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A retrospective record review of the impact of intellectual disability on the forensic observation process

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A retrospective record review of the impact of intellectual disability on the forensic observation process

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of

Master of Medicine in the branch of Psychiatry

Supervisor: Associate Prof ABR Janse Van Rensburg

Johannesburg, 2015

DECLARATION

I, Louis Johannes Van Rooyen, declare that this research report is my own work. It is being submitted in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry. It has not been submitted before for any degree or examination at this or any other University.

Dr L.J. van Rooyen

22nd day of June 2017

DEDICATION

This work is dedicated to my parents, aunt and brothers for their unwavering patience, support and love

ACKNOWLEDGEMENTS

I wish to acknowledge my supervisor Professor Bernard Janse van Rensburg for his constant assistance, support and motivation during the undertaking of this project.

I also sincerely wish to thank Dr Natali Raman for her assistance in the development of the protocol for this report.

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ABSTRACT

Background: It is estimated that, in South Africa, 11% of referrals for forensic psychiatric observation have intellectual disability. Assessments are challenging in this group due to cognitive limitations. The impairment may impact on their fitness to stand trial, whether they were able to appreciate the wrongfulness of the offence that they were charged with and if they were able to act accordingly. Depending on the degree to which intellectual disability affects fitness to stand trial and accountability, a recommendation has to be made regarding whether the observandi should be referred back to the criminal judicial system or whether they should be admitted to a psychiatric hospital for further management.

Objectives: To identify and describe a group of individuals with intellectual disability admitted to Sterkfontein Hospital (SFH) for forensic observation during a specified study period, in terms of their demographic and clinical characteristics and investigate these characteristics in terms of the nature of the alleged crimes committed and in terms of the outcome of their forensic assessment, namely their capacity to stand trial and the measure of their criminal responsibility.

Method: A retrospective record review was conducted, including observandi with intellectual disability referred to SFH during 2011 and 2012. Information was obtained from the summary of the forensic observation findings in their files. Statistics were mostly descriptive but a statistician was consulted to compare the degree of disability with the outcome of the observation process.

Results: The study found that 8.7% of referrals had intellectual disability. The majority of subjects were between 21 and 30 years old (49.0%), male (96.1%), single (98.0%) and unemployed (76.5%). Only 31.4% were educated in special schools while 39.2%

never progressed beyond primary school. The degree of disability was moderate in 51.0% and mild in 43.1%. The most common charge was rape (45.1%). Medical co-morbidities were diagnosed in 21.6% of cases with and an equal percentage of psychiatric co-morbidities were present. The majority of observandi were not fit to stand trial and not accountable (62.7%). In the majority of cases (66.7%), referral for further management, i.e. involuntary admission to a psychiatric facility under the Mental Health Care Act, was recommended. A strong association between the degree of disability and the outcome of the process was found ($p<0.001$).

Conclusions: Although intellectual disability impacts on fitness to stand trial and accountability, observandi with disability may be fit to stand trial and/or have criminal responsibility. An association exists between the degree of impairment and the outcome of the forensic psychiatric observation process, but categorizing observandi according to the level of disability may be difficult and objective methods of doing this is often not applied. The degree of disability tends to correlate with the outcome, but this is not always the case. The recommendation made following observation is important in terms referral to appropriate facilities as this may improve risk management.

DEFINITIONS AND ABBREVIATIONS

ICD-10: The International Classification of Diseases, 10th Edition

DSM IV – TR: The Diagnostic and Statistical Manual for Mental Disorders, 4th Edition, Revised

AAIDD: The American Association on Intellectual and Developmental Disabilities

SSAIS: The Senior South African Individual Scale – Revised

CPA: The Criminal Procedure Act

CJS: Criminal Justice System

PD: Personality Disorder

Assault with GBH: Assault with intent to do grievous bodily harm

Robbery WAC: Robbery with aggravating circumstances

MITP: Malicious injury to property

Observandi: Individuals referred for forensic observation after being charged with a criminal offense to determine if they are fit to stand trial and/or have criminal capacity.

Fitness to stand trial: The ability to understand and follow court procedures, to understand the nature of the charge and the ability to assist in the preparation of his defence.

Criminal capacity/responsibility: The ability to understand the wrongfulness of an act/omission of a criminal nature and the capacity to act in accordance with such appreciation of wrongfulness.

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CHAPTER 1. INTRODUCTION

1.1 **Background**

A number of terms are being used for intellectual disability with varying levels of acceptability across disciplines and professions. The International Classification of Diseases (ICD-10), as well as the Diagnostic and Statistical Manual for Mental Disorders (DSM IV–TR), use the term mental retardation.[1,2] In South Africa, the term intellectual disability is more widely accepted and in line with the human rights of a person and will therefore be used in this study.[3] The DSM IV–TR classification will however be used here when referring to the degree of intellectual impairment.

It is generally accepted that the term intellectual disability encompasses any set of conditions resulting from genetic, neurological, nutritional, social, traumatic or other factors occurring prior to birth, at birth, or during childhood up to the age of brain maturity, that affect intellectual development.[4] The American Association of Intellectual and Developmental Disabilities (AAIDD) defines intellectual disability as a disability characterised by significant limitations both in intellectual functioning and in adaptive behaviour, which covers many everyday social and practical skills, while originating before the age of 18 years.[5] The AAIDD stresses that professionals must take additional factors into account, such as the community environment typical of the individual's peers and culture when making this diagnosis. Professionals should also consider linguistic diversity and cultural differences in the way people communicate, move and behave.

The DSM IV–TR description of the degrees of intellectual impairment is as follows:[2]

- Mild (85%): (an individual) can usually achieve social and vocational skills adequate to minimal self-support, but may need guidance and assistance when under unusual social or economic stress (IQ 50-55 – 70);
- Moderate (10%): (an individual) may achieve self-maintenance in unskilled or semiskilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress (IQ 35-40 – 50-55); and
- Severe (4%): (an individual) may contribute partially to self-maintenance under complete supervision; can develop self-protection skills to a minimal useful level in a controlled environment (IQ 20-25 – 35-40).

Intellectual functioning, also called intelligence, refers to general mental capacity, such as learning, reasoning and problem solving.[7] One measure of intellectual functioning, conducted by psychologists, is an intellectual quotient (IQ) test, e.g. the Senior South African Individual Scale – Revised (SSAIS-R).[6] Kaliski notes that functional assessments, conducted by occupational therapists, can also determine limitations in adaptive behaviour, while focusing on the required conceptual, social and practical skills.[7] Assessors must assume that limitations in individuals often co-exist with strengths, and that a person's level of life functioning will improve if appropriate personalised support is provided over a sustained period.[7]

1.1.1 **Accountability and criminal responsibility**

While the vast majority of intellectually disabled people are law abiding citizens. prevalence studies of offenders with intellectual disability are complicated due to methodological variations and diagnostic inconsistencies.[7] The majority of individuals with intellectual disability who break the law, should be dealt with in a different way than the general population.[7] This highlights the importance of the forensic observation process in terms of identifying these individuals, determining the impact of their disability on their offence and referring them to an appropriate facility for further management.

It is estimated that at least 11% of defendants referred by the courts for psychiatric assessment in South Africa, have intellectual disability.[7] In criminal cases where a court has reason to believe that a defendant may be mentally ill, that person is usually referred to a psychiatric hospital for observation in terms of the Criminal Procedure Act, No. 51 of 1977 (as amended in 1998 and 2002).[8] Section 77 of the Criminal Procedure Act (CPA) is based on the premise that an accused must be able to understand trial proceedings and must be able to instruct his/her defence counsel in order to make a proper defence (triable). If at any stage of the criminal trial it appears to the court that the accused may be suffering from a mental illness, or mental defect, the court will order an inquiry into the matter.

Section 78 of the CPA states the following*: "A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable of appreciating the wrongfulness of his or her act or omission, or of acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such act or omission."* [8]

1.1.2 **Forensic assessment**

Forensic assessments are conducted in terms of Section 79 of the CPA and provides for the referral of a defendant for psychiatric and/or psychological assessment, usually for a period of 30 days. For non-violent crimes, as specified by the CPA, the enquiry into the mental capacity of an accused can be conducted by the medical superintendent of a psychiatric hospital, or a psychiatrist designated by the superintendent. In cases of violent crimes, the court appoints a panel of psychiatrists and a clinical psychologist "where the court so directs".[8] The accused is then admitted to a psychiatric hospital for observation after such a court order has been issued.

During the forensic evaluation, a comprehensive assessment is undertaken by different members of the multi-disciplinary team (psychiatric/medical, nursing, psychology, nursing, occupational therapy), referring to all the health care professionals dealing with the accused during the time of his/her admission for observation. A forensic report is compiled from these different assessments, considering daily observations of behaviour, functioning and social interactions. The

CPA requires that mental illness or defect, or certain other factors such as “non-pathological incapacity”, must be present before the question of fitness to stand trial or criminal responsibility can be answered.[8] A common example of non-pathological incapacity would be when the court determines that a crime committed was an automatism in the absence of medical or psychiatric illness, where an act was committed in an automatic, reflexive or involuntary state where there was an antecedent build-up, such as a period of conflict, discord or dispute. A trigger event may result in an overwhelming response and may be followed by a period of total amnesia. It is for the court to decide whether the accused has criminal responsibility in these cases.[7]

Kaliski highlights the fact that forensic observation and assessment of intellectually disabled people present with many challenges.[7] Limited attention spans, distractibility and impulsivity complicates assessments. Conceptual understanding and abstract thinking is typically impaired. This creates problems with understanding complex information, direction and comprehension. They may often find it difficult to give a logical and structured account of events obtaining a chronological version from them may be problematic.[7] According to Kaliski, assessors should be aware that underlying emotional difficulties or co-morbidities can easily be overlooked due to the fact that it may be difficult for the intellectually disabled person to express emotional problems and symptoms. It is therefore important to have a high index of suspicion for these possible problems that may impact on the outcome of the forensic observation process. Intellectual disability may sometimes also be overlooked in individuals with adaptive functioning that falls at the upper end of the functional continuum, as they may deny or try to mask their impairment.[7]

With regards to the assessment itself, assessors have to use methods such as observations, interviews, psychological tests and inferences made from collateral data to determine whether there are any deficits in the observandus's relevant functional abilities. A battery for diagnosis and assessment of intellectual disability may include an individually administered intelligence test (e.g. SSAIS-R),[6] an achievement test (e.g. Wechsler Individual Test)[9] and measures of adaptive functioning (e.g. the Vineland Adaptive Behaviour Scales).[10] Where a person has no functional language or is from a culture for which there is no appropriate instrument, a non-verbal test such as the Ravens Standard Progressive Matrices,[11] or the Leitner International Performance Scale,[12] may be useful. The range of error of the intelligence test must be taken into account when determining IQ for diagnosis. Kaliski notes that itis also important to bear in mind that most psychological tests are, at least partially, culturally biased.[7] Kaliski further stresses that limitations in education, comprehension, decision making, communication or living in an impoverished environment may impact negatively on performance during testing. While assessors often have no choice but to use an instrument that was standardised on the general population, the results must be interpreted with great caution, well documented and appropriately communicated to the referring agent.[7]

On completion of the forensic assessment process, three different options for referral are available. If the accused is found not to be fit to stand trial/add to his own defence he or she will either be treated as a state patient or involuntary patient under the Mental Health Care Act, No. 17 of 2002 until such time when he/she may be ready to stand

trial.[13] If a person is found not to be responsible for an offence allegedly committed, the same two possible referral routes apply. The severity of the crime also determines whether a recommendation is made to become a state patient, or to be further detained as an involuntary patient.[7] State patients are usually subsequently admitted for longer periods than involuntary patients. When granted leave of absence, they are closely followed-up and monitored in the community before they may be conditionally discharged and possibly permanently discharged - two years further down the line, should they adhere to treatment and not violate conditions determined before they left the hospital for periods of leave of absence. The third referral route would be back to the criminal justice system (CJS) to stand trial for an alleged offence/s if the person is fit to stand trial and had criminal capacity at the time of the offence.

1.2 Literature Review

1.2.1 Intellectual disability and the criminal justice system

Sondenaa et al. note that behaviours that are considered criminal by the courts might be seen as reflecting behaviour problems by the welfare system, thus rendering the responsibility unclear.[14] It is therefore essential to consider the extent and nature of services available for offenders with intellectual disability to ensure appropriate policy and to deal with practical issues in order to prevent failures of justice, as well as to ensure protection from maltreatment by the criminal justice system (CJS).[14] Important issues that apply to this dilemma have been explored and researched in available literature.

(1)

(2) **Prevalence**

The emphasis of many reviews have been on prevalence studies, risk assessment, characteristics of offenders with intellectual disability, the CJS, treatment and psychometric assessment of intellectually impaired offenders.[15] The British project *"No one knows"* has published a systematic review of prevalence studies, difficulties in the CJS, problems in provision of services and examples of good practice.[16] Nancy Loucks depicts in this review an alarmingly high percentage of people with learning disabilities and impairments (20-30%) within the British CJS.[16] Their disability, according to her, interferes with their ability to cope within the system and they are often targeted in custody and they have a high risk of re-offending because of unidentified needs and consequent lack of support and services. Staff members in various settings of the CJS who are working with this population are often unfamiliar with the challenges involved when dealing with this group of alleged or convicted offenders.[16]

The proportion of prisoners identified as having intellectual disability varies across settings and cultures, and is at least partly due to differences in definition and assessment. Studies of custody samples, e.g. Crocker et al., found a prevalence of almost 20% in individuals with an IQ of less than 70 and co-morbidity with a substance use disorder of about 60%.[17] Dwyer and Frierson note that offenders with a low IQ had more previous convictions than their counterparts without intellectual disability, but were rarely diagnosed as having intellectual disability.[18] Prevalence studies in prison

samples e.g. Hayes et al., found a prevalence of 7.1% of individuals with an IQ less than 70.[19] Chitsabesan at el., studied young offenders in custody and in the community, to evaluate their mental healthcare needs and found that 20% of the sample were identified as having a learning disability (IQ < 70), while a further 31% were identified as being within the borderline range (IQ 70-79).[20]

(3) **Co-morbidity**

Lindsay et al. explored psychometrically distinctive characteristics, mainly in the area of personality disorder, which generally supported previous work on personality and intellectual disability.[21] A wide range of personality disorders were studied by Lindsay et al.in a large forensic intellectual disability sample (n = 164), who reported that antisocial personality disorder was found in 22.1% of the sample.[21]

In a British study looking at the prevalence of personality disorders in adults with learning disabilities and behavioural problems, Flynn et al. found 39% of subjects to have had a co-morbid diagnosis of a personality disorder (PD), with paranoid personality disorder the most frequently diagnosed personality disorder, followed by anti-social personality disorder.[22] Pridding and Proctor note that assessment and diagnosis of a PD in people with intellectual disability, however, is complex due to amongst other, their lack of linguistic and cognitive ability it may be difficult to elicit symptoms of an abstract nature, such as feelings of emptiness or identity disturbance.[23] These individuals' limited understanding of concepts such as empathy and remorse can complicate the confirmation of a diagnosis of antisocial PD.[23]

(4) **Violence and serious offending**

Violent offenders with intellectual disability have been described in several papers, emphasizing the prevalence and risk assessment associated with this type of offence.[14] A high rate of violent offences was found by Crocker et al.among men with intellectual disability in pre-trial detention.[17] Another study by Crocker and co-workers explored the prevalence and types of aggressive behaviour among non-offenders with intellectual disability in a large sample of people with intellectual disability receiving services from rehabilitation agencies.[24] They found a 51.8% prevalence of aggressive behaviour, with property damage (24.4%) as most common and physical aggression as least common (9.8%). The study by Dwyer and Frierson of murder defendants referred for pre-trial evaluation, identified almost 20% as having an IQ below 70.[18] A review by Lindsay cited that some researchers reported higher rates of sexual offences amongst people with intellectual disability.[10] However, he concluded that overall “there was no clear evidence for the over- or under-representation of people with developmental disabilities among sex offenders”.[21]

Another review by Holland et al., cited a 1973 study by Walker and McCabe which, which found that one third of a sample of men, in a psychiatric hospital population, who were of below-normal intelligence, were responsible for more than half of the sexual offences of the group.[25,26] However, Holland et al. also referred tomore recent studies which showed that sex offending cannot be sufficiently explained by onlya

person's (low) IQ.[26] What was evident from a study of 950 sex offenders by Blanchard et al. was that sex offenders with intellectual disabilities were more likely to commit offences against younger children and male children.[27]

In a study by Fyson, who investigated etiological factors contributing to sex offending in people with intellectual disability, the main factors identified included school dropout rates and previous inappropriate sexual behaviour without appropriate responses.[28] Steptoe et al., found that poor relationships, less motivation to change and a lower level of integration were also main factors.[29] In a review article, Jones reports that the majority of studies looking at the relationship between intelligence and offending found that similar characteristics and risk factors between the general population lead people with intellectual disability to increased contact with the CJS.[30] These included male gender, psychosocial disadvantage, familial offending, history of behavioural problems, unemployment and co-morbid mental-health needs.[30]

(5) **Special requirements**

The role of the CJS in relation to offenders with intellectual disability is the focus of several studies.[14] Sondenaa et.al. have discussed the entrance into the CJS, the social climate in forensic hospitals and the general situation for offenders or alleged offenders with intellectual disability and the CJS.[14] Leggett et al. explored the experience of being interviewed by the police, from the perspective of people with intellectual disability, in a discussion of 15 cases.[31] Their study pointed out the importance of having an appropriate adult present as support through the interview.

The extent to which the CJS is unfit to confront the needs of offenders or alleged offenders with intellectual disability has also been emphasized in two other inquiries which highlight critical problems facing offenders with intellectual disability in their relations with the CJS.[32, 33] These authors recommend several options for improvement, most importantly highlighting the importance of effective and reciprocal information sharing between the CJS, mental health, social services and education departments and the development of alternatives to custody.

1.2.2. **Intellectually disabled offenders in psychiatric hospitals**

In a recent large Scandinavian retrospective record review published online in January 2015, Sondenaa et al. reviewed patients with intellectual disabilities admitted to forensic asylums and hospitals over almost 70 years, from 1915-1982.[34] In this study, 272 patients were included and the investigators examined these patients' background based on the characteristics of their lives prior to admission, including key elements from their childhood and important life experiences.[33] This were categorised as numerical and descriptive variables. Findings from this study included that:[33]

- the mean age of this group on first admission to a forensic psychiatric hospital was 31 years, and all patients in this group were male;
- 17.2% had a severe medical illness, mainly epilepsy and encephalitis, with 8.6% of these with a history of a severe (head) injury due to accidental falls;
- although 66.5% had entered normal schools only 21% of the study population completed primary school; some subjects were transferred to special schools (23.9%);

- a large proportion had no previous work experience (43.8%) and those with work experience were mostly unskilled or casual workers (44.1%);
- some offenders had a history of multiple offences; 30.5% of the subjects had a (prior) history of committing petty theft and 4% had a history of being involved in organised crime or robbery; in total, 30.1% committed sexual offences, namely attempted rape (13.2%), rape (6.3%) and/or indecent exposure (15.5%);
- a significant percentage of these subjects (34.4%) also had a history of violent crimes, including homicide (4.4%), “serious violence offences” (15.1%) and “less serious violent offences” (18%); 14.3% had a history of being charged for damaging property; 9.6% committed arson;
- other offending behaviour included illegal begging (6.3%), threats (18.4%) and public order offences (25%);
- co-morbid diagnosis of psychosis was present in 20.6% of cases and other psychiatric disorders with less-specific descriptions were diagnosed in 14.3% of the subjects.

1.2.3. **South African data**

During the 2001 census, a total of 2 255 982 South Africans reported that they had some kind of disability that prevented them from full participation in life activities.[35] This number constituted 5% of the total population enumerated in the census. Intellectual disability was reported in 12.4% of cases of disability. The 2011 census, however, only recorded difficulties that prevent a person from full participation in life activities, with the result that a figure for intellectual disability per se is not reported on.[36]

A descriptive, retrospective study conducted at the Free State Psychiatric Complex describes the profile of forensic psychiatric inpatients who were admitted over a four year period.[37] A total of 120 patients admitted under Section 42 of the Mental Health Care Act were included in the study. Most of the offences that these patients were charged with were of a sexual nature (45.8%). Ten percent of the subjects had a diagnosis of intellectual disability. Another study, similar to this research project in many ways, analysed the accountability and fitness to stand trial of intellectually disabled people awaiting trial referred to the Free State Psychiatric Complex from 1993 to 2003 for forensic psychiatric observation according to Sections 77 and 78 of the CPA.[38] These results showed that 71.25% of the intellectually disabled observandi in this study was not triable and unaccountable. The majority of subjects were male (96.3%), unmarried (76.3%) and unemployed (63.8%). The median age was 27 years, while 49% received some sort of schooling and 16% attended a special school. The highest number of offences was of a sexual nature (78%). Of the subjects, 62.4% had mild intellectual disability, while 16% were diagnosed with moderate disability.

Sterkfontein Psychiatric Hospital (SFH) located near Krugersdorp, Gauteng, is one of the large specialised psychiatric hospitals in the country and is included in the academic circuit of the University of the Witwatersrand. As such SFH also undertakes research and provides academic training to undergraduate and postgraduate students. While one of its primary service delivery functions is to serve as a referral facility for the assessment of forensic observation cases, its other services include care, treatment and rehabilitation of users admitted under Section 42 of the Mental

Health Care Act, No. 17 of 2002 (previously known as “state president’s detainees”). It also caters for mentally ill patients referred from other hospitals or courts, after forensic observation, for involuntary care. One study conducted at Sterkfontein Hospital reviewed individuals who allegedly committed sexual offences against minors.[39] This retrospective record review was done of all observandi referred between January 2007 and December 2009 for a charge of a sexual nature and included 128 subjects. The most common diagnoses made in this group were intellectual disability and substance related (27.34% each).[38]

1.3 **Study purpose and objectives**

No specific study, however, had been done though at SFH on the impact of intellectual impairment on the forensic observation process. The purpose of this study was therefore, to ascertain the outcome in a population of offenders referred for forensic psychiatric observation at SFH. The objectives of the study were:

1) To identify and describe individuals with intellectual disability admitted to SFH for forensic observation during a specified study period, in terms of their demographic and clinical characteristics; and
2) To investigate these characteristics in terms of the nature of the alleged crimes committed and in terms of the outcome of their forensic assessment, namely their capacity to stand trial and the measure of their criminal responsibility.
3) To investigate the outcome of forensic assessment in the study population.

1.4 **Hypothesis**

The hypothesis was that the degree of intellectual disability would affect the outcome of the forensic assessments in terms of fitness to stand trial, criminal responsibility and recommendation.

CHAPTER 2. METHODS

2.1 Study design

This study was a descriptive, retrospective clinical audit of the data collected from clinical files of the observandi and CPA reports of the assigned state psychiatrists.

2.2 Study population

All individuals with intellectual disability referred for observation to Sterkfontein Hospital over a two-year period from January 2011 until December 2012. The study period was determined based on the number of referrals during this period and the anticipated percentage of cases of intellectual disability based on local literature.

2.3 Data collection

A data collection sheet was compiled to be used for the collection and collation of data and for recording it in an electronic spread sheet (Appendix A). The following variables from the clinical files of the observandi and CPA reports of the assigned state psychiatrists were included: age; sex; race; marital status; employment; highest level of education; charge; reason for referral; DSMIV-TR diagnosis; fitness to stand trial; criminal responsibility; and the recommendation for referral after assessment. Clinical

notes of the psychiatrists who diagnosed intellectual disability and the degree of impairment were not always available, only a summary of their conclusions. It was therefore not always possible to determine how they made their final diagnosis and recommendation. Assessment by other practitioners e.g. psychologists and occupational therapists is not necessarily standard practice.

Some qualitative themes obtained from the reviewed records were included in the results, where relevant, to provide more insight with regard to the profile of observandi and the nature of offences allegedly committed as well as their perception of the charges made against them. Aspects of methods of assessment in some of the cases were also discussed in the results to highlight issues with the observation process. There was only one investigator who gathered the information.

2.4 **Data analysis**

A quantitative analysis of all variables in the data set was made according to acceptable statistical principles and calculations and some comparative statistics. A statistician was consulted to assist with the data analysis. Although most of the analyses were descriptive, the association between the degree of disability (mild or moderate) and the outcome of the observation process - in terms of fitness to stand trial, was examined using t-tests and Fischer's exact tests. Using the same statistical principles, the mild and moderate groups were also compared with regard to the recommendation on whether observandi should be referred to the criminal judicial system, or be referred back to Sterkfontein Hospital as an involuntary user (or "state

patient" under the Mental Health Care Act, No 17 of 2002). Finally, the degree of disability of the two categories (mild and moderate disability) was compared to the outcome regarding examiners' recommendation on whether the accused was considered to be able to appreciate the wrongfulness of the alleged crime and act according to such appreciation. A p-value of less than 0.05 was considered to be of statistical significance.

2.5 **Ethics clearance**

The study protocol was submitted to the Human Research Ethics Committee (Medical) of the University of Witwatersrand. Permission to conduct the study at SFH was obtained from the Chief Executive Officer of Sterkfontein Hospital. If the participant was a state patient at the time of data collection, additional permission to be included in the study was also obtained from such patients or their relatives in cases where a patient was too impaired to consent. This was a specific request from the ethics committee. The information document and consent form for this purpose have been attached as Appendices B and C respectively. The ethics clearance certificate obtained has been included as Appendix D.

No interviews were conducted during this study, nor was active participation required from participating subjects. Confidentiality was maintained at all times as names and hospital numbers were not recorded on the data sheet. Only the principal researcher had access to the names of the obervandi which corresponded to the participant numbers on the data collection sheet.

CHAPTER 3. RESULTS

3.1 Descriptive data

A total of 589 adult observandi were referred to Sterkfontein between January 2011 and December 2012. The majority were male (89.6%, n=528), while only 10.36% (n=61) were female. Intellectual disability was diagnosed in 8.7% (n=51) of the 589 referrals following their assessment.

3.1.1 Demographic variables

(1) Age

Of the 51 observandi included in the study, the majority (49.0%, n=25) were in the age group 21 to 30 years. Two of the subjects were 18 years old and therefore the youngest in the study. A 52-year old observandus was the oldest and also the only person in the category 51-60 years. Only male adolescents are referred to Sterkfontein Hospital for forensic observation, as adolescent girls are referred to Weskoppies Hospital in Pretoria. All observandi below the age of 18 were therefore excluded from the study. Figure 1 shows how the age categories in the study were represented.

(2) Gender

Of the 51 observandi included in the study, 96.0% (n=49) were male, while only 4.0% (n=2) were female.

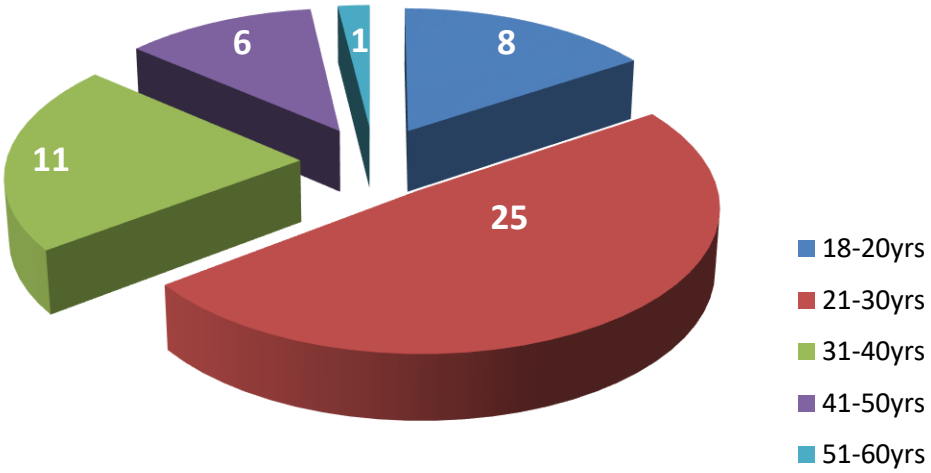


Fig 1. Age categories of observandi with intellectual disability, SFH 2011-2012 (n=51)

(3) **Race**

Figure 2 illustrates the race categories of observandi. The majority of individuals with intellectual disability during the study period was black (84.3%, n=43). No Asians with intellectual disability were referred, while 9.8% (n=5) were white and 5.9% (n=3) coloured.

(4) **Marital Status**

Only one observandus (2.0%) was married, the others were single (98.0%, n=50).

(5) **Highest Level of Education**

Most of the observandi (39.2%, n=20) in the study never progressed beyond primary school. Four subjects in the study were never schooled at all (7.8%). Only

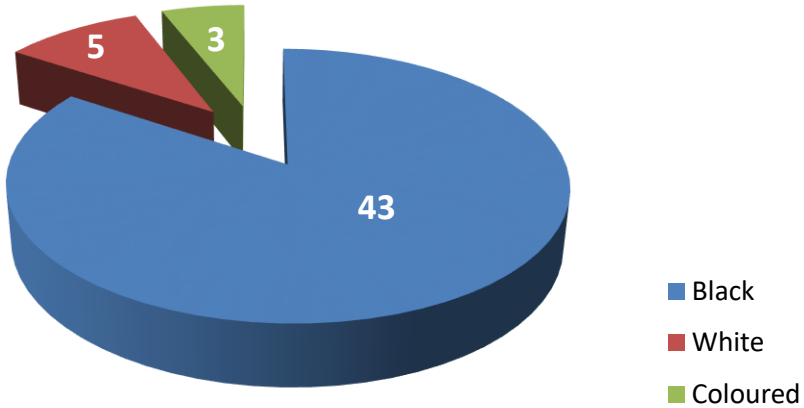


Fig.2 Race categories of observandi with intellectual disability, SFH 2011-2012 (n51)

one observandus attended a training centre, which is a facility where no academic work is done at all and learning is focused on acquiring practical skills, improving language and communication and developing life skills. About a third attended a special school (31.4%, n=16). No level comparable to standard education is achieved in such institutions; basic academic skills such as reading and writing is the goal and learners are broadly evaluated according to what degree they achieve these skills (such as elementary or full achievement or not achieved at all). Only 19.6% (n=10) reached secondary school. This category would include any grade completed in a

secondary school. None of the observandi included in the study managed to successfully complete secondary education, i.e. passing Grade 12. Figure 3 shows the various categories of highest level of education.

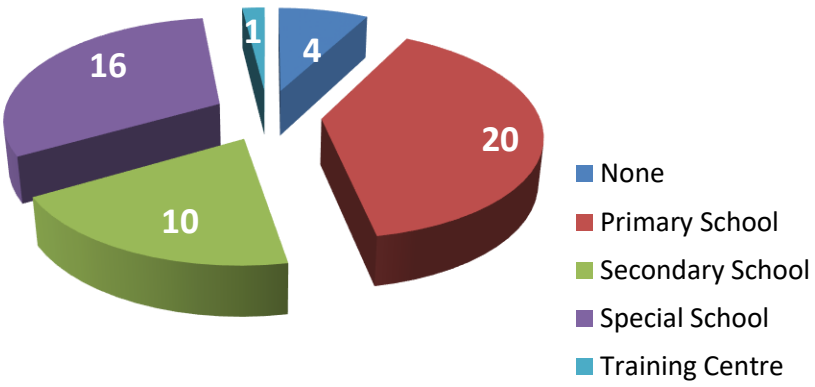


Fig 3. Highest level of education of observandi with inellectual disability, SFH 2011-2012 (n=51)

(6) **Employment Status**

Figure 4 illustrates the employment status of observandi in the study and clearly illustrates that the vast majority were unemployed at the time of admission for observation (76.5%, n=39). The second highest category included observandi who received a social grant in view of their disability and inability to function in an occupation (13.7%, n=7). Only two (3.9%) were formally employed and one (2.0%) was self-employed. One (2.0%) subject attended sheltered employment, where a person with disability performs tasks at a basic level with supervision for a minimal

income. One person in the study was still a scholar – attending a special educational facility –when he was assessed.

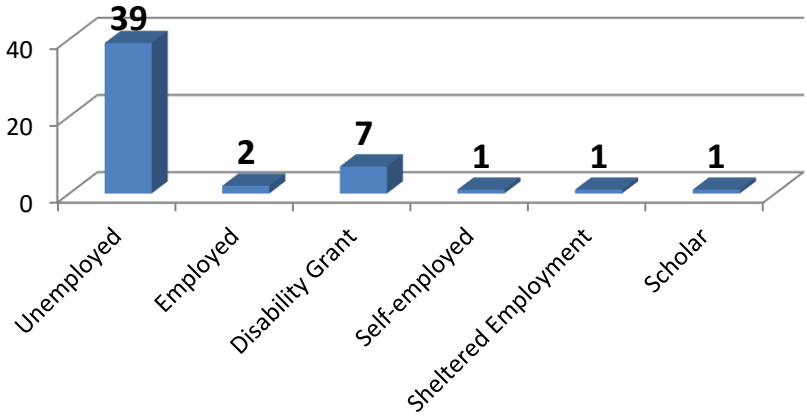


Fig 4. Employment status of observandi with intellectual disability, SFH 2011-2012 (n=51)

3.1.2 **Criminal charges**

Figure 5 shows the distribution of the various crimes of which observandi were accused. The most frequent charge was rape (45.1%, n=23).

Six observandi (11.8%) were charged with assault with the intention to do grievous bodily harmed, followed by 5 cases (9.8%) of attempted rape. Two observandi each were respectively charged with assault (3.9%), malicious injury to property (3.9%), robbery (3.9%), robbery with aggravating circumstances (3.9%), sexual assault (3.9%) and theft (3.9%). One case (2.0%) of each of the following was represented in the

study: attempted murder, attempted rape with aggravating circumstances, drug possession, murder and sexual exposure.

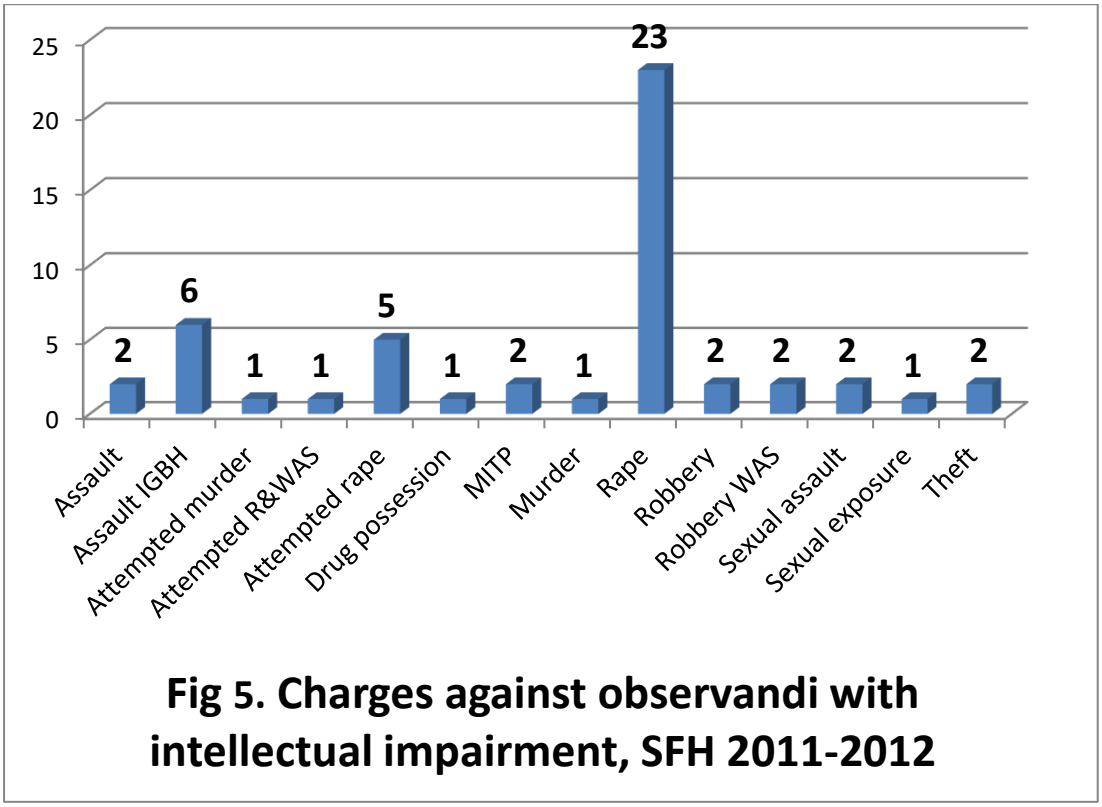


Fig 5. Charges against observandi with intellectual impairment, SFH 2011-2012

Assault IGBH – Assault with intent to do grievous bodily harm; R&WAS Robbery with aggravating circumstances; MITP - Malicious injury to property; WAS - with aggravating circumstances

3.1.3 **Reason for referral**

The most common reason why people with intellectual disability who were accused of committing an offence was referred for forensic psychiatric observation, was that collateral information was obtained from the family that suggested that the person is or may be intellectually impaired (41.2%, n=21). In most of these cases, the collateral information would be related to the highest level of education. The family would provide information such as that the person never went to school and can't read or

write, that they attended an institution that accommodates learners with intellectual disability or that they repeatedly failed grades in school.

The second largest category is represented by cases where observandi had a past psychiatric history (25.9%, n=13). Some of these observandi were known to the child psychiatric services and had been diagnosed with intellectual disability before the age of 18. In other instances, they may have presented in adulthood with behaviour problems related to their disability (such as disinhibition) or due to a co-morbidity. Examples of co morbidities will be discussed later in this chapter.

In a significant number of cases (17.7%, n=9) the forensic observation was requested by a lawyer. Lawyers often rely on information provided by family about possible impairment or a past psychiatric history, but in these cases the reason documented in the file specifically stated “requested by lawyer” as the reason for referral.

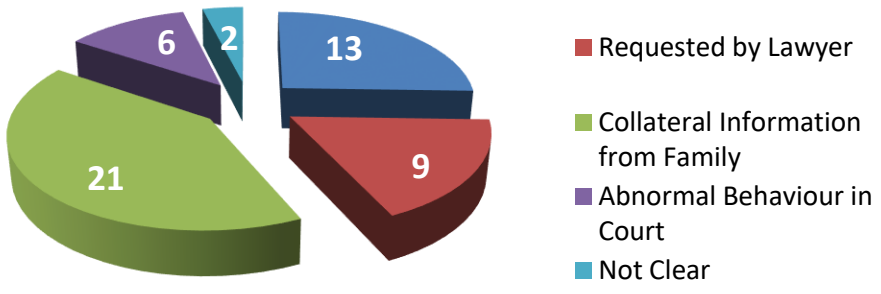


Fig 6. Reason for referral of observandi with intellectual disability, SFH 2011-2012 (n=51)

3.1.4 **Axis I diagnoses**

Figure 7 shows the various co-morbid Axis I diagnoses that were made in the study population. It is important to note that the majority of observandi had no diagnosis on Axis I at all (78.4%, n=40). At the same time, more than one Axis I diagnosis was present in the remaining 11 cases. Two observandi (3.9%) had three diagnoses and in four cases (7.5%), two diagnoses were present on Axis I. Substance misuse disorders were diagnosed in seven observandi (13.7%), some of who misuse more than one substance. A combined total of 11 diagnoses of substance misuse disorders were made. In one case, substance induced psychotic disorder was co-morbid with the misuse of the alcohol and cannabis. Other psychotic disorders were present in sixobservandi (11.8%), equally distributed into psychotic disorders not otherwise specified (n=2), psychosissecondary to a general medical condition (n=2) and schizophrenia (n=2).

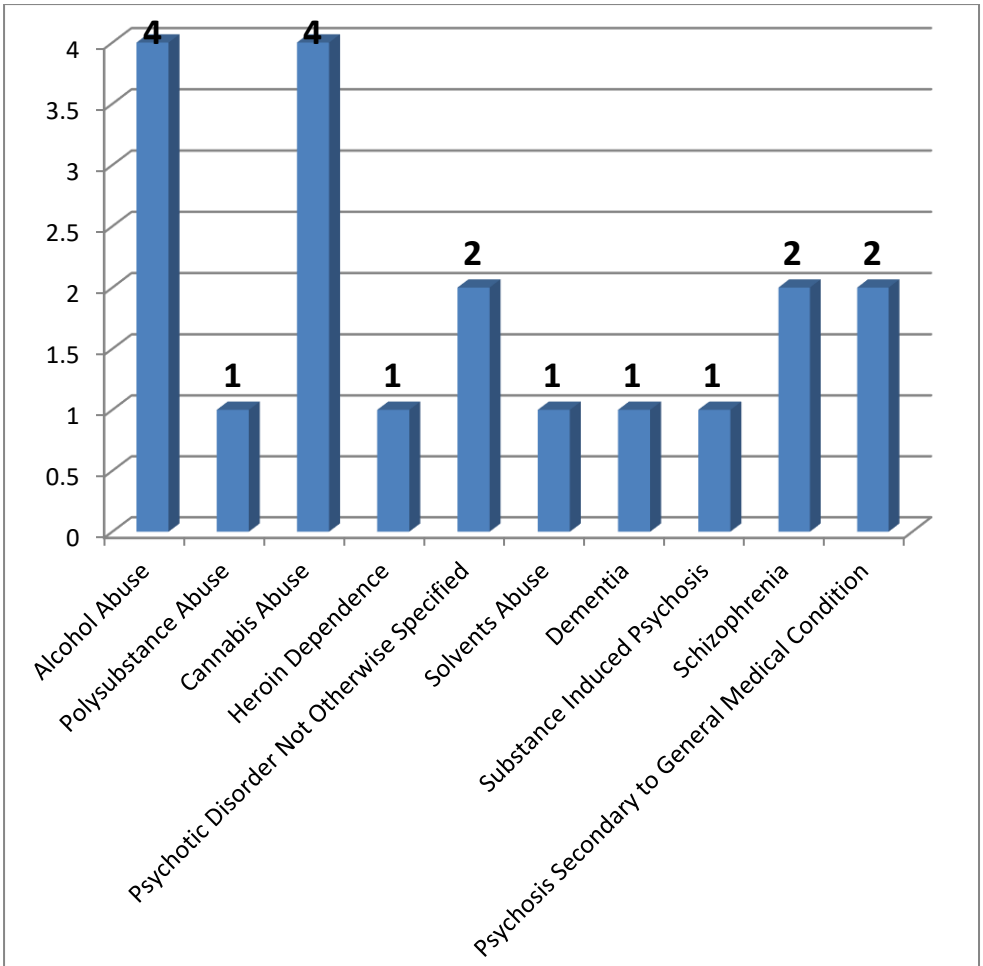


Fig 7. Axis I diagnoses of observandi with intellectual disability, SFH 2011-2012 (n=51)

3.1.5 **Degree of intellectual disability**

In figure 8, the degree of intellectual disability of observandi - as classified in DSM IV-TR on Axis II – is shown. Detailed information of the classification was described in Chapter 1. The majority of referrals fell in the moderate range (51.0%,n=26), followed by 22 referrals (43.1%) with mild disability. Only two cases (3.9%) were diagnosed with severe impairment; one being so impaired that he wasn't able to give any account when he was asked about his version of the offence. In one case (2.0%) the degree

of intellectual disability was not specified; in this case the outcome of the observation was determined more by the co-morbid Axis I condition, namely psychotic disorder not otherwise specified.

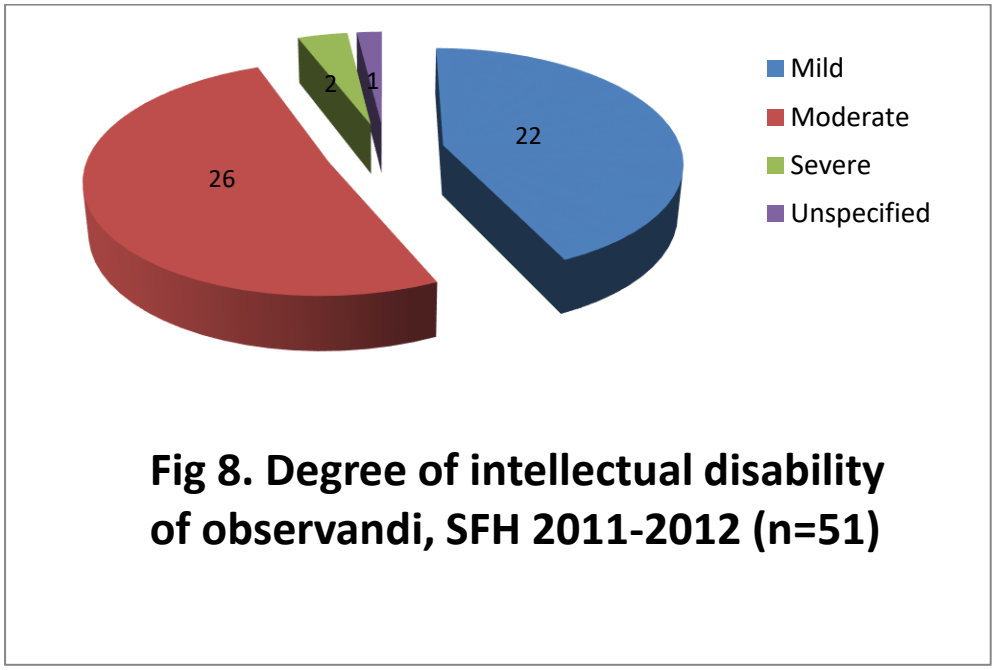


Fig 8. Degree of intellectual disability of observandi, SFH 2011-2012 (n=51)

3.1.6 **Axis II co-morbidities (personality disorders)**

In only one case (2.0%) a personality disorder was made, namely antisocial personality disorder.

3.1.7 **Axis III diagnoses (medical conditions)**

At least one co-morbid Axis III diagnosis (general medical condition) was present in 21.6% of the observandi (n=11). In one case, three diagnoses were present on Axis III: epilepsy, hypertension and a previous traumatic brain injury. Another subject had two co-morbid medical conditions: diabetes and epilepsy. Of the 11 observandi in this group, nine only had one condition on Axis III. The most frequent diagnosis made on

AxisIII was epilepsy, which was present in 15.7% (n=8) of the observandi in the study.Two of the observandi were HIV positive (3.9%). Only one case of each of the remaining medical conditions represented in Figure 9 was present.

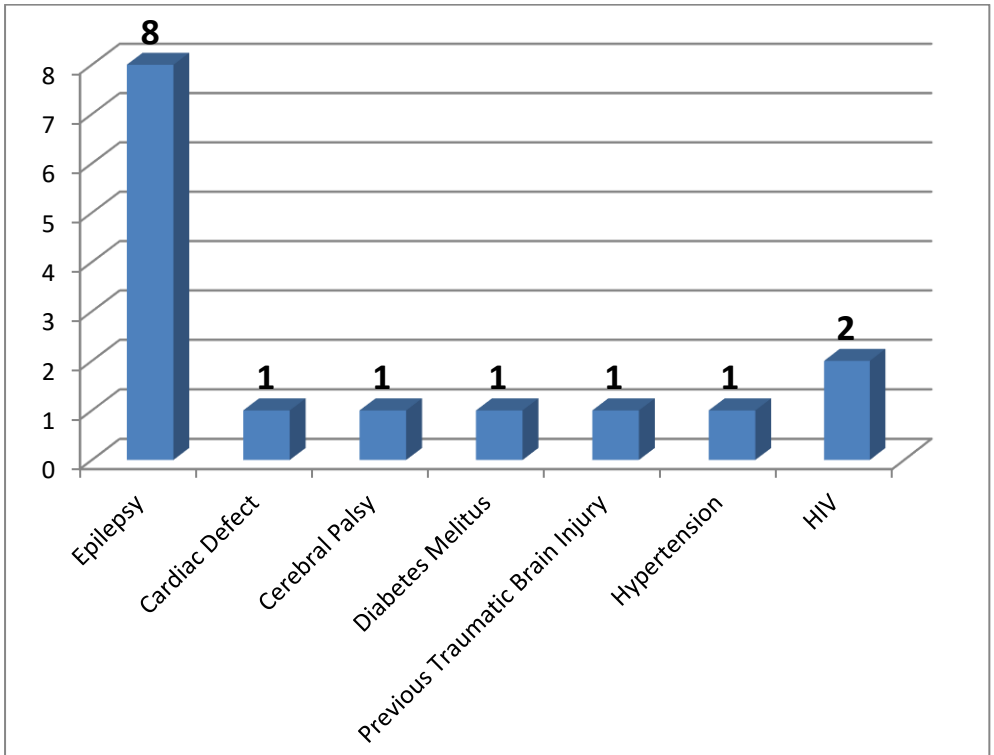


Fig 9. Axis III diagnoses of observandi with intellectual disability, SFH 2011-2012 (n=51)

3.1.8 **Fitness to stand trial**

Figure 10 shows the outcome of the assessment of observandi after the 30-dayobservation period in terms of their fitness to stand trial. The number of observandi not fit to stand trial (62.7%, n=32) was greater than when the finding was that they were fit to stand trial (37.3%, n=19).

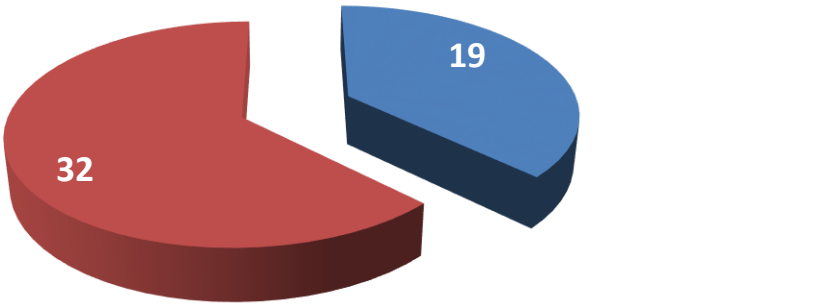


Fig 10. Fitness of observandi with intellectual disability to stand trial, SFH 2011-2012 (n=51)

3.1.9 **Accountability**

Figure 11 illustrates the categories of possible outcome of the assessment in terms of accountability, which is divided into two legs: whether a person was able to appreciate the wrongfulness of their commission or omission of an act and whether they were deemed to be able at this time to act in appreciation of such wrongfulness. The three possible combinations of these two possibilities is shown in this figure. The most common combination was where the observandi appreciate the wrongfulness, but was not able to act accordingly due to various reasons which were discussed in chapter one (39.2%, n=20). In 18 cases (35.3%), the observandi were deemed to have both being able to appreciate wrongfulness as well as act in accordance to this. In 12 observandi (23.5%), the finding was that they were neither able to appreciate wrongfulness, nor act according to appreciation of wrongfulness. In onecase, the panel was not able to comment on accountability due to limited information that was available.

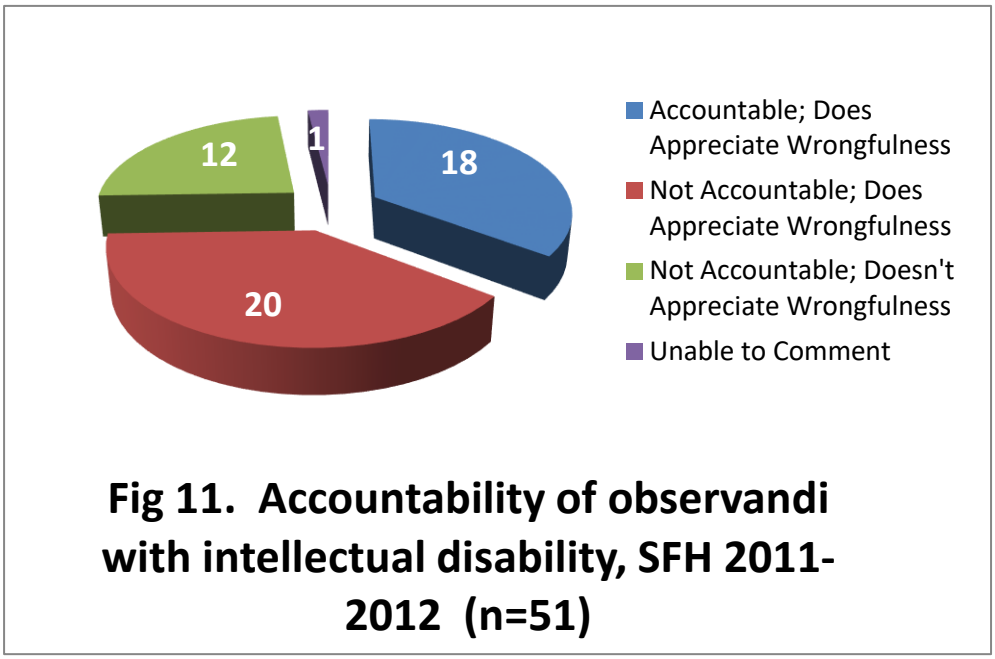


Fig 11. Accountability of observandi with intellectual disability, SFH 2011-2012 (n=51)

3.1.10 **Outcome of assessment process (recommendations)**

Based on the findings of the panel following the observation process (shown in Figure 10 and Figure 11), the possible recommendations are illustrated in Figure 12. In 25 of the reports (49.0%), it was recommended that the court should refer the observandi back to Sterkfontein Hospital to be admitted as state patient, either based on reduced accountability or fitness to stand trial.

For another nine observandi (17.7%), the recommendation was that they should be admitted too, but as involuntary users according to the Mental Health Care Act. The reasons were similar as for the former category, but the risk was usually judged to be lower in these cases due to the nature of the crimes or the past history of the observandi. Only in 17 cases (33.3%)the observandi were found to be fit and responsible enough to be referred to the criminal judicial system to stand trial.

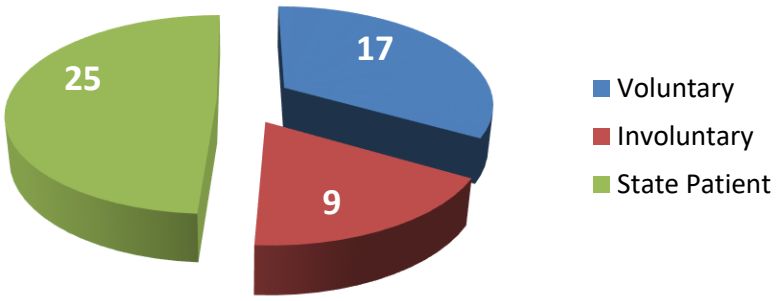


Fig 12. Recommendation/outcome of process for observandi with intellectual disability, SFH 2011-2012 (n=51)

3.2 Comparative Variables

Table 1 summarises the comparison between the severity of intellectual impairment compared with fitness or not to stand trial, with the recommendation after the forensic assessment and with the finding regarding accountability and criminal responsibility.

Table 1. Severity of intellectual disability compared to fitness to stand trial, recommendation and criminal responsibility of observandi with mild and moderate intellectual disability at Sterkfontein Hospital 2011-2012

1. Severity versus fitnessto stand trial (n=48)			
Severity of intellectual impairment	**Not fit to stand trial**	**Fit to stand trial**	**p-value**
Mild	6	16	<0.001
Moderate	24	2	

2.Severity versus recommendation (n=48)				
Severity of intellectual impairment	**Referral back to CJS**	**Involuntary**	**State**	**p-value**
Mild	16	1	5	<0.001
Moderate	1	7	18	

3. Severity versus accountability (n=48)				
Severity of intellectual impairment	**Accountable**	**Not accountable, appreciates wrongfulness**	**Not accountable, doesn't appreciate wrongfulness**	**p-value**
Mild	16	5	1	<0.001
Moderate	2	15	9	

3.2.1 **Severity versus fitness to stand trial**

The outcome in terms of fitness to stand trial was compared against the degree of disability for the two categories of mild and moderate intellectual disability. Of the 30 observandi with moderate disability, 92.3% (n=24) were not fit to stand trial, while only 7.7% (n=2) were fit.

In the group with mild disability only 11.8% (n=6) were not fit to stand trial, while 31.4% (n=16) were fit. The association between the degree of disability and fitness to stand trial was strong ($p<0.001$).

3.2.2 **Severity versus recommendation**

The recommendation following assessment was compared against the degree of disability for observandi with mild and moderate intellectual disability. In the majority of cases for the moderate group (69.2%, n=18), it was recommended that the observandi should be referred back to be admitted as state patients, followed by 26.9% (n=7) of recommendations for involuntary care and only 3.9% (n=1) for referral to stand trial.

This order did not apply for the group with mild disability. Of the 26 observandi in this group, the recommendation in 72.7% of cases was for voluntary care (n=16), followed by state patient (22.7%, n=5) and in the minority of cases, involuntary care (4.6%, n=1). A strong association between the degree of disability in these groups and the outcome in terms of recommendation was present ($p<0.001$).

3.2.3 **Severity versus accountability and criminal responsibility**

The degree of disability for the mild and moderate group was also compared against the outcome of the observation process in terms of criminal responsibility. In the group with mild disability, only 27.3% (n=6) had reduced criminal responsibility, while 72.7% (n=16) were deemed responsible for the crimes they were charged with.

In the group with moderate disability, only 7.7%(n=2) were found to have been able to appreciate the wrongfulness of their alleged crimes and act according to appreciation of such wrongfulness, while 92.3% (n=24) had reduced criminal responsibility. A strong association between the degree of disability and the finding in terms of criminal responsibility was demonstrated ($p<0.001$).

3.3. **Qualitative Information**

The majority of observandi (45.1%) were charged with rape. A recurrent theme in these cases was a child-like account of events and a lacking ability to take responsibility, which seemed to be most pertinent where the victims were minors. In one case, the accused claimed that a neighbour had forced him to rape a 9-year old. Another observandus reported consensual intercourse with a 5-year old. According to one subject, a 10-year old had forced him to penetrate her and that she persisted despite his protest.

The two female observandi were charged with drug possession and assault respectively.

The two charges of robbery had a component of confrontation and physical for e.g. grabbing someone's handbag after pushing them over, as was alleged in one case, as opposed to the two charges of theft, where one of the observandi tried to leave a department store with a television without paying for it. The other person charged with theft was accused of stealing a small amount of money. The two observandi charged with robbery with aggravating circumstances (with their respective co-accused) were both allegedly armed.

In the murder case, the accused hit his victim over the head with a brick after the victim refused him access to his shop. In his version of events he claimed that the victim was holding a 'knob kierie' and that he acted in self-defence.

CHAPTER 4. DISCUSSION

This study reviewed intellectually disabled people charged with criminal offenses who were referred to SFH for forensic psychiatric observation during 2011 and 2012, and describes the demographic profile, clinical characteristics and the type of crimes committed by this group. The outcome of these assessments were examined in terms of their fitness to stand trial and of their criminal responsibility, in order to gain an understanding of the impact of intellectual disability on the recommendation of the eventual report compiled from a panel of clinicians' assessment in the forensic unit.

From a large total number of 589 referrals during the study period, 51 cases of intellectual disability were identified and included in the study. When compared to local studies, where the estimated percentage of referrals is between 10 and 11%, the percentage of referrals to Sterkfontein appears to be a bit lower (8.7%).[7, 37] The discrepancy may be a result of the small sample. One will also have to consider the possibility of under-referral due to cases that may have been overlooked within the criminal judicial system.

The highest percentage (49.2%) of observandi was in the age category 21 to 30 years. This is consistent with a similar retrospective record review from the Free State Psychiatric Complex that was published in the South African Journal of Psychiatry in 2007, where the mean age was 27.[38] The overall trend in terms of gender of all referrals is that the majority of observandiwere male: 89.6% of the total of 589 during the two-year study period. In the sample of 51 patients this trend is even more marked with 96.1% being male. This may be related to the fact that the overwhelming gender of sex offenders in general populations is male and a large percentage of observandi

in this study (58.8%, n=30) was charged with rape, attempted rape and sexual assault (cumulatively). The gender distribution in this sample is similar to the study conducted at the Free State Psychiatric Complex, where 96.3%of their subjects were male.[38] The high percentage of black observandi (84.3%) is consistent with the fact that the largest percentage of South Africans are black, 79.2% according to the latest census.[36]

The majority of observandi was educated in the mainstream educational system (58.8%), although none completed school successfully, while 19.6% of the observandi managed to complete primary school. This finding is similar to the results in the Scandinavian study by Sondenaa and colleagues, which reported a 21% rate of completion of primary school education.[34] However, a higher percentage of subjects (41.9%) attended some form of special schooling for the intellectually disabled in the study by Sondenaa, compared with this study whereas only 31.4% attended a special school.[34] This Scandinavian study was, however, conducted in a first world setting, which may account for the discrepancy. In the Free State Psychiatric Complex study only 16.0% of the subjects had a background of special schooling though.[38] The low level of referral to the special educational system is alarming and may be an indication that people with intellectual disability may often be ignored within the public education system. Similarly, although 62.6% of observandi were considered to be too impaired to stand trial and 74.5% did not have criminal responsibility, only 13.7% were earning a disability grant, while most of them were unemployed (77.0%). Although it is beyond the spectrum of this study, one may question how many people with intellectual disability within the criminal justice system are not appropriately referred either.

As mentioned before, offences of a sexual nature is prominent in this study (58.8%), followed by assault with the intent to do grievous bodily harm (11.8%). Rape, specifically, was the most common charge (49.0%). The Free State Psychiatric Complex study reported an even higher frequency of alleged sexual offences (78.0%).[38] The profile of offences in the first world retrospective review by Sondenaa follows a different profile with sexual offences forming only 30.1% of offences committed.[34] In this Scandinavian study, however a number of offences are represented in a higher percentage: theft and robbery 34.4% (versus 11.8% in this study); violent offences 34.4% (19.6% in this study); damage to property 14.3% (3.9% in this study); arson 9.6%, illegal begging 6.3%, threats 18.4%, public order offences 25.0% (none for these four categories in this study). It is possible that some of these offences, especially illegal begging, threats and public order offences may be underreported in a developing country such as South Africa.

Reasons for referral for observation in this study were collateral from relatives (41.2%), past psychiatric history (25.5%), requested by the lawyer accused (17.7%) or abnormal behaviour that was displayed in court (11.8%). In two cases the reason was not clear. It has to be noted though that there may often be an overlap in reasons, e.g. where collateral information from relatives include both a history of special schooling and treatment by a psychiatrist in the past. A history of poor school performance in the past or attending a special school seemed to be the most common type of collateral history mentioned in reports. Due to the fact that this was not always clearly reported, the specific nature of collateral information was not measured in the study.

One or more DSMIV-TR Axis I psychiatric disorder was present in 21.6% of the observandi. Substance misuse disorders were the most common diagnosis and present in 63.6% of cases where at least one Axis I condition was present. It is important to consider the difficulty in diagnosing psychiatric conditions in people with intellectual disability, however, for various reasons. They may e.g. have difficulty in expressing themselves, or struggle to interpret questions and the clinician often has to rely heavily on information provided by family or other professionals who are dealing with the person. This may have impacted on the percentage reported. It is important to note that this sub-group of intellectually disabled offenders with co-morbid psychiatric issues is at higher risk for offending.[7]In total, 60.8% of the subjects only had a diagnosis of intellectual disability. In the Sondenaa study, this percentage is significantly lower – only 44.1% of the subjects had no other diagnosis than intellectual disability.[34] The percentage of patients with psychosis was reported as 20.6% in their study, which is higher than the 9.8% in this study. It is difficult to compare other diagnoses between the two studies, due to the less specific descriptions of other conditions in the Scandinavian study such as neurosis, sociopathy, sexual perversions and deviant emotional personality which were used before the DSM IV-TR.[34] The lower rates of co-morbidities in comparison to the study published by Sondenaa and colleagues may be explained by the fact that the intellectual disability in observandi in this study was often the reason for reduced criminal capacity or fitness to stand trial, and was therefore emphasised in the diagnostic formulation. Again, the possibility that other diagnoses may have been overlooked has to be considered. Table 2 compares the characteristics of observadani in this study with the study population in the study by Sondenaa et al.[34]

Table 2. Comparison of characteristics of observandi in this study with the study population in the study by Sondena et.al.[34]

	Sterkfontein observandi	**Scandinavian study population, Sondenaa et al.[34]**
Mean age	25	31
Gender: male	89.6%	100.0%
Medical Conditions/Axis III	21.6%	17.2%
Unemployed	76.5%	43.8%
Charges 1. Theft	 3.9%	 30.5%
2. Robbery	7.7%	4%
3. Sexual Offences	62.7%	30.1%
5. Homicide	2.0%	4.4%
6. Serious Violence	13.7%*	15.1%
7. Less Serious Violence	3.9%**	18.0%
8. Damage to Property	3.9%	14.3%
9. Arson	0.0%	9.6%
10. Illegal Begging	0.0%	6.3%
11. Threats	0.0%	18.4%
12. Public Order Offences	25.0%	0.0%
13. Drug Possession	2.0%	0.0%
Axis I Comorbid Conditions	21.6%	34.9%

*Included: Attempted Murder. **Included: Assault with Intention to do Grievious Bodily Harm

Only one diagnosis of a personality disorder, namely anit-social personality disorder, was made (2.0%) in this study. This is much lower than what was reported by Lindsay et al., where a diagnosis of anti-social personality disorder was made in 22.1% of a

forensic intellectual disability sample of 164 subjects.[21] The study by Flynn and colleagues also reported a much higher prevalence of personality disorders in their study population (39.0%).[22] This may, again, illustrate the difficulties in diagnosing co-morbid psychiatric disorders in people with intellectual disability. One of the key features in anti-social personality disorder is a lack of remorse. If an intellectually disabled person is so impaired that they can't appreciate the wrongfulness of the crime they have committed, as was the case in 23.5% of observandi in this study, it almost goes without saying that there would be a lack of remorse. As pointed out by Pridding and Procter, the concepts of empathy and remorse are abstract and may be difficult to explore in a group of intellectually disabled offenders.[23]

General medical conditions were present in 21.6% of observandi in this study with epilepsy being the most common diagnosis, reported in 15.7% of the subjects. This is not surprising, as epilepsy is a common co-morbidity in general in intellectual disability, often as a result of a history of some sort of trauma in the developing brain.[4] The high incidence of epilepsy is of importance as epilepsy per say may impact on criminal capacity, if ictal symptoms occurred around the time of the offence. Only 3.9% of the study population was reported to be HIV positive. It is highly likely that the actual percentage would have been higher if all the subjects were tested, especially in view of the sexual nature of many of the crimes. A Zambian study looked at the prevalence rate of HIV amongst prison populations in Southern Africa and found that the highest reported rate was in South Africa with an estimated figure as high as 41.4%.[40] No studies are available for HIV prevalence amongst intellectually disabled prisoners, but there appears to be a gross discrepancy.

The majority of cases either had moderate (51.0%) or mild (43.1%) intellectual disability. This is different from the Free State study, where only 16% were diagnosed with moderate disability and 62.5% with mild impairment.[38] This also implies that they reported a higher percentage of severe disability, while only3.9% of observandi in this study had severe intellectual disability. Only one forensic report in this study did not specify the degree of impairment. This may reflect the fact that examiners find it important to categorise the severity to help with the decision of whether observandi are fit to stand trial or criminally responsible.

This conclusion fits with the comparative statistics, where a strong association between the degree of disability and the outcome of the assessment was demonstrated. Some concern may be raised regarding the accuracy of the diagnosis of the level of impairment. Only 11.8% observandi had a formal cognitive assessment of sorts. In some way, this could be explained by the fact that adaptive functioning plays an important role when dealing with intellectually disabled people in general, but even more so when a judgment regarding fitness and responsibility has to be made within the forensic context. This would explain why a larger percentage was referred for functional assessments by an occupational therapist (49.0%). An equal percentage (49.0%) was neither assessed by an occupational therapist nor a clinical psychologist at all. However, according to Kaliski, if an assessor identifies deficits, it has to be confirmed by either using assessment scales or a battery of diagnostic tests.[7]

Although DSMIV-TR gives a description of how patients with various degrees of disability function in different spheres, which means that a clinical interview in combination with collateral information may be sufficient for diagnosis, a specific IQ

value is still attached to each degree of severity (as specified in Chapter 1). Considering that the majority of observandi were not fit to stand trial (62.8%), in view of the fact that the most common degree of disability that was diagnosed was moderate and the fact that the association between degree of disability and fitness to stand trial was strong, this result is not surprising.

Likewise, an outcome of reduced responsibility in terms of criminal capacity was found in the majority of observandi (62.8%), based on either reduced accountability and/or the ability to appreciate wrongfulness of a commission or omission of an act leading to a charge. This is also consistent with the strong association that was found between degree of disability a criminal responsibility.

In 49.0% of cases, the most common category under recommendation, it was advised that theobservandi should be referred back to Sterkfontein as state patients. Similar to the other two categories of outcome, i.e. fitness to stand trial and criminal responsibility, this fits with the association demonstrated between the degree of disability and recommendation. Given the serious nature of many of the alleged crimes, the relatively low percentage (17.7%) of cases where the recommendation was involuntary treatment under the Mental Health Care Act at Sterkfontein Hospital, is to be expected. One would also question the purpose of admitting someone with intellectual disability to a psychiatric hospital as the condition per se is not treatable, unless co-morbid psychiatric conditions or behavioural issues have to be addressed. Similar local studies do not report on assessment outcomes in terms of recommendation, which makes it difficult to compare referral routes in different centres that fall under the same national legislation.

On balance, 66.7% of observandi were deemed not fit to stand trial and/or not criminally responsible. This is consistent with the fact that the majority of observandi was either moderately or severely impaired. This result can be compared to the outcome of the Free State Psychiatric Complex study, where in 71.3% the outcome of the observation was that the observandi were found neither fit to stand trial nor accountable for the crimes they were accused of.[38]

Limitations

The study takes into account only those individuals who have been referred for psychiatric observation to Sterkfontein Hospital during the proposed study period. The accuracy and completeness of the proposed retrospective data is an acknowledged limitation, as it is depending on how meticulous information has been documented in the files. Some of the categories in the data sheet may be open to interpretation, e.g. reason for referral: there may be many possible explanations for abnormal behaviour in court and the nature of collateral information obtained from family could be diverse.

The summary of the observation period, which includes all the information that was retrieved for the data sheet, is not compiled by the psychiatrists on the panel, but registrars or sometimes medical officers or intern psychologists. Although they are usually familiar with the cases and are typically the first professionals to interview the observandi, they may still be junior with limited experience. The qualified psychiatrists on the panel usually write a letter which states what the outcome of the observation process was and write a recommendation as to where the patient should be referred.

This letter is always present in the files, but their notes of interviews are not necessarily available.

There is a lack of both international and national similar studies available for comparison of results. This may have impacted on conclusions that were made.

The sample was also fairly small with 51 subjects. However, enough observandi were included to find statistically significant associations and an adequate study was allowed.

CHAPTER 5. CONCLUSION

A significant number of observandi referred for forensic psychiatric observation in South Africa are intellectually disabled, an estimate of 11.0% according to local literature, while in this study it was 8.7%.[7,38] The majority of referrals (51.0%) were in the moderate range of impairment.

Co-morbidities were present in the sample. One or more Axis I (psychiatric) condition were present in 21.6% of observandi and the same number (21.6%) had at least one Axis III (general medical) co-morbid condition. Clinicians in the forensic setting should therefore consider the possibility of co-existing conditions in this population as this may affect the outcome of the observation period. These conditions often have to be treated as well, in order to act in the best interest of the observandus.

The serious nature of the charges, with rape being the most common (45.1%), is of great concern and highlights the responsibility of the both the forensic psychiatric as well as the criminal justice system to assess and refer observandi in this population appropriately, to ultimately control risk.

Assessments in these cases present many challenges due to the nature of the disability. Interviews are usually the central component of evaluations and observandi, although intellectual disabled individuals often have difficulty with understanding questions, ways of expressing themselves and may find the situation overwhelming and difficult to make sense of. Consistent with the hypothesis of the study, the degree of disability did have an impact on the outcome of the process in terms of criminal responsibility, fitness to stand trial and the recommendation on completion of the

assessment. Categorizing observandi according to their degree of disability is also not an easy task. Adaptive functioning is a guide for clinicians, although an IQ value is attached to the degree of disability in the DSM-IV and a clinical diagnosis based on an interview and collateral information is often subjective. Given this challenge, this study concludes that other diagnostic instruments, such as formal functional and intellectual assessments are often under-utilized.

Even though an association between the degree of disability and the outcome of the forensic psychiatric observation process seems to exist, being able to specify the level of disability (mild, moderate or severe) does not provide a simple solution in terms of what the examiners should recommend in terms of whether observandi with intellectual disability should stand trial, have criminal responsibility, and whether they should be managed within the criminal judicial system or as involuntary or state patients. Although observandi in this study diagnosed with mild disability were more likely to be fit to stand trial and have criminal capacity, 27.3% were still considered not to be fit to stand trial, while an equal percentage within this group (27.3%) were deemed to have reduced criminal capacity - either based on their inability to appreciate the wrongfulness of the alleged crime or to act in accordance with such appreciation. Likewise, although the highest percentage within the group with moderate disability was not fit to stand trial and had reduced criminal responsibility, in two cases within this group, the finding was that they are fit to stand trial and in two cases the observandi had full criminal responsibility.

Examining the impact of the categories of intellectual disability on the outcome of the forensic observation process was the central goal of the study. It was shown with this

study that this impact is significant: the majority of cases were not fit to stand trial (62.8%); while 64.7% had reduced criminal capacity (based on either or both legs of responsibility); and in the majority of cases (66.7%), the recommendation was that the observandi should be admitted at Sterkfontein Hospital - either as involuntary or state patients. At the same time, intellectual disability does not automatically exclude a person from standing trial and having criminal responsibility, as illustrated by these findings.

Future studies may include observandi over a longer period of time to increase the number of subjects to create a bigger sample. Specific research looking at assessment methods will be valuable in terms of improving the accuracy of diagnoses made and ultimately improve recommendations. Research is needed on how intellectually disabled people are managed once they return to a psychiatric hospital as a result of the recommendation after the observation period as insight will likely lead to improved treatment and services for these patients and a reduction in future risk.

5.1 Recommendations

With regards to the observation process per se and the forensic psychiatric evaluation, an attempt should be made to make use more often of objective assessment methods, e.g. formal intellectual testing and reports from occupational therapists on adaptive functioning. It will also be useful if the reasoning behind the outcome of the assessment was motivated and available. Specific detail on how the panel reached the conclusions that influenced the outcome and what the motivations for decisions were, may assist the courts better as well as professionals who subsequently may

refer to the notes in future, should observandi be referred back for treatment as state or involuntary patients. This will also be useful when research in the same field is conducted in future as it will provide more insight.

Relevant literature and the results of this report highlight problems with the management of people with intellectual disability within the social and criminal justice system. While the condition of intellectual disability may be static, co-morbidities and behavioural problems should be managed appropriately to prevent criminal behaviour. Medication should be prescribed when indicated and patients should be included in structured behavioural and rehabilitation programs. The availability of such programs is a problem and this should be addressed by governing authorities. Families of people with intellectual disability should also be educated on how to reduce risk. The high rate of charges for rape of minors is alarming and suggests that supervision is often inadequate.

The poor educational and employment history likely contributes to crime incidence. In this population, people with intellectual disability should be referred for special or remedial education, rather than just being allowed to fail in school and to ultimately stop attending school altogether. If they qualify for a social grants, they should be referred for application.

REFERENCES

[1] World Health Organisation. International Statistics Classification of Diseases and related problems. 10th Edition. 2010.

[2] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th Text Revision Edition. 2000.

[3] Health Systems Trust. Intellectual Disability Month, 2006. Available: www.hst.org.za; Retrieved 9 January 2011.

[4] World Health Organisation. Ageing and intellectual disabilities – improving longevity and promoting healthy ageing: summative report. 2000 Available: www.who.int/mental_health. Retrieved 9 January 2011.

[5] American Association of Intellectual and Developmental Disabilities: Definition of intellectual disability. 2010. Available: www.aamr.org; Retrieved 9 January 2011.

[6] Van Eeden R. Manual for the Senior South African Individual Scale – Revised. Human Science Research Council, Pretoria. 1992.

[7] Kaliski S. Psycho-legal assessment in South Africa. Oxford University Press, Cape Town. 2006; Chapter 3,19: 42-50; 289-296.

[8] Criminal Procedure Act, Act Number 51 of 1977. Government Gazette no. 5532. 6 May 1977.

[9] Wechsler D. Wechsler Adult Individual Achievement Assessment.Manual for the Wechsler Adult Intelligence Scale.Psychological Corpotation, Oxford, England. 1955.

[10] Sparrow S, Cicchetti D, Balla D.Vineland Adaptive Behaviour Scales. Second Edition. AGS Publishing, Circle Pines. 2005.

[11] Raven J, Raven JC, Court JH. Manual for Raven's Progressive Matrices.Harcourt Assessment, San Antonia. 2003.

[12] Roid GH, Miller LJ, Pomplun M. Leiter International Performance Scale. Third Edition. Stoelting, Co, Wood Dale. 1997.

[13] The Mental Health Care Act, Act Number 17 or 2002.Government Gazette no. 24024. 6 November 2002.

[14] Sondenaa E, Rasmussen K, Nottestad JA. Forensic issues in intellectual disability. Current Opinion in Psychiatry. 2008; 21(5):449-453.

[15] Chaplin EH. Forensic aspects in people with intellectual disabilities. Current Opinion in Psychiatry. 2006; 19:486-491.

[16] Loucks N. No one knows: offenders with learning disabilities and learning difficulties: review of prevalence and associated needs. London Prison Reform Trust. 2007.

[17] Crocker AG, Cote G, Toupin J, St-Onge B. Rate and characteristics of men with intellectual disability in pre-trial detention. Journal of Intellectual Developmental Disability. 2007; 35:162-167.

[18] Dwyer RG, Frierson RL. The presence of low IQ and mental retardation among murder defendants referred for pre-trial evaluation. Journal of Forensic Sciences. 2006; 51:678-682.

[19] Hayes S, Shackell P, Mottram P, Lancaster R.The prevalence of intellectual disability in a major UK prison.British Journal of Learning Disabilities. 2007; 35:162-167.

[20] Chitsabesan P, Kroll L, Bailey S. Mental health needs of young offenders incustody and in the community. British Journal of Psychiatry. 2006; 188:534-540.

[21] Lindsay WR, Hogue TE, Steptoe L. Internal consistency and factor structure of personality disorders in a forensic intellectual disability sample.Journal of Intellectual Developmental Disability. 2007; 32:134-142.

[22] Flynn A, Matthews H, Hollins S. The validity of the diagnosis of personality disorders in adults with learning disability and severe behavioural problems. British Journal of Psychiatry. 2002; 180:543-546.

[23] Pridding A, Procter NG. A systematic review of personality disorder amongst people with intellectual disability with implications for the mental health nurse practitioner. Journal of Clinical Nursing. 2008; 17:2811-2819.

[24] Crocker AG, Mercier C, Allaire JF, Roy ME. Profiles and correlates of aggressive behaviour among adults with intellectual disabilities.Journal of Intellectual Disability. 2007; 51:786-801.

[25] Hollard T,Clare IC, Mukhopadhyay T. Prevalence of criminal offending by men and women with intellectual disability and the characteristics of offenders: implications for research and service development. Journal of Intellectual Disability Research. 2002 May; 46 Suppl 1:6-20.

[26] Walker W, McCabe S. Crime and Insanity in England, Volume 2. Oxford University Press. 1973.

[27] Blanchard R, Watson M, Choy, Dickey R, Klassen P, Kuban N, Feren DJ. Paedophiles: mental retardation, maternal age and sexual orientation. Archives of Sexual Behaviour. 1999; 28:111-127.

[28] Fyson R. Young people with learning disabilities who sexually harm others: the role of criminal justice within a multiagency response. British Journal of Learning Disabilities. 2007; 35:181

[29] Steptoe L, Lindsay WR, Forrest D, Power M. Quality of life and relationships in sex offenders with intellectual disability. Journal of Intellectual Developmental Disability.2006; 31:13-19.

[30] Jones J. Persons with intellectual disabilities in the criminal justice system. Int J Offender Ther Comp Criminol. 2007; 51: 723-733

[31] Leggett J, Goodman W, Dinani S. People with learning disabilities' experiences of being interviewed by the police.British Journal of Learning Disabilities. 2007; 35:168-173.

[32] Hayes S. Missing out: offenders with learning disabilities and the criminal justice system. British Journal of Learning Disabilities. 2007; 35:146-153.

[33] Talbot J, Riley C. No one knows: offenders with learning difficulties and learning disabilities. British Journal of Learning Disabilities. 2007; 35:154-161.

[34] Sondenaa E, Gudde C, Thomassen. Patients with intellectual disabilities in the forensic asylums 1915-1982: before admission. Scandinavian Journal of Disability Research. 2015; 17:1.14-25. DOI 10.1080/15017419.2013.868824

[35] Statistics South Africa. Census 2001. Online www.statssa.gov.za; Accessed January 2011.

[36] Statistics South Africa. Census 2011. Online www.statssa.gov.za; Accessed 20 January 2012.

[37] Strydom N, Pienaar C, Dreyer A. Profile of forensic psychiatric inpatients referred to the Free State Psychiatric Complex, 2004-2008. South African Journal of Psychiatry. 2011; 17:40-43.

[38] Calitz FJW, Janse van Rensburg PHJ, De Jager PP, Olander ML, Thomas L, Venter R et al. Psychiatric evaluation of intellectually disabled offenders referred to the Free State Psychiatric Complex, 1993–2003. South African Journal of Psychiatry. 2007; 13:147-152.

[39] Govender N. A retrospective record review of individuals charged with sexual offences against minors, referred for forensic psychiatric observation. MMed Research Report. University of the Witwatersrand. 2014.

[40] Jurgnes R, Nowak M, Day M. HIV and incarceration: prisons and detention. Journal of the International AIDS Society. 2011; 14:26.

APPENDICES. A retrospective record review of the impact of intellectual disability on the forensic observation process

Appendix A. Data Collection Sheet p72

Appendix B. Information Document p73

Appendix C. Sterkfontein Hospital Consent Form p74

Appendix D. WITS Human Research Ethics Committee (Medical) Ethics Clearance Certificate p76

Appendix A DATA COLLECTION SHEET

Demographic Data: Record Number:

Age
Sex Male ; Female
Race Black ; Coloured ; Asian ; White ; Other
Marital Status Single ; Married ; Divorced ; Widowed ; Not specified
Level of Education None; Primary; Secondary; Special education ; Not specified
Employment Unemployed ; Employed ; Disability Grant ; Not specified

Criminal Data:

Charge: Murder ; Assault ; Theft ; Sexual offences ;other ; Malicious damage to property
Reason for Referral: Past psychiatric history ; Requested by lawyer ; Collateral from relative ; Abnormal behaviour in court ; Other

Clinical Data: (Specify according to DSM IV-TR)

Axis I Diagnosis: Psychiatric diagnosis
Axis II Diagnosis: Intellectual impairment and/or personality trait/disorder

Significant Special Investigations

CT Scan ; EEG ; Other (specify)

Outcome

Fit to Stand Trial	;	Not Fit to Stand Trial
Accountable Accountable, Does Appreciate Wrongfulness Not Accountable, Does Not Appreciate Wrongfulness		

Recommendation

Voluntary User (Can stand trial) ; State Patient (Admission to SFH) ; Involuntary User (Admission to SHH)

Appendix B. INFORMATION DOCUMENT

Study Title: The Impact of Intellectual Disability on the Forensic Observation Process at Sterkfontein Hospital.

To: The Patient/Family Member of the State Patient

Introduction:

I, Dr Louis van Rooyen, am doing research on how psychiatric assessments are affected when the person accused of committing a crime is intellectually disabled. I am asking you for permission to collect information from your file/the file of your family member for the period when you/your family member was admitted for a 30day observation period after being admitted for the crime allegedly committed.

What is Involved in the Study:

Any person (subject to consent) admitted for observation between January 2011 and December 2012 who suffers from intellectual disability will be included in this study. Consent for access to such records for the purposes of this study will be obtained from anyone who has since become a state patient or their family member where the patient isn't mentally fit to consent. No active participation will be required. Information from these files will be used to ultimately get a better understanding of how many of these people were found to be fit to stand trial and how many were found to be responsible for the crime allegedly committed.

There are **no risks** involved in being included in the study. There is **no direct benefit** for a patient who is included in the study either.

Consent is voluntary. Refusal to participate will involve no penalty or loss of benefits to which a patient is otherwise entitled.

There will be **no reimbursement** for being included in the study.

The identity of participants will only be known to myself, Dr Van Rooyen, as the principal researcher. As a result, **confidentiality** and **anonymity** is guaranteed.

Ethical clearance to conduct this study was obtained from WITS Human Research Ethics Committee (Medical). Any concerns or complaints regarding this study can be directed to this committee through its secretary, MsAnisaKeshav Tel: 011-7171234; Fax: 011-3395708; Email anisa.keshav@wits.ac.za

Appendix C. STERKFONTEIN HOSPITAL: INFORMED CONSENT FORM FOR A RETROSPECTIVE RECORD REVIEW STUDY

TITLE OF STUDY: The Impact of Intellectual Disability on the forensic observation process at Sterkfontein Hospital.

I, _____, hereby consent to:

Clinical information about myself/my family member_____

_____, to be used for the above mentioned study, provided that confidentiality and anonymity (or that of my relative) is assured.

Signed: _____ Date: _____

Relation to patient (where applicable): _____

Witness: _____Designation_____

Date: _____

Appendix D. WITS Human Research Ethics Committee (Medical) Ethics Clearance Certificate

R14/49 Dr Louis J van Rooyen

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130749

NAME: (Principal Investigator) Dr Louis J van Rooyen

DEPARTMENT: Psychiatry
Neurosciences, University of Witwatersrand
Sterkfontein Hospital

PROJECT TITLE: A Retrospective Record Review of the Impact of Intellectual Disability on the Forensic Observation Process

DATE CONSIDERED: 26/07/2013

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR: Prof Janse van Rensburg

APPROVED BY: _____
Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 02/08/2013

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 Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized 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 the application to the Committee. **I agree to submit a yearly progress report**.

_____ _____
Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES