This could result in relapse of psychotic symptoms and increase the risk of dangerous behaviour..

The analysis showed that 45.2% of the patients were apsychotic, thereby not displaying psychotic symptoms which include delusions, hallucinations, disorganised speech and behaviour or catatonic behaviour as defined by the DSMIV (American Psychiatric Association, 1994). The question arises as to why so many patients are currently in hospital when this many patients have been apsychotic. Even though these patients may be clinically stable, due to their histories of violence, they still require close supervision by the hospital staff. This suggests that the reasons for their ongoing detention in hospital must be looked at. Other non-psychotic psychiatric conditions may require that apsychotic patients be detained in psychiatric wards. When mentally ill offenders fit clearly in the hospital system, their placement may not be problematic. However, when there is doubt about the availability of appropriate services, there may be difficulty in placing patients. Examples of these are the mentally handicapped offenders, who make up 6.6% of the patients in the forensic unit, and whom it may be difficult to allocate to either prison or hospital as the most appropriate placement. Then there is the mentally ill offender who is deemed to be not treatable, and the offender who is unacceptable for a secure unit but for whom there is no alternative accommodation. Only a small group of patients, however, seem to be treatment-resistant

chronically psychotic individuals who have displayed symptom-driven violent behaviour. For these patients indefinite institutionalisation seems inevitable.

Initially all state patients are managed in maximum security. The aim of successful management is to see the patient's progression to a medium secure ward and through a system of graded security to a completely open ward. One of the most important principles in dealing with these patients is the evaluation of their potential risk to the community. The forensic wards operate on behaviour modification principles. The emphasis is on rewarding positive behaviours by increasing privileges. Eventually as patients are promoted, they become eligible for vacational leave and finally discharge. However, if their behaviour is considered problematic or they become an increased risk, they are demoted and lose certain privileges.

The patient's progress in the hospital system is hampered by the influence of situational factors on the individual. One situational factor is the containment of a large group of patients for a prolonged period in the wards. This raises several problems. For example, criminality and the potential for behaviour disturbance are greatly increased. Violent behaviour is discussed by team members and in less secure wards a more democratic system is in place, in which patients participate and take greater responsibility for their own behaviour and that of their fellow-patients' behaviours. 42.3% of patients have displayed violent behaviours since being admitted to hospital. 40.6% of these violent behaviours occurred on hospital premises while 33.6% displayed violence both in their community while on leave as well as on hospital premises. The incidence of violence in psychiatric facilities is high in comparison with other studies e.g. Surveys of New York psychiatric hospitals indicate the rate of reported assaults to be in the range of 7-10% of patients as based on only a 1-3 month period of observation (Tardiff & Sweillam, 1980). Incident reports in files tend to include only the most significant or consequential acts of violence both in community and in hospital, and therefore, perceived minor incidents may not be reported at all.

Other problem behaviours also influence decisions around discharge and leave. Verbal abuse, aggression against property and incomplete assaultive attempts are often ignored and, therefore not all of these behaviours would necessarily have been recorded in the files. 45.5% of the problem behaviours involved aggression. This may have involved verbal aggression towards staff or other patients, or, for example, smashing a window in the ward and so on. Several accounts of conflictual interactions were recorded particularly with regards to patients wanting to be discharged or granted leave when the time is inappropriate to do so. Another reason for these conflicts between staff and patient is non-compliance with medication where the patient becomes aggressive about not wanting to comply with treatment.

Absconding from hospital is another difficult behaviour that the staff component is compelled to manage. 26.1% of the problem behaviours involved patients absconding from hospital. Patients who abscond may need to be placed in seclusion facilities once they are returned to hospital. This may cause some difficulty due to the limited space in the wards. For example if a patient has absconded from an open ward, this means that on return to hospital, space will have to be made in a secure ward to detain the patient and prevent him from absconding again. However, as a result another potentially higher risk patient may have to be transferred from the secure ward to provide an opening in the ward for the absconder. A scenario such as this may occur frequently due to the limited facilities in the forensic unit.

22.4% of the problem behaviours displayed was sexual misbehaviour. Sexual disinhibition of patients towards fellow-patients or staff members was recorded. These included both same-sex and opposite-sex encounters. Patients in open wards are allowed to roam the hospital grounds and come in to contact with other patients and staff members from other psychiatric wards. Sexual activity between patients cannot be noted unless it is reported as well as sexual misbehaviour which occurs outside of the hospital grounds while patients are on vacation leave. It is also very difficult to determine in which cases consent was given or not. Therefore, the percentage of sexual misbehaviours may be underreported.

Apart from violent behaviour and other problem behaviours, substance abuse is also a problematic issue in the forensic unit. Some patients are from a criminal subculture where substance abuse is widespread. Substance abuse statistics were surprisingly low where it was reported that 41.4% of the patients were abusing substances in the form of alcohol, mandrax and/or cannabis. This statistic may not be a true reflection as substance abuse is a deviant behaviour and, therefore, may have been underreported. 58.5% of those who abuse cannabis were reported to be violent. Although there may not be a direct association between use of hallucinogenic substances such as cannabis and violent behaviour, these drugs may induce a psychotic state or increase agitation, which could lead to violent behaviour. Surprisingly a lower percentage (56%) of patients who abuse alcohol as opposed to cannabis, displayed violent behaviour. 65.7% of all the patients who abuse substances displayed violent behaviour. This could be as a result of the loss of inhibition when abusing substances particularly when substances are combined. For example if a patient consumes alcohol in conjunction with a benzodiazepine which may be a prescribed medication, this may lead to the patient becoming hyperactive, more aggressive and behave inappropriately resulting in violent or problematic behaviour.

Finally, with regard to mental state, 58.6% of the patients who were psychotic displayed violent behaviour. A possible explanation for this may be that patients displayed symptom-driven behaviour for example where the patient may have felt compelled to behave violently due to auditory hallucinations. However, more significantly 75.9% of the patients were not only apsychotic but also displayed no violent behaviour.

In light of what has been said, one needs to ask, whether it is the hospital's responsibility to detain and treat non-mentally ill violent individuals? Is violence a valid reason for being detained in hospital as opposed to prison where there is a fixed time period of incarceration and violence does not necessarily influence the length of detention? 67.6% of the patients charged with physically and sexually violent charges have not yet been considered for discharge. Of those patients who displayed violent behaviour since admission to hospital, 52.9% have not been considered for discharge. This raises another issue around whether the type of offence should determine the length of detention in hospital as in Correctional services?

