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A RETROSPECTIVE RECORD REVIEW OF PERPETRATORS OF INTIMATE PARTNER HOMICIDE REFERRED FOR FORENSIC PSYCHIATRIC OBSERVATION TO STERKFONTEIN HOSPITAL

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(303256)

A Research Report (in the format of a “submissible” paper) submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Medicine (Psychiatry)

Johannesburg, 2020.

DECLARATION

I, Sonali Narandass Valabdass, declare that this Research Report is my own, unaided work. It is being submitted for the degree of Master of Medicine in Psychiatry (in submissible format with my protocol) in the branch of Psychiatry at the University of the Witwatersrand, Johannesburg. This Research Report has not been submitted before for any degree or examination at this or any other university.



(Signature of candidate)

7th day of April 2020 in Johannesburg

CONTRIBUTION OF THE CANDIDATE TO THE PAPER

Declaration: Student's contribution to article(s) and agreement of co-author(s)

I, Sonali Narandass Valabdass, student number 303256, declare that this Research Report is my own work and that I have contributed significantly towards the research findings presented in the paper intended for publication below.

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Agreement by co-authors: By signing this declaration, the co-authors listed below agree to the use of the article by the student as part of her Research Report. In cases where the student is not the 1st author of a published article, the primary supervisor must explain (under comments) why the student is entitled to use the paper for his/her degree purposes.

Article Title: A retrospective record review of perpetrators of intimate partner homicide referred for forensic psychiatric observation to Sterkfontein Hospital

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_____

_____

This research report is dedicated to my fiancé, Devesh Naidu.

Thank you for all of your support.

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ABSTRACT

Intimate partner homicide (IPH) is a global public health problem. This study evaluated the profile and outcomes of accused persons referred for psychiatric observation for a charge of IPH i.e. murder or attempted murder of their intimate partners. A retrospective study of 163 files was conducted at Sterkfontein Psychiatric Hospital over a nineteen-year period. A total of 88% of the sample were found fit to stand trial and 82% were found criminally responsible. Gender, the level of education completed, employment status, salary, previous psychiatric illness, medical illness, forensic history, history of domestic violence perpetration, motive and the presence of a psychiatric illness at the time of the offence were variables found to significantly influence fitness and responsibility. The characteristics highlighted in this study can contribute to the development of risk assessment tools which can be used to identify likely perpetrators of IPH. Other interventions such as controlling access to firearms, reducing substance abuse, and improving mental health services should all be addressed in order to reduce the incidence of IPH.

TABLE OF CONTENTS PAGE

TITLE PAGE……i
DECLARATION……...ii
CONTRIBUTION OF THE CANDIDATE TO THE PAPER……...iii
DEDICATION……...iv
ACKNOWLEDGMENTS……v
ABSTRACT……vi
TABLE OF CONTENTS……vii
LIST OF TABLES…….....ix
LIST OF ACRONYMS……x

CHAPTER 1: Research Report in the format of a "submissible" paper

Title Page…….....1
Abstract……....2
Introduction……...3
Aims
Methods……5
Study design and setting
Study population
Data collection
Data analysis
Ethical considerations
Results……...6
Profile of accused persons
Offence characteristics
Observation outcomes
Fitness and responsibility
Discussion……...13
Conclusion……..16
Study Limitations……17
References……..17

APPENDICES:

A. Approved research protocol with appendices…….....20
B. Ethics clearance certificate……..47
C. Turn-it-in report of Originality for Research Report in the format of a "submissible" paper……...49
D. Guidelines for Authors submitting to the South African Journal of Psychiatry……55

LIST OF TABLES

Table 1: Socio-demographic, clinical and forensic profile of accused persons…….7

Table 2: Offence characteristics……9

Table 3: Observation outcomes……..10

Table 4: Accused and offence characteristics and diagnosis according to the categories of observation outcomes with p values……...12

LIST OF ACRONYMS

Assault GBH: Assault with intent to do grievous bodily harm

CPA: Criminal Procedure Act

DG: Disability grant

IPH: Intimate partner homicide

IPV: Intimate partner violence

PD: Personality disorder

SA: South Africa

SPH: Sterkfontein Psychiatric Hospital

SUD: Substance use disorder

A RETROSPECTIVE RECORD REVIEW OF PERPETRATORS OF INTIMATE PARTNER HOMICIDE REFERRED FOR FORENSIC PSYCHIATRIC OBSERVATION TO STERKFONTEIN HOSPITAL

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The authors declare that there is no conflict of interest

ABSTRACT

Background: Intimate partner homicide (IPH) is a global public health problem. One study conducted over 66 countries found that 13.5% of all homicides and 38.6% of female homicides were committed by an intimate partner. In South Africa, there are no published studies that examine perpetrators of IPH that are observandi i.e. referred for mental observation.

Aim: To describe the profile of accused persons referred for psychiatric observation for a charge of murder/attempted murder of their intimate partners. Certain characteristics were further examined according to the observation outcomes.

Setting: The study was conducted at Sterkfontein Psychiatric Hospital, a forensic hospital in Gauteng, South Africa.

Methods: A retrospective record review of 163 files was conducted over a nineteen-year period. The definition of intimate partners included current or former spouses and partners, same-sex partners, and rejected suitors.

Results: A total of 88% of the sample were found fit to stand trial and 82% were found criminally responsible. Gender, the level of education completed, employment status, salary, previous psychiatric illness, medical illness, forensic history, history of domestic violence perpetration, motive and the presence of a psychiatric illness at the time of the offence were variables found to significantly influence fitness and responsibility.

Conclusion: The characteristics highlighted in this study can contribute to the development of risk assessment tools which can be used to identify likely perpetrators of IPH. Other interventions e.g. controlling access to firearms, reducing substance abuse and improving mental health services are also important in the prevention of IPH.

Introduction

Intimate partner homicide (IPH), defined as "the intentional killing of one's current or former partner",[1] is considered the most extreme form of intimate partner violence (IPV). Such homicides may involve spouses, ex-spouses, current or former partners, or partners of same-sex relationships and refers to both male and female victims.[1,2] Fatal IPV can be best understood as "an extension of the IPV phenomenon rather than within the scope of general homicide".[3]

A global study conducted over 66 countries found that 13.5% of all homicides and 38.6% of female homicides were committed by an intimate partner.[4] A national study of female homicides in South Africa (SA) found that, in 1999 and 2009, approximately 50% of victims were murdered by an intimate partner.[5,6] This highlights that IPH is a global public health problem that needs to be addressed. In order to curb incidences of IPH, understanding the profiles of these offenders (as well as those charged with attempted murder) might assist with perpetrator identification.

Some literature on IPH considers the high prevalence of mental illness among perpetrators.[1,2,7-9] In a study that examined 153 perpetrators referred for observation for a charge of murder in Illinois, Missouri, Indiana, Colorado or Arizona, 45.8% had a psychiatric diagnosis.[2] Another study, that was a consecutive case series of all convicted IPH perpetrators in England and Wales between 1997 and 2008, found a 32% lifetime prevalence rate of mental illness.[7] In a national study conducted in Portugal, 14.3% of IPH perpetrators who were subjected to a forensic psychiatric evaluation, were found not criminally responsible due to mental illness.[3] An Italian study showed similar results (12.6%).[10] In SA, a study that examined homicide perpetrators (of which 44% were IPH perpetrators) referred for psychiatric observation to Weskoppies Psychiatric Hospital, found that 56% had a psychiatric diagnosis at the time of the incident that impacted on criminal responsibility.[11]

Significant gaps exist in the current literature with regard to the profile of accused and offence characteristics in cases of IPH referred for psychiatric observation. Despite much research on the general population that commits IPH, few studies have addressed alleged perpetrators that are referred for forensic observation.

Forensic observations are conducted when the court has reason to believe accused persons may be suffering from a mental illness or intellectual disability which may be impacting on the individual's fitness to stand trial (the ability to comprehend court proceedings) and/or criminal responsibility (the ability to appreciate the wrongfulness of an act and to act in accordance with such an appreciation).[12]

Within the South African context, such accused persons (observandi) are referred by the court to a psychiatric hospital for a forensic psychiatric observation in terms of sections 77, 78 and 79 of the Criminal Procedure Act (CPA) 51 of 1977, as amended.[13,14] During the observation period, the accused person may undergo several assessments by members of the multi-disciplinary team (psychiatrists, clinical psychologists, occupational therapists, social workers and nurses). These assessments might include psychiatric interviews, physical examinations, laboratory tests, psychological assessments, occupational assessments and social worker reports. A final report is completed by the psychiatrist/s for the court, which comments on the accused person's diagnosis (if any), their fitness to stand trial and criminal responsibility.

For those who are found not fit and/or not criminally responsible, for a serious/major offence (for example murder, attempted murder, sexual assault or assault with intent to do grievous bodily harm (assault GBH)), the accused is usually admitted to the forensic unit as a State patient in terms of section 42 of the Mental Health Care Act 17 of 2002 for care, treatment and rehabilitation.[15]

As there is no specific charge of IPH/IPV, this research study focussed on murder and attempted murder of intimate partners in the context of forensic psycho-legal assessments in Johannesburg, SA. Assault GBH was not included in this study as we elected to only investigate murder and attempted murder, which represents the most extreme aspects of IPV.

Aims

The primary aim of this study was to describe the socio-demographic, clinical and forensic profile of accused persons referred for forensic psychiatric observation, under the CPA, to Sterkfontein Psychiatric Hospital (SPH) for a charge of IPH i.e. murder or attempted murder of an intimate partner. The study also sought to examine

offence characteristics and to describe the outcomes of the observation. The accused and offence characteristics, as well as diagnosis, were further examined according to the categories of observation outcomes, i.e. whether they were found to be either: fit or not fit and criminally responsible or not responsible.

Methods

Study design and setting

This was a retrospective record review of accused persons referred for observation to SPH with a charge of IPH during a nineteen-year period, from 1 January 2000 to 31 December 2018.

The study was conducted at the forensic section of SPH, a tertiary psychiatric hospital providing both general and forensic psychiatric services, situated outside of Krugersdorp in the Gauteng province.

Study population

The sample included all adult (age≥18 years) males and females. The definition of intimate partners included current or former spouses and partners, same-sex partners, and rejected suitors. The definition of IPH includes those homicides that were successful and those that were unsuccessful, i.e. files included in this study were of those accused persons referred for observation with a charge of murder or attempted murder of their intimate partner.

Data collection

Case files for IPH were identified via the forensic unit admission register, psychiatric reports and clinical records. Data was collected from psychiatric reports and clinical records. Data was captured using a data collection sheet which included socio-demographic, clinical, forensic, offence and observation factors.

Data analysis

All statistical analyses were conducted using Python (Scipy.stats module; https://docs.scipy.org/doc/scipy/reference/stats). All tests were two-tailed probability values. Categorical variables were summarised using frequency tables. Fitness and criminal responsibility classifications were compared against accused characteristics,

offence characteristics and diagnosis. Pearson's chi-squared test was used to determine statistical significance. A *p*-value of < 0.05 was considered significant.

Ethical considerations

The protocol was approved by the University of the Witwatersrand's Human Research and Ethics Committee, protocol number M180530. All data was collected by the primary investigator who was responsible for ensuring the anonymity, confidentiality and security of data obtained.

Results

Profile of accused persons

A total of 145 male and 18 female offenders were included in this study (Table 1). Forty-four percent of accused persons were unemployed. Thirty-three accused persons had a previous psychiatric illness (18 described a mood disorder, 14 a psychotic disorder and one a personality disorder (PD)). Fifty-seven offenders were found to have one or more medical illnesses and 108 accused persons admitted to using one or more substances. Ethanol and cannabis were the most commonly reported substances used. Ten percent of accused persons reported that they had experienced childhood trauma. Thirty-seven percent reported a forensic history, with a few accused persons reporting more than one charge. Of the sample, 26% were previous perpetrators of IPV.

Table 1: Socio-demographic, clinical and forensic profile of accused persons

Characteristics	Category	*N* (%)
Age	18 to 30	50 (31)
	31 to 40	52 (32)
	over 40	61 (37)
Gender	Female	18 (11)
	Male	145 (89)
Marital status (at the time of the offence)	Single	73 (45)
	Married	59 (36)
	Separated	19 (12)
	Divorced	12 (7)
Cohabiting	No	79 (48)
	Yes	84 (52)
Schooling	Mainstream	156 (96)
	Special	3 (2)
	No formal education	4 (2)
Highest level of education	No formal education	4 (2)
	Primary education	20 (12)
	Secondary education	91 (56)
	Tertiary education	48 (29)
Employment status	Employed	91 (56)
	Unemployed not on a disability grant	65 (40)
	Unemployed on a disability grant	7 (4)
Salary	R0–R5000	4 (2)
	R5000–R10000	28 (17)
	>R10000	59 (36)
Previous psychiatric illness	No	130 (80)
	Yes	33 (20)
Previous psychiatric diagnosis	Antisocial PD	1 (1)
	Schizophrenia	10 (6)
	Schizoaffective disorder	1 (1)
	Psychotic disorder due to another medical condition	2 (1)
	Substance induced psychotic disorder	1 (1)
	Major depressive disorder	13 (8)
	Mood disorder due to another medical condition	2 (1)
	Bipolar disorder I	2 (1)
	Bipolar disorder II	1 (1)
Medical illness	No	106 (65)
	Yes	57 (35)
Medical diagnosis	Previous head trauma	29 (18)
	Epilepsy	21 (13)
	Diabetes mellitus	10 (6)
	HIV	6 (4)
History of substance use	No	55 (34)
	Yes	108 (66)
Substance	Ethanol	79 (48)
	Cannabis	46 (28)
	Nicotine	27 (17)
	Stimulants	11 (7)
Childhood trauma	No	146 (90)

	Yes	17 (10)
Nature of childhood trauma	Physical and/or sexual abuse	10 (6)
	Witnessed domestic violence	5 (3)
	Both of the above	1 (1)
	Other	1 (1)
Forensic history	No	103 (63)
	Yes	60 (37)
Previous charge	Murder	4 (2)
	Attempted murder	5 (3)
	Assault GBH	26 (16)
	Domestic violence	2 (1)
	Protection order contravention	10 (6)
	Robbery	20 (12)
	Malicious damage to property	1 (1)
History of violent behaviour	No	86 (53)
	Yes	77 (47)
Perpetrator of domestic violence	Indicated – no	34 (21)
	Indicated – yes	42 (26)
	Not indicated	87 (53)
Victim of domestic violence	No	156 (96)
	Yes	7 (4)

Offence characteristics

The vast majority of the victims were the current spouse or partner of the accused (Table 2). Stabbing (using a knife) was the most common killing method, followed by gunshot. The majority of offences occurred at a residence.

Sixty-nine percent of accused persons did not use a substance at the time of the offence. Considerably more accused persons indicated a motive. Of those that indicated a motive, rage, infidelity and separation were the most common.

Table 2: Offence characteristics

Characteristics	Category	*N* (%)
Nature of the charge	Murder	124(76)
	Attempted murder	39 (24)
Relationship to the accused	Spouse	75 (46)
	Partner	65 (40)
	Ex-partner	10 (6)
	Ex-spouse	5 (3)
	Fiancé	4 (2)
	Rejected suitor	4 (2)
Killing method	Stabbing	76 (47)
	Gunshot	43 (26)
	Strangulation	16 (10)
	Blunt trauma	13 (8)
	Arson	4 (2)
	Poisoning	1 (1)
	Other	6 (4)
	Mixed	4 (2)
Murder weapon	Knife	70 (43)
	Firearm	43 (26)
	Bodily force	14 (9)
	Fire	4 (2)
	Poison	1 (1)
	Other	27 (17)
	Mixed	4 (2)
Setting	Residence	128(79)
	Street	14 (9)
	Other	21 (13)
Substance use at the time of offence	No	112(69)
	Yes	51 (31)
Motive	Indicated	115(71)
	Not indicated	48 (29)
Nature of the motive	Rage	51 (31)
	Infidelity	36 (22)
	Separation	35 (21)
	Jealousy	21 (13)
	Self-defence	11 (7)
	Possessiveness	3 (2)
	Financial benefit	1 (1)
	Retaliation	1 (1)

Observation outcomes

Half of the sample were found to have a psychiatric diagnosis (Table 3). Of these, some were found to have more than one diagnosis. Overall, 18% had a substance use disorder (SUD), 15% a PD, 15% a psychotic disorder, nine percent a mood disorder, three percent a neurocognitive disorder and one percent an intellectual disability. Considerably more observandi were found fit than not fit and responsible than not responsible.

Table 3: Observation outcomes

Characteristics	Category	*N* (%)
Psychiatric diagnosis	Not present	82 (50)
	Present	81 (50)
Diagnosis	Antisocial PD	20 (12)
	Borderline PD	3 (2)
	Narcissistic PD	1 (1)
	Dependent PD	1 (1)
	SUD	29 (18)
	Schizophrenia	11 (7)
	Schizoaffective disorder	1 (1)
	Psychosis not otherwise specified	2 (1)
	Psychotic disorder due to another medical condition	9 (6)
	Substance induced psychotic disorder	1 (1)
	Major depressive disorder	12 (7)
	Mood disorder due to another medical condition	2 (1)
	Intellectual disability	2 (1)
	Neurocognitive disorder	5 (3)
Fitness to stand trial	Fit	143(88)
	Not fit	20 (12)
Criminal responsibility	Responsible	134(82)
	Not responsible	29 (18)

Fitness and responsibility

Gender was found to be a significant predictor for fitness and responsibility (Table 4). Males were more likely to be found fit and responsible whereas females were more likely to be found not fit and not responsible.

The level of education completed also had a significant association with fitness and responsibility. Offenders who achieved lower levels of education were more likely to be found not fit and not responsible. Those who had obtained a tertiary education were more likely to be found fit and responsible.

Employment status and salary were significantly associated with fitness and responsibility. Employed offenders were more likely to be found fit and responsible. Those offenders who earned more than R10000 were more likely to be found fit and responsible.

Previous psychiatric illness was found to be a significant predictor for fitness and responsibility. Offenders with a previous psychiatric illness, particularly a psychotic disorder, were more likely to be found not fit and not responsible compared to those

without a previous psychiatric diagnosis who were more likely to be found fit and responsible. Those diagnosed with a previous mood disorder were more likely to be found fit and responsible.

Those with a medical illness were more likely to be found not fit and not responsible compared to those without a medical illness who were more likely to be found fit and responsible. Offenders with a diagnosis of epilepsy were more likely to be found not responsible.

Forensic history was significantly associated with criminal responsibility but not fitness to stand trial. Offenders with a forensic history were more likely to be found responsible compared to those with no forensic history, who were more likely to be found not responsible.

A history of IPV perpetration and reporting a motive were significantly associated with fitness and responsibility. Offenders with a history of committing previous IPV were more likely to be found fit and responsible compared to those offenders who weren't previous IPV perpetrators, who were more likely to be found not fit and not responsible. Offenders who indicated a motive were more likely to be found fit and responsible.

The presence of a psychiatric diagnosis at the time of the offence was significantly associated with fitness and responsibility. Having psychopathology in keeping with a psychiatric diagnosis, particularly a psychotic or neurocognitive disorder, at the time of the offence, made it more likely for offenders to be found not fit and not responsible.

Table 4: Accused and offence characteristics and diagnosis according to the categories of observation outcomes with p values

Characteristics	Category	*N*	Fitness		Responsibility	
			% Not fit	*P*	% Not responsible	*p*
Age	18 to 30	50	12	0.14	14	0.09
	31 to 40	52	6		12	
	over 40	61	18		26	
Gender	Female	18	44	**<0.01**	56	**<0.01**
	Male	145	8		13	
Marital status (at the time of the offence)	Single	73	14	0.75	15	0.53
	Married	59	12		22	
	Separated	19	5		11	
	Divorced	12	17		25	
Highest level of education	No formal education	4	25	**0.02**	50	**0.01**
	Primary education	20	30		35	
	Secondary education	91	12		19	
	Tertiary education	48	4		6	
Employment status	Employed	91	4	**<0.01**	11	**0.02**
	Unemployed not on a DG	65	20		25	
	Unemployed on a DG	7	43		43	
Salary	R0–R5000	4	0	**<0.01**	25	**0.03**
	R5000–R10000	28	14		18	
	>R10000	59	0		7	
Previous psychiatric illness	No	130	8	**<0.01**	14	**0.02**
	Yes	33	30		33	
Previous psychiatric diagnosis	PD	1	0	**<0.01**	0	**<0.01**
	Psychotic disorder	14	64		71	
	Mood disorder	18	6		6	
Medical illness	No	106	7	**0.01**	10	**<0.01**
	Yes	57	23		32	
Medical diagnosis	Previous head trauma	29	24	0.07	31	0.07
	Epilepsy	21	24	0.17	38	**0.02**
	HIV	6	33	0.33	50	0.12
History of substance use	No	55	16	0.38	25	0.11
	Yes	108	10		14	
Childhood trauma	No	146	12	0.75	18	0.73
	Yes	17	12		12	
Nature of childhood trauma	Physical and/or sexual abuse	10	20	0.82	20	0.81
	Witnessed domestic violence	5	0		0	
	Both of the above	1	0		0	
	Other	1	0		0	
Forensic history	No	103	17	0.06	23	**0.03**
	Yes	60	5		8	
History of violent behaviour	No	86	17	0.06	22	0.19
	Yes	77	6		13	
Perpetrator of domestic	Indicated - no	34	32	**<0.01**	47	**<0.01**
	Indicated - yes	42	0		5	

violence	Not indicated	87	10		13	
Victim of domestic violence	No	156	11	0.05	17	0.21
	Yes	7	43		43	
Substance use at the time of offence	No	112	13	0.70	19	0.80
	Yes	51	10		16	
Motive	Indicated	115	8	**0.02**	11	**<0.01**
	Not indicated	48	23		33	
Psychiatric diagnosis	Not present	82	0	**<0.01**	1	**<0.01**
	Present	81	25		35	
Diagnosis	PD	25	0	0.09	4	0.09
	SUD	29	10	0.97	17	0.86
	Psychotic disorder	24	67	**<0.01**	83	**<0.01**
	Mood disorder	14	7	0.85	21	0.99
	Intellectual disability	2	0	0.58	0	0.79
	Neurocognitive disorder	5	60	**0.01**	80	**<0.01**

*Significant values are shown in bold.

Discussion

This study concurred with the findings in the literature that perpetrators of IPH are predominantly men.[2,7-9,16-18]

Some studies indicate that approximately half of male perpetrators of IPH had not completed high school and the majority of female offenders have limited educational achievements.[19,20] This is contrary to our findings which showed that 14% of the sample had not completed secondary education.

A high percentage of offenders (44%) were unemployed at the time of the offence, a finding consistent with those of most studies.[5,7,19,21-23] The finding that there is an association between employment status and fitness to stand trial corresponds with those findings of another South African study.[24] The high unemployment rate in SA, however, needs to be taken into consideration when interpreting these results.

In a study that examined characteristics of IPH perpetrators, mental illness was rarely diagnosed before the incident,[17] contrary to a Dutch study which showed that 59% of offenders had previous contact with psychiatric services.[23] Our study showed that 20% of the sample had been diagnosed with a mental illness prior to the offence.

Few studies have addressed the presence of medical illnesses among IPH perpetrators. Bourget and Gagné reported that 64% of women and 43% of men in their sample had chronic illnesses.[8] In Hanlon and colleagues' study, 11% of the sample had epilepsy,[2] which is similar to our results of 13% having epilepsy. The

importance of epilepsy in this context warrants further study, particularly preictal, ictal and postictal psychopathology.

Literature suggests childhood trauma plays a significant role in the risk of IPH perpetration.[23,25,26] Childhood trauma can include physical and/or sexual abuse or witnessing violence between parents. Putkonen and colleagues found that 61% of female homicide offenders and 39% of male homicide offenders had experienced physical violence in their family.[21] However, only 10% of our sample reported childhood trauma.

In this study, 37% of perpetrators had a forensic history and 47% had a history of violent behaviour. These findings were similar to those in the literature which shows that approximately 25–50% of all male IPH perpetrators have been imprisoned for a previous brutal crime.[1-3,9,23] Female IPH offenders show less previous criminality compared to their male counterparts.[8,19,21]

In SA, domestic violence is quoted as the main causal factor that results in IPHs.[20] It is very uncommon for a fatal act of violence against a partner to be the first occurrence of IPV.[3,5,10,23,25] In Leth's study, 50% of victims had experienced previous IPV.[18] While spousal homicides often occur in the setting of IPV, it is important to consider this in the context of gender. Literature consistently indicates that "male perpetrators are likely to have subjected their partner to previous IPV, and are more likely to murder them following an escalation of violence, whereas women are more likely to kill in self-defence, as an extreme reaction to their victimization, and/or to protect children".[9,18] This is further supported by the findings from two national studies conducted from 2003–2015 in North America.[17,27] In our study, however, only 26% of the sample reported being previous perpetrators of IPV. It is possible, though, that this percentage is significantly under-estimated as the records mainly consisted of information obtained from the perpetrators' account and no victim characteristics were examined in this study, such as forensic autopsies, which may have provided more objective information.

Our study found a similar proportion of victims that were killed by their spouses (46%), in comparison to those that were killed by a non-marital partner (42%). This is

contradictory to the literature which shows that IPH occurs more frequently within common-law relationships than those in marital relationships.[6,8,25]
Offenders killed their intimate partners most often in private residences, using a knife or firearm, which is supported by previous research.[2,3,6,8,9,17-20,25,27]

Despite the high incidences of substance use in cases of non-fatal IPV, and a study indicating that a significant relationship exists between male perpetrator alcohol abuse and violence against intimate female partners,[28] some studies reveal that most IPH perpetrators did not use alcohol or drugs at the time of the homicide, in spite of their normally high substance abuse rates.[1,2,8] This was similar to our findings which showed that 69% of the sample reported not using substances at the time of the offence. Our findings resembled those of Hanlon and colleagues which showed that there is a significant lifetime prevalence of illicit drug use among these perpetrators with cannabis being the most preferred substance.[2]

Women rarely kill an intimate partner after the couple has separated but men are at greater risk of perpetrating IPH when separation of the relationship has occurred or is imminent.[1,3,9,18,23,25,26] A Portuguese study found that most women were murdered by ex-partners within a year of separation, highlighting that a significant risk persists even after the couple's separation.[3] Jealousy and infidelity are common motives for men to commit IPH.[3,17,18,22,25] Our study was consistent with the literature which showed rage, infidelity and separation as the most common motives for murder.

Our study showed that 50% of the sample were found to have a psychiatric diagnosis at the time of the offence. These results, however, must be interpreted with caution as PDs and SUDs were included in this category and these disorders alone do not impact fitness and responsibility. Following psychiatric observation (for a charge of IPH), studies indicate that psychotic disorders are most common, followed by mood disorders and anxiety disorders.[2,11,23] Our study found similar results: 15% had a psychotic disorder and nine percent a mood disorder. Oram and colleagues, however, found contradictory results in that affective disorders were most common.[7] Our findings resembled the literature in that there is a high prevalence of PDs in this population, particularly cluster B pathology.[2,10,23,25,26] Research indicates that approximately 10–20% of IPH perpetrators have a lifetime primary diagnosis of

substance dependence.[3,23] Our study showed similar findings with 18% of offenders being found to have a SUD.

Multiple studies revealed that 14–20% of IPH perpetrators, referred for observation, were deemed not responsible due to the presence of a psychiatric disorder.[3,7,19,21] Our study showed similar results (18%). This reinforces the need to refer accused persons of IPH for forensic observation.

Conclusion

This is the first published study examining IPH within the context of forensic psychiatric observations.

The main findings of this study were: (1) history of violent behaviour is prevalent; (2) homicides mostly occur in private homes; (3) knives and firearms are most often used; (4) infidelity, separation and jealousy are common motives; (5) psychotic disorders, PDs and SUDs feature prominently. These findings are consistent with those of other international studies.[1-3,6-11,16-20,22,23,25-27] Some of our findings, however, differed to the international literature.[18,21,23,25,26] These included the findings for childhood trauma and previous IPV perpetration. These differences may be explained by the fact that data was collected from records mostly based on the perpetrators' accounts. Accused persons may have withheld/ denied certain information in order to protect their reputation and avoid incrimination and as a result these values may have been under-estimated. Also, incidences of IPV and childhood trauma may have been under-reported by victims and statistics for these is not routinely collected in SA. It is essential that an understanding of childhood trauma and IPV perpetration in the context of IPH is pursued, especially in developing countries, so that data can be compared globally.

The study highlights multiple risk factors for IPH. This information is valuable in that it can assist in preventing IPH, through the development of risk assessment tools which can be used for identification of likely perpetrators. Other interventions such as monitoring access to firearms, interventions to reduce alcohol and substance abuse, and improving mental health services should all be addressed in order to reduce the incidence of IPH.

Study Limitations

The study's retrospective nature is a limitation, in that data may not always be complete and information gathered from others' notes also has the potential to be inaccurate. Furthermore, given the small number of female perpetrators, we were not able to explore differences by gender. Future research is needed to examine gender differences among IPH perpetrators in SA. Another limitation is that offenders with PDs or SUDs were included amongst those individuals that were found to have 'severe' psychiatric illness whose fitness and responsibility were impacted. Additionally, these are alleged IPH perpetrators (who are still awaiting trial) so one has to be wary of drawing conclusions about actual convicted perpetrators.

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APPENDIX A: Approved research protocol with appendices

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Dear Dr Sonali Valabdass

Master of Medicine: Approval of Title

We have pleasure in advising that your proposal entitled *A retrospective record review of perpetrators of intimate partner homicide referred for forensic psychiatric observation to Sterkfontein Hospital* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

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TITLE:

A retrospective record review of perpetrators of intimate partner homicide referred for forensic psychiatric observation to Sterkfontein Hospital.

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INTRODUCTION

Intimate partner homicide (IPH), defined as “the intentional killing of one’s current or former partner” (Kivisto, 2015:300) is a serious social issue that requires input from a forensic psychiatric perspective (Oram et al, 2013). Such homicides may involve “spouses, ex-spouses, current or former boyfriends or girlfriends, or partners of same-sex relationships” and refers to both male and female victims (Hanlon et al, 2016 and Kivisto, 2015:300).

In order to curb incidences of IPH there is a growing need to understand the characteristics of perpetrators and the offence. From a forensic mental health perspective, it is further necessary to consider the presence of psychiatric illness in accused persons and the impact thereof on their fitness to stand trial and criminal responsibility. The current study thus proposes to evaluate such characteristics by means of a retrospective file review of accused persons referred for a 30-day forensic psychiatric evaluation at Sterkfontein Hospital in Johannesburg, South Africa.

REVIEW OF THE LITERATURE

Review of the literature point to possible areas of investigation to consider in cases of IPH. Discussions on the perpetrator and offence characteristics below yield variant scientific gaps to be addressed within the present study.

Perpetrator characteristics

Demographic characteristics

Gender

“IPH may be best understood within the gendered context in which it occurs. Certain socio-demographic characteristics, such as offender-victim age disparity, ethnic background and social and economic disadvantage share commonalities across gender.” (Eriksson and Mazerolle, 2013:4).

Perpetrators of IPH are predominantly men (Bourget and Gagné, 2012; Eriksson and Mazerolle, 2013; Hanlon et al, 2016; Oram et al, 2013 and Sabri, Campbell and Dabby, 2016) while female offenders constitute 10% to the entity of arrested homicide perpetrators (Hellen et al, 2015).

Age

Consideration of age characteristics appears to be an important distinguishing feature among IPHs. Individuals who murder their intimate partners tend to be significantly older than those who perpetrate non-intimate partner homicide (Oram et al, 2013). Men older than 45 years of age are more likely to perpetrate IPH and that women under 34 years of age are at higher risk for being victimized by IPHs (Sabri, Campbell and Dabby, 2016).

A further distinguishing feature is that the risk of IPH is increased with a large age gap between victim and perpetrator (Bourget and Gagné, 2012 and Sabri, Campbell and Dabby, 2016). However, in Sabri and colleagues' (2016) study, a large age gap appeared to be a risk factor for only those homicides perpetrated by males. The authors established that "the average age gap between male perpetrators and their female victims was greater than the average age gap between female perpetrators and their male victims." Men who committed IPH were approximately six years older than their intimate partners.

Relationship status and cohabitation

Relationship status may be an important considering factor with reference to demographic characteristics within those who commit IPH. Men and women in common-law relationships are more likely to kill their intimate partner than those in a legal marriage (Bourget and Gagné, 2012). Furthermore, estrangement may be considered a further risk factor for female victimisation in IPHs. Women rarely kill an intimate partner after the couple has separated but men are at greater risk of perpetrating IPH when separation of the relationship has occurred or is imminent (Kivisto, 2015 and Sabri, Campbell and Dabby, 2016). In relation to this feature, the literature fails to yield information on cohabitation within IPH populations and should be considered as a potential distinguishing feature.

Education

It was found that approximately half of male perpetrators of IPH have not completed high school and the majority of female offenders have limited educational achievements (Hellen et al, 2015 and Hesselink and Dastile, 2015).

Employment, occupation and socio-economic status

Commonalities among educational, occupational and socio-economic status should be considered in cases of IPH. There is a high prevalence of unemployment amongst perpetrators of IPH (Putkonen et al, 2011). Oram and colleagues (2013) reported that almost 40% of all IPH perpetrators are unemployed at the time of the offence.

Research has shown that homicidal females are often socioeconomically disadvantaged (Hellen et al, 2015). Bourget and Gagné (2012) found that the majority of female offenders of IPH were employed at the time of the offence, which is contrary to the findings of multiple studies that report females that kill are often unemployed (Putkonen et al, 2011). According to Abrahams and colleagues (2013) lower earning potential and education are risk factors for men to become violent.

Medical illness

A review of the literature reveal, that despite much research on the presence of mental illness in perpetrators of IPH, few studies have addressed the presence of medical illnesses in this population. Bourget and Gagné (2012) reported that 63.6% of women and 42.6% of men in their sample had chronic illnesses including heart conditions, hypothyroidism, osteoarthritis and other degenerative diseases. In Hanlon and colleagues' (2016) study, which used a sample of 153 participants (both men and women) who were referred for forensic psychiatric evaluation following a charge of murder, 11.1% of the sample were known to have seizure(s), and 8.5% were on antiepileptic medication. The presence of a medical illness, in particular a neurological condition, would be an important characteristic to investigate in offenders of IPH.

Substance use history

Substance use history and its relation to the time of the offence is a further domain to be investigated within cases of IPH. Surprisingly, despite the high incidences of substance use in cases of nonfatal intimate partner violence (IPV), Hanlon and colleagues (2016) as well as Kivitso's (2015) study reveal that most perpetrators of IPH did not use alcohol or drugs at the time of the homicide, in spite of their normally high substance abuse rates. Population-based research indicates that "10% of IPH perpetrators have a lifetime primary diagnosis of substance dependence, with 80 percent of these individuals being alcohol dependent and 20 percent drug dependent" (Kivisto, 2015). There is a significant lifetime prevalence of illicit drug use

amongst these perpetrators (78%) with cannabis being the most preferred substance (Hanlon et al, 2016). Nonetheless, Bourget and Gagné (2012) reported that only one in six IPH perpetrators were using substances at the time of the offence.

Childhood trauma

Literature suggests childhood trauma plays a significant role in the risk of perpetration of IPH. Childhood trauma can include physical and/or sexual abuse or witnessing violence between parents. Putkonen and colleagues (2011) found 61% of female homicide offenders and 39% of male homicide offenders had experienced physical violence in their family.

Previous history of domestic violence toward partner

A further consideration in cases of IPH is a prior history of domestic violence. “Domestic violence is often quoted as the main causal factor that results in intimate partner killings in South Africa” (Hesselink and Dastile, 2015). According to Abrahams and colleagues (2013), it is very uncommon for a fatal act of violence against a partner to be the first occurrence of intimate partner violence.

While spousal homicides often occur in the setting of domestic violence, it is important to consider this in the context of gender. “Male perpetrators are likely to have subjected the victim to previous domestic abuse and are more likely to murder their wives following an escalation of violence, while women are more likely to kill in self-defence, as an extreme reaction to their victimization, and/or to protect children” (Sabri, Campbell and Dabby, 2016).

Previous forensic history and history of violent behaviour

Approximately 25 to 50 percent of all male perpetrators of IPH have been imprisoned for a previous brutal crime (Hanlon et al, 2016 and Kivisto, 2015). Female offenders of IPH show less previous criminality compared to their male counterparts (Bourget and Gagné, 2012; Hellen et al, 2015 and Putkonen et al, 2011). The majority of men who kill have been convicted for an offence of violence (Sabri, Campbell and Dabby, 2016). Hanlon and colleagues (2016) reported that over a third of their sample carried a diagnosis of conduct disorder. Based on the above, it is important to investigate previous forensic history and previous violent behaviour in perpetrators of IPH.

Previous psychiatric illness

Some literature on IPH considers the high prevalence of mental illness among perpetrators (Bourget and Gagné, 2012; Hanlon et al, 2016; Kivisto, 2015; Oram et al, 2013 and Sabri, Campbell and Dabby, 2016).

In Hanlon and colleagues' (2016) study, which used a sample of 153 participants (both men and women), referred for forensic psychiatric evaluation following a charge of murder, 45.8% of the sample had a psychiatric diagnosis. Another study found a 32% lifetime prevalence rate of mental illness in men and women that commit IPH (Oram et al, 2013). Hanlon and colleagues' (2016) study indicate that psychotic spectrum disorders were most common, followed by mood disorders and anxiety disorders. While, Oram and colleagues (2013) found that 6% of IPH perpetrators had received a primary diagnosis of Schizophrenia and other delusional disorders and 17% with an affective disorder. In addition, almost 40% of Hanlon and colleagues' (2016) sample were found to have a personality disorder as compared to 7% of Oram and colleagues' (2013) sample. Antisocial personality disorder was easily the most prevalent (29.4% of the sample). Other personality diagnoses included borderline (3.9%), personality disorder NOS (3.3%), paranoid (1.3), narcissistic (0.7%), obsessive compulsive (0.7%) and schizoid (0.7%) (Hanlon et al, 2016).

Offence characteristics

Research also considers offence characteristics in cases of IPH. Offenders killed their intimate partners most frequently in a private home, using a knife or firearm (Bourget and Gagné, 2012; Hanlon et al, 2016; Hellen et al, 2015; Hesselink and Dastile, 2015 and Sabri, Campbell and Dabby, 2016).

Forensic psychiatric evaluations

On the basis of the aforementioned presence of a possible psychiatric history among perpetrators of IPH, it is imperative to consider forensic psychiatric evaluations and its outcome within cases of IPH.

Mental observations are conducted when the court has reason to believe accused persons may be suffering from a mental illness or intellectual disability and that it may have bearing on the individual's fitness to stand trial and/or criminal responsibility. Within the South African context the accused persons (observandi) are then referred

by the court to a psychiatric hospital for a 30-day observation period to ascertain fitness to stand trial and criminal responsibility. Fitness to stand trial refers to the ability to comprehend court proceedings and criminal responsibility refers to the appreciation of the wrongfulness of an act (leg one) and the ability to act in accordance of such an appreciation (leg two) (Kaliski, 2006).

It has been found that the incidence of severe mental illness among IPH perpetrators is more significant in forensic samples (Kivisto, 2015). There is also a high prevalence of personality disorders in this population, namely unspecified PD, narcissistic, antisocial, and borderline personality disorder (Hanlon et al, 2016).

A study revealed that four out of seven IPH perpetrators referred for forensic observation were found to be fully criminally responsible and one out of seven was deemed not criminally responsible due to the presence of a psychotic disorder. The other two cases were considered to have had diminished responsibility (Hellen et al, 2015).

Putkonen and colleagues (2011) found that 51% of the women and 57% of the men in their sample were considered to have been fully responsible. 30% of female perpetrated cases were judged to have been of diminished responsibility compared with 23% of the men. Lack of criminal responsibility was found in 14% of both men and women.

20% of IPH perpetrators had symptoms of psychosis (7%) or depression (13%) at the time of the homicide suggesting that only a minority of IPH perpetrators had symptoms of mental illness at the time of the homicide (Oram et al, 2013). Oram and colleagues (2013) found less than 1% of the sample was found not fit to stand trial and not criminally responsible due to the presence of a mental illness.

Significant gaps exist in the current scientific knowledge base with regard to the profile of accused and offence characteristics in cases of IPH referred for a psychiatric observation in the South African context. The literature mostly focuses on the general population that commits IPH. On the basis of the uniqueness of the South African context and the interpretation of the South African law among forensic

mental health practitioners, it is necessary to conduct a study within the South African context specifically.

Future direction and research question

This study is concerned with the adult perpetrator and offence characteristics of persons referred for a 30-day psychiatric observation following a charge of IPH within the South African context. The study questions: 'What are the perpetrator and offence characteristics among the categories of observation outcomes?' In this regard, categories of observation outcomes refer to persons found to be either: a) fit and responsible on both legs; b) not fit and not responsible on both legs; c) not fit and not responsible on the second leg; d) fit but not responsible on both legs; e) fit and not responsible on the second leg.

AIM

The aim of the study is to describe the profile of adult perpetrator and offence characteristics of persons referred for forensic psychiatric observation to Sterkfontein Hospital for a charge of IPH according to the categories of observation outcomes discussed in the former section.

STUDY OBJECTIVES

1. To determine the demographic and clinical profile of perpetrators
2. To determine offence characteristics
3. To determine the outcomes of the observation (in terms of the CPA)
4. To compare the perpetrator and offence characteristics according to the categories of observation outcomes

METHODS

Site of study and context

The study will be conducted at Sterkfontein Hospital, a tertiary psychiatric hospital situated outside of Krugersdorp in the Gauteng province. It provides general (involuntary) and forensic in-patient care for the population of Southern Gauteng and parts of the North West Province. With regard to forensic services, Sterkfontein Hospital caters for approximately 38 courts in Gauteng and additional courts in the North West province. Services include mental observations and rehabilitation of State patients.

Within South Africa, accused persons are referred for a forensic psychiatric observation in terms of section 77, 78 and 79 of the Criminal Procedure Act 51 of 1977, as amended (CPA) (Republic of South Africa, 1977). During the 30-day observation period, the accused person undergoes several assessments by all members of the multi-disciplinary team which includes psychiatrists, psychiatric registrars, clinical psychologists, occupational therapists, social workers and nurses. These assessments include psychiatric interviews, a physical examination, psychological assessment, occupational assessment and a social worker's report. All the above assessments are documented in the clinical file and a final psychiatric report is completed by the psychiatrist/s for the court. The final report comments on the accused person's diagnosis, their fitness to stand trial and responsibility.

Those who are found not fit and/or not criminally responsible for the crime by virtue of mental illness or defect, and the crime was minor, are referred to the general section of the hospital for involuntary care and treatment. If the crime was a major offence (sexual assault, murder, attempted murder or assault with intent to do grievous bodily harm), the accused is usually admitted to the forensic unit as a State patient in terms of Section 42 of the Mental Health Care Act 17 of 2002 (MHCA) for care, treatment and rehabilitation (Republic of South Africa, 2002).

Study design

The study will be a retrospective record review of accused persons referred for observation to Sterkfontein Hospital with a charge of IPH during a ten-year period, from 1 January 2008 to 31 December 2017.
Data will be collected from clinical records and psychiatric reports. No interventions are to be made.

Study population

The sample will include all adult (age>18) male and female perpetrators of IPH. The definition of intimate partners will include current or former spouses and boyfriends or girlfriends, same-sex sexual partners, and rejected suitors.

Research procedure

Case files for murder will be identified via the observation booking log in ward 15.

All offenders who have been referred from court for observation to Sterkfontein Hospital, irrespective of the charge, are recorded in these books. The following information is recorded: The name and age of the accused, gender, the name and contact details of the referral court, case number, charge, prosecutor, panel (single vs. joint) and the date referred for the observation period. These books will thereby assist in identifying perpetrators of homicide. Once the files of these identified perpetrators of homicide have been taken out of registry and screened, homicide of an intimate partner can then be determined and the case file included in the study.

Data will be collected from the relevant observation files (clinical records and psychiatric reports) and recorded on a data sheet. The following details will be documented:

Accused information:

Demographics, previous psychiatric illness, medical illness, history of substance use, previous forensic history, childhood trauma, history of violent behaviour, perpetrator of domestic violence, victim of domestic violence

Offence information:

Killing method, murder weapon, setting, substance use at the time of the offence, motive

Outcome of the observation:

Psychiatric illness, fitness to stand trial and criminal responsibility

DATA ANALYSIS

All statistical analyses will be conducted using R software (R version 3.4.2; https://www.r-project.org). All tests will be two-tailed probability values, and statistical significance accepted when $\alpha \leq 0.05$. The data set for this study will be generated mainly from assessments of categorical scores. Categorical data are usually non-normal, so appropriate non-parametric analyses will be used.

Statistical analyses used in each of the three objectives are outlined below:

Objective 1:

For the offender characteristics variables, descriptive statistics (frequency; percentage) will be reported for the different variables (i.e. demographics, previous psychiatric illness, medical illness, history of substance use, previous forensic history, childhood trauma, history of violent behaviour, perpetrator of domestic violence, and

victim of domestic violence) and its components (e.g. male vs. female). Then, the contributions of the components to each variable will be analysed separately using Chi-squared good of fitness tests.

Objective 2:

For the offence characteristics variables, descriptive statistics (frequency; percentage) will be reported for the different variables and its components (will be collected: killing method, murder weapon, setting, substance use at the time of the offence, and motive). The contributions of the components to each variable will be analysed separately using Chi-squared good of fitness tests.

Objective 3:

The results of the outcome of the observation (in terms of the CPA), involving psychiatric illness, fitness to stand trial, and criminal responsibility, will be described using frequency/percentage. Next, the contribution of the components to each variable will be analysed separately using Chi-squared good of fitness tests. The data will also be assigned to five categories, namely: a) fit and responsible on both legs, b) not fit and not responsible on both legs, c) not fit and not responsible on the second leg, d) fit but not responsible on both legs, e) fit and not responsible on the second leg. The percentage of patients in each category will be determined and Chi-squared good of fitness tests used to assess variation from a null hypothesis. Finally, the relationship between the variables collected in Objectives 1 and 2 will be analysed against these five categories using a multinomial generalised linear model (GLM), with appropriate distribution and link functions.

Sample size

From an assessment of Z scores of expected frequencies, a sample size of 300 will detect statistical significance at the 5% level for the multinomial tests in objective 3. Realistically, statistical significance can be expected with a minimum sample of 150 patients. This target will be reached by including observandi referred in the period 2007 to 2017. This period, however, may need to be extended at time of data collection in order to reach the desired figure. Cases will be selected in a retrograde manner working backwards from December 2017.

ETHICS

As data will be captured from observandi files, consent to conduct the study and for perusal of observation records will be obtained from the Sterkfontein Hospital

Research Committee. Approval will be sought from the Postgraduate Committee of the Witwatersrand University. Ethics approval will be sought from the University of Witwatersrand's Human Research and Ethics Committee (HREC). Data will only be collected once the protocol has been approved by the Ethics Committee. The accused person's personal information will be protected at all times as only the primary researcher will have access to the data which will be stored in a locked cupboard. Confidentiality regarding individuals' identities will be maintained by exclusive use of file numbers, for retrieval of all information. Observandi will remain anonymous as their names will not appear on the data collection sheet.

TIMING

Data collection will commence as soon as the protocol is approved by the Postgraduate Committee and the Ethics Committee.

February- March 2018	Literature review and protocol preparation
April 2018	Presentation to Postgraduate Committee
May 2018	Presentation to Ethics Committee
June- July 2018	Data collection
August- October 2018	Data capturing and analysis
November 2018- January 2019	Write up of thesis and review by supervisor

FUNDING

Due to the low cost nature of the study, all costs will be borne by the researcher.

ITEMS	ESTIMATED AMOUNT
Travel costs	R1500
Photocopying and stationery	R1500
Statistician	R2000
Other	R1000
Total budget	R6000

LIMITATIONS

As this is a retrospective study and the results are dependent on clinical records, incomplete or unavailable data will be the major obstacle.

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APPENDIX

DATA COLLECTION SHEET

STUDY NUMBER

ACCUSED

AGE (at the time of the observation)

18-30	31-40	>40

GENDER

Male	Female

MARITAL STATUS

Single	Married	Divorced	Separated	Widowed

IF MARRIED

Cultural	Legal

COHABITING

Yes	No

SCHOOLING

Mainstream	Remedial	Special

HIGHEST LEVEL OF EDUCATION

No formal education	Primary education	Secondary education	Tertiary education

OCCUPATION

EMPLOYMENT STATUS

Employed	Unemployed on a disability grant	Unemployed not on a disability grant

IF EMPLOYED

R0-R5000	R5000-R10 000	>R10 000

RELIGION

Christian	Islamic	Hindu	Other	None

PREVIOUS PSYCHIATRIC ILLNESS

Yes	No

IF YES

Diagnosis

MEDICAL ILLNESS

Yes	No

IF YES

HIV	Neurosyphilis	Thyroid disease	Diabetes mellitus	Previous head trauma	Epilepsy	Other

HISTORY OF SUBSTANCE USE

Yes	No

IF YES

Substance

PREVIOUS FORENSIC HISTORY

Yes	No

IF YES

Charge

CHILDHOOD TRAUMA

Yes	No

IF YES

Physical and/or sexual abuse	Witnessed domestic violence	Other

HISTORY OF VIOLENT BEHAVIOUR

Yes	No

PERPETRATOR OF DOMESTIC VIOLENCE

Indicated	Not indicated

VICTIM OF DOMESTIC VIOLENCE

Yes	No

OFFENCE

KILLING METHOD

Stabbing	Gunshot	Strangulation	Poisoning	Arson	Other	Mixed

MURDER WEAPON

Knife	Firearm	Bodily force	Poison	Fire	Other

SETTING

Residence	Street	Other

SUBSTANCE USE AT THE TIME OF THE OFFENCE

Yes	No

IF YES

Substance use by the accused	Substance use by the victim	Substance use by both the accused and the victim

MOTIVE

Indicated	Not indicated

IF INDICATED

Separation	Jealousy	Rage	Possessiveness	Entitlement	Retaliation	Self-defence	Financial benefit

OUTCOME OF OBSERVATION

PSYCHIATRIC ILLNESS

Present	Not present

IF PRESENT

Diagnosis

FITNESS TO STAND TRIAL

Fit	Not fit

CRIMINAL RESPONSIBILITY

-FIRST LEG

Yes	No

-SECOND LEG

Yes	No

health and social development
Department: Health and Social Development
GAUTENG PROVINCE

STERKFONTEIN HOSPITAL
CLINICAL DEPARTMENT
Enquiries: *Dr. T. Schutte*
Telephone : *(011)951-8341*
Facsimile : *(011) 951-8391*
e-Mail: Hannie.Smith@gauteng.gov.za

Mr. J. Mapunya
Act. Chief Executive Officer
Sterkfontein Hospital
KRUGERSDORP

Dear Mr. Mapunya

STUDY : A RETROSPECTIVE RECORD REVIEW OF PERPETRATORS OF INTIMATE PARTNER HOMICIDE REFERRED FOR FORENSIC PSYCHIATRY OBSERVATION TO STERKFONTEIN HOSPITAL
RESEARCHER: DR. SONALI NARANDASS VALABDASS

The above study was discussed at the Research Committee meeting. We recommend that permission be granted that Sterkfontein Hospital be used as a site for the above research.

Upon completion of the study, a copy thereof should be submitted to Sterkfontein Hospital

Thank you.

.....
DR. T. SCHUTTE
ACT. CHAIRPERSON: RESEARCH COMMITTEE
22/03/2018

Approved.

Mr M.J. Mapunya Bcur Edu & Admin (UP)
MBA (UJ) UNIVERSITY
CHIEF EXECUTIVE OFFICER
MR. J. MAPUNYA
CHIEF EXECUTIVE OFFICER
2018/03/23

303256:Sonali_Proposal_6_Turnitin.doc

by Sonali Valabdass

Submission date: 12-May-2018 03:51PM (UTC+0200)
Submission ID: 962798212
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Character count: 20509

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ORIGINALITY REPORT

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SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	wiredspace.wits.ac.za Internet Source	2%
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3	Bushra Sabri, Jacquelyn C. Campbell, Firoza Chic Dabby. "Gender Differences in Intimate Partner Homicides Among Ethnic Sub-Groups of Asians", Violence Against Women, 2015 Publication	1%
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6	Ahlem Houidi, Saeeda Paruk, Benn Sartorius. "Forensic psychiatric assessment process and outcome in state patients in KwaZulu-Natal, South Africa", South African Journal of Psychiatry, 2018 Publication	1%

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APPENDIX B: Ethics clearance certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Dr SN Valabdass

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M180530

NAME: (Principal Investigator)	Dr SN Valabdass
DEPARTMENT:	School of Clinical Medicine Department of Psychiatry Sterkfontein Hospital Forensic Unit
PROJECT TITLE:	A retrospective record review of perpetrators of intimate partner homicide referred for forensic psychiatric observation to Sterkfontein Hospital
DATE CONSIDERED:	25/05/2018
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Professor U Subramaney and Ms A Edge
APPROVED BY:	CB Penny Professor CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	06/07/2018

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **May** and will therefore be due in the month of **May** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature _____ Date _____

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX C: Turn-it-in report of Originality for Research Report in the format of a “submissible” paper

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by Denise Nicholson

Submission date: 01-Apr-2020 05:50PM (UTC+0200)
Submission ID: 1287022106
File name: 5fc1-39cb-4147-8c16-a3dc731048e4_303256_MMED.docx_Valabdass.docx (47.94K)
Word count: 4337
Character count: 23490

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ORIGINALITY REPORT

12%	7%	5%	8%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

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Ana Rita Pereira, Duarte Nuno Vieira, Teresa

8	Magalhães. "Fatal intimate partner violence against women in Portugal: A forensic medical national study", Journal of Forensic and Legal Medicine, 2013 Publication	1%
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29	Ahlem Houidi, Saeeda Paruk. "Profile of forensic state patients at a psychiatric unit in KwaZulu Natal, South Africa: demographic, clinical and forensic factors", The Journal of Forensic Psychiatry & Psychology, 2018 Publication	<1%
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APPENDIX D. Guidelines for Authors submitting to the South African Journal of Psychiatry

SUBMISSION GUIDELINES

Overview

The author guidelines include information about the types of articles received for publication and preparing a manuscript for submission. Other relevant information about the journal's policies and the reviewing process can be found under the about section. The **compulsory cover letter** forms part of a submission and must be submitted together with all the required **forms.** All forms need to be completed in English.

Original Research Article

An original article provides an overview of innovative research in a particular field within or related to the focus and scope of the journal, presented according to a clear and well-structured format. Systematic reviews should follow the same basic structure as other original research articles. The aim and objectives should focus on a clinical question that will be addressed in the review. The methods section should describe in detail the search strategy, criteria used to select or reject articles, attempts made to obtain all important and relevant studies and deal with publication bias (including grey and unpublished literature), how the quality of included studies was appraised, the methodology used to extract and/or analyse data. Results should describe the homogeneity of the different findings, clearly present the overall results and any meta-analysis.

Word limit	3000-4000 words (excluding the structured abstract and references)
Structured abstract	250 words to include a Background, Aim, Setting, Methods, Results and Conclusion
References	60 or less
Tables/Figures	no more than 7 Tables/Figure
Ethical statement	should be included in the manuscript
Compulsory supplementary file	ethical clearance letter/certificate

Original Research Article full structure

Title: The article's full title should contain a maximum of 95 characters (including spaces).

Abstract: The abstract, written in English, should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of six paragraphs labelled Background, Aim, Setting, Methods, Results and Conclusion.

- Background: Summarise the social value (importance, relevance) and scientific value (knowledge gap) that your study addresses.
- Aim: State the overall aim of the study.
- Setting: State the setting for the study.
- Methods: Clearly express the basic design of the study, and name or briefly describe the methods used without going into excessive detail.
- Results: State the main findings.
- Conclusion: State your conclusion and any key implications or recommendations. Do not cite references and do not use abbreviations excessively in the abstract.

Introduction: The introduction must contain your argument for the social and scientific value of the study, as well as the aim and objectives:

- Social value: The first part of the introduction should make a clear and logical argument for the importance or relevance of the study. Your argument should be supported by use of evidence from the literature.
- Scientific value: The second part of the introduction should make a clear and logical argument for the originality of the study. This should include a summary of what is already known about the research question or specific topic, and should clarify the knowledge gap that this study will address. Your argument should be supported by use of evidence from the literature.

- Conceptual framework: In some research articles it will also be important to describe the underlying theoretical basis for the research and how these theories are linked together in a conceptual framework. The theoretical evidence used to construct the conceptual framework should be referenced from the literature.
- Aim and objectives: The introduction should conclude with a clear summary of the aim and objectives of this study.

Research methods and design: This must address the following:

- Study design: An outline of the type of study design.
- Setting: A description of the setting for the study; for example, the type of community from which the participants came or the nature of the health system and services in which the study is conducted.
- Study population and sampling strategy: Describe the study population and any inclusion or exclusion criteria. Describe the intended sample size and your sample size calculation or justification. Describe the sampling strategy used. Describe in practical terms how this was implemented.
- Intervention (if appropriate): If there were intervention and comparison groups, describe the intervention in detail and what happened to the comparison groups.
- Data collection: Define the data collection tools that were used and their validity. Describe in practical terms how data were collected and any key issues involved, e.g. language barriers.
- Data analysis: Describe how data were captured, checked and cleaned. Describe the analysis process, for example, the statistical tests used orsteps followed in qualitative data analysis.
- Ethical considerations: Approval must have been obtained for all studies from the author's institution or other relevant ethics committee and the institution’s name and permit numbers should be stated here.

Results: Present the results of your study in a logical sequence that addresses the aim and objectives of your study. Use tables and figures as required to present your findings. Use quotations as required to establish your interpretation of qualitative data. All units should conform to the **SI convention** and be abbreviated accordingly.

Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Discussion: The discussion section should address the following four elements:

- Key findings: Summarise the key findings without reiterating details of the results.
- Discussion of key findings: Explain how the key findings relate to previous research or to existing knowledge, practice or policy.
- Strengths and limitations: Describe the strengths and limitations of your methods and what the reader should take into account when interpreting your results.
- Implications or recommendations: State the implications of your study or recommendations for future research (questions that remain unanswered), policy or practice. Make sure that the recommendations flow directly from your findings.

Conclusion: Provide a brief conclusion that summarises the results and their meaning or significance in relation to each objective of the study.

Acknowledgements: Those who contributed to the work but do not meet our authorship criteria should be listed in the Acknowledgments with a description of the contribution. Authors are responsible for ensuring that anyone named in the Acknowledgments agrees to be named.
Also provide the following, each under their own heading:

- Competing interests: This section should list specific competing interests associated with any of the authors. If authors declare that no competing interests exist, the article will include a statement to this effect: *The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.* Read our **policy on competing interests**.
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- Disclaimer: A statement that the views expressed in the submitted article are his or her own and not an official position of the institution or funder.

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