A REVIEW OF INDIVIDUALS CHARGED WITH COMMON ASSAULT AND ASSAULT WITH INTENT TO DO GRIEVOUS BODILY HARM, REFERRED FOR FORENSIC PSYCHIATRIC OBSERVATION

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A research report 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 in the branch of Psychiatry

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DECLARATION

I, Mallorie Govender, hereby declare that this research report is my own work. It is being submitted for the degree of Master of Medicine in the branch of Psychiatry to the University of the Witwatersrand, Johannesburg. It has not been previously submitted for any degree or examination at this or any other University.

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This _____ day of _____, 2019

DEDICATION

This work is dedicated to my parents and grandparents for your constant guidance and support

PRESENTATION ARISING FROM THIS STUDY

1. Oral presentation

   Annual Psychiatry Research Day – Department of Psychiatry, University of the Witwatersrand

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ABSTRACT

BACKGROUND: Common assault and assault with intent to do grievous bodily harm comprise the majority of contact crime in South Africa and have been on the rise over the years. Some international studies have demonstrated a link between violent crimes and psychiatric illness. There is, however, a lack of information in our setting regarding this link.

AIMS: To determine and compare the demographic and clinical profiles, and the outcomes of the observation process, of individuals charged with the minor offence of common assault and those charged with the serious offence of assault with intent to do grievous bodily harm, referred for forensic observation.

OBJECTIVES: To describe the clinical and demographic profiles of individuals admitted for observation, charged with common assault and assault GBH, over a three year period; to determine the number of these individuals assessed to be fit to stand trial and criminally responsible, and the number found not fit to stand trial and/or not criminally responsible; to compare the characteristics and the outcomes of those charged with common assault versus those charged with assault GBH.

METHODS: This study was conducted as a retrospective record review at Sterkfontein Hospital from January 2013 to December 2015. It included all individuals charged with common assault or assault GBH. Clinical files and Criminal Procedure Act reports were used to obtain the data.

RESULTS: The total sample size was 118, and included 25 individuals charged with common assault and 93 charged with assault GBH. Due to the large discrepancy in numbers, the two groups could not be compared. In cases of common assault 96% of individuals were male, 92% were unemployed, 56% had an incomplete high school education, and 84% were known to the complainant. With respect to assault GBH 90.3% of accused were male, 87.1% were unemployed, 45.2% had an incomplete high school education, and 69.9% were known to the complainant. Females represented the majority of complainants in both groups (64% in common assault and 48.4% in assault GBH). In the case of assault GBH the most common weapon used was a blunt object (45.2%), whereas with common assault, in most cases no weapon was used (56%). For common assault 64% of individuals were found not fit and not responsible, and this was the case for 53.8% of those charged with assault GBH. For both common assault and assault GBH, where a diagnosis was present, psychotic disorders were the most common (60% and 58.1% respectively), followed by substance use disorders (36% and 52.7% respectively).

CONCLUSIONS: The study found that almost four times the number of these individuals referred for observation were charged with assault GBH compared to common assault. For both groups, the majority were found not fit and not

responsible. It is recommended that when these individuals are referred back as patients they receive pharmacotherapy if indicated, and rehabilitation in the form of occupational therapy, psychotherapy and social interventions. These measures should include intensive psycho-education regarding their psychiatric illness so as to improve adherence to treatment regimens and reduce the risk of recidivism. .

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DEFINITIONS

Contact crime: refers to violent crime against individuals that involves physical contact. This includes murder, attempted murder, sexual offences, assault with the intent to do grievous bodily harm (GBH), common assault, aggravated robbery, and other robbery.[1]

Observandi: persons awaiting trial who are referred for forensic psychiatric observation.[2]

Minor / child: an individual below the age of 18 years, in accordance with the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.[3]

1.0 INTRODUCTION

1.1 Background

The United Nations Office on Drugs and Crime performed a survey of 60 countries from 1998-2000[4] which established that South Africa was the country ranked second for assault and murder, and first for rape. Another survey of 93 countries[5] rated South Africa as being the fifth highest with regards to number of total crimes. South African Police Service (SAPS) crime statistics revealed reduced levels of crime between 2003 and 2011. However the annual rate of reduction has since slowed.[6]

Common assault is the "unlawful and intentional direct and indirect application of force to the body of another person; or threat of application of immediate personal violence to another, in circumstances in which the threatened person is prevailed upon to believe that the person who is threatening him has the intention and power to carry out his threat." Assault with intent to do grievous bodily harm (GBH) is defined as the "unlawful and intentional direct or indirect application of force to the body of another person with the intention of causing grievous bodily harm to that person." What differentiates these two is that the determining factor for common assault is the use of force or violence; whereas for assault GBH the determining factor is the intention to cause serious injuries.[7]

According to SAPS crime statistics for the financial year 1st April 2014 to 31st March 2015[6] common assault had decreased by 2.8% and assault GBH had increased by

0.1%. Assault GBH for the period 2014/2015 formed 29.59% of total contact crimes and was the highest reported contact crime followed by common assault which constituted 26.17% of all contact crimes. Together they made up more than half of all contact crimes; and this had been the trend for at least the past ten years.[6] It has been postulated that the apparent decrease in assault is not a true reflection of the occurrence of assault in South Africa, as not all cases are reported to authorities and nor are all cases recorded when they are reported.[5]

Crime in South Africa imposes a significant burden on the economy. Part of this burden may include sick leave taken as a result of injuries, money spent on the victims seeking medical attention, and costs to the state incurred from incarceration of perpetrators. Other effects also range from financial losses suffered by both the perpetrators and the victims to the untoward psychological effects on both parties affected by violent crimes.[8] One United Nations study stated that "non-conflict armed violence produces direct and indirect economic effects that can exceed the costs of armed conflict. The economic cost of (lethal) non-conflict armed violence in just 90 countries measured in terms of lost productivity is 95 billion United States (US) dollars and may reach as high as 163.3 billion US dollars or 0.14 percent of the annual global gross domestic product in 2004."[9]

According to the 2015 South African budget speech,[10] the government would spend 163 billion rands on public order and safety and defence. Police services received about 48% of this total allocation. Of the total aforementioned amount, 492 million

rands was allocated to improving access to justice. These changes were to have taken effect from 1st April 2015.

Individuals who are arrested and are suspected of being psychiatrically unwell are referred for forensic psychiatric observation. They are often placed on long waiting lists while they remain in correctional services until beds are available for the observation to begin. Therefore part of the abovementioned funds would be used to maintain these individuals whilst they are awaiting observation. The Department of Justice is responsible for funding the 30 day observation period.

1.2 Aims

To determine and compare the demographic and clinical profiles, and the outcomes of the observation process, of individuals charged with the minor offence of common assault and those charged with the serious offence of assault GBH referred for forensic observation.

1.3 Objectives

1. To describe the clinical and demographic profiles of individuals admitted for observation, charged with common assault and assault with intent to do grievous bodily harm, from the period 1st January 2013 to 31st December 2014.

2. To determine the number of these individuals assessed to be fit to stand trial and criminally responsible; and the number found not fit to stand trial and/or not criminally responsible.
3. To compare the characteristics and the outcomes of those charged with common assault versus those charged with assault GBH.

2.0 LITERATURE REVIEW

2.1 Mental Illness and Crime

Hodgins *et al*[11] critically reviewed five epidemiological investigations of post-World War II birth cohorts that looked at the relationship between psychiatric disorders and criminality. All these epidemiological studies had achieved similar results despite having been performed in different countries and with birth cohorts being born two decades apart. This review showed an association between major mental disorders and criminality.

A prospective study by Tiihonen *et al*[12] examined the quantitative risk of criminal behaviour associated with mental illness. An unselected birth cohort from Northern Finland was studied from 1966 till 1992. The results demonstrated that the risk of criminal behaviour was higher amongst individuals with psychotic disorders. The highest risk for commission of offences was among those diagnosed with schizophrenia with co-morbid substance abuse.

2.2 Mental Illness and Violent Crime

Tehrani *et al*[13] looked at the relationship between violent crime and psychiatric illness. This Danish study, utilising data from psychiatric hospital records and official criminal arrests and conviction data, revealed a seven-fold increase in violence in patients admitted to psychiatric facilities. It also reflected that despite male mental

health care users comprising only five percent of the total population of males born in Denmark during the study period (1944-1947), they were responsible for 29% of violent crimes committed by all men in the cohort. Female psychiatric patients comprised just over five percent of the total female population of the cohort, yet were responsible for 50% of violent crimes.

Yang and Coid[14] looked at a cross-sectional random sample of 8397 individuals in Britain and utilised questionnaires to measure violent behaviour and psychiatric illness. Violent men were not found to be "more vulnerable to the effects of psychiatric morbidity". Violent women however were found to have a higher rate of personality disorders, specifically antisocial personality disorder. It was also found that the higher prevalence of alcohol misuse and conduct disorder in males may have contributed to the higher rates of violence amongst males than females.

Several other studies conducted on the general population have shown that the rate of violent behaviour amongst females is lower than males. An Israeli study by Stueve and Link[15] looked at the gender differences in the relationship between mental illness and violence. They cited Hodgkins (1992), Hodgkins *et al* (1996) and Swanson *et al* who reported that the gender disparity mentioned above differs amongst people diagnosed with a mental illness. There seems to be a smaller gender gap amongst mental health care users. However, other studies cited in Stueve and Link's study,[15] such as those by Eronen *et al* and Swanson *et al* found similar associations between gender and violence amongst psychiatric patients and members of the general population. The study by Stueve and Link[15] found that the association between

gender and violent behaviour was smaller among research participants who had recently been treated for psychiatric illnesses.

Arboleda-Florez *et al*[16] completed a critical appraisal of the literature with the aim of assessing whether mental illness causes violent behaviour. Some of the conclusions drawn from these individual studies were that the prevalence of mental illness among prisoners was high, that psychiatric patients with a prior forensic history are at an increased risk of arrest and violence when released back into communities, that psychiatric inpatients are at high risk of committing violent offences whilst in hospital, and that family members are more likely to be targets of the patient. Despite these conclusions, the authors concluded that, due to methodological weaknesses in the studies reviewed, direct causal links between psychiatric illness and violence remain uncertain. This study highlighted that it is discriminatory and unjust to stigmatise mental health care users as dangerous and violent based on the aforementioned research. Further studies were recommended that proposed the inclusion of mentally ill patients not on treatment, patients without a prior history of violence and cohort studies that adequately control for confounding variables.

2.3 Violence, Substance Use and Schizophrenia

Wallace *et al*[17] examined the psychiatric history of individuals from Victoria, Australia between 1993 and 1995 by case linkage to a register that listed all contact with psychiatric services. It was found that there was an association between mental disorders and serious criminal offending. A significant association between mental

disorders (including schizophrenia) and violent offences was found. However, it was stated that this association may have been over-represented due to co-morbid substance misuse.

Wessely[18] conducted a population-based longitudinal study on 538 individuals in London between 1964 and 1984, comparing the rates of criminal convictions in schizophrenic patients with a control group of patients with other mental disorders. It was found that the rate of conviction amongst males with schizophrenia and controls did not differ, but an increase in the rate of violent crime (including assault) compared to other offences was higher. It was found that there was a notable increase in the female conviction rate amongst those with schizophrenia. It was also determined that a diagnosis of schizophrenia, unemployment, male gender, substance use, earlier age of onset of illness and belonging to an ethnic minority were all risk factors for conviction. The study also showed that a diagnosis of schizophrenia and substance use both independently increased the risk of conviction. Overall it was found, however, that previous convictions were the strongest indicator of 'post illness conviction' in all subjects.

Fazel and Grann[19] conducted a longitudinal study in Sweden from 1973 to 2006 to determine the risk of violent crime in patients diagnosed with schizophrenia as well as the role of substance use in mediating this risk. Their study concluded that the risk of committing a violent crime by an individual with schizophrenia was minimal unless associated with substance use.

Rasanen *et al*,[20] using data from national registers, looked at the association between schizophrenia, violent behaviour and alcoholism. They determined that individuals with schizophrenia are more likely to commit violent crime than members of the general population. It was also found that concomitant alcohol use further increased this risk of engaging in violent crime. A significant finding included that "one-fifth of male subjects with schizophrenia were already alcoholics before the age of 27, and they were seven times more likely to commit a violent crime than non-alcoholic subjects with schizophrenia". The study also determined that non-alcoholics with schizophrenia had a risk of committing violence that was approximately half of that compared to individuals with other types of psychoses.

In 2002 Walsh *et al*[21] published a literature review on schizophrenia and violence. Their results suggest that although a link does exist between schizophrenia and violent crime, it forms only a small percentage of total violent crime statistics and that further studies are required to eliminate bias. There is currently very little literature published on the association between violence and mental disorders other than schizophrenia.

2.4 Mental Illness and Assault

As common as assault as a violent crime has been found to be,[6] there is very little literature focusing on it specifically. One such study that was a clinical review of 1410 patients diagnosed with schizophrenia across the United States, by Swanson *et al*,[22] was found. Here the authors sought to determine the correlates of violence amongst

patients with schizophrenia living in the community. Violence was classified into two categories including minor violence associated with simple assault without injury or use of weapons; and serious violence being associated with assault resulting in injury, which involved the use of, or threat with, a lethal weapon. It was determined that positive psychotic symptoms increased the risk of both minor and serious crime whilst negative symptoms decreased this risk.

2.5 Forensic Observation Studies

Very little is available in the literature specifically looking at a charge of assault during observation for mental illness. One study by Henn *et al*[23] did partly comment on this. This study looked at, amongst other factors, the relationship between mental illness and the type of crime committed between 1952 and 1973, as well as competency to stand trial and "insanity". In this article competent referred to the defendant being fit to stand trial and "insane" referred to the "opinion of the psychiatrist regarding the defendant's sanity at the time he committed the criminal act". The study found that psychotic patients did not commit more crimes against persons than members of the general public. Here, crimes against persons referred to assault, robbery and homicide. Of the 1197 individuals who had committed crimes against persons, referred to the forensic service during this period, 33% were found to have schizophrenia, 32% affective disorders, 42% organic brain disorders, 32% mental retardation, 33% alcoholism and drug abuse, 32% personality disorders, 29% other diagnoses (including 'sexual deviation, epilepsy, neurosis and various medical diagnoses') and 49% had no psychiatric illness. Of the 433 individuals charged with crimes against persons, 18% were found incompetent and 28% were "insane".