However, before patients can be considered for vacation leave and eventually discharge, their family circumstances need to be investigated by the relevant hospital staff members. Families play an important role in whether a patient can be given vacation leave or are eventually discharged from hospital. The importance of ongoing contact with family and work facilitates the process of rehabilitation and independence of the patient. Home circumstances must be favourable and supportive otherwise discharge will not be approved. 64.2% of the patients who came from good family circumstances were nonviolent and were half as likely to be violent than those patients who came from poor family circumstances where there was no or little support. 39.7% of patients came from poor family circumstances and 8.8% have had no contact with their families which may have influenced the decision to discharge the patient from hospital. In cases such as this where the patient is not able to be discharged but is not a security risk, application may be made to change the status of the patient while he remains in hospital. It seems that in cases such as this, more long-term medium to low secure facilities would be more appropriate for this kind of patient.

### **Strengths and Limitations of Study**

This was an archival study, which has both advantages and disadvantages over other research methods. Four criteria of documented information in assessing its quality are authenticity, credibility, representativeness and meaning (Scott 1990).

Collecting secondary data in this way has some distinctive **advantages** over primary data collection efforts (Stewart 1984). The sample group involved the population of State patients at Valkenberg's Forensic unit, and this ensured the *representativeness* of the study. When answers to questions, particularly of a large population group, are required quickly, the only practical alternative is to consult secondary sources. The more significant advantage, therefore, is related to time and cost. A stringent budget and time constraints were imposed on this research, and secondary research of this nature was likely to have provided higher quality data than could be obtained with a new research project. This information needed to have *meaning* and be able to target the real gaps and oversights in knowledge of the forensic wards at VBH with regard to which patients are being admitted and what behaviours have been displayed by patients who have remained in the wards from May 1997-May 1999. The question around the *credibility* of the research is evident in that the truth and accuracy of information is assumed as records are produced with the knowledge that the information recorded may be used in court.

The **disadvantages** of secondary research include the fact that this data was collected with a specific purpose in mind and, therefore needs to be evaluated carefully.

The *authenticity* of the information may be in question as some of the files were not always completely reliable and complete. Entries to files were not always clear and regular, and as a result those patients who had few entries in the last two years, were discarded for purposes of this study. A chronic problem with research in the social sciences is that of missing data. This can be dependent on who is writing in the file and can be dictated by the subjective approach the person takes in determining what is important and what is not in terms of making notes in the file. Different clinicians have different styles, therefore, the type and quality of information that was recorded did vary. One cannot assume that State patient files contain all the information which influence the clinician's views about dangerousness and deciding upon who would be granted leave or discharge. It is possible that clinicians may have evaluated State patients as dangerous or been aware of some antisocial behaviours but this may not necessarily have been explicitly recorded in the files. Another drawback of archival data is that records may have been lost or destroyed or essential information inconsistently recorded, mislaid or illegible.

### **Recommendations for Future Research**

On inpatient units the occurrence of assaultive behaviour has merited study since it is in this setting that psychopathology is likely to be most severe and that the staff has to decide about discharge once the patient has stabilised.

Clinical predictions of dangerousness have always been subject to controversy. Although they seem to be better than previously expected, the predictors are still inadequate and have not been adapted to South African populations. With a database of the profile of patients, methods of predicting dangerousness and management of these situations may assist in furthering the efficacy of these methods, and aid in developing methods which are more adapted to the South African context.

This study has also indicated that there is a need to look closely at service delivery to ascertain where the needs lie, and also develop a clear focus on what is required in terms of security of these patients. This raises a question about whether patients who are not susceptible to treatment should rather be returned to prison and become the responsibility of the Justice system rather than be released or incarcerated ad infinitum in the hospital under the responsibility of the Health system. However, in light of South Africa's high crime rate, the Justice system and Correctional services too are under-resourced. Therefore, bearing in mind that the Correctional services in South Africa are also overburdened other alternatives need to be explored. It is necessary to look at those who reoffend and have a range of services from secure provision in hospital to community outpatient facilities in light of the move towards de-institutionalisation of patients. The concerns about de-institutionalisation of patients seem to be leading to the reduction of hospital services and premature discharge rates of patients.

While staff losses form part of an overall health rationalisation and cost-cutting programme which is being implemented in order to modernise its approach to mental and psychiatric health care, patients are being detained in hospital indefinitely until policies around discharge are reviewed. As has been mentioned before, the wards have more patients listed than their actual bed status allows. For example Ward 12 can only accommodate 40 patients in the ward at one time. However, the number of patients the staff are expected to manage and treat is 102. Staff are, therefore, required to keep track of those patients who are out on leave and monitor patient's stability in addition to other responsibilities physically within hospital. This places additional strain on staff members who are required to monitor the patient's progress when patients who are derived from rural areas have no access to psychiatric facilities. Staff shortages, structural limitations and overpopulation restrict the institution in its endeavor to fulfill its responsibility of ensuring the safety of personnel and patients.

## REFERENCES

- American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Washington D.C.
- Barrat, D., Cole, T. (1991). Sociology Projects A student's guide. London Routledge.
- Barrow, O.J. Juta & Co. Ltd. (1998). The Criminal Procedure Act 51 of 1977 (as amended). Tenth Edition. Kenwyn.
- Berger, P.A. & Gulevich, G.D. (1981). Violence and mental illness, pp.141-168. Biobehavioural aspects of aggression. D.A. Hamburg & M.B. Trudeau (Eds.). New York: Alan R. Liss.
- Bluglass, R. & Bowden, P. (1998). Principles and Practice of Forensic Psychiatry. Churchill Livingstone, London.
- Buchanan, A. (1998). The Investigation of acting on delusions as a tool for risk assessment in the mentally disordered. British Journal of Psychiatry, 12-16.
- Calabrese, L.V., Miccolo, R & Tansella, M. (1990). Patterns of care for chronic patients after the Italian Psychiatric Reform. A longitudinal Case Register Study. Social Science and Medicine 31:815-22.
- Cocozza, J.J. & Steadman, H.J. (1978). Prediction in Psychiatry: An example of misplaced confidence in experts. Social Problems, 25, 265-276.
- Cohen, A. (1991). The psychiatric assessment of dangerousness at Valkenberg Hospital. Unpublished MA dissertation, University of Cape Town.
- Cohen, D.A. (1995). Notes on the Clinical Assessment of Dangerousness in Offender Populations. Publication from Internet: Psychiatry on-line 1997
- Cumella, S. & Samson, D. (1994). A regional mental impairment service. Mental Handicap Research 7, 257-272.
- Dell, S (1988), Sentenced to Hospital: Offenders in Broadmoor. Oxford University Press. Oxford.
- Duckitt, J. (1998). The Prediction of Violence. South African Journal of Psychology, 18.
- Duffy, A. (1998, May 22-28). Seven killed by released mental patients. Mail & Guardian, pp 1, 6, 7.
- Duggan, C. (Ed.). (1997). Assessing risk in the mentally disordered. The British Journal of Psychiatry, 170 (Suppl 32)
- Floud, J. & Young, W. (1981). Dangerousness and criminal justice. London: Heinemann.
- Fornari, U. & Ferracuti, S. (1995). Special Judicial psychiatric hospitals in Italy and the shortcomings of the mental health law. The Journal of Forensic Psychiatry, 6 (2), pp 381-392.
- Kaliski, S (1998). Newsletter for Forensic Mental Health Association
- Gibbens, T.C.N. (1958). Sane and insane homicide. Journal of Criminal Law, 49: 110.
- Gibbens, T.C.N. & Robertson, G. (1983) . A survey of the criminal careers of hospital order patients. British Journal of Psychiatry, 143, 362-369.
- Grubin, D. (1997). Predictors of Risk in Serious Sex Offenders. British Journal of Psychiatry, 170 (Suppl.32). 17-21.
- Gulevich, G.D. & Bourne, P.G. (1970). Mental illness and violence, pp.309-326. Violence and the struggle for existence. D.N. Daniels, M.F. Gilula & F.M. Ochberg (Eds.). Boston: Little, Brown & Co.
- Gunn, J. & Farrington, D.P. (1982). Abnormal Offenders: Delinquency and the Criminal Justice System. Wiley: Chichester.
- Gunn, J & Taylor, P.J. (1984). Psychosis in remand cases. British Medical Journal, 288, 1945-1949.
- Gunn, J. & Taylor, P. J. (1993). Forensic Psychiatry: Clinical, Legal & Ethical Issues Butterworth-Heinemann Ltd., Oxford.
- Gunn, J., Maden, T. & Swinton, M. (1991). Mentally Disordered Prisoners. London Home Office.
- Hafner, H. & Boker, W. (1973). Mentally disordered violent offenders. Social Psychiatry, 8, 220-229.
- Halleck, S.L. (1975). A multi-dimensional approach to violence.
- Halleck, S.L.(1986). The mentally disordered offender. Rockville, MD:NIMH
- Hamilton, J.R. (1982). A quick look at the problems. In Dangerousness : Psychiatric assessment and management, pp. 1-3. J.R. Hamilton & H Freeman (Eds.). London: Gaskell.
- Hargreaves, D. (1997). The transfer of severely mentally ill prisoners from HMP Wakefield : a descriptive study. Journal of Forensic Psychiatry, 8 (1), pp 62-73.
- Hepworth, D. (1982). The influence of the concept of 'danger' on the assessment of 'danger to self and to others'. Medicine, Science and the Law, 22, 245-254.
- Herbst, K.R. & Gunn, J. (1991). The Mentally Disordered Offender. Oxford: Butterworth-Heinemann.
- Hinton, J.W. (1982). Dangerousness: Problems of Assessment and Prediction. London: Allen & Unwin.
- Hodgins, S. (1993). Mental Disorder and Crime. Saga Publications London.
- Humphreys, M, Johnstone, E. & Macmillan, F. (1994). Offending amongst first episode schizophrenics. Journal Of Forensic Psychiatry, 5, pp 51-61.
- Humpreys, M.S., Johnstone, E.C., Macmillan, J.F. & Taylor, P.J. ( 1992). Dangerous behaviour preceding first admissions for schizophrenia. British Journal of Psychiatry, 161, 501-505.
- Jackson, M.W. (1986). Psychiatric decision-making for the courts: Judges, psychiatrists, lay people? International Journal of Law and Psychiatry, 9, 507-520.

- Kay, S.R., Wolkenfeld, F. & Murril, L.M. (1998). Profiles of Aggression Among Psychiatric Patients. The Journal of Nervous and Mental Disease, 176 (9).
- Kennedy, J., Harrison, J., Hillis, T. (1995). Analysis of violent incidents in a regional secure unit. Medicine, Science and the law, 35, 255-260.
- Kennedy, J., Wilson, C. & Cope, R. (1995). Long-stay patients in a regional secure unit. Journal of Forensic Psychiatry, 6 (3), pp 541-551.
- Kruger, A. (1980). Mental Health Law in South Africa. Durban. Butterworths.
- Lamb, H.R. & Weinberger, L.E. (1998). Psychiatric Services. Persons with severe mental illness, pp 483-492.
- Lanzcron, J. (1963). Murder and Insanity: A survey. American Journal of Psychiatry, 119, 754-758.
- Lindquist, P. & Allebeck, P. (1990). Schizophrenia and crime. British Journal of Psychiatry: A longitudinal follow-up of 644 schizophrenics in Stockholm, 157, 345-350.
- Link, B.G., Andrews, H. & Cullen, F.T. (1992). The Violent and Illegal Behaviour of Mental Patients Reconsidered. American Sociological Review, 57, pp 275.
- MacCulloch, M., Bailey, J., Jones, C. & Hunter, C. (1994). Nineteen male serious re-offenders who were discharged from a Special Hospital : III. Illustrated administrative issues Journal of Forensic Psychiatry 5, pp 63-81.
- MacDonald, J.M. (1976). Psychiatry and the criminal. (3<sup>rd</sup> ed.). Charles. C Thomas Publisher. Springfield USA.
- Maden, A., Curle, C., Meux, C., Burrows, S. & Gunn, J. (1995). Treatment and security needs of special Hospital patients. London: Whurr Publishers.
- Marra, H.A., Konzelman, G.E. & Giles, P.G. (1987). A clinical strategy for the assessment of dangerousness. International Journal of Offender Therapy and Comparative Criminology, 31, 291-299.
- McClintock, T. & Evans, C. (1995). Admissions to a close supervision unit. Do patients with repeated short admissions constitute the revolving door patients of minimum secure provision? Journal of Forensic Psychiatry, 6, pp 63-75.
- Megargee, E.I. (1976). The Prediction of Dangerous Behaviour. Criminal Justice & Behaviour, 3, 3-21
- Menuck, M. (1983). Clinical aspects of dangerous behaviour. The Journal of Psychiatry and Law, 15, 277-304.
- Menzies, R.J., Webster, C.D. & Sepejak, D.S. (1987). At the mercy of the mad: Examining the relationship between mental illness and violence. Advances in Forensic Psychology and Psychiatry, 2, pp. 63-100. B.T. Butler (Ed.).
- Menzies, R.J., Webster, C.D. & Butler, B.T. (1981). Perceptions of dangerousness among forensic psychiatrists. Comprehensive Psychiatry, 22, 387-397.
- Monahan, J. (1981). The Clinical Prediction of Violent Behaviour. Washington DC : G.P.O.
- Monahan, J. & Steadman, H.J. (1983) . Crime and mental disorder: An epidemiological approach. Crime and justice : An annual review of research, 4, pp.145-188. M. Tonry & N. Morris (Eds.). Chicago: University of Chicago Press.
- Monahan, J. (1992). Mental disorders and violent behaviour: Perceptions and evidence. American Psychologist, 47, 511-521.
- Moore, S., Freeman, W.H. & Co. (1979). Statistics : Concepts and Controversies. San Francisco.
- Mouton, J. (1996). Understanding Social Research. J.L van Schaik Publishers. Pretoria.
- Mulvey, E.P. (1994). Assessing the link between mental illness and violence. Hospital and community psychiatry, 45, 663-668.
- Mulvey, E.P. & Lidz, C.W. (1984). Clinical considerations in the prediction of dangerousness in mental patients. Clinical Psychology Review, 4, 379-401.
- Mulvihill, D.J. & Tumin, M.M. (1969). Crimes of violence (Vol. 12) Washington DC: Government Printing Office.
- Neumann, W.L. (1997). Social Research Methods- Qualitative and Quantitative Approaches. (3<sup>rd</sup> ed). Allyn & Bacon. Boston.
- Newhill, C.E. (1992). Assessing Danger to others in Clinical social work Practice. The Social Service Review, 66, pp. 64.
- Norton, S.C. (1988). Predictor variables of violent behaviour. American Journal of Forensic Psychology, 6 (3), 53-66.
- Oates, M. (1997). Patients as parents: the risk to children. British Journal of Psychiatry, 170 (suppl. 32) 22-27.
- Planansky, K. & Johnston, R. (1977). Homicidal aggression in schizophrenic men. Acta Psychiatrica Scandinavia, 55, 65-73.
- Pollock, N and Webster, C. (1990). The clinical assessment of dangerousness. In principles and practice of Forensic Psychiatry (eds. Bluglass & Bowden). p. 492. Edinburgh: Churchill Livingstone.
- Prins, H. (1992). The Diversion of the mentally disordered: some problems for criminal justice, penology and health care. Journal of Forensic Psychiatry 3 (3), pp431-443.
- Prins, H. (1986). Dangerous Behaviour, The Law and mental disorder. Tavistock Publications. London.
- Quinsey, V.L. & Maguire, A. (1986). Maximum security patients: actuarial and clinical prediction of dangerousness. Journal of Interpersonal Violence, 1, 143-171.
- Rappeport, J.R. & Lassen, G. (1965). Dangerousness: Arrest rate comparisons of discharged patients and the general population. American Journal of Psychiatry, 121, 776-783.
- Rasmussen, K. & Levander, S. (1996). Symptoms and personality characteristics of patients in a maximum security psychiatric unit. International journal of Law and Psychiatry, 19 (1), pp 27-37.
- Reed, J. (1992). Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. London: HMSO.

- Reed, J. (1997). Risk assessment and clinical risk management: The lessons from recent enquiries. The British Journal of Psychiatry, 170 (Suppl 32).
- Rice, M.E. & Harris, G.T. (1992). A comparison of criminal recidivism among schizophrenic and non-schizophrenic offenders. International Journal of Law & Psychiatry, 15, 397-408.
- Rice, M.E. & Harris, G.T. & Cormier, C.A. (1992). An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. Law and Human Behaviour, 16, 399-412.
- Scott, J. (1990). A matter of record. (Documentary sources in social research). Polity Press. Cambridge UK.
- Scott, P. (1977). Assessing Dangerousness in criminals. British Journal of Psychiatry, 131, 127-142.
- Segal, S, Watson, M, Goldfinger, S & Averbeck, D. (1988). Civil commitment in the psychiatric emergency room. II: Mental Disorder indicators and three dangerousness criteria. Archives of General Psychiatry, 45, 753-8
- Shaw, J., McKenna, J., Snowden, P., Boyd, C., McMahon, D. & Kilshaw, J. (1994). The North-West Region. I : Clinical features and placement needs of patients in special hospitals Journal of Forensic Psychiatry 5:1 May pp93-105.
- Short, J. (1995). Characteristics of absconders from acute admission wards. The Journal of forensic Psychiatry, 6 (2), pp. 277-284.
- Snowden, P. (1997). Practical aspects of clinical risk assessment and management. The British Journal of Psychiatry, 170 (Suppl 32), 32-34.
- Sosowsky, L. (1978). Crime and Violence Among Mental Patients Reconsidered in view of the New Legal Relationship Between the State and the Mentally Ill. American Journal of Psychiatry 135 (1).
- Steadman, H.J. & Coccozza, J.J. (1974). Careers of the criminally insane – Excessive social control of deviance. Lexington Books USA.
- Steadman, H.J. & Coccozza, J.J. (1980). The prediction of dangerousness – Baxtrom : A case study. In G, Cooke, ed. The Role of the Forensic Psychologist. Springfield, II.: Thomas. Pp 204-215.
- Stewart, D.W. (1984). Secondary Research – Information Sources and Methods. Applied Social Research Methods Series Vol. 4. Sage Publications USA.
- Swanson, J.W., Holzer, C.E. & Ganju, V.K (1990). Violence and Psychiatric disorder in the community: evidence from the Epidemiological catchment area surveys. Hospital and community psychiatry 41, 761-770.
- Tardiff, Kenneth and Sweillam, (1982). Attia Assaultive behaviour Among Chronic Inpatients. American Journal of Psychiatry 139, 2.
- Taylor, P.J *et al.* (1998). Mental disorder and violence. A Special (High Security) Hospital Study. The British Journal Of Psychiatry 172, 218-226.
- Taylor, P. J, (1985). Motives for Offending amongst violent and psychotic men. British Journal of Psychiatry 147, 491-498.
- Thomas, G. & McMurrin, M. (1993). Alcohol-related offending in male special hospital patients. Medicine, Science and the Law. 33, 29-32.
- Thomson, L, Bogue, J, Humphrey, M, Owens, D & Johnstone, E. (1997). The State Hospital Survey: A description of psychiatric patients in conditions of special security in Scotland. The Journal of Forensic Psychiatry, 8 (2), pp 263-284.
- Toch, H & Adams, K. (1990). The Disturbed Violent offender. Connecticut: Yale University Press.
- Tremblay, P.F., King, P.R & Baines, G.R. (1994). Clinical and demographic characteristics of voluntary and involuntary psychiatric in-patients. Canadian Journal of Psychiatry, 39, pp 297-299.
- Tufte E.R. (Ed.), (1970). The Quantitative Analysis of Social Problems In series of Behavioral Science : Quantitative Methods. Addison-Wesley Publishing Company, USA
- Turk, J, (1989). Forensic aspects of mental handicap. British Journal of Psychiatry, 155, 591-594.
- Virkkunen, M. (1974). Observations of violence in schizophrenia. Acta Psychiatrica Scandinavia, 50, 145-151.
- Wallace, C; Mullen, P; Burgess, P; Palmer, S; Ruschena, D & Browne, C. (1998). Serious criminal offending and mental disorder. Case linkage study. British Journal of Psychiatry. 172, 477-484.
- Werner, P.D, Rose, T, Yesavage, J.A. & Sean, K. (1984). Psychiatrists' judgements of dangerousness in patients on an acute care unit. American Journal of Psychiatry, 141, 263-6
- Wessely, S. (1997). The epidemiology of crime, violence and schizophrenia. British Journal of Psychiatry, 170 (suppl. 32). 8-11.
- Williams, W. & Miller, K.S. (1977). The role of personal characteristics in perceptions of dangerousness. Criminal Justice and Behaviour, 4, 241-252.
- Woods P, (1995). Patient Dangerousness: The views of nurses on low dependency wards.
- Woods P. & Mason T. (1998). The British journal of Developmental Disabilities, 44, (Part 2) no.87.
- Woods, P. & Mason, T. (1997). Twenty years of Admissions to a Special Hospital. Psychiatric care, 4, (1), 22-25.
- Woods P. & Mason T. (1996). Diversion of Mentally Disordered Offenders: Indications from a Special hospital.
- Zabow, T (1981). Management of mentally disordered offenders in South Africa: The assessment of and rehabilitation program in Cape Town. International Journal of Law and Psychiatry, 4,449-455.
- Zabow, T. (1990). Forensic Psychiatry Unpublished lecture notes. Department of Psychiatry. University of Cape Town.
- Zitrin, A., Hardesty, A., Burdock, E. & Drossman, A (1976). Crime and violence among mental patients. American Journal of Psychiatry, 133, 143-149

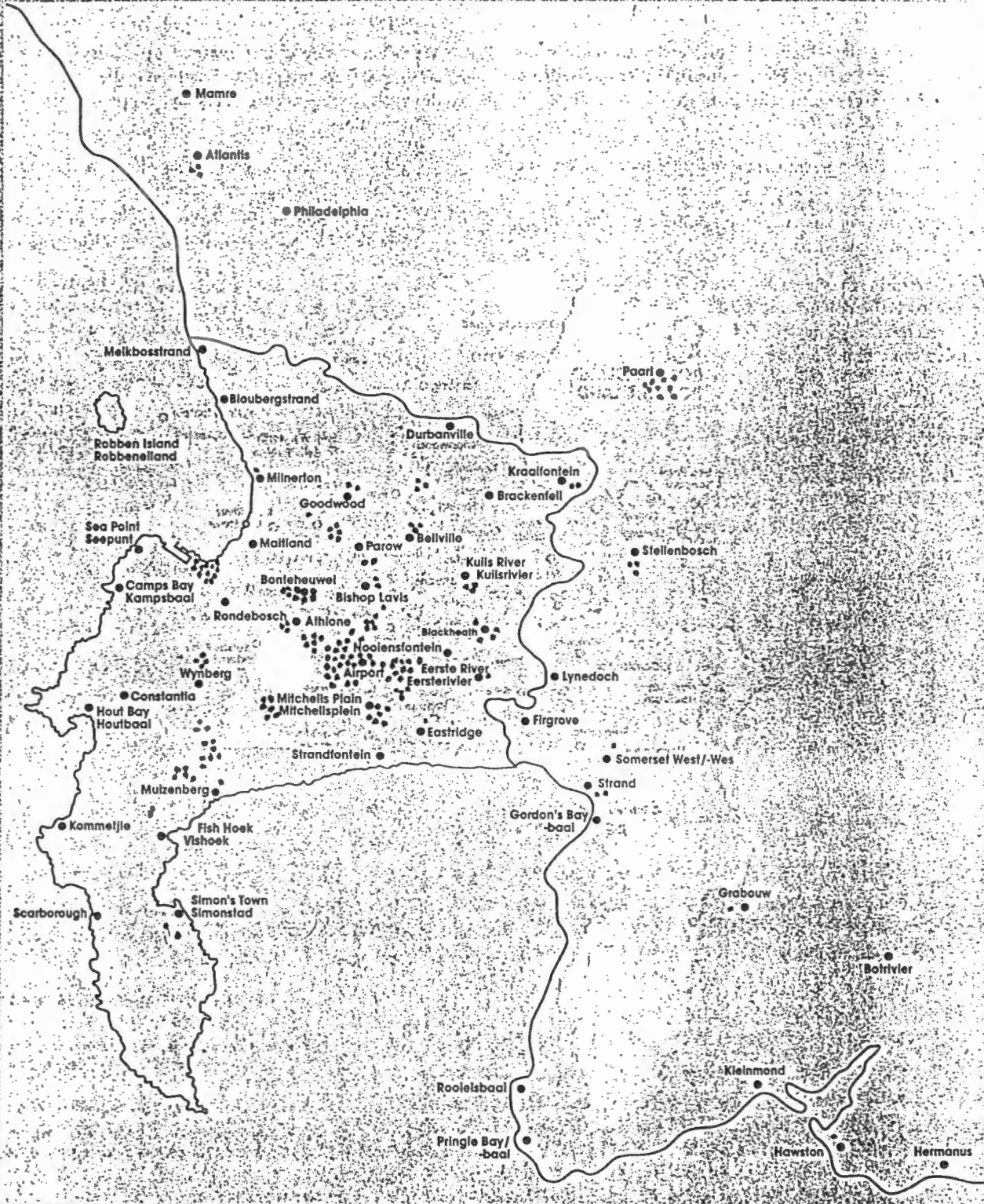
Criminal Procedure Act No. 51 (Chapter 13) of 1977.  
Government Gazette 6 May 1977. No 5532.

The Declaration and Detention of Persons as State Patients under the Criminal Procedure Act, Act 51 of 1977, and the discharge of such persons under the Mental Health Act, Act 18 of 1973, including the burden of proof with regard to the mental state of an accused or convicted person – South African Law Commission. August 1995 Pretoria.

Mental Health Act No. 18 of 1973. Government Gazette 4 April 1973. No. 3837.



**APPENDIX II(a) : Map of Geographical Origin of Patients**



## APPENDIX II(b)

### Numbers of patients who come from areas outside of the Cape region:

Atlantis	3	Malmesbury	2
Bathurst	1	Merweville	1
Beaufort West	4	Mossel Bay	2
Bedfordview, - Gauteng	1	Oudtshoorn	8
Bethlehem	1	Paarl	9
Bredasdorp	1	Pacaltsdorp	1
Burgersdorp	1	Rawsonville	1
Calvinia	1	Riebeek Kasteel	1
Carnavon	1	Riversdal	3
Citrusdale	1	Riviersonderend	1
Darling	1	Robertson	1
De Doorns	1	Stellenbosch	3
Franschoek	3	Strand	2
Genadendal	1	Transkei	1
George	7	Uitenhage	1
Gobabis	1	Uitsig	2
Grabouw	1	Uniondale	1
Grahamstown	1	Upington	3
Hawston	1	Vredenburg	1
Hornlee	1	Vredendal	1
Kalksteentfontein	1	Vryburg	1
Kamieskroon	1	Warenton	1
Kimberly	4	Wellington	3
Knysna	4	Willowmere	1
Ladysmith	1	Worcester	1
Lambertsbaai	1		
Lutzville	1		

**APPENDIX III****TABLE OF CHARGES**

<b>CHARGE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>	<b>CUMULATIVE</b>
Abduction	1	0.4%	0.4%
Arson	3	1.3%	1.7%
Assault	79	33%	34.7%
Attempted murder	6	2.5%	37.2%
Attempted rape	9	3.8%	41.0%
Attempted theft	1	0.4%	41.4%
Bomb threat	1	0.4%	41.8%
Crimen injuria	1	0.4%	42.2%
Drunken driving	1	0.4%	42.6%
Housebreaking	5	2.1%	44.7%
Indecent Assault	15	6.3%	51.0%
Intimidation	1	0.4%	51.4%
Malicious damage	15	6.3%	57.7%
Murder	49	20.5%	78.2%
Possession of weapon	2	0.8%	79.0%
Rape	22	9.2%	88.2%
Robbery	6	2.5%	90.7%
Sodomy	2	0.8%	91.5%
Theft	15	6.3%	97.8%
Threatening	1	0.4%	98.2%
Trespassing	1	0.4%	98.6%
No charge	3	1.3%	100.0%
<b>TOTAL</b>	<b>239</b>	<b>100.0%</b>	

## APPENDIX IV

### TABLE OF DIAGNOSES

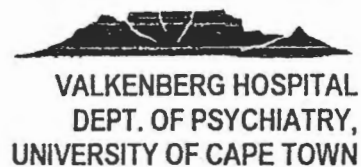
<b>DIAGNOSIS</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>	<b>CUMULATIVE</b>
BPAD	40	16.7%	16.7%
Brief Psychotic Disorder	1	0.4%	17.2%
Delusional Disorder	4	1.7%	18.9%
Dementia	6	2.5%	21.4%
Epilepsy	2	0.8%	22.2%
Huntington's Disorder	1	0.4%	22.6%
Mental Handicap	16	6.6%	29.2%
Neurosyphilis	3	1.3%	30.5%
PD due to Head Injury	2	0.8%	31.3%
Schizoaffective Disorder	27	11.3%	42.6%
Schizophrenia	137	57.3%	100.0%
<b>TOTAL</b>	<b>239</b>	<b>100.0%</b>	

**APPENDIX V**

**TABLE OF FAMILY CIRCUMSTANCES**

<b>FAMILY CIRCUMSTANCE</b>	<b>VIOLENCE</b>		<b>Total</b>	<b>Percent</b>
	<b>N</b>	<b>Y</b>		
<b>GOOD</b>	34	14	48	20.1%
<b>NO CONTACT</b>	14	7	21	8.8%
<b>POOR</b>	45	50	95	39.7%
<b>REASONABLE</b>	45	30	75	31.4%
<b>Total</b>	138	101	239	100.0%

# FORENSIC PSYCHIATRY UNIT



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## MISSION STATEMENT

The forensic psychiatry unit at Valkenberg Hospital is dedicated to providing psychiatric assessments of defendants referred by the courts and rehabilitation of mentally disordered offenders. The Unit is subsumed under the Department of Psychiatry, University of Cape Town, and therefore is responsible for educating students and colleagues. Research into current issues has a high priority. Within the greater context of mental health care in the community the Unit recognizes that it has to lobby for patients' rights and for needed reforms.

## WARDS:

The Unit consists of the following :

Maximum Security Ward	20 (including observation cases)
Secure Wards	9/10
Closed/Controlled Ward	7
Open Ward	12
OPD	

Ward 20 is the most secure and contains potentially dangerous patients and prisoners (i.e. observation cases). Wards 9 and 10 are medium secure, and contain patients who have been stabilised in ward 20 but do not function well enough for open wards. Ward 7 is a closed ward that houses low functioning long-term patients. Ward 12 is an open ward, which prepares patients for discharge (usually by allowing them extended periods of leave and freedom of movement), although it does cater for chronic patients whose social circumstances are an obstacle to discharge.

The patients are graded from high security risk through to low risk. Ward 20 is designated a Maximum Security Ward in terms of the Mental Health Act. Low risk patients are eventually placed in ward 12.

Each ward has a programme constructed within a behavioural/milieu system. Patients are placed into groups and given privileges accordingly. The general divisions are as follows:

- |         |   |
|---------|---|
| GROUP A | All ward privileges, including ground parole, week-end and long leaves, attendance at industrial therapy etc.   |
| GROUP B | Limited ground parole, usually alternate week-end leaves.   |
| GROUP C | Newly transferred patients are usually allocated to this group.   |
| GROUP D | This is the restrictive group. The period spent in this group may vary (although is usually one month). Patients wear pyjamas and do not leave the ward). |

Evaluation by the therapeutic team (for promotion or demotion) occurs weekly. The privileges granted may vary according to the circumstances in a ward.

### **Ward routines**

Feed-back occurs every morning in ward 20 at 08h45. Members of the clinical team, including all registrars attend. All problems, especially those encountered with acute and observation patients are discussed.

## **Ward rounds**

DAY	WARD	ROUND	TIME
Monday	20	Observation cases	9h00
Tuesday	7	Reviews	14h00
Wednesday	12	Climate meeting & reviews	8h30
	9/10	Reviews	10h00
Thursday	20	Reviews	9h00
	12	Reviews	8h30
	20	Observation grand round	10h30
Friday	20	Administrative meeting	9h30
	OPD	Outpatients (Prof Zabow)	13h30

### **PATIENT CARE:**

The wards are divided between the 2 unit registrars who should co-ordinate their duties so as to ascertain full exposure to the diverse material and various responsibilities within the Unit.

### **General duties**

The registrars are directly responsible for the care of all patients. Ward problems should in the first instance be directed to them. Registrars are expected to inform and discuss difficult problems with the consultants (who will always assume ultimate responsibility).

Registrars are directly responsible for their wards and are expected to be easily available at all times of the day for problems. Should one be unavailable, he/she must ensure that the other registrar will cover. The time officially allocated for teaching will, if possible, be covered by the consultants.

Registrars should make contact with their allocated wards daily and arrange for suitable times to review patients for discussion at the weekly team ward round. Registrars will clerk cases for presentation at observation and review rounds.

### **THE PATIENT:**

Registrars must be acquainted with the relevant sections of the Criminal Procedure Act and Mental Health Act. Because of medico-legal implications all decisions regarding forensic patients must be made with a unit consultant's knowledge. All transfers between wards must be negotiated in the administrative meeting, or in cases of need with the consultant. No patient from the general wards may be admitted to Ward 20 without prior discussion with a forensic unit consultant.

The registrar is encouraged to familiarise himself/herself with the management of aggressiveness in patients. Never take unnecessary risks with any patient.

Apart from the formal reviews chronic patients must be evaluated continuously by registrars. It is expected that at least 5 patients in each ward will be informally assessed each week.

## **Observation cases:**

- I. The courts refer all observation cases under a double order, for Pollsmoor and Valkenberg Hospital. They are admitted from Pollsmoor as beds become available. All are admitted to 20.
- II. Clerking of observation cases should alternate between the registrars, ward clinical psychologist and intern psychologist and 6<sup>th</sup> year medical intern. Other members of the team will occasionally clerk cases. Overall supervision of case allocation and clerking remains registrars' responsibility.
- III. Consultants will alternate responsibility for these cases.
- IV. The registrar will also complete, with adequate detail, the routine request forms for E.E.G., psychometric testing and social worker's background report.
- V. Observation cases should be seen *at least weekly* during their 30 day stay. Please record notes of all consultants and ward round/case conference discussions.
- VI. Current resources are under increasing threat. Therefore it is requested that all members of the team assist in the gathering of collateral information. The psychosocial circumstances of the serious cases (especially murder charges) should continue to be assessed by the social workers.
- VII. Medication as a rule is not to be prescribed for observation cases except where he is a known patient on maintenance medication, is overtly disruptive/aggressive or the patient is suffering severe symptoms. Discussion with the consultant must occur before prescribing psychotropics.
- VIII. Female observations are assessed at Lentegeur or Stikland Hospitals.

## **Clerking of observation patients**

The standard Maudsley clerking scheme is to be used. Because of the medico-legal context a great deal of detail must be elicited. The following scheme is to be used:

- a. Demographics
- b. Summary of court proceedings and allegations against the patient.
- c. Account of the alleged offence  
The events of the alleged offence (as related by the patient) should include the period preceding (which may vary from a few hours to months) which is relevant to understanding the circumstances of the offence. It is important to note influences such as intoxication, provocation, psychosis etc. in detail. Elicited factors must undergo elaboration (for example, intoxication should be followed with description of past/ongoing abuse). If symptoms were important motivational factors then a psychiatric history should be inserted at this stage. It is often advisable to elicit anxiety disorder (PTSD) symptoms as these may indicate remorse.
- d. Criminal and psychiatric history
- e. Family genogram and history
- f. Review of development  
In addition to developmental milestones and educational progress special attention must be given to presence of conduct disorder symptoms, central nervous system insults or deficits (including attention deficit disorder) and occupational history.  
  
Psychosexual history is not important in minor offences, but is paramount for sexual offences. In such cases paraphilias (especially sadistic behaviours) should be explored.
- g. Mental state examination  
A Mini Mental test should be conducted always to assess cognition. It is recommended that tests for malingering be used.

h. Assessment

Although a full formulation is not always required a multi-axial diagnosis must be provided. On axis 1 it is expected that a good differential diagnosis be provided and that the most likely diagnosis be highlighted. The forensic assessment involves evaluation of fitness to stand trial and criminal responsibility. Finally any other clinical feature that may be relevant to the court proceedings must be discussed, such as the role of intoxicants, mitigating factors etc.

i. Report

The consultant will generally write the court report. However in many cases the clinician who clerked the case may also do so (under supervision). Always attempt to read the final report of cases.

**CLINICAL REPORTS (general):**

Good note keeping is of the utmost importance due to the medico-legal nature of these patients.

**PLEASE WRITE LEGIBLY:** unreadable notes may as well not have been written.

Please remember that unlike other psychiatric data, information on observation cases is not always privileged and **MAY** be later revealed in court under special circumstances. Hence unfounded speculations should be written and language must always be temperate and professional.

Please remember to improve the organisation of all clinical folders. All previous notes should be condensed into the current file in chronological order. The ward clerk will assist with this, if instructed clearly.

**Reviews of chronic patients**

The long term patients must be seen at least once every 3 months. Cases will be presented to the unit team regularly at each ward's weekly round. Each review should be considered to be a progress report and be compared to previous reviews, and therefore should contain the following:

- |    |                   |   |  |
|----|-------------------|---|--|
| 1. | Psychiatric state | - | Review briefly <ul style="list-style-type: none"> <li>(i) identifying data, include Section of M.H.A.</li> <li>(ii) offence</li> <li>(iii) past history</li> <li>(iv) illness course</li> </ul> <ul style="list-style-type: none"> <li>- Present M.S.E.</li> <li>- Review diagnosis (D.S.M. IV)</li> <li>- Assess risk of violent behaviour (high to low)</li> </ul> |
| 2. | Medication        | - | <ul style="list-style-type: none"> <li>(i) dosage</li> <li>(ii) indications</li> </ul> <ul style="list-style-type: none"> <li>- Check for side-effects (T.D.K.) or previous reactions documented</li> </ul>  |
| 3. | Physical state    | - | Document current and past illness <ul style="list-style-type: none"> <li>- Yearly medical examination</li> <li>- Monitor investigations</li> </ul>   |
| 4. | Function          | - | Ward behaviour, esp. aggression <ul style="list-style-type: none"> <li>- Relations             <ul style="list-style-type: none"> <li>(i) with staff</li> <li>(ii) with peers</li> </ul> </li> <li>- O.T. / Industrial therapy</li> <li>- General functioning</li> <li>- Substance abuse</li> </ul>  |
| 5. | Social resources  | - | <ul style="list-style-type: none"> <li>- Home town/area</li> <li>- Family circumstances</li> <li>- Note nature and quality of contact</li> </ul>   |

6.	Recommendations	-	Suitability in ward
		-	? Transfer
		-	? Discharge
		-	? Rehabilitative changes

The above are guidelines for documentation of important patient formation. Documentation should be clearly and coherently summarised at each interview.

The patient will be interviewed after the presentation and thereafter the team will conjointly modify (if necessary) the management plan.

### **POLLSMOOR PRISON (CORRECTIONAL PSYCHIATRY):**

As part of training in Forensic Psychiatry it is essential that registrars are introduced to the concepts of prison psychiatry. Unfortunately the Unit does not presently provide a service for prisoners at Pollsmoor Prison. If possible the registrars and other members of the team will have an opportunity to visit the prison clinics with a consultant. He/ she will, if necessary, also assist in clerking observation cases detained at the prison. Occasionally already sentenced prisoners are brought to the hospital for psychiatric assessment.

### **COURT ATTENDANCE:**

Whenever possible, the registrars will accompany the consultant to both Magistrate and Supreme Court trials. Some exposure will thus be given to the problems of giving expert evidence as well as learning basic court procedures.

### **TEACHING AND SUPERVISION:**

This is an academic unit and therefore teaching and supervision are fundamental priorities.

Registrars are encouraged to arrange with their consultant a mutually acceptable regular time for supervision. These should be used to provide the registrar with ongoing feedback and guidance with respect to their performance in the unit. Similarly intern psychologists will receive supervision from the senior clinical psychologist.

Similarly it is expected that senior members of the team will assume responsibility for the teaching of juniors. In particular registrars are encouraged to teach the medical students.

Most teaching will occur in ward rounds within the context of cases under discussion. Extra sessions will be organised to discuss specific topics on the last Wednesday of the month.

### **MEETINGS**

There is an administrative meeting for the whole forensic unit every Friday at 09:30. Registrars are expected to attend. This is attended by the Superintendent and senior nursing staff. Events within the Unit over the past week are reviewed and discussed. Transfers between wards are agreed upon. Note\* transfer from the maximum secure ward requires approval from the multidisciplinary team. Daily feed-backs in ward 20 should be used to discuss any issues within the unit.

### **SECURITY**

A private security firm provides security officers. Unfortunately the turnover of staff in these companies is generally high. Staff should constantly be aware that security officers need ongoing training in the ward. Orientation for new officers will be undertaken jointly by staff and the supervisor at the firm. Communication of problems should be immediate to supervisors and consultants. The administrative meetings on Friday mornings will include discussion with the security supervisor on security matters.

## **POLICY**

### ***Transfers between wards***

Most transfers will be discussed and arranged at during the administrative meeting on Friday mornings. Often patients in the medium secure or open wards need to be contained in other wards, especially ward 20. This is to be discussed with the consultant of both wards. No transfers after hours are to be effected except after discussion with the consultant on call. Admission to the maximum secure ward which has not been ordered by a court must be certified by 2 doctors, one of whom must be a consultant.

### ***Seclusion***

Seclusion is to be used as a 'time out' procedure for disruptive patients, and is to be applied for the minimum period possible. It must not be applied punitively. Patients in seclusion are checked every 10-15 minutes, and sedation must be prescribed unless otherwise indicated. No patient must be kept in seclusion for longer than 48 hours without a break outside the seclusion room. The concept of using the least restrictive environment necessary must be followed, and all seclusion details, including the indications and doctor's signature, must be recorded.

### ***Ground parole***

The group system allows for patients to be granted ground parole. This is usually limited by time. Those in group B should be given a definite time period, not longer than 3 hours at a time. Group A patients are generally given parole to attend IT and if they are in ward 12 are able to move freely in the grounds. Occasionally the team may grant patients special parole to do chores (such as apply for ID documents or collect a pension). Patients that abuse parole should be demoted.

### ***Vacation leave***

Rehabilitation depends on allowing patients trial periods of leave in the community. Following promotion to group B families should be contacted for an assessment of home circumstances. These are discussed at ward rounds.

Initially patients should be granted periods of week-end leave only. With time and further promotion these periods can be gradually lengthened. Eventually some may be allowed home on extended leave, such as 1-3 months. Patients are to be encouraged to work and function at as high a level as possible.

### ***Alcohol and substance abuse***

Most patients in the unit are substance abusers. Smuggling of substances into the hospital is an ongoing problem. Patients who are found to be intoxicated should be demoted to lower groups and privileges accordingly removed. Those who are aggressive and in need of containment should be secluded until the effects of the intoxication have subsided or behaviour improved.

Patients, visitors or staff found with substantial quantities of any illegal drug or alcohol on hospital premises must be reported to the Police. Charges should be laid.

### ***Assaults***

Serious assaults on staff or patients are not tolerated. All incidents must be reported and, if appropriate, charges with the police laid.

### ***Inappropriate sexual behaviour***

'Sodomy' between patients is a difficult problem to resolve. In many cases the sexual behaviour is consensual, but it is often not easy to determine whether consent was given freely. In those cases where sexual advances are forced on more vulnerable patients stringent procedures must be undertaken to protect them. Perpetrators, especially if habitual, should be placed in single rooms at night, and reasonable measures taken to ensure that vulnerable patients are protected as well.

## APPENDIX VII EXPLANATORY NOTES ON SECTIONS

Extracted from: Zabow, T (1991) Forensic Psychiatry Unpublished lecture notes for UCT

All patients managed in psychiatric institutions or licensed institutions are admitted in terms of the Mental Health Act. Section 3 (Voluntary) and Section 4 (Patient by Consent) of Chapter 3 of the Act provides for the majority of admissions. These persons either agree to being admitted or do not object. Their protection remains inherent in the procedure followed in relation to admission, enquiry and discharge

Compulsory admission in terms of Section 9 of the Mental Health Act relates to reception orders, urgency admissions and potentially dangerous mentally ill persons. Medical certificates in support of application affidavits are necessary for the admission of these patients, as is ultimate investigation and issue of a retention order by a judge of the Supreme Court following hospitalisation. The Mental Health Act clearly requires the medical practitioner issuing the relevant certificates to certify that the patient cannot be admitted alternatively under Sections 3 or 4.

Where an accused has been charged with a minor offence (e.g. trespassing), the prosecution may at its discretion withdraw or halt the proceedings. This is done with the understanding that the hospital will undertake further management of the accused in terms of Section 19 of the MHA (Civil Commitment).

If an accused is found to be unfit to stand trial due to a mental illness or defect then the court must halt proceedings and declare the accused a State patient. He is then referred to a mental hospital under Section 28 of the MHA and managed as a mentally ill patient.

Occasionally it may arise that a State patient is not able to be discharged. If the patient is not considered to be a security risk, application may be made for reclassification from Section 28 to Section 19 of the MHA. In practice this makes the management more simple. He remains hospitalised. It should not be used as a manoeuvre to circumvent the usual discharge procedure.