A South African study by Schutte and Subramaney[24] looked at outcomes and psychiatric morbidity of forensic observation referrals. The authors compared two groups: individuals charged with minor offences (common assault included) versus those charged with serious offences (assault GBH included). The study revealed that cases involving minor offences are significantly more likely to be committed by psychiatrically unwell individuals, who are usually found to be both unfit and not responsible. Conversely, more serious offences are more often committed by psychiatrically normal individuals who are likely to be fit and responsible.

Calitz *et al*[25] performed an analysis of offenders referred to the Free State complex according to sections 77 and 78 of the Criminal Procedure Act No. 51 of 1977. The observandi had been charged with various crimes including murder (18.9%); assault (18.1%); rape (16.2%); theft (27.8%); and "a few cases" of drunken driving, vandalism and fraud. The type of assault, i.e. common assault versus assault GBH, was not specified. Almost half the observandi were found to be "triable and accountable" (fit to stand trial and criminally responsible), whereas 40.3% were found to be "untriable and unaccountable." Nearly five percent were found to have diminished accountability, and three and a half percent were found to be unaccountable for their actions.

Violent crime, including both common assault and assault GBH, forms the majority of contact crime in South Africa.[5] Despite their significant impact on our society and economy there exists a lack of information and studies done in our setting regarding the link between psychiatric illness and assault specifically. Studies are often

conducted on other more serious crimes, for example sexual offences[26-28] and murder,[29,30] despite these forming a smaller percentage of total crime than assault.

3.0 SUBJECTS AND METHODS

3.1 Background / Procedure

In accordance with South African law, in terms of section 79 of the Criminal Procedure Act (CPA) No. 51 of 1977,[31] the court must decide whether to appoint a single psychiatrist or a panel of psychiatrists to observe an individual referred for a 30 day psychiatric observation. In instances where the accused is charged with a serious offence such as assault GBH, murder, sexual offences or any charge involving serious violence the court appoints a panel consisting of at least two psychiatrists. In cases of minor offences such as common assault, theft and common robbery, a single psychiatrist is responsible for the observation.

The individual's current mental state which affects his ability to stand trial is dealt with in section 77 of the CPA; whilst section 78 deals with criminal responsibility, i.e. the individual's ability to appreciate the wrongfulness of his actions and to act in accordance with appreciation of such wrongfulness at the time of the alleged offence.

Individuals may be referred for forensic observation for various reasons. Examples of these would be a history of mental illness, the legal representative having difficulty consulting with the accused, and odd behaviour observed in court or at time of arrest.

During the 30-day observation period the accused is evaluated by the psychiatrist(s); and psychology and occupational therapy assessments, as well as special investigations, are also performed where required. Nursing observations and collateral information reports compiled by the social worker are also a vital component of the assessment. A physical examination and urine multi-drug screening are also conducted on admission.

Depending on the outcome of the observation, those individuals charged with serious offences who are found to be not fit and/or not responsible, would be declared state patients and referred back to a forensic hospital to be detained and managed pending a final decision by a Judge in Chambers. Those found not fit and/or not responsible who are charged with minor offences would usually be treated as involuntary patients in the general section of a psychiatric hospital and managed as any other mental health care user.[31]

3.2 Study Design

Retrospective record review of individuals admitted to a forensic psychiatric hospital unit for observation, charged with common assault and assault GBH, from 1st January 2013 to 31st December 2015.

3.3 Study Site

Sterkfontein Hospital is a specialised psychiatric referral hospital in Krugersdorp, Gauteng which renders treatment to involuntary mental health care users who have been difficult to manage in other hospitals. Another one of the hospital's primary functions is the provision of forensic services by way of observations of awaiting-trial detainees and management of state patients.

3.4 Study Population

This included all adults and minors charged with common assault and assault GBH in the aforementioned period.

3.5 Sample Size

Sample size estimation is based on the key research question, namely the association between the demographic, clinical, and outcome study variables on the one hand, and the charge (common assault / assault GBH) on the other. This requires a chi-square test for 2x2 (e.g. gender versus charge) to 4x2 (e.g. outcome versus charge) tables. Illustrative sample size calculations were based on the chi-square test, the 5% significance level and 80% power, and small, medium and large effect sizes (w = 0.1, 0.3 and 0.5). The results are tabulated below:

Table size (number of categories in each variable)	Estimated sample size required for: Large effect size	Medium effect size	Small effect size
2x2	31	87	785
3x2	39	108	964
4x2	44	122	1091

Studies typically aim for the detection of at least a medium effect size, should it exist. Unbalanced data (e.g. if the ratio of the two charges is not 1:1) increases the sample size requirements further. Given the unbalanced data in the current study it was calculated that a combined sample size of 122 would be required.

An estimated 50-60 cases of common assault and assault GBH were observed per year, and therefore the target was met.

3.6 Data Collection

Data was collected from psychiatrists' CPA reports that are submitted to the courts as well as the accused individuals' clinical records.

3.7 Material

Data sheets were used to collate the following information:

i. Information on the accused (Appendix 1):

Age, gender, marital status, highest level of education, employment, charge, type of weapon(s) used (where applicable), reason for referral, psychiatric (or other relevant) diagnosis, substance use at time of offence, fitness to stand trial, and criminal responsibility.

ii. Information on the complainant (Appendix 2):

Age, gender and relationship to the accused.

3.8 Data Analysis

The data were analysed descriptively as follows: categorical data was described by frequency, and illustrated by pie- and bar charts. For objectives 1 and 2, x^2 tests were used to analyse single fixed factor categorical (count) data for either the whole data set or categories that were sufficiently large enough to detect significant differences. Contingency table analyses were conducted or 2 x k analyses (e.g. fitness to stand trial and psychiatric diagnoses). Specific comparisons were then made with Fisher's exact test. Analyses were conducted in Statistica version 7 (www.statsoft.com). All tests were two-tailed and alpha was set at 0.05.

Separate statistical analyses were run for those charged with common assault and those charged with assault GBH because of the skew in the data set to assault GBH

(see Results). Therefore, analyses for objective 3 (i.e. comparison between common assault versus assault GBH) were done qualitatively.

3.9 Ethics

Approval from the University of the Witwatersrand Human Research Ethics Committee was obtained on 15/04/2016 with clearance certificate number M160305 (Appendix 3). As this was a retrospective study there was no interaction or intervention with the observandi. Information obtained from the records was kept confidential and no identifying details such as names or hospital numbers were recorded. Permission was obtained from the CEO of Sterkfontein Hospital to obtain access to records for data collection.

3.10 Funding

The principal researcher incurred all costs.

4.0 RESULTS

4.1 Charges Against the Observandi

A total of 122 individuals were admitted during the study period. However, four were excluded due to the type of assault being unclear. The final sample size of 118 still remains statistically valid in order to obtain a medium size effect. Of the remaining 118, significantly fewer (x^2_1=24.86; p<0.001) were charged with common assault (n=25, 21.2%) than with assault GBH (n=93, 78.8%).

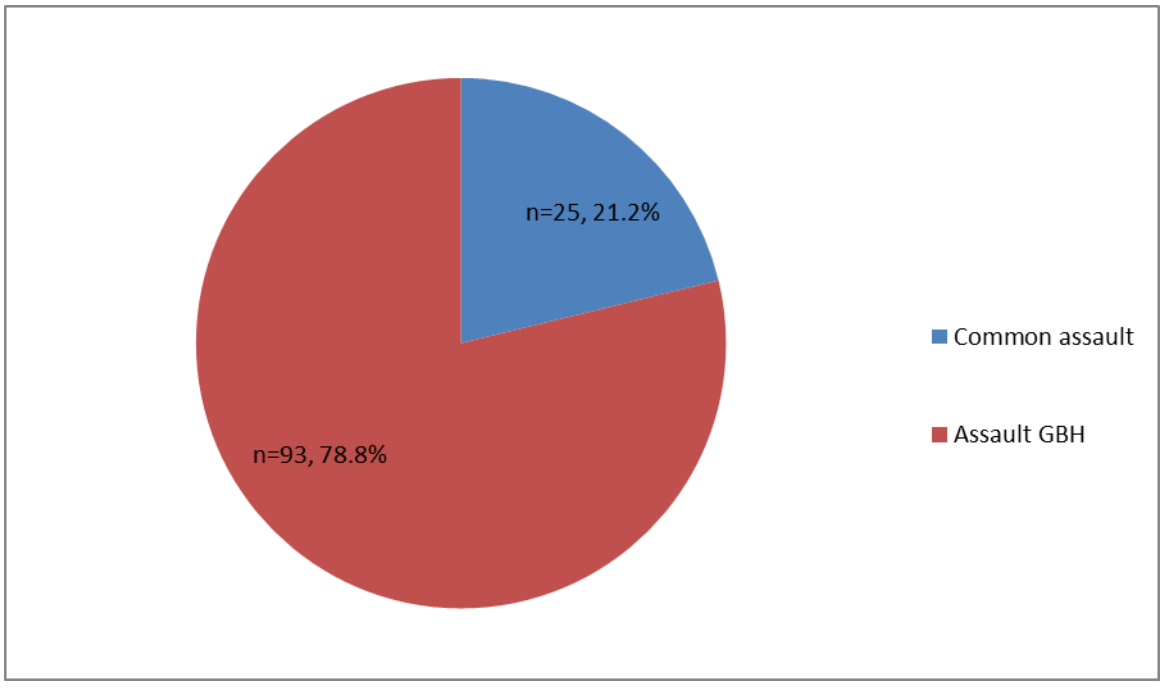

Figure 4.1: Distribution of common assault and assault GBH in 118 patients at Sterkfontein Hospital

Due to the large discrepancy between the number of individuals charged with common assault and those charged with assault GBH during the study period, these two types of assault could not be meaningfully compared.

4.2 Characteristics of the Study Population

Socio-demographic data for the observandi in this study are provided in Table 4.1. Due to low numbers for categories of some variables, values for categories were pooled into meaningful categories, as described below.

Of the 118 observandi, the youngest subjects were 16 years old and the oldest was 78 years old. Age classes were divided into 3 categories (<=29yrs, 30-45yrs, >45yrs). For common assault, there was no significant difference in the distribution of the observandi by age category (x^2_2=5.12; p=0.077). In contrast, for assault GBH significantly more of the observandi were in the <=29yrs and 30-45yrs compared to the >45yrs age category (x^2_2=17.48; p=0.001).

Only one (4%) out of 25 who had been charged with common assault was female (versus 24 males, 96%), which deviated significantly from chance (x^2_1=21.16; p<0.001). Similarly, significantly fewer females (n=9, 9.7%) than males (n=84, 90.3%) were charged with assault GBH (x^2_1=60.48; p<0.001).

For relationship status, two categories were considered (single versus in a relationship). Most of the observandi were single: 21 (84%) for common assault and 85 (91.4%) for assault GBH. In both cases, being single was significantly more associated with common assault (x^2_1=13.50; p<0.001); and assault GBH (x^2_1=66.13; p<0.001).

Most individuals had some high school education (complete or incomplete) for both those that allegedly committed common assault (n=19, 76%; x^2_4=50.80; p<0.001) and assault GBH (n=62, 66.7%; x^2_4=140.78; p<0.001).

Significantly more of the observandi were unemployed in both the common assault (n=23, 92%; x^2_1=17.64; p<0.001) and assault GBH (n=79, 84.9%; x^2_1=53.49; p<0.001) groups.

Substance use at time of offence was not analysed, due to high levels of missing data.

Table 4.1: Characteristics of the study population

		Common assault (n)	Common assault (%)	Assault GBH (n)	Assault GBH (%)
Age	<=29yrs	11	44	40	43
	30-45yrs	11	44	41	44.1
	>45yrs	3	12	12	12.9
Gender	Male	24	96	84	90.3
	Female	1	4	9	9.7
Relationship status	Single	21	84	85	91.4
	In a relationship	3	12	7	7.5
	Missing data	1	4	1	1.1
Highest level of education	None	0	0	2	2.2
	Primary school	3	12	16	17.2
	High school:				
	Complete	5	20	20	21.5
	Incomplete	14	56	42	45.2
	Tertiary education	3	12	5	5.4
	Special education	0	0	5	5.4
	Missing data	0	0	3	3.2
Employment status	Employed	2	8	8	8.6
	Unemployed	23	92	81	87.1
	Missing data	0	0	4	4.3

4.3 Data Relating to the Complainants

There was insufficient information regarding the specific age of the complainants in most cases, and therefore this category was divided into children and adults. The majority of complainants were adults for both common assault (n=14, 56%; x^2_1=7.12; p=0.008) and assault GBH (n=60, 64.5%; x^2_1=37.70; p<0.001). Children were victims in three cases of common assault (12%) and in nine cases of assault GBH (9.7%). More females were the complainants in both instances, i.e. common assault (n=16, 64%) and assault GBH (n=45, 48.4%). Males were complainants in only nine cases of common assault (36%) and 38 cases of assault GBH (40.9%). In neither case did the male/female ratio deviate significantly from parity (common assault - x^2_1=19.96; p=0.162; assault GBH - x^2_1=0.59; p=0.442). Twenty one individuals charged with common assault (84%) knew the complainant, which deviated significantly from chance (x^2_1=13.50; p<0.001). For assault GBH, observandi were also mostly (n=65, 69.9%) acquainted with the complainant (x^2_1=38.37; p<0.001).

Table 4.2: Data relating to the complainants

		Common assault (n)	Common assault (%)	Assault GBH (n)	Assault GBH (%)
Age	Adult	14	56	60	64.5
	Child	3	12	9	9.7
	Missing data	8	32	24	25.8
Gender	Male	9	36	38	40.9
	Female	16	64	45	48.4
	Missing data	0	0	10	10.8
Relationship to accused	Stranger	3	12	11	11.8
	Known to	21	84	65	69.9
	Missing data	1	4	17	18.3

4.4 Forensic Information

4.4.1 Type of Weapon Used

The weapon used differed significantly for common assault (x^2_2=13.30; p=0.001) but not assault GBH (x^2_1=4.94; p=0.085). In most cases of common assault no weapon was used (n=14, 56%). Forms of common assault included, for example punching, kicking and slapping. This was more prevalent than in the case of assault GBH (n=29, 31.2%). There were no significant associations between common assault and the other weapon types, i.e. sharp (n=1, 4%) and blunt (n=5, 20%) weapons. For assault GBH, a blunt weapon was the most common weapon (n=42, 45.2%) even though its use was not significantly different from when no weapon or a sharp weapon was used. The least common type of weapon used in assault GBH was a

sharp weapon (n=25, 26.9%). There was missing data in five cases of common assault, and more than one type of weapon was recorded in three cases of assault GBH.

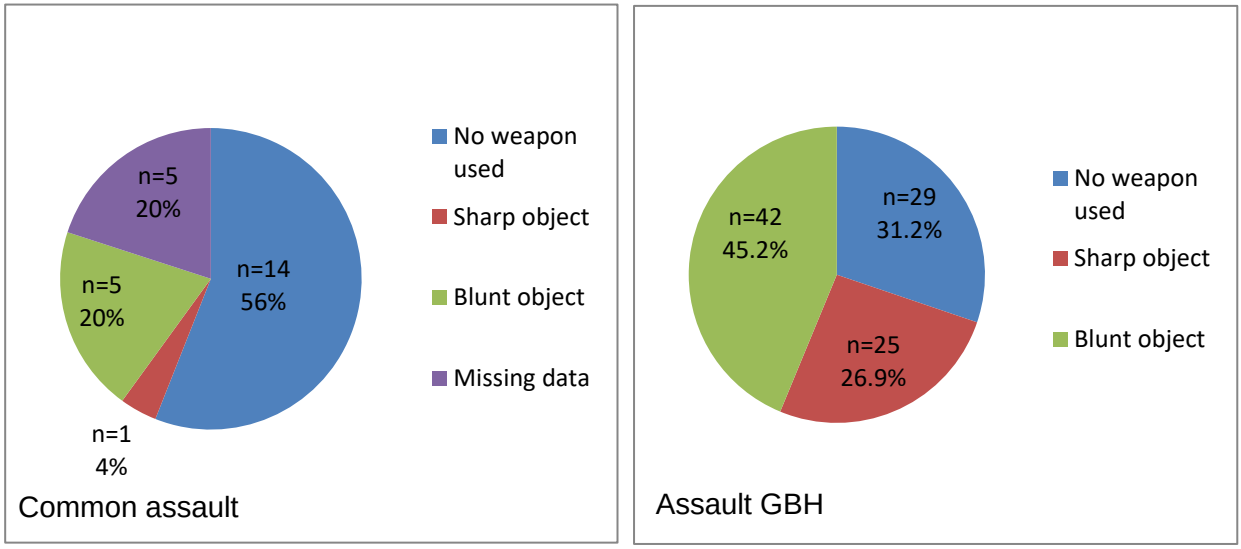

Figure 4.2: Type of weapon used in common assault and assault GBH

4.4.2 Reasons for which an Accused may be Referred for Forensic Psychiatric Observation

The reasons for referral differed significantly from chance in observandi with alleged common assault (x^2_6=25.00; p<0.001). The most common reason for referral was accounts given by family members (n=11, 44%) that the accused was a known mental health care user. This was followed by abnormal behaviour displayed in court or at the time of arrest (as observed by the arresting officer usually) (n=7, 28%). Other reasons for referral included proof of mental illness (n=6, 24%), such as reports from health care practitioners stating that the accused is a known mental health care user; referral requested by the defence (n=2, 8%); or when the accused himself told the court that he was mentally ill ("self-referral") (n=1, 4%). In the case of

minors below the age of fourteen years, the reason for referral was to establish criminal capacity in terms of the Child Justice Act[32] (CJA) (n=1, 4%). In some cases there was more than one reason for referral.

With regard to assault GBH, the reasons for referral also differed significantly from chance in the observandi (x26=91.32; p<0.001). The main reasons for referral were proof of mental illness presented to court (n=38, 40.9%) and abnormal behaviour observed in court or at time of arrest (n=32, 34.4%). Other reasons for referral were statements given by family members (n=16, 17.2%), referral by the defence (n=13, 14%), "self–referral" (n=2, 2.2%), and in one (1.1%) case referral in terms of the CJA. In two cases (2.2%) the reason for referral was unclear.

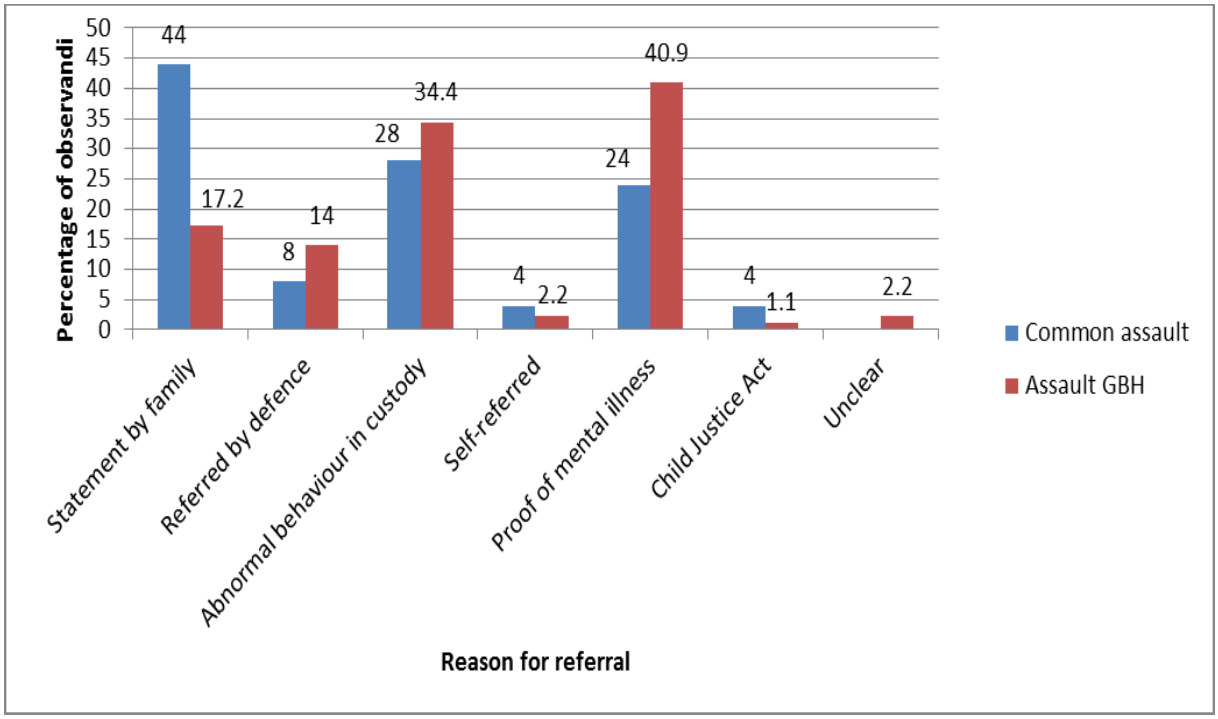

Figure 4.3: Reason for referral for common assault and assault GBH

4.4.3 Outcomes of the Observation Process

4.4.3.1 Diagnoses

The clinical diagnoses varied significantly for observandi with alleged common assault (x^2_{10}=20.73; p=0.023). The most common diagnosis amongst those charged with common assault was a psychotic disorder (n=15, 60%). (Psychotic disorders included schizophrenia, schizoaffective disorder, and substance-induced psychotic disorder.) This was followed by substance use disorders (n=9, 36%). It was also found that three (12%) individuals each had a mood disorder and a neurocognitive disorder. (Mood disorders included substance-induced mood disorder and bipolar disorder.) Neurocognitive disorder included neurocognitive disorder due to traumatic brain injury, human immunodeficiency virus (HIV) or vascular causes. Two (8%) individuals each had personality disorder traits and conduct disorder. Three (12%) individuals were found to have no psychiatric diagnosis, and there were three (12%) individuals who were found to have other relevant medical conditions which included HIV, epilepsy and traumatic brain injury. Many individuals had more than one diagnosis.

Likewise, amongst those individuals charged with assault GBH, clinical diagnoses varied significantly among patients (x^2_{10}=126.00; p<0.001). Again, it was found that psychotic disorders (which included schizophrenia, schizoaffective disorder, psychotic disorder not otherwise specified, substance-induced psychotic disorder and psychotic disorder due to another medical condition) were most common (n=54, 58.1%), and this was closely followed by substance use disorders (n=49, 52.7%). Six (6.5%) had no psychiatric diagnosis, 21 (22.6%) had mood disorders (which included

bipolar disorder, substance-induced mood disorders and mood disorders due to another medical condition), 11 (11.8%) had intellectual disability, five (5.4%) had neurocognitive disorders, seven (7.5%) had a personality disorder or traits thereof, three (3.2%) had conduct disorder and 13 (14%) had other relevant medical conditions (HIV, epilepsy and traumatic brain injury). One (1.1%) individual was found to be malingering.

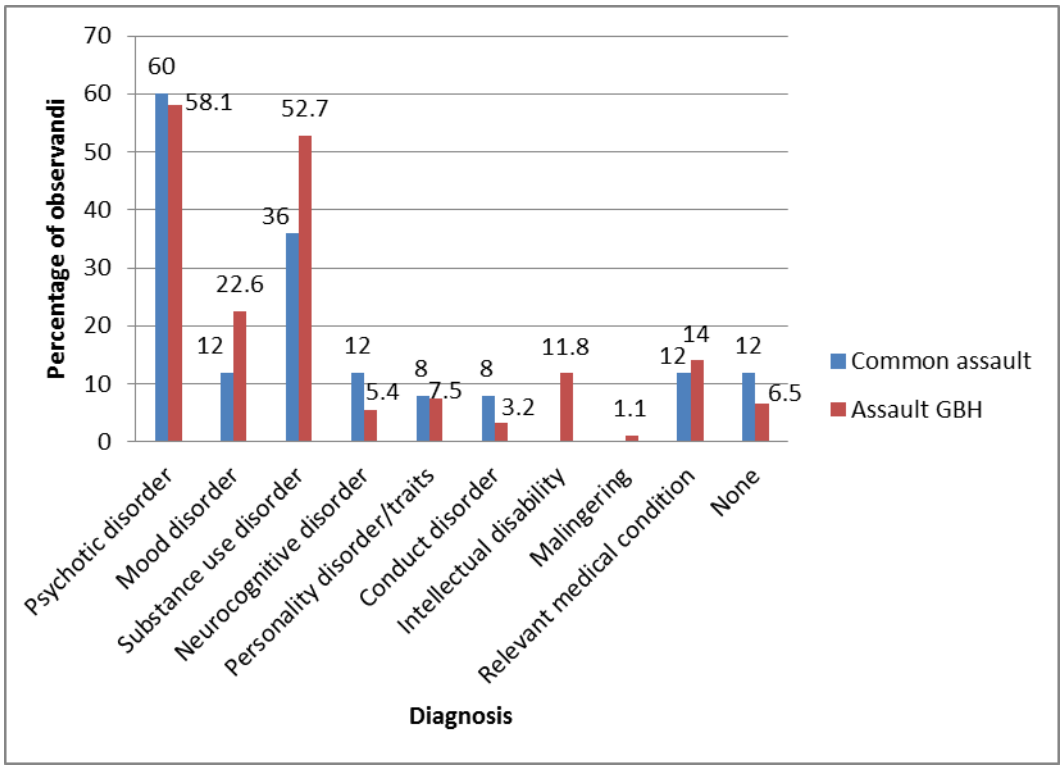

Figure 4.4: Psychiatric diagnoses in individuals charged with common assault and assault GBH

4.4.3.2 Fitness to Stand Trial and Criminal Responsibility

With regards to common assault, there was a significant deviation from chance (x^2_5=36.8; p<0.001). Seven (28%) observandi were found fit to stand trial and criminally responsible, two (8%) were fit but not responsible, and sixteen (64%) were

found not fit and not responsible. None of the individuals in the sample were found not fit but responsible.

There was also a significant deviation from chance for assault GBH (x^2_5=98.56; p<0.001). Thirty one (33.3%) observandi charged with assault GBH were found fit and responsible, 10 (10.8%) were fit but not responsible, one (1.1%) was not fit but responsible, and 50 (53.8%) observandi were found not fit and not responsible. In one (1.1%) case the accused was not fit to stand trial but there was insufficient information to comment on criminal responsibility.

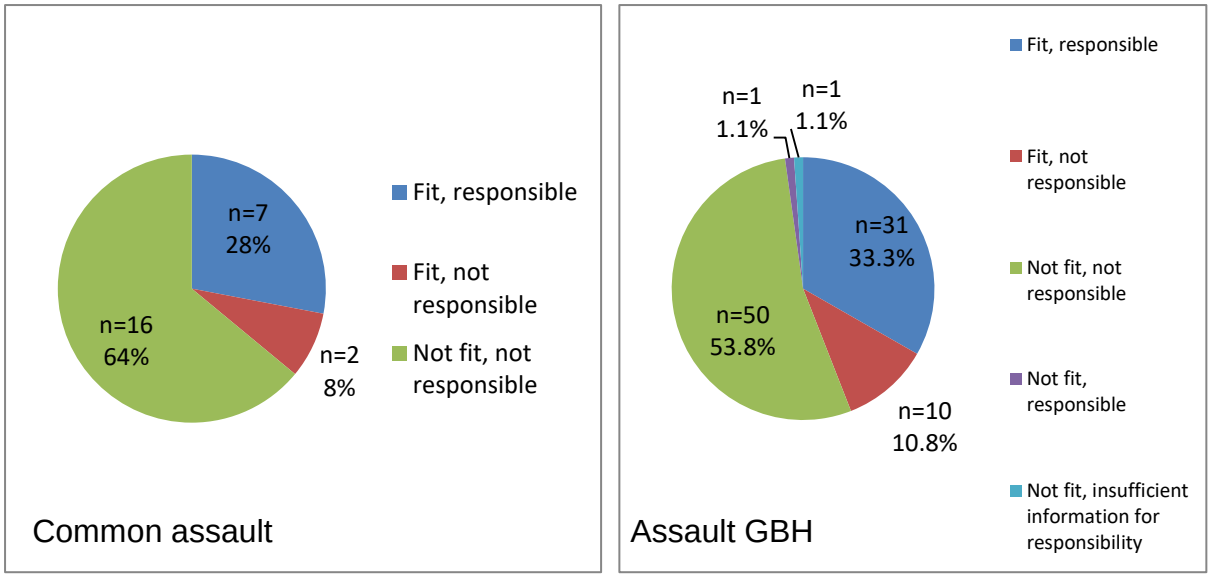

Figure 4.5: Outcome of the observation process for individuals charged with common assault and assault GBH

In order to obtain a more specific outlook in the following sections, regarding various outcomes versus fitness and responsibility respectively, the aforementioned were separated below.

4.4.3.3 Outcome of the Diagnosis versus Fitness to Stand Trial

There was a significant association between the diagnosis and fitness or not to stand trial in observandi charged with common assault (contingency table analyses x^2_7=16.49; p=0.021). Most observandi with psychotic disorders charged with common assault were not fit to stand trial (n=14, 93.3%; p<0.001; Fisher's exact test). Two thirds of observandi with mood disorders (n=2), as well as two thirds with substance use disorders (n=6), were also found not fit. All those with neurocognitive disorders (n=3), other relevant medical conditions (n=3) and personality disorder traits (n=2) as well as half with conduct disorder (n=1) were also not fit (although none were statistically significant, Fisher's exact test). Those with other relevant medical conditions, substance use disorders, personality disorder traits and conduct disorder who were found not fit had co-morbid psychiatric illnesses which accounted for them not being found fit.

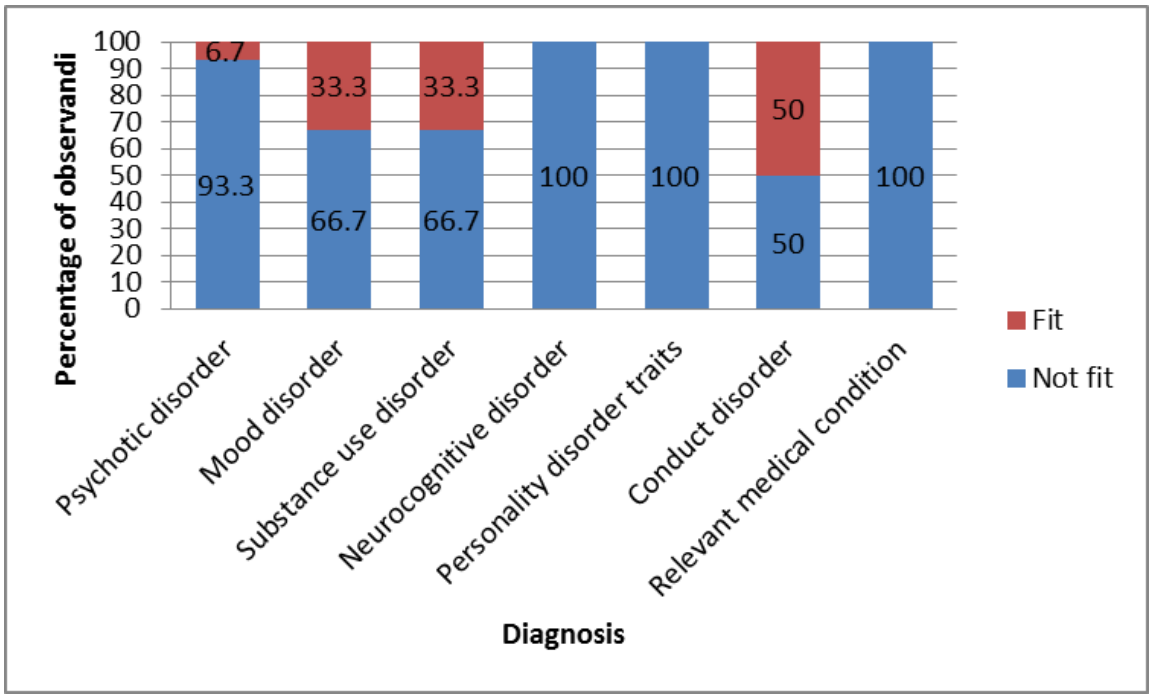

Figure 4.6: Outcome of the diagnosis versus fitness to stand trial for common assault

There was a significant association between the diagnosis and fitness or not to stand trial in observandi charged with assault GBH (contingency table analyses x^2_{10}=21.97; p=0.015). Two significant categories were found using Fisher's exact test: 38 (70.4%) individuals charged with assault GBH who were diagnosed with psychotic disorders (p=0.005), and 10 (90.9%) with intellectual disability (p=0.020) were not fit to stand trial. The majority of individuals with mood disorders (n=11, 52.4%) were also found not fit to stand trial (non-significant effect; Fisher's exact test). Two individuals with neurocognitive disorders (40%), 24 (49%) with substance use disorders, five (71.4%) of those with personality disorders and two (66.7%) with conduct disorders were found fit to stand trial (non-significant effects; Fisher's exact test) – all of these (excluding neurocognitive disorders) found not fit had co-morbid psychiatric illnesses which at the time of observation rendered them not fit to stand trial. Seven observandi with other relevant medical conditions such as HIV, epilepsy and traumatic brain injury (53.8%) were found not fit to stand trial.

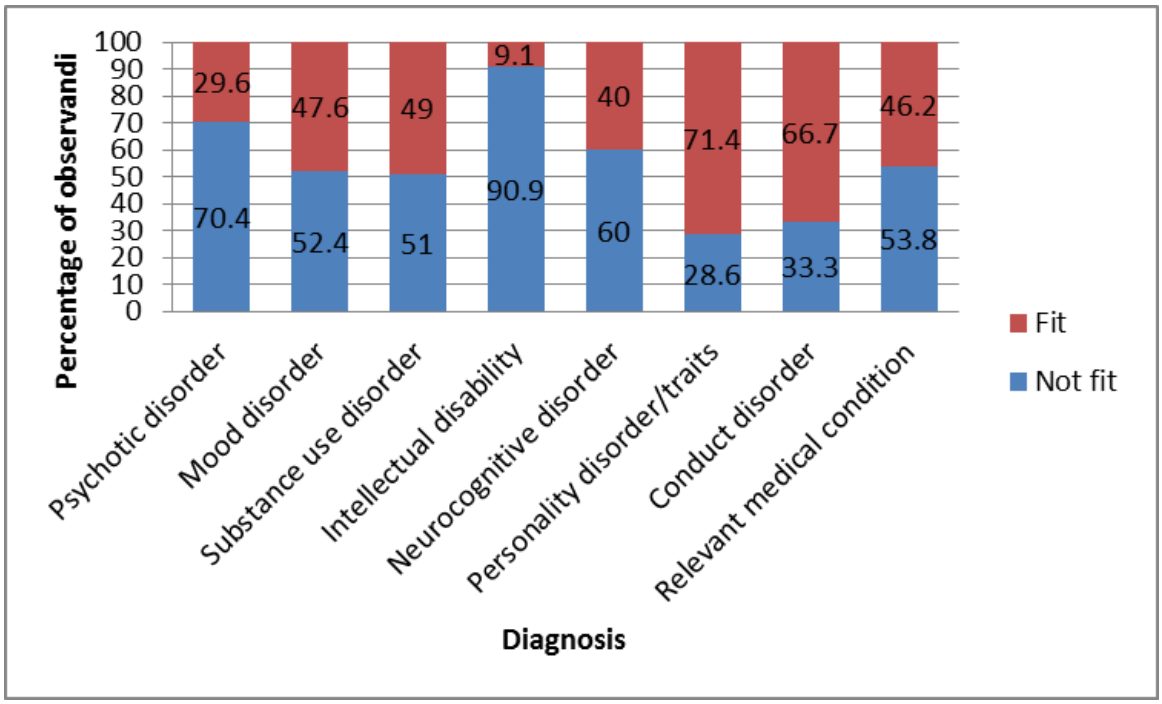

Figure 4.7: Outcome of the diagnosis versus fitness to stand trial for assault GBH

4.4.3.4 Outcome of the Diagnosis versus Criminal Responsibility

There was a significant association between the diagnosis and criminal responsibility in observandi charged with common assault (contingency table analyses x^2_7=22.68; p=0.002). All 15 observandi charged with common assault who were diagnosed with psychotic disorders were found to be not responsible (p<0.001; Fisher's exact test). Moreover, all those with mood (n=3), neurocognitive (n=3), personality disorder traits (n=2) and other relevant medical conditions (n=3) were found not responsible (all non-significant). Another two thirds of those with substance use disorders (n=6) and half (n=1) of those with conduct disorder were also found not responsible (non-significant). Those individuals with a substance use disorder, conduct disorder or traits of a personality disorder, also had other psychiatric disorders which rendered them not responsible at the time of commission of the offence.

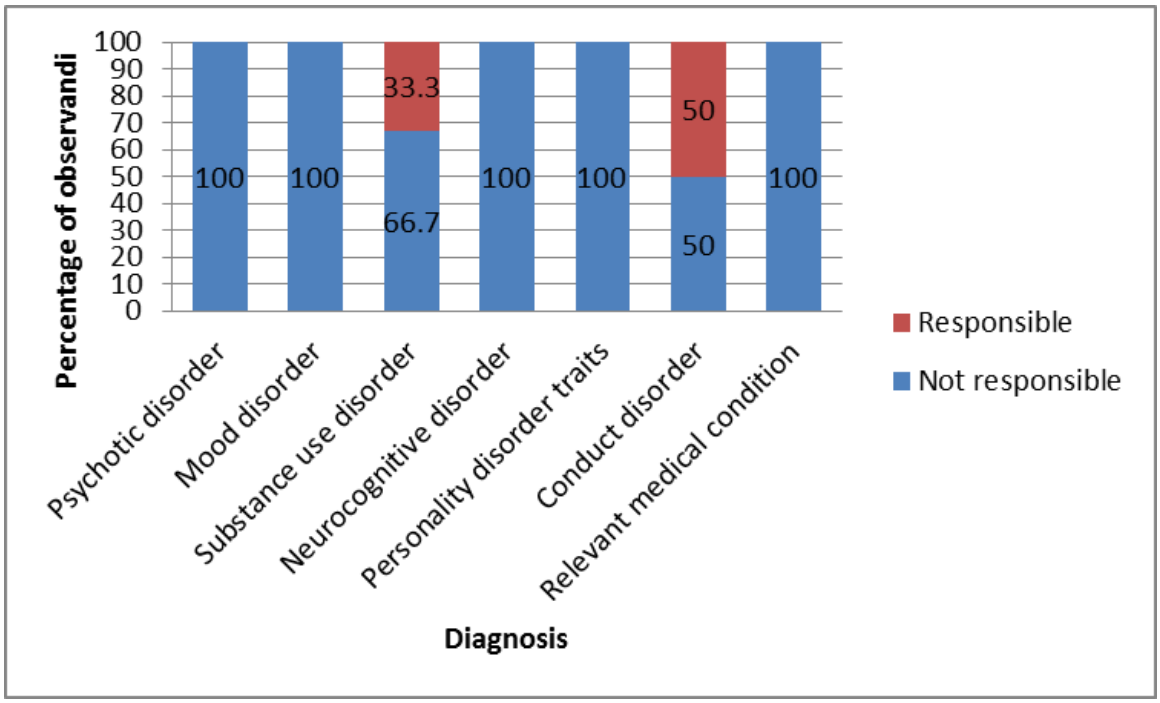

Figure 4.8: Outcome of the diagnosis versus criminal responsibility for common assault

There was a significant association between the diagnosis and criminal responsibility in observandi charged with assault GBH (contingency table analyses x^2_{10}=39.15; p<0.001). All 11 individuals charged with assault GBH who were diagnosed with intellectual disability were found not responsible (p=0.007; Fisher's exact test). Most observandi with psychotic disorders (n=42 of 54, 77.7%; p=0.002; Fisher's exact test) were also found not responsible. Fifteen (71.4%) of those with mood disorders and three (60%) with neurocognitive disorders were found not responsible (non-significant). Three observandi (42.9%) with personality disorders or traits thereof, 28 (57.1%) with substance use disorders, one (33.3%) with conduct disorder, and eight (61.5%) with other relevant medical conditions, were found not responsible (non-significant) as a result of co-existing psychiatric disorders which rendered them not responsible. In one individual diagnosed with a psychotic disorder (1.9%) it was found that there was insufficient information to comment on responsibility.

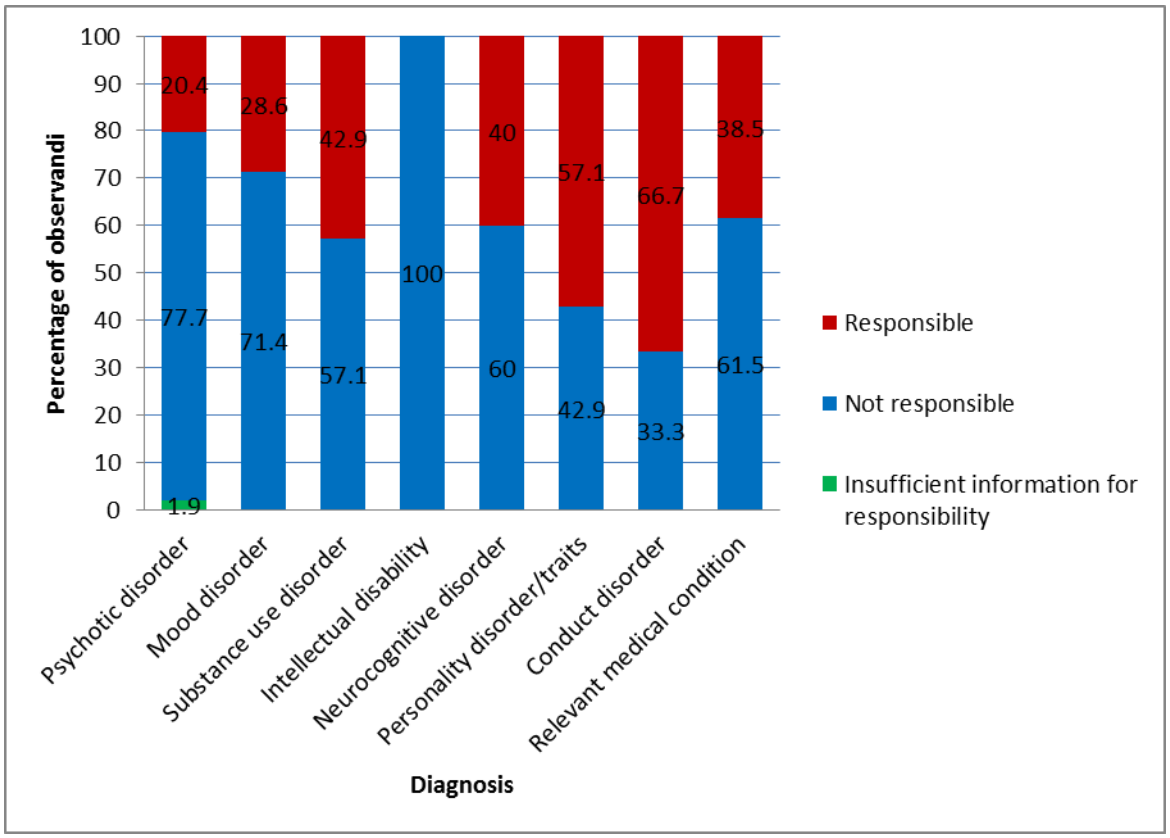

Figure 4.9: Outcome of the diagnosis versus criminal responsibility for assault GBH

4.4.3.5 Outcome of the Reason for Referral versus Fitness to Stand Trial

The association between the reason for referral and fitness or not to stand trial in observandi charged with common assault was not significant (contingency table analyses x^2_5=10.12; p=0.072). In five (83.3%) cases where the accused was referred due to proof of mental illness having been provided, the individual was found not fit. Likewise, for those referred due to abnormal behaviour having been observed in court or police custody (n=5, 71.4%), as well as in those instances where there were statements from family members that the accused was mentally ill (n=9, 81.8%), the majority of individuals were found not fit. The one individual (4%) who was referred to establish criminal capacity in terms of the CJA was found fit. The one individual who was self-referred, and both who were referred by the defence, were found fit.

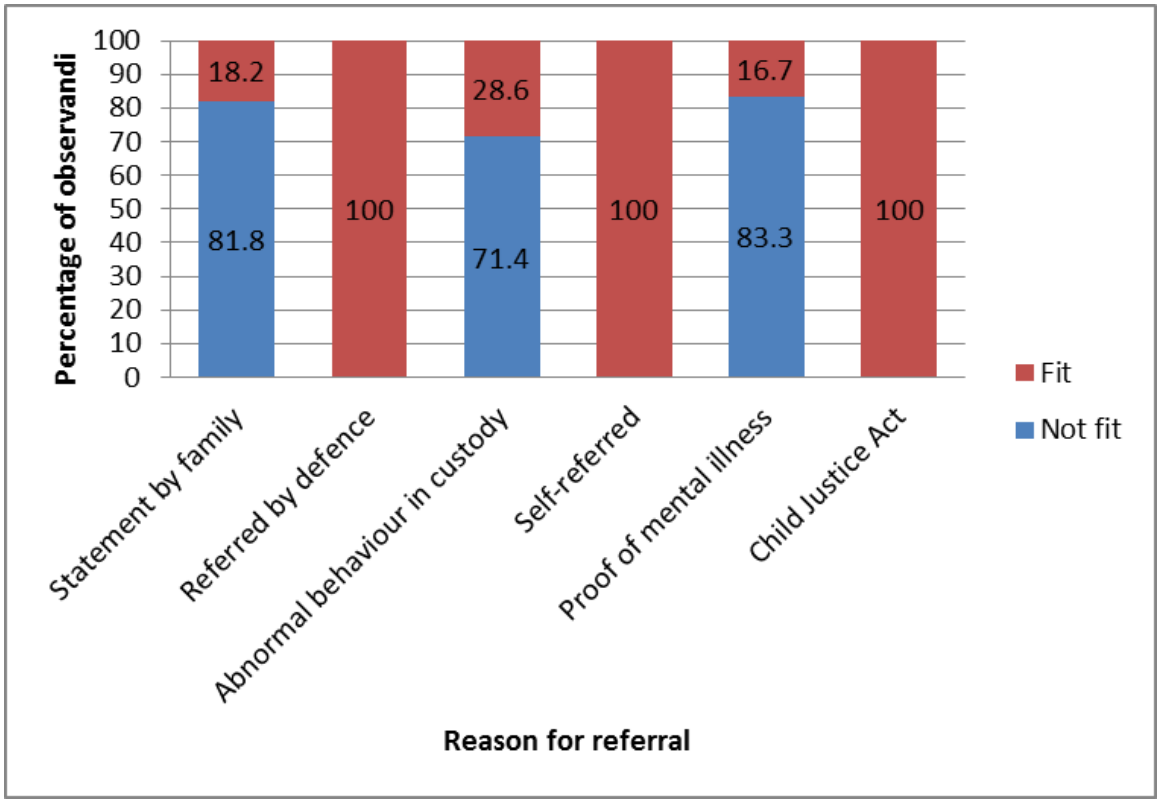

Figure 4.10 Outcome of the reason for referral versus fitness to stand trial for common assault

The association between the reason for referral and fitness or not to stand trial in observandi charged with assault GBH was also not significant (contingency table analyses x^2_5=7.25; p=0.203). Where an observandus was referred due to abnormal behaviour displayed in court, 21 (65.6%) individuals were found not fit to stand trial; as well as in nine (56.3%) cases where statements were given by family members, and seven (53.8%) cases where an individual was referred by the defence. For the majority of those cases where proof of mental illness was provided resulting in a referral (n=22, 57.9%), the individuals were found not fit. In both cases where the reason for referral was unclear, and in the one case where the individual was referred in terms of the Child Justice Act, all these individuals were found fit. Furthermore, all (n=2) of those who were "self-referred" were found fit to stand trial.

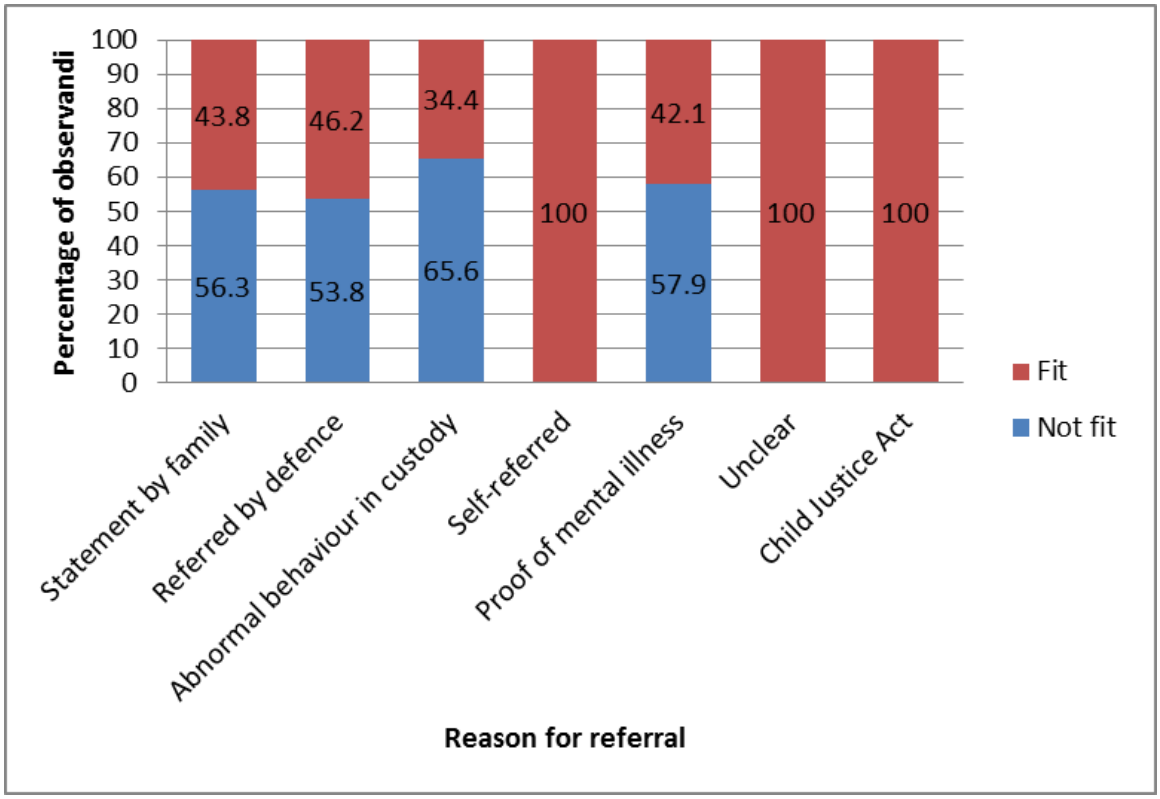

Figure 4.11: Outcome of the reason for referral versus fitness to stand trial for assault GBH

4.4.3.6 Outcome of the Reason for Referral versus Criminal Responsibility

There were significant associations between the reason for referral and criminal responsibility in observandi charged with common assault (contingency table analyses x^2_5=14.70; p=0.012). Observandi were found not criminally responsible in six (85.7%) cases referred due to them having displayed abnormal behaviour, nine (81.8%) cases where statements were made by family members that they (accused) were mentally unwell, and all six of those where proof of mental illness was provided. The single "self-referred" individual and the two referred by the defence (trend toward significance – p=0.070; Fisher's exact test) were found to be criminally responsible. The single observandus referred in terms of the Child Justice Act was also found criminally responsible.

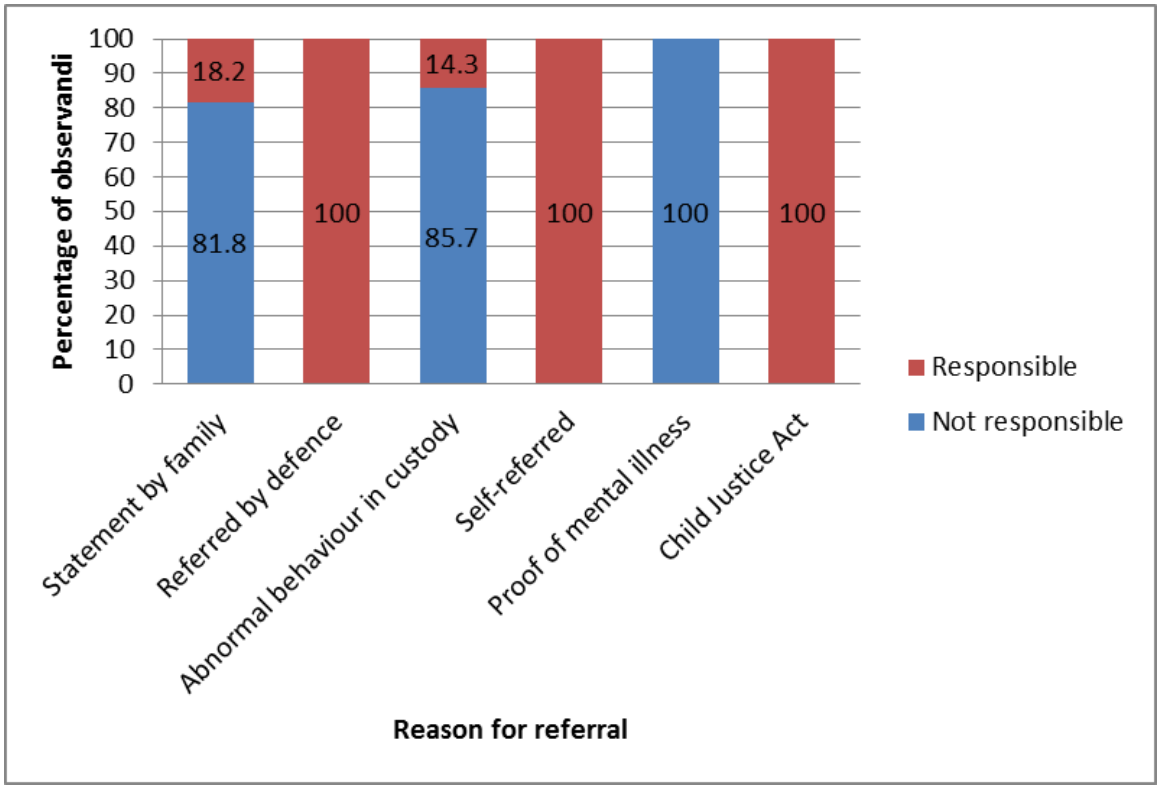

Figure 4.12: Outcome of the reason for referral versus criminal responsibility for common assault

The association between the reason for referral and criminal responsibility in observandi charged with assault GBH was not significant (contingency table analyses x^2_5=5.75; p=0.331). Observandi were found not criminally responsible in 22 (68.8%) individuals who had displayed abnormal behaviour in court or at the time of arrest, 23 (60.5%) referred due to proof of mental illness being provided, eight (61.5%) instances where the defence had referred the individual, and in nine (56.3%) cases where families had made statements claiming that the accused was mentally unwell. In one case (2.6%) where proof of mental illness was provided to the court, there was insufficient information to comment on responsibility. Similar to common assault, “self-referred” individuals (n=2, 100%) were found criminally responsible; as well as the single individual referred in terms of the CJA. In both cases where the reason for referral was unclear, the individuals were found responsible.

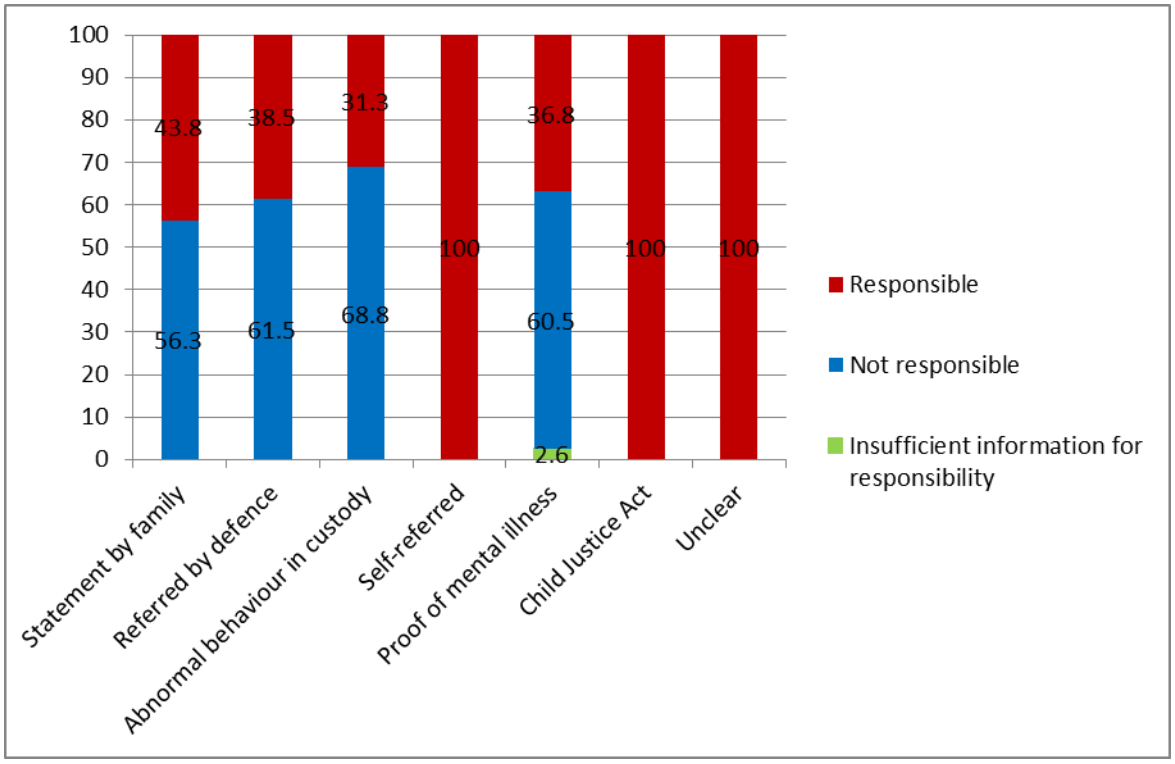

Figure 4.13: Outcome of the reason for referral versus criminal responsibility for assault GBH

5.0 DISCUSSION

The objectives of the study of describing the clinical and demographic profiles of individuals charged with common assault and assault GBH was met, as well as commenting on their fitness and responsibility, and will be further discussed below.

5.1 Charges Against the Observandi

In the 2014/2015 South African Police Services statistics,[6] assault GBH formed only 3.42% more of contact crime than common assault. In the current study however, the number of cases of assault GBH (78.8%) far outweighed that of common assault (21.2%). It is important to bear in mind that this study only considered those individuals referred for forensic observations whereas the SAPS statistics mentioned above are reflective of the general population which could partially account for the discrepancy which exists between the two populations.

As common assault is a minor offence, there is the possibility that many of these cases may not proceed to trial (compared to assault GBH), as the State may more readily choose to dismiss minor offences, or perpetrators may be “let off” with fines or suspended sentences before much resources are spent on proceeding with a lengthy trial. This may provide one possible explanation as to why, in this study, there was such a large difference between these two offences, in the number of cases referred for observation, relative to the number of these charges in the general population in South Africa.

Another important reason for this discrepancy is that during the period of data collection a psychiatrist at Sterkfontein Hospital also conducted assessments of individuals referred from only nearby (for logistical reasons) courts, charged with minor offences (including common assault) on an outpatient basis. The current study did not take these cases into account. Furthermore at different points in time the ratio of observation beds allocated for panel versus single offences have varied within the observation ward, and this may have affected the balance between the two groups.

5.2 Characteristics of the Study Population

In a report by the World Health Organization (WHO)[33] it was found that both fatal and non-fatal assaults committed by young people contribute significantly to the global burden of 'premature death, injury and disability'. The finding of the current study was in keeping with these global trends. Akin to another local study by Calitz *et al*,[25] the current study determined that most of the observandi charged with both common assault and assault GBH were young (below the age of 45 years). Calitz *et al*[25] found the median age of their study participants to be 30 years old. Internationally, Yang and Coid[14] reported that with increasing age there was a decline in reported violent crime in a psychiatric population. This trend toward younger individuals engaging in violent crime may be linked to higher rates of substance use amongst this group, with substance use being a well-established factor in the commission of offences.[11] In instances where the observandi are known mental health care users, substance use may also lead to treatment non-adherence and precipitate a relapse which may then be accompanied by violent behaviour. Clinical practice demonstrates that older individuals may benefit from being supervised by, and have their medication issued

by, caregivers which would render them less vulnerable to a relapse and engaging in violent behaviour.

Males, both worldwide and within the South African population, have been found to have higher rates of committing violent acts than females.[34] Furthermore, Stueve and Link[15] considered gender differences in the relationship between mental illness and violence and found that males were more likely to report recent fighting. Similar to other studies[21,30] the current study also found that most observandi referred for psychiatric evaluation were male. Calitz *et al*[25] found that 94.6% of offenders referred for psychiatric evaluation were male, whilst Schutte and Subramaney's study[24] on 'single' versus 'panel' appointed forensic mental observations found that 90% of those referred for forensic observation were male. Govender's record review[2] of individuals charged with sexual offences against minors who were referred for forensic observation also found that the majority of observandi were male. It is postulated that higher rates of substance use amongst males versus females may also explain the gender disparity that exists in violent acts committed.[14]

The current study also found that the majority of observandi for both common assault and assault GBH were single. Again, this is similar to the findings of other South African observation studies.[2,24,25] The majority of individuals in the current study were found to be psychiatrically unwell. Individuals with psychiatric disorders may remain single due to the nature of the illness e.g. psychotic behaviour, impaired social functioning, the stigma associated with having a mental illness or even co-morbid conditions such as substance use disorders.[2,35]

In the current study most observandi charged with common assault and assault GBH had an incomplete high school education, similar to Calitz *et al*[25] who found that most of their observandi had only some exposure to primary school education or some secondary school education. They found that only 14% of observandi in their study had passed grade 12, which was similar to the current study where only 20% of those charged with common assault and 21.5% of those charged with assault GBH had passed grade 12. Govender's study[2] also revealed that most observandi had some form of high school education although they had not necessarily matriculated. Schutte and Subramaney's study[24] also found that although most defendants had entered high school, they had not matriculated. This was expected as South Africa is a developing country with most individuals living below the breadline, and this would be expected to have a direct impact on access to educational facilities.[36] These findings are in contrast to international studies such as the American study by Swanson *et al*[22] and the British study by Yang and Coid[14] in which individuals had achieved higher levels of education including tertiary education. Households in first world countries have higher rates of income and therefore better access to education. Within a South African context, environmental factors such as poor socio-economic status, which impact on access to education are associated with increased rates of violent crime.[34]

The vast majority (92% of those with common assault and 87.1% with assault GBH) were unemployed at the time of offence. This is higher than those found in other South African studies[24,25] which showed unemployment rates of 59.5% and 60% in their study populations. It is however important to note that the aforementioned studies were performed prior to 2011 and unemployment rates in South Africa have

increased since then and this could account for the discrepancy between those studies and the current study.[37] The increased rates of mental illness as well as lower levels of education within this study population are likely to have accounted for the unemployment rate being higher than that of the general population.

5.3 Data Relating to the Complainants

The majority of complainants for both common assault and assault GBH were adult females. Age groups could not be categorised as the ages of the complainants were not available in most files. The Statistics South Africa National Victims of Crime Survey[34] notes that "violence against women is often compounded by gender inequality and their economic dependence on men" and this may explain the gender bias towards female victims. With respect to gender based violence, a Statistics South Africa report on crime against women in South Africa[38] showed that 3.3% of men and 2.3% of women in South Africa find a man hitting a woman to be acceptable. This report[38] noted that attitudes toward women within society are largely driven by cultural and religious beliefs, and that these determine how women are treated. Patriarchy within the South African context continues to serve as a catalyst that legitimises violence and discrimination against women.

A 2012 United Nations International Children's Emergency Fund (UNICEF) report on violence against children in South Africa[39] stated that 12645 children were victims of common assault and 10630 children were victims of assault GBH. In the current study, although there were far fewer child than adult victims, it is still important to

remember that children do constitute a vulnerable group, and thus require further attention and intervention. Violent crime against minors may be under reported and some reasons for this may include children being too young to report assault having occurred, being afraid to report the individual for fear of further victimisation or not being believed, uncertainty as to who to inform, or not knowing what may occur following reporting of the crime.[39]

In the current study, in most cases of common assault and assault GBH, the accused was known to the complainant (84% and 69.9% respectively). Similarly Schutte and Subramaney[24] found that in more than half of their sample the alleged perpetrators were either family members or acquaintances of the victims. Another South African study[2] also found that most perpetrators of sexual offences against minors were known to their victims. One French study[40] which compared the characteristics of murderers with and without mental illness, found that the mentally ill were significantly more likely to have been known to their victims compared to those who were psychiatrically well. Regarding the general population, the Statistics South Africa National Victims of Crime Survey[34] also found that “most assault victims knew the perpetrators”. The perpetrators were either from the same community (34.2%), a spouse or lover (16.8%), or a relative (9.2%). Some of the reasons provided by females as to why they believe they may be assaulted by partners include them leaving home without informing the partner, arguing with the partner, refusing to have sexual intercourse, neglecting children and burning food.[34]

5.4 Forensic Information

5.4.1 Type of Weapon Used

In South Africa firearms remain the most commonly used weapon. Whilst women are less likely to be victims of this gun violence, firearms still play a role in violence against females. Guns have been used in femicide, sexual assaults, as well as to threaten and intimidate.[41] The results of a femicide study in South Africa[41] showed that the number of women killed by their intimate partner has decreased from four women a day in 1999 to three in 2009. What accounts for this drop in femicide is a decline in the number of females that were shot and murdered compared to deaths by other means, including sharp force and blunt injuries.

In most cases of common assault no weapon was used, which is expected, as common assault is considered a minor offence with less serious injuries sustained than assault GBH. The most frequently utilised weapon in 46.7% of cases of assault GBH was a blunt object. Upon review of the files, most of these objects were household items (kettles, brooms, bottles, tins and garden tools) which may have been easily available to the accused. No other studies could be found that commented on the type of weapons used in commission of these offences in a forensic population. Within the general population however, Statistics South Africa found that in cases of assault the most commonly used weapons included knives (51.5%) and sticks (22%).[34]

5.4.2 Reasons for which an Accused may be Referred for Forensic Psychiatric Observation

Statements provided by family members indicating that the accused was a known mental health care user, was on treatment for a psychiatric illness, or displayed symptoms suggestive of a mental illness or intellectual disability, was the most common reason for referral for common assault and third most likely for assault GBH (44% and 17.2% respectively). Similarly, Govender's forensic observation study[2] determined that this was the most common reason for referral. Schutte and Subramaney[24] found that in 28% of cases individuals were referred for observation due to oral evidence from the family. A pre-existing psychiatric condition may affect the individual's fitness and/or responsibility and therefore would warrant a referral for observation. It is, however, not a given that when a family member reports that an accused is mentally ill, that he will be found not fit and/or not responsible.

For both common assault and assault GBH, about one third of observandi were referred due to abnormal behaviour displayed by the accused in court or at the time of arrest. This was the most common reason for referral in Schutte and Subramaney's study.[24] In 24.2% of observandi in Govender's study[2] 'odd behaviour observed by court or police' was found to be the indication for referral for observation. This would constitute a valid reason for referral for observation as abnormal behaviour may suggest current mental illness and may affect the individual's ability to communicate with his/her lawyer, assist in his/her defence, and follow court proceedings.

In more than 40% cases of assault GBH and almost a quarter of those charged with common assault, individuals were referred due to proof of mental illness or intellectual disability having been submitted to the court. This was the reason for referral 21.5% of the time in Schutte and Subramaney's study[24] and in almost 20% of cases in Govender's retrospective study.[2] Proof of mental illness indicates that a psychiatric condition exists/existed which may subsequently affect the fitness of the accused or retrospectively have impaired his/her responsibility.

In a few instances of both types of assault, observandi were referred upon request of the defence. Similarly, Schutte and Subramaney[24] found that in 11.5% of cases attorneys were unable to consult with the accused. In Govender's study[2] 7.8% of observandi were referred due to defence lawyers requesting an observation. The reasons for these requests from these lawyers were not stated in all cases in court documents. However some reasons provided included being unable to consult with their clients and concerns from the defence that the client was displaying abnormal behaviour which the lawyer felt may have been accounted for by mental illness.

In four percent of cases of common assault and 2.2% of cases of assault GBH, the accused reported himself as being psychiatrically unwell, and was thus referred for observation, despite having no prior psychiatric history or objective reports from legal personnel. Schutte and Subramaney[24] found this to be the reason for referral in 7.5% of their study population. Govender[2] also cited this as a reason in 5.47% of referrals.

Relatively few individuals were referred in terms of the Child Justice Act. One of the objectives of the CJA includes ”reinforcing children's respect for human rights and the fundamental freedoms of others by holding children accountable for their actions and safe-guarding the interests of victims and the community.” By law, children below the age of 10 years are assumed not to be responsible for their criminal actions and are then further managed in terms of section 9 of the CJA. Children above the age of 14 years are assumed to have criminal capacity, but where mental illness or intellectual disability is suspected, like with adults, they may be referred in order to establish criminal capacity in terms of the Criminal Procedure Act. Children between the ages of 10 and 14 years constitute a grey area – they are assumed to lack criminal capacity, but this may be rebuttable.[32]

In only 2.2% of cases of assault GBH was the reason for referral unclear. Schutte and Subramaney[24] likewise found that this had been the reason for referral in only one and a half percent of referrals, and Govender[2] in 4.69% of referrals. The reason for referral assists the psychiatrist when performing the evaluation; and in cases where it is not provided, often leads to challenges when the accused is not overtly mentally unwell.

5.4.3 Outcomes of the Observation Process

5.4.3.1 Diagnoses

A record review by Henn *et al,*[23] which examined the likelihood of a mental illness leading to violence, determined that schizophrenia was the second most common

diagnosis (18.1%) amongst defendants. Govender's observation study of sexual offences against minors[2] revealed that almost one quarter of her study population were found to have psychotic disorders. In her local study comparing observandi with first episode mental illness versus those with existing mental illness, Ramouthar[42] found schizophrenia to be the second most common diagnosis amongst observandi. Schutte and Subramaney[24] determined that a significant number of defendants (44.2%) suffered from psychotic disorders (including schizophrenia, substance-induced psychosis, psychosis due to a general medical condition, schizoaffective disorder, and psychotic disorder not otherwise specified). Calitz *et al*[25] found schizophrenia to be the most common diagnosis within their study population of observandi, and this was similar to the findings of the current study which determined that the most common diagnosis for both charges was psychotic disorders.

Whilst violent behaviour amongst those with schizophrenia is not considered to be common, there are various reasons as to why in some cases individuals may display aggression.[22] Individuals with psychotic disorders may experience persecutory delusions towards a person which may result in them assaulting that person. They may also experience command auditory hallucinations influencing them to harm others, as well as display disorganized behaviour and/or poor judgement which may lead to interpersonal violence.

A 2014 United Nations World Drug Report,[43] commenting on drug use statistics in South Africa, showed that 7.06% of our population utilise some form of substance,

and that one in fourteen individuals uses these substances on a regular basis. This report also showed that 38.4% of people were treated for cannabis dependence.

Rueve and Welton[44] state that "substance use disorders have been proven to vastly increase the risk of a violent incident". Bonta *et al*[45] found that one of the indicators of future violent behaviour amongst individuals with psychiatric illness is the presence of substance abuse. Individuals with substance use disorders who are intoxicated may be more predisposed to engaging in violent behaviour toward others as substance use is known to impair one's judgement. Substance intoxication may also cause an individual to become disinhibited and thus increase the individual's risk of engaging in a potentially violent situation.[43] Furthermore, substance use, under certain circumstances, may result in automatisms leading to the commission of violent crimes.[46]

A substance use disorder was the second most common diagnosis for both common assault (36%) and assault GBH (52.7%) in the current study. Henn *et al*[23] also found that a significant number of defendants had been abusing substances (alcohol and illicit drugs). Schutte and Subramaney[24] found a large proportion (>70%) of their sample was dependent on substances, and Govender[2] found that just over 25% of observandi had substance-related disorders.

One explanation for individuals engaging in violent behaviour may be that substance use disorders are frequently co-morbid with another psychiatric disorder,[20] which

often results in violent actions.[46] Substance use in an individual with a psychiatric disorder can also lead to non-adherence to medication, thereby precipitating a relapse.[47]

Wallace *et al*[17] commented that there is a strong relationship between co-morbid substance use and offending in schizophrenia. Swanson *et al*[22] found that substance abuse amongst schizophrenic patients living in the community was the most common diagnosis amongst those reporting past violent acts, and was present in 42% of violent individuals. The study by Wallace *et al*,[17] that looked at serious criminal offences and mental disorders, found that schizophrenic males with a history of substance misuse were more than eight times likely than the general population to commit violent acts. Wessely's study[18] on crime and schizophrenia found that abusing substances independently increased one's risk of a first time conviction; and Holcomb and Ahr[48] determined that substance users (who had no psychiatric illness) had more arrests than patients with psychiatric conditions (that included schizophrenia, personality disorders and mood disorders).

In the current study, in most cases, the type of substance used was not recorded. However in those cases where this information had been documented, alcohol and cannabis were found to be the most commonly used substances. Similarly, Wallace *et al*[17] found both alcohol and cannabis to be the most frequently utilised substances. In the current study, it was also not documented in most cases as to whether the accused was under the influence of substances at the time of the alleged offence. Calitz *et al*[25] noted that approximately one fifth of their study population was under

the influence of alcohol, and almost one quarter had used cannabis, at the time of the offence. In the current study, possible reasons as to why this information was not recorded may be that the psychiatrist performing the observation was unable to obtain reliable information from the observandus, or in some cases may have failed to enquire regarding this. Another reason is that objective measures of substance use at the time of the offence (such as urine or blood multi-drug screens) cannot be utilised as individuals present for observation at a much later time following the offence.

It was not specified in all cases as to the type of mood disorder the accused had been diagnosed with. This may have been due to unreliable reports from the observandus or insufficient collateral information to differentiate between the various mood disorders. It is also difficult to distinguish between a substance-induced mood disorder and a primary mood disorder (within a one-month observation period) if the accused has used substances within the last month. Manic or hypomanic patients may be irritable or aggressive and engage in violent behaviour because they are impulsive, partake in high risk behaviour as it is the nature of the illness, or even (in manic patients) experience psychotic features that result in them acting out in an aggressive manner toward others.[2]

In this study mood disorders were diagnosed in 12% of cases of common assault and 22.6% of cases of assault GBH. Calitz *et al*[25] found that bipolar mood disorder was diagnosed in less than five percent of their observation study. The difference in these figures may be accounted for by the fact that in the current study the various

types of mood disorders were broadly categorised together. Henn *et al*[23] found much lower rates of mood disorders in their sample – only 0.1% of defendants were manic, and 0.4% were suffering from depression. Wallace *et al*[17] found that just less than two percent of offenders suffered from "affective disorders" (not specified), and their study commented that "robust associations emerged" between interpersonal violent acts and affective disorders. In her study, Ramouthar[42] commented that charges of attempted murder and theft did have an association with a diagnosis of major depressive disorder, although it was unclear as to whether the onset of this was before or after arrest. In the current study there were no individuals diagnosed with depressive disorders, and this may be due to the fact that depression resulting in violent acts is usually not a common event.[49]

Two percent of individuals charged with common assault and 11.8% of those charged with assault GBH had intellectual disability (ranging from mild to severe). Local observation studies have found between five percent and 12.8% of individuals within their study populations to have evidence of impaired intellectual functioning.[2,24,25,42] Regarding international statistics, Henn *et al*[23] found that 2.4% of defendants suffered from "mental retardation". Hodgins' study[11] revealed that males with an intellectual disability were five times more likely to commit violent acts, some of which included sexual assault, assault and robbery. Another study by Barron *et al*[50] found sexual offences to be the most common type of offence in those with a diagnosis of intellectual disability. Individuals with this disability may struggle to differentiate between right and wrong, or even if they are able to make this differentiation, be unable to act accordingly. They may act impulsively, especially if

they feel threatened or insulted, and may retaliate physically. They may also be influenced by other individuals to engage in illegal activities.[51]

In the current study, only two individuals (8%) charged with common assault and seven individuals (7.5%) charged with assault GBH, were diagnosed with personality disorders or traits thereof. Govender[2] found that less than five percent of observandi in her study were given the diagnosis of antisocial personality disorder. Antisocial and borderline personality disorders have a close relationship with acts of violence.[52] Individuals with personality disorders may use aggressive acts to control or intimidate others, more specifically intimate partners.[52] Some studies have found high rates (approximately 90%) of personality disorders in offender populations.[53,54] Fountoulakis *et al*[52] found that the research supported a link between antisocial personality disorder and violence, especially in the presence of substance abuse. This study[52] also pointed toward a relationship between borderline personality disorder and violent acts. Putkonen *et al*[55] showed that more than 80% of female homicide offenders in their study population were found to have personality disorders. International research conducted in a high security psychiatric hospital[56] revealed that 30% of patients in this study population (psychiatric patients admitted after committing offences) met criteria for psychopathy.

Although personality disorders are included in DSM-5 “few psychiatrists regard them as mental disorders or illnesses”. Individual personality traits which collectively constitute the various disorders are found in most individuals and the law requires that people maintain control over these some of which include aggression and

impulsivity.[57] The low prevalence of personality disorders in local observation studies may be due to clinicians' hesitancy to record these diagnoses on court reports, being wary of the term "disorder" being misinterpreted as having bearing on the fitness and responsibility of the accused. However, in South Africa, personality disorders are generally found not to affect the ability of an accused to stand trial or be held not responsible for his actions.[57]

In this study neurocognitive disorders were almost twice as common amongst those charged with common assault (12%) than assault GBH (5.4%). Schutte and Subramaney[24] found that nine percent of defendants were suffering from cognitive impairment. The total number of neurocognitive disorders in the current study is lower compared to other diagnoses such as psychotic and mood disorders, and a possible reason for this may be that neurocognitive disorders are generally more common amongst the elderly,[58] and this study had few elderly individuals. Taylor and Parrott[59] noted that older individuals contribute less to overall crime rates and that a "more lenient approach" may be taken toward the elderly who do offend, thereby reflecting lower crime rates in this age group.

People diagnosed with neurocognitive disorders, regardless of the cause, may display impulsivity, and/or inappropriate behaviour which may lead to them engaging in violent acts.[2] Miller *et al*[60] looked at the association between aggression and fronto-temporal dementia, and found a relationship between pathology in these areas of the brain and antisocial activities. Kim *et al*[61] found that almost one percent of forensic patients had dementia, including Alzheimer's disease, vascular dementia

and alcohol-related dementia. The study commented that demented individuals who consume alcohol committed violent crimes, whereas those without a history of alcohol intake engaged in non-violent criminal activity. In the current study the neurocognitive impairment was as a result of varying pathology which included TBI, vascular causes and alcohol.

None of the individuals charged with common assault, and very few with assault GBH (1.1%), were found to be malingering. Singh *et al*[62] estimate that the prevalence of malingering among psychiatric patients to be approximately one percent in the general population and five percent in a military setting. These rates are reported to be higher (between 10%-20%) in a medico-legal setting.[62] Similar to the current study Ramouthar,[42] found 2.3% of her study population to be malingering. Govender's study[2] found a higher rate (approximately eight percent). The rate of malingering may be higher with more serious offences that carry longer prison sentences, and these individuals may feign symptoms in an attempt to avoid incarceration.[24]

The medical conditions in this study include cerebrovascular accidents, epilepsy and traumatic brain injury (26%). Govender's study[2] showed that almost eight percent of individuals had general medical conditions including stroke, head injury and epilepsy. Rueve and Welton[44] commented that up to 70% of individuals with traumatic brain injury due to blunt force injury, may display irritability and signs of aggression. Strokes, as well as traumatic brain injuries, affecting regions of the brain such as the

prefrontal cortex (specifically the orbitofrontal cortex) can result in aggression and disinhibition, which in turn may lead to violence.[63]

With regards to epilepsy, sufferers require careful evaluation to determine whether a seizure had occurred, and if it had had an impact on the commission of the offence. Automatisms, where present as a result of ictal events, would occur during the seizure or in the post-ictal period. Diagnosing an epileptic automatism would also require a history of epilepsy prior to the accused's offence. Those epileptics displaying pre-ictal aggression or targeted violence are likely to be found responsible.[64] Individuals may also suffer from psychotic or mood disorders due to epilepsy which could then result in violent behaviour.[64] Calitz *et al*[25] found less than five percent of their study population to be epileptic, and Henn *et al*[23] demonstrated that 2.3% of defendants were epileptic. Both of these studies[23,25] did not comment on the relationship between the diagnosis of epilepsy and the competence of these individuals to stand trial nor their criminal responsibility.

In the current study eight percent of adolescents charged with common assault and 3.2% of those charged with assault GBH were diagnosed with conduct disorder. In order to establish a diagnosis of conduct disorder, DSM-5 considers four possible categories, including "aggression toward people and animals, destruction of property, deceitfulness or theft, and serious violation of rules".[65] In the United States the approximate prevalence of conduct disorder is nine and a half percent with a higher estimate being found amongst males.[66] By virtue of the criteria required to

establish the diagnosis, it stands to reason as to why children engaging in violent acts may be diagnosed with conduct disorder.

5.4.3.2 Fitness to Stand Trial and Criminal Responsibility

The current study showed that the majority of individuals for both charges were found not fit and not criminally responsible. On the other hand, Calitz *et al*[25] determined that less than half (40.3%) of individuals in their study (looking at various minor and serious offences) were untriable and unaccountable for their actions. Schutte and Subramaney's study[24] demonstrated that single cases (as in the case of common assault) are more likely to be found unfit for trial (55.5%) and not criminally responsible for their actions (almost 59.6%), and that those individuals charged with serious offences (such as assault GBH) are usually fit (almost 66.7%) and responsible (64.8%). Henn *et al*[23] found far lower numbers of unwell persons amongst individuals charged with crimes against persons – 18% were found to be incompetent and 28% were deemed insane.

5.4.3.3 Outcome of the Diagnosis versus Fitness to Stand Trial

Regarding common assault, significant associations were found between having the diagnosis of a psychotic disorder and being found not fit to stand trial. With respect to assault GBH, significant associations, between being found not fit to stand trial and diagnoses of psychotic disorders and intellectual disability, were found. This is explained by the fact that individuals with moderate or severe intellectual disability, or those who are actively psychotic, may not adequately be able to follow court

proceedings or have the ability to instruct their lawyers. Schutte and Subramaney[24] found a significant association between major psychotic disorders and being found not fit. Their study further found that non-psychotic disorders were mostly found fit.

Although no significant associations were found, most of those with neurocognitive and mood disorders were also found not fit to stand trial. These were similar to the findings of Govender's study[2] which found that where mental disorders were present, most individuals with intellectual impairment, psychotic disorders, cognitive impairment and mood disorders were not fit to stand trial.

In this study neurocognitive disorders and relevant medical conditions (such as HIV and traumatic brain injury) were separated into different categories as these medical conditions did not necessarily result in cognitive impairment but may have resulted in psychotic or mood disorders. Similarly not all neurocognitive disorders represented in the sample were as a result of medical conditions. As would be expected, the current study also found that individuals with a sole diagnosis of a substance use disorder, personality disorder/traits, or conduct disorder/features were found fit to stand trial as these diagnoses, on their own, do not impede the ability of an accused to follow court proceedings or assist in his defence. These aforementioned diagnoses, for which individuals were found not fit to stand trial, was as a result of co-morbid diagnoses such as, for example, a psychotic disorder presenting with acute symptoms during the observation period.

5.4.3.4 Outcome of the Diagnosis versus Criminal Responsibility

In the current study, with respect to common assault a significant association was found between psychotic disorders and criminal responsibility in that all these individuals were found not responsible. In those charged with assault GBH, significant associations were found between diagnoses of intellectual disability (100%) and psychotic disorders (77.7%) being found not responsible. In cases of individuals charged with assault GBH diagnosed with a psychotic disorder, who were found responsible, this may be explained by the fact that being psychotic does not always impact on an individual's ability to differentiate between right and wrong or to act in accordance with such knowledge. Another explanation may be that even if the accused had been diagnosed with a psychotic disorder (or other psychiatric illness), he/she may have been well-controlled on psychiatric treatment at the time of the offence.

All observandi who were charged with common assault and who were diagnosed with neurocognitive disorders, and 60% of these charged with assault GBH, were found not criminally responsible. All observandi with a charge of assault GBH and who were diagnosed with intellectual disability were also found not responsible. Depending on the severity of the disorder, individuals with neurocognitive disorders and intellectual disability may not be able to distinguish between right and wrong, or even if they can, may not always be able to act in accordance with this due to the impulsivity inherent to their conditions. In this study, the one individual with intellectual disability who was found to fit but not responsible had mild intellectual disability with a co-morbid substance-induced psychotic disorder, the latter diagnosis

being the reason he was found not criminally responsible, i.e. he was psychotic at the time of the offence.

With respect to the individual charged with common assault who was diagnosed with conduct disorder and found not responsible, this was as a result of a co-morbid diagnosis impacting on his ability to appreciate the wrongfulness of his actions. In all cases of individuals diagnosed with relevant medical conditions and who were found not responsible, these resulted in either mood or psychotic disorders which rendered the person not responsible for their actions.

Those observandi with mood disorders who were found not responsible had displayed features of mania at the time of the offence, in some cases with accompanying psychotic features (as established from history-taking and collateral information). Conduct disorder and personality disorders alone did not absolve observandi of criminal responsibility as these diagnoses, on their own, do not affect one's ability to distinguish between right and wrong or to act accordingly.

All those diagnosed with relevant medical conditions (HIV, epilepsy, traumatic brain injury) who were charged with common assault were found not criminally responsible. In the case of assault GBH 61.5% of observandi with this diagnosis were found not criminally responsible. In some instances these individuals were found not responsible due to a co-morbid unrelated psychiatric illness, and in other instances it was as a result of a psychiatric disorder due to the relevant medical

condition. The latter included mood and psychotic disorders which developed as a result of relevant medical conditions such as HIV, traumatic brain injuries and epilepsy. In those individuals who were found to be criminally responsible the medical conditions present either had no impact on both legs of responsibility or no bearing on the psychiatric illness present.

5.4.3.5 Outcome of the Reason for Referral versus Fitness to Stand Trial

There were no significant associations found between the reason for referral and fitness to stand trial for both types of charges. For those observandi charged with assault GBH who were found not fit, the most common reason for referral was abnormal behaviour displayed by the observandi in the courtroom or observed by police officers at the time of arrest (65.6%). In the case of individuals charged with common assault and referred for the above-mentioned reason 71.4% of observandi were found not fit. Odd behaviour in court was the most common reason for referral for single cases in Schutte and Subramaney's study,[24] and they further found that 80% of this group of participants were not fit to stand trial. This may be seen as a more objective reason for referral than other reasons often provided.

All those referred by defence attorneys who were charged with common assault were found fit to stand trial. However, in those charged with assault GBH who were referred for the above-mentioned reason, more than half were found not fit to stand trial. This may be regarded as a surprising finding because one might hypothesise that, as suggested by Schutte and Subramaney[24] defence attorneys may suggest the

possibility of being psychiatrically unwell to their clients as a means to evade imprisonment, and one might expect this to be the case where the offence is of a more serious nature. Referrals by defence attorneys may also arise for a reason as simple as differences in vernacular languages between the two parties, which may lead to difficulties in communication. This is often easily overcome during observation with the assistance of translators. Furthermore, anecdotally, observandi in the hospital setting, have often reported having communicated only briefly with their lawyers; and this would therefore not be an appropriate reason for referral where the defence had seemingly not made an adequate attempt to converse with the accused.

For both types of assault, where family members provided statements that the accused was a known mental health care user or had displayed odd behaviour, most observandi were found not fit. This was in fact the reason for referral where most observandi charged with common assault were found not fit to stand trial (81.8%). These observandi may have had a history of being mentally unwell, but may possibly not have been overtly problematic prior to arrest. Families may then volunteer information about their mental illness following a criminal charge. This untreated psychosis may then have been detected during the observation process. In some instances where the accused did display problematic behaviour prior to arrest, families may have attempted to manage the individual's behaviour on their own or by seeking help from other avenues such as traditional healers.

Although not statistically significant, for all cases of common assault and assault GBH, observandi who were referred because they had told the court that they were mentally unwell were found fit to stand trial. This may be due to an attempt to delay the court process or an intention to malinger psychiatric illness so as to avoid conviction and imprisonment. Another possible explanation may be that an accused who correctly/truthfully reported his psychiatric illness to the court was able to do so as he was stable on treatment and had some degree of insight.

More than 80% of observandi charged with common assault and almost 60% of those charged with assault GBH who were referred due to proof of mental illness having been provided were found not fit to stand trial. As may be expected, prior documentation of a history of mental illness therefore seems to be a reliable indicator of current psychiatric illness in individuals charged with these offences. Schutte and Subramaney[24] found that in 52% of individuals with a past psychiatric history, just less than half were found fit to stand trial. This study did not take into account whether the information provided in the reason for referral represented proof of prior mental illness or evidence of current/recent mental illness. This information would be relevant were a mental illness present around the time of the offence and/or during court proceedings.

This study found that 100% of individuals charged with both common assault and assault GBH and referred in terms of the CJA were fit to stand to trial. It is important to remember that although comments on fitness to stand trial were included in the

psychiatrist's report to court, this assessment on fitness is not in fact a requirement in terms of the CJA.

In both cases of assault GBH where individuals were fit to stand trial, it was found that the reason for referral was unclear. A clear reason for referral not being provided in a prosecutor's report is not an uncommon occurrence and leads to great difficulty when assessing an accused. In these cases this may imply that where a reason for referral is not provided this may in fact be a baseless referral.

5.4.3.6 Outcome of the Reason for Referral versus Criminal Responsibility

In cases of common assault significant associations were found between the reason for referral and lacking criminal responsibility in cases where observandi were referred due to them having displayed abnormal behaviour in court or at the time of arrest, when statements were made by family members that the observandi were mentally unwell, and where proof of mental illness was provided. Furthermore, a trend toward significance was found for the one individual who was self-referred and the two referred by the defence who were found criminally responsible. Similar to possible reasons provided regarding fitness, in cases where individuals suggest that they may be have been psychiatrically unwell during commission of an offence, this may have been strategic and in an attempt to avoid imprisonment. There were no significant associations found for assault GBH. In 2.6% of cases of assault GBH where individuals were referred due to evidence of mental illness having been provided, there was insufficient information to comment on responsibility – this

occurs on the rare occasion that it is not possible to gather sufficient information regarding the accused's mental state at the time of the offence. A possible explanation for the discrepancy that exists between the two groups (common assault and assault GBH) may be due to the sample size for assault GBH being higher therefore increasing the likelihood of variation.

All CJA assessments at Sterkfontein Hospital are conducted by a registered forensic psychiatrist who also holds a child psychiatry subspecialist qualification. In this study, all children charged with common assault and assault GBH, and referred in terms of the CJA, were found to have criminal capacity. It may therefore be inferred that most children within this age category (10-14 years) do in fact have criminal capacity, or rather, that such is the trend seen for CJA assessments performed at Sterkfontein Hospital. This must however be interpreted with caution as during the study period these figures consisted of only one individual each for common assault and assault GBH referred in terms of the CJA.

6.0 LIMITATIONS

The sample size of 118 individuals, while statistically sufficient, is still inadequate to allow for conclusions to be drawn. This limited sample size may have been partly due to some common assault referrals being conducted as outpatient assessments and therefore not having been included in the current study. The discrepancy between the sample sizes in the common assault and assault GBH groups did not allow for significant comparisons to be made. It is however noteworthy that the current study was a review of common assault and assault GBH rather than a comparison of the two groups.

In four cases the court documents did not clearly document the type of assault the accused had been charged with, and this led to these cases being excluded from the study. With respect to those cases which were included in the study there was, not infrequently, some information required which was not recorded in files and hence had to be excluded during data collection. It was further found that prosecutors' reports often did not contain much information regarding the complainant and clinical notes had to be relied on in these cases. At times this information was also not available in the clinical file.

When assessing observandi, the diagnosis is based on the level of expertise of the psychiatrist(s) performing the evaluation and whilst all joint assessments at Sterkfontein Hospital are initially reviewed in an academic forum comprising all

members of the forensic unit (psychiatrists, registrars, psychologists, occupational therapists, social workers and nursing staff) there is still room for human error which should be taken into consideration. Less experienced multi-disciplinary team members also contribute to these assessments which may also leave room for error.

At times it may be difficult to comment on criminal responsibility. This is done in retrospect, and in some instances, information available from the observandi as well as sources of collateral, may be insufficient to provide comment. It is also difficult in certain situations to obtain reliable collateral information from family members or other relevant persons regarding the observandus' state of mind at the time of the commission of the offence, which may then make it difficult to reliably comment on responsibility.

Substance use is a known factor in precipitating violent behaviour.[45] Unfortunately in most cases in this study the accused's use of substances at the time of the offence was not recorded during observation, and therefore no comment could be made regarding the potential effects substance use may have had on the commission of the alleged offence. Reasons for this information not being recorded may include the accused being unable or unwilling to provide this information, or the assessing clinician not having questioned the accused about this. Such information is also not usually provided in referral documents, as toxicology tests are not routinely carried out on arrest in any event. It is important to keep in mind that even when this information is recorded, the reliability of an accused's response may also be called into question.

This study would also naturally have missed those individuals charged with assault who are suffering from psychiatric illnesses, but who, for various possible reasons, may not have been referred for observation. In some instances charges may have been dropped/withdrawn, or at other times cases may have been diverted. Another possible explanation is in instances where individuals are quietly psychotic (in that they do not display problematic behaviour) their psychiatric illnesses may have remained undetected by family, community or those in the legal system; and as a result they may not have been referred for observation.

7.0 RECOMMENDATIONS

In those observandi that are found to have mental illnesses that impact especially on their criminal responsibility, various measures including hospitalisation, pharmacological treatment, as well as psychotherapeutic interventions are currently employed so as to rehabilitate the patient. Some of these interventions include psychological interventions as well as occupational therapy and social worker interventions that involve actively engaging the individual in group or individual therapy. Psycho-education should routinely be implemented for both patients and their families regarding their illnesses, the need for adherence to medication, abstinence from substances, and regular follow-up on discharge is vitally important to reduce their risk of relapse and recidivism. In instances where individuals are found not fit but were responsible he/she should be treated until such time that he/she is psychiatrically stable and should then return to court for legal proceedings to continue.

In cases where individuals are found fit but not responsible, the assessing psychiatrist may recommend, where felt appropriate, that the court use other options (other than psychiatric admission) that are available at their disposal, such as release with or without conditions. In these cases it should still be recommended that ongoing psycho-education and other forms of rehabilitation be continued in the community.

In the current study substance use disorders formed the second largest diagnostic group for both types of assault. As in other studies, such as those cited by Reagon,[43] substance use frequently leads to relapses and, as such, warrants additional attention which may be in the form of referrals to rehabilitation facilities. There is a need for more community-based drug awareness campaigns; and perhaps on a national level, stricter laws and programmes to be implemented to reduce the increasing drug problem.[42]

As part of the follow-up/reviews of psychiatric patients, risk assessments should be regularly performed so as to gauge the individual's risk of reoffending. It is important on follow-up, especially for those individuals with psychotic, mood and neurocognitive disorders, to screen for impulsivity, aggression and on-going psychotic and mood symptoms so that these issues may be addressed by the treating doctor, be it in hospital or on outpatient reviews.

It is imperative that there are more mental health awareness campaigns within communities so that mentally ill individuals are identified early on and help sought prior to them presenting within a forensic context. It is also important that legal personnel are given basic training regarding signs of mental illness so that psychiatrically unwell individuals already within the justice system are detected early on and appropriately referred.

As this study determined that the vast majority of complainants were female it is important to implement means to protect this vulnerable group. One of the ways in which this may be done is to create awareness regarding gender-based violence through community and national campaigns. These campaigns should also highlight the avenues that are available to women in abusive environments to use to seek help. Tools such as helplines and organisations designed specifically to aid women who have been targets of violence, and the use of shelters for abused women, should be easily accessible to assist this group.

In this study it was not possible to compare the profiles and outcomes of those charged with common assault against those charged with assault GBH due to the sample size of the common assault group being very small compared to the assault GBH group. In order for a comparison to be achieved a longer study period should be considered. It is recommended that future research focus on a comparative study of individuals charged with common assault and assault GBH in order for meaningful comparisons to be drawn between these two groups.

8.0 CONCLUSIONS

During this study period nearly four times the number of individuals charged with assault GBH were referred compared to common assault. Due to the large discrepancy in the number of individuals between both groups, a comparison was not statistically possible. For both charges, most complainants were adult females who were known to the accused. In most cases of common assault no weapon was used, and blunt objects were most common for assault GBH. For both groups most observandi were single, unemployed males with an incomplete high school education.

The majority of individuals referred for observation, for both common assault and assault GBH, were found not fit to stand trial and not criminally responsible. The leading diagnoses for both groups were psychotic disorders, followed by substance use disorders. It is recommended that those observandi declared involuntary mental health care users or state patients post-observation, receive pharmacotherapy if indicated, psycho-education and rehabilitation with a large focus on reducing their risk of recidivism. As having a substance use disorder was also found in a large proportion of these individuals charged with assault, it is further recommended that more attention be given, within the health system, and on a national level, in addressing this problem.

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ACCUSED NUMBER

APPENDIX 1: Data collection sheet for the accused

Age					
Gender					
Male 0	**Female 1**				
Race					
Black 0	**White 1**	**Asian 2**	**Coloured 3**	**Other 4**	
Marital Status					
Single 0	**Married 1**	**Divorced 2**	**Separated 3**	**Widowed 4**	**Living together 5**
HLOE					
None 0	**Primary school 1**	**High school**		**Tertiary education**	**Special school 6**
		complete 2	**incomplete 3**	**complete 4**	**incomplete 5**
Employment					
Full time 0		**Part time 1**		**No 2**	
Charge					
Common assault 0		**Assault GBH 1**		**Type of assault unclear 2**	

Type of weapon used				
Reason for referral				
Psychiatric Diagnosis				
None **0**	**Psychotic disorder** **1**	**Mood disorder** **2**	**Substance use disorder** **3**	**Intellectual disability** **4**
Neurocognitive disorder **5**		**Personality disorder/** **traits 6**	**Conduct disorder/** **features** **7**	**Malingering** **8**
Psychiatric disorder due to another medical condition 9		**Other relevant medical condition 10**		
Substance use at time of offence				
Yes 0	**No 1**	**Unknown 2**	**Type of substance used (if known)**	
Outcome of section 77 and section 78				
Fit, responsible **1**	**Fit, not responsible** **2**	**Not fit, responsible** **3**	**Not fit, not responsible** **4**	**Insufficient information to comment on criminal responsibility 5**

APPENDIX 2: Data collection sheet for the complainant

Age		
Gender		
Male 0	**Female 1**	
Relationship to the accused		
Stranger 0	**Known to 1**	**Not stated 2**

APPENDIX 3: Ethics approval

R14/49 Dr Mallorie Govender

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160305

NAME: (Principal Investigator)	Dr Mallorie Govender
DEPARTMENT:	Psychiatry Sterkfontein Hospital
PROJECT TITLE:	A Review of individuals Charged with Common Assault and Assault with Intent to Do Grievious Bodidy Harm, Referred for Forensic Psychiatric Observation
DATE CONSIDERED:	01/04/2016
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Navanthree Govender
APPROVED BY:	Professor P. Cleaton-Jones,Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/04/2016

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 in Room 10004,10th floor, Senate House/2nd floor, Philip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the 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 review in March and will therefore be due in the month of March each year.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES