

THE MENTALLY RETARDED OFFENDER IN A FORENSIC SETTING

—

A SOUTH AFRICAN STUDY

**A THESIS SUBMITTED IN PARTIAL FULFILMENT
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ABSTRACT:

This study examined, within the South African context, the prevalence of mental retardation in a forensic observation setting, and the impediments of and successes to forensic rehabilitation. The results of the study indicated that a significant amount of forensic observation patients (25.16%) are ultimately diagnosed as being mentally retarded, with 39.24 percent of such offenders being found unfit to plead. Further 32.91 percent of the same sample was found to be not responsible for their actions. A link was also drawn between the mentally retarded offender and violent offenses. The advantages and disadvantages of a current rehabilitative process are discussed in light of alternate community-based forms of rehabilitation that are being implemented in other countries, for example the United States of America, with a view towards investigated their usefulness and adaptability to South African circumstances. The findings of the study have implications for mental health professionals working within forensic settings concerning the future management of mentally retarded offenders, particularly within the rehabilitative process.

DEDICATION:

I

Above everyone else, this thesis is dedicated to my parents, Laurence and Shirley Anne ...

- For their implicit faith and belief in my abilities, no matter how plagued with doubt I was
- For gracefully reconciling themselves to having an extremely driven, single minded, cynical (thanks, Mom), definitively wayward eccentric as a son
- For the good advice which I asked for, listened to and probably ignored
- And for everything else I am too ignorant to think of and mention

II

To G.G. and K.S. – friends who were like brothers ... I still struggle to understand why you are both no longer here.

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TABLE OF CONTENTS:

CHAPTER I: LITERATURE REVIEW

1.0 INTRODUCTION

1.2 UNDERSTANDING AND DEFINING MENTAL RETARDATION

1.2.1 A BRIEF ACCOUNT OF THE DEVELOPMENT OF CLASSIFICATION SYSTEMS

1.2.2 THE MODERN DEFINITION OF MENTAL RETARDATION

1.2.3 DEFINING MENTAL RETARDATION ACCORDING TO *DSM-IV-TR*

1.2.4 CONTROVERSIES CONCERNING THE DEFINITION OF MENTAL RETARDATION

1.2.5 AETIOLOGY AND PREVALENCE RATES IN THE GENERAL POPULATION

1.3 MENTAL RETARDATION AND THE FORENSIC CONTEXT

1.3.1 MENTAL RETARDATION AND FORENSIC PROBLEMS

1.3.2 PREVALENCE RATES

1.3.2.1 IN GENERAL

1.3.2.2 INTERNATIONALLY

1.3.3 THE SOUTH AFRICAN CONTEXT

1.4 FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY

1.4.1 PREFACE

1.4.2 A BRIEF HISTORY OF FITNESS TO PLEAD

1.4.3 THE PURPOSE OF FITNESS TO PLEAD LAWS

1.4.4 A BRIEF HISTORY OF CRIMINAL RESPONSIBILITY

1.4.4.1 THE M'NAUGHTEN RULE

**1.4.5 CRITICISMS OF THE M'NAUGHTEN RULE AND ADDENDUMS TO THE LAWS
REGARDING CRIMINAL RESPONSIBILITY**

1.4.5.1 THE A.L.I. STATUTE

1.5 FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY IN SOUTH AFRICA

1.5.1 PREFACE

1.5.2 DEFINITIONS ACCORDING TO SOUTH AFRICAN LAW

1.5.2.1 FITNESS TO PLEAD

1.5.2.2 CRIMINAL RESPONSIBILITY

**1.5.3 THE IMPLICATIONS OF FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY
IN SOUTH AFRICA**

1.6 REHABILITATION PROGRAMS

1.6.1 PREAMBLE

1.6.2. GENERAL CHARACTERISTICS

1.6.3 REHABILITATION PROGRAMS IN THE USA

1.6.3.1 THE DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM

1.6.3.2 DEVEREUX KANNER PROGRAMS

1.6.4 REHABILITATION PROGRAMS IN SOUTH AFRICA

1.6.4.1 IN-PATIENT PSYCHIATRIC HOSPITAL REHABILITATION – FORT ENGLAND HOSPITAL

1.7 RATIONAL FOR THE PRESENT STUDY

1.8 RESEARCH GOALS

CHAPTER II: METHODOLOGY

2.0 RESEARCH PARTICIPANTS

2.1 DATA COLLECTION INSTRUMENTS AND PROCEDURES

2.1.1 DATA ANALYSIS

2.1.1.1 IN A SOUTH AFRICAN FORENSIC OBSERVATION SETTING

2.1.1.2 IN A SOUTH AFRICAN FORENSIC REHABILITATION SETTING

2.1.2 DATA PROCESSING

2.2 ETHICS

CHAPTER III: RESULTS

3.0 INTRODUCTION

3.1 PERTAINING TO SECTION 2.2.1.1

3.1.1 QUESTION I

3.1.2 QUESTION II

3.1.3 QUESTION III

3.1.4 QUESTION IV

3.2 PERTAINING TO SECTION 2.2.1.2

3.2.1 QUESTION I

3.2.2 QUESTION II

3.2.3 QUESTION III

CHAPTER IV: DISCUSSION

4.0 INTRODUCTION

4.1 CLINICAL IMPLICATIONS OF THE FINDINGS

4.1.1 IN A SOUTH AFRICAN FORENSIC OBSERVATION SETTING

4.1.2 IN A SOUTH AFRICAN FORENSIC REHABILITATION SETTING

4.2 CONCLUSIONS

4.3 LIMITATIONS OF THE RESEARCH

4.4 SUGGESTIONS FOR FUTURE RESEARCH

REFERENCES

LIST OF TABLES:

TABLE I: TOTAL SAMPLE SIZE AND INDICATION OF THE NUMBER OF MENTALLY RETARDED REFERRALS

TABLE II: PERCENTAGE OF MENTALLY RETARDED OBSERVATION CASES STRATIFIED BY YEAR

TABLE III: CHARGES AGAINST MENTALLY RETARDED OFFENDERS AS CATAGORISED PER YEAR

TABLE IV: CHARGE PERCENTAGES OF MENTALLY RETARDED OFFENDERS AS CATAGORISED PER YEAR

TABLE V: NUMBER OF CHARGES PER CATEGORY AS DEFINED BY SEVERITY OF MENTAL RETARDATION IN 2003

TABLE VI: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN 2001

TABLE VII: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL RESPONSIBILITY IN 2001

TABLE VIII: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN 2002

TABLE IX: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL RESPONSIBILITY IN 2002

TABLE X: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN 2003

TABLE XI: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL RESPONSIBILITY IN 2003

TABLE XII: OVERALL RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD

TABLE XIII: OVERALL RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL RESPONSIBILITY

LIST OF FIGURES:

FIGURE I: A GRAPHICAL REPRESENTATION OF THE OVERALL PERCENTAGES LISTED IN TABLE XII

FIGURE II: A GRAPHICAL REPRESENTATION OF THE OVERALL PERCENTAGES LISTED IN TABLE XIII

APPENDICES:

APPENDIX A: FORENSIC UNIT DATA CAPTURE SHEET

55

CHAPTER I: LITERATURE REVIEW

1.0 INTRODUCTION:

Over the past decade, there has been a notable worldwide increase of attention by both mental health and legal professionals towards the mentally retarded offender (Hayes, 1996) with specific emphasis placed on both early identification of such offenders and alternate forms of rehabilitation (Beail, 2002). Such growing international concern has not escaped notice in South Africa (Louw, 1998). The establishment of various specialist forensic facilities around the country has begun the process of facilitating the expansion of the knowledge base in regard to the mentally retarded offender, specifically within a South African context.

As with the general population, the vast majority of individuals with mental retardation are responsible citizens. Nevertheless, some individuals who are mentally retarded will become involved in the legal system (The Arc of New Jersey, 1992). As such, the legal system should take proper account of such an individual's disabilities and capabilities in all circumstances of involvement (The Arc of New Jersey, 1992). However, this is not always the case. People who are mentally retarded therefore face numerous problems within the legal system. In particular, people that are mentally retarded have cognitive impairments and deficits in adaptive behaviour, which may limit meaningful interaction with the legal system (Davis, 1995). The early identification of the mentally retarded offender therefore enables appropriate assessments to be carried out to inform the judicial process regarding limitations around issues such as fitness to plead and criminal responsibility, thereby ensuring appropriate safeguards are in place where such issues or limitations exist (Beail, 2002).

Such limitations frequently cause problems such as an inability to stand trial because the individual fails to understand court proceedings, and/or an inability to assist in their own defense (Davis, 1992). Consequently, legal professionals began referring people who they suspected of having mental retardation for a period of forensic observation in order for mental health professionals to assist in recommendations to the court (Schlesinger, 2003).

Offenders who are mentally retarded pose complex ethical and practical problems for the criminal justice system. They frequently have limited or no understanding of criminal procedure and are vulnerable to coercion and exploitation (Barron, Hassiotis & Banes, 2002).

Mentally retarded offenders (i) may not communicate at appropriate age levels – displaying limited vocabulary or possible speech deficits, difficulty understanding or answering questions, and an inability to read or write; (ii) may not behave at an appropriate age level – preferring younger persons (possibly children) for friends, displaying inappropriate interactions with peers or members of the opposite sex, have a low frustration tolerance, and are easily influenced by and anxious to please others; (iii) may not understand the consequences of situations in which they are involved – in that they do not appreciate the seriousness of certain situations and thereby act impulsively without reflecting on the legality of their **actions**; (iv) may not behave appropriately in legal situations – in that the mentally retarded offender may not understand his or her rights, may be overly willing to confess, and may experience difficulty recalling facts or the details of an offence (psychiatry.com, n.d.).

The issues of fitness to plead, criminal responsibility and the appropriate diversion (in regards to rehabilitation) to either psychiatric or other treatment facilities of mentally retarded offenders have challenged legal systems around the world for at least two centuries (Barron et al., 2002).

1.2 UNDERSTANDING AND DEFINING MENTAL RETARDATION:

1.2.1 A BRIEF ACCOUNT OF THE DEVELOPMENT OF CLASSIFICATION SYSTEMS:

Since the early 1960's, scholars have attempted to uncover the lives of inarticulate and dependent groups, writing about people in, for example, mental hospitals and prisons. However, until 1984, when Taylor and Bell published *Caring for the Retarded in America: A History* there were no official academic histories of mental retardation. Previous studies had focused on the deliverance of “mental defectives from ignorance and superstition” (Brockley, 1999, pp. 25), describing such individuals as “ever misunderstood, appearing always as shadows in the brightest spots of human civilization” (Brockley, 1999, pp. 25). As such, mentally retarded individuals have throughout history been relegated and stereotyped within society due to their disabilities.

Throughout the later 200 years of the second millennium, several terms were coined to describe, what was then broadly referred to as ‘mental defectiveness’, with the American census of 1840 attempting the first official categorisation of those who were considered to be

'mentally defective' into a group labelled 'idiots/insanity' (American Psychiatric Association, 2000). By the time of the American census of 1880, the labelling of those who were considered to be 'mentally defective' (a group consisting of both mentally retarded and mentally ill individuals) had expanded into seven categories, namely mania, melancholia, monomania, paresis, dementia, dipsomania and epilepsy (American Psychiatric Association, 2000). While these terms were primarily used as a means for statistical classification, it may be seen that such efforts were the beginnings of the various mental disorder classification systems. However, no specifiers concerning degree of severity (especially in regard to those individuals who were mentally retarded) were yet established. By the 1900's those individuals who were mentally retarded had again been reclassified into two groups labeled, "educable" and "trainable" which roughly correlate with the modern specifiers of Mild and Moderate for degree of severity of retardation (American Psychiatric Association, 2000).

1.2.2 THE MODERN DEFINITION OF MENTAL RETARDATION:

The American Psychiatric Association (2000) in its *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision* defines mental retardation as "significantly sub-average general intellectual functioning ... and concurrent deficits or impairments in adaptive functioning" (p.39). Such deficits or limitations in adaptive functioning cover a number of skill areas such as work, self-care, health and safety. To qualify for the diagnosis, these problems must have begun before the age of 18. Mental retardation is thus defined in terms of level of behavioural performance, with no information provided on causal factors, such as biological, psychosocial, socio-cultural dynamics or various permutations thereof (Carson, Butcher & Mineka, 1996).

Consequently, any functional equivalent of mental retardation that has its onset after age 18 must be considered a dementia rather than mental retardation. The distinction is an important one, for the psychological situation of a person who acquires a pronounced impairment of intellectual functioning after attaining maturity is vastly different from that of a person whose intellectual resources were subnormal throughout all or most of their development (Carson et al., 1996). Specifically, individuals who acquire an impairment of intellectual functioning after attaining maturity may display less of a deficit in, for example, their levels of adaptive functioning as compared to mentally retarded individuals who from birth have been unable to

acquire the necessary skills to be able to comprehend and obey modern societal and social norms and morays.

Overall, mental retardation, like other DSM diagnostic categories, is treated as a specific type of disorder, and while it is itself coded on Axis II of *DSM-IV-TR*, it may occur in combination with other disorders appearing on either Axis I or Axis II of DSM.

1.2.3 DEFINING MENTAL RETARDATION ACCORDING TO *DSM-IV-TR*:

An individual is considered to be mentally retarded based on the following three criteria: (i) level of intellectual functioning (IQ) has been empirically measured on an individually administered test to be below 70 to 75, (ii) concurrent significant limitations or impairments (that is, the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) are present in two or more adaptive skills areas, such as communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety, and (iii) the condition is present from childhood, defined as onset before age eighteen (American Association on Mental Retardation, 2004; American Psychiatric Association, 2000).

Further, mental retardation can be subdivided into four categories based on the degree of severity as categorised by IQ. Mild mental retardation is present when the individual's IQ has been empirically measured to be from between 50 to 55 to approximately 70. Moderate mental retardation is present when the individual's IQ has been empirically measured to be from between 35 to 40 to approximately 50 to 55. Severe mental retardation is present when the individual's IQ has been empirically measured to be from between 20 to 25 to approximately 35 to 40. Profound mental retardation is present when the individual's IQ has been empirically measured to be below 20 to 25 (American Psychiatric Association, 2000).

1.2.4 CONTROVERSIES CONCERNING THE DEFINITION OF MENTAL RETARDATION:

As stated above, mental retardation appears to be primarily defined in terms of behavioural performance, which lends it strong features of both arbitrariness and pragmatism (Carson et al., 1996). Current international policy is to diagnose and specify the severity of mental retardation based on a standardised test of intelligence administered on an individual basis in

which standardised norms are utilised for interpretation of estimated IQ values (Lezak, 1995). However, debate continues to fester concerning what the quantitative cut-off IQ score should be that distinguishes the so-called 'normal' individual from the mentally retarded one (American Association on Mental retardation, 1992; Lezak, 1995). Issues such as culture, race, level of education and adaptive functioning, standardisation of norms to an individual's background, and assessment method reliability and validity, remain vociferous points of contention (Lindsay, 2002).

It should always be noted that an IQ score standing alone is not a completely accurate representation of an individual's level of functioning and is therefore not sufficient as the sole basis for making a diagnosis of mental retardation (Schlesinger, 2003). Rather, a diagnosis of mental retardation should be made on the basis of both a standardised test of intelligence, and interviews as well as collateral information, which permits the examiner to assess the individual's level of adaptive functioning; thereby allowing for a comprehensive based decision.

1.2.5 AETIOLOGY AND PREVALENCE RATES IN THE GENERAL POPULATION:

Causative factors in mental retardation include genetic conditions, prenatal exposure to toxins and infections, perinatal trauma, acquired conditions and sociocultural factors (Sadock & Sadock, 2003). However, these factors rarely work in isolation and in approximately 30 to 40 percent of individuals seen in clinical settings, no clear aetiology can be determined (American Psychiatric Association, 2000).

DSM-IV-TR (American Psychiatric Association, 2000) estimates that the prevalence rates of mental retardation in the general population at any one time is approximately one percent. The incidence of mental retardation is complicated to accurately calculate due to the difficulty of identifying the onset of the disorder (Sadock & Sadock, 2003). For example, if an individual has a high level of adaptive functioning, a formal diagnosis may not be made until a particular point in the individual's life when deficits in either cognitive or adaptive functioning become more apparent or pronounced.

1.3 MENTAL RETARDATION AND THE FORENSIC CONTEXT:

1.3.1 MENTAL RETARDATION AND FORENSIC PROBLEMS:

Murphy, Coleman & Hayes (1983) contend that the relationship between behavioural disturbances and forensic problems in people who are mentally retarded is extremely subtle, as many behavioural disturbances displayed by mentally retarded individuals are not seen within the context of their diagnosis and as such are interpreted as the actions of so-called 'normal' individuals (Dexter, 1995). This often results in the involvement of mentally retarded individuals with the legal system. For example, a mentally retarded individual who is lost and wandering aimlessly in the street may be arrested by the police for disturbing the peace, as their appearance, demeanour and behaviour may be construed by the police as the actions of a 'normal' individual who is intoxicated. Ultimately, there is no doubt that many behavioural problems displayed by individuals with mental retardation are construed as offences in more able individuals (Clare & Murphy, 1998).

The involvement of the mentally retarded individual within the legal system is possibly due to a number of reasons, especially widely held beliefs concerning the criminal propensity or deviancy of individuals with mental retardation having strong roots (Barron et al., 2002; Ho, 2003; Jahoda, 1995) and the continuing support of this fallacy in the mass media (Jahoda, 2002). Offenders with mental retardation are a group of people with complex needs (Barron et al., 2002), and many myriad misconceptions remain regarding mentally retarded individuals who become involved within the legal system (Ho, 2003). However, it should be strongly noted that mentally retarded individuals are also volitionally capable of committing criminal acts, and in some cases, due to the lack of severity of the condition (especially if the individual's level of adaptive functioning is relatively high), with full regard given to societal laws and established social norms.

1.3.2 PREVALENCE RATES:

1.3.2.1 IN GENERAL:

A comprehensive worldwide review by Lindsay et al. (2002) of relevant literature and statistical data concerning prevalence rates concluded that it was extremely difficult to draw

any firm conclusions as to the number of mentally retarded offenders (Reichard, Spencer & Spooner, 1980), citing three main variables which hampered any definitive agreement among researchers. First, the definition of mental retardation that was used in the various studies were not homogenous especially when it is considered that some of the studies undertaken were done by mental health professionals and others by legal professionals. Secondly, mental retardation was defined in some studies relying solely on the basis of a non-standardised test or tests of intelligence, which led to the production of differing results (Reichard et al., 1980). Thirdly, the studies appear to have all been conducted in different settings, for example hospitals or police stations, in which prevalence rates do not remain static over time due to changes in procedure and policy (Hayes, 1996). Overall, it would appear as if there exists little agreement as to the actual prevalence of mentally retarded offenders involved in legal systems (Reichard et al., 1980). As Noble and Conley (1992) conclude:

“There is little point in trying to nail down to the nearest decimal point the percentage of people with mental retardation and other mental disabilities who reside in the nations prisons. We know that the number is significant and that many inmates are not receiving appropriate services” (p.51).

1.3.2.2 INTERNATIONALLY:

Studies conducted in the United States of America (USA) have noted that the prevalence rates for offenders with mental retardation are considerably higher than the general population (Barron et al., 2002; Murphy et al., 1983). This is especially true for sexual offenses (Day, 1994; Murphy et al., 1983) and arson (Raesaenen, Hirvenoja, Hakko & Vaeisaenen, 1994). Specifically, research in the USA indicates that while people with mental retardation constitute somewhere between two-and-a-half and three percent of the total population, experts estimate that people diagnosed with mental retardation may constitute between two and ten percent of the prison population (Human Rights Watch, 2001; Noble & Conley, 1992).

In the United Kingdom, there appears to be no definitive agreement among authors as to an actual figure regarding the percentage of incarcerated mentally retarded individuals (Lindsay, 2002), as the methodological differences between studies that have so far been conducted as well as the methodological issues within the studies themselves make it extremely difficult and problematic to draw firm conclusions (Lindsay, Law & Macleod, 2002). Further, while

some authors continue to espouse the link between mental retardation and type of offence no apparent correlations between the mentally retarded offender and type of crime have yet been agreed upon or identified (Lindsay, 2002).

1.3.3 THE SOUTH AFRICAN CONTEXT:

An extensive literature search conducted by this author has not revealed any type of data regarding prevalence rates in South Africa nor on the outcomes of decisions taken by either mental health or legal professionals (such as recommendations concerning fitness to plead and criminal responsibility). Further, no significant research exists within the South African context as to whether or not mental retardation may be correlated with particular types of offenses or indeed one specific offense.

1.4 FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY:

1.4.1 PREFACE:

Mental health professionals, particularly psychologists and psychiatrists, conducting forensic assessments on individuals referred by the courts for a period of observation (in which a multi-disciplinary team over a formal time period assesses an individual's competence or fitness to stand trial and criminal responsibility at the time the offense was committed) are faced with the enormous task of evaluating the impact that mental retardation has in terms of recommendations to the court and the eventual implementation of these recommendations (Schlesinger, 2003). Principally, the most crucial recommendations are those concerning fitness to plead and criminal responsibility (Dr H. Erlacher, personal communication, 3 October 2003), which are ultimately legal not clinical decisions. Mental health professionals offer an opinion and the court makes its decision based on this opinion (Dexter, 1995).

1.4.2 A BRIEF HISTORY OF FITNESS TO PLEAD:

The law on fitness to plead stems from the prohibition against trial in absentia (Roesch, Zapf, Golding & Skeem, 1999). If an individual is unable to be present in the courtroom because of physical illness, the trial is postponed until the person recovers and is able to attend the proceedings. However, if a defendant is present physically but is so confused mentally and

therefore unable to understand the legal process or aid in his or her own defense, to continue with the trial would be as unfair as if the person were not there (Roesch et al., 1999). Accordingly, the trial is postponed until the defendant regains his or her mental faculties and can be present both physically and mentally (Schlesinger, 2003).

The original purpose of the concept of fitness to plead was to excuse from criminal proceedings only those individuals who were floridly psychotic or significantly mentally retarded. Slovenko (as cited in Schlesinger, 2003) argued:

“An unsophisticated layman or the custodial officer is able to apply the test Psychiatric [or psychological] examination does not further the inquiry. . . . The judge can by himself make as valid a decision as anyone from the basis of a few ordinary and simple questions put to the defendant” (1973, p. 95).

However, what began as a simple notion has become extremely complicated, with almost every issue related to the concept of fitness to plead, litigated and debated in most democratic countries, with McGaha, Otto, McClaren, and Petrila (as cited in Schlesinger, 2003) contending that fitness to plead is perhaps the most studied area of mental health law.

1.4.3 THE PURPOSE OF FITNESS TO PLEAD LAWS:

Ideally, the laws regarding fitness to plead serve four main purposes: (i) to safeguard the accuracy of criminal adjudication, (ii) to guarantee a fair trial, (iii) to preserve the dignity and integrity of the legal process, and (iv) if the defendant is found guilty, to ensure that he or she knows why he or she will be punished (Felthous, 2003).

According to Brakel (2003), determinations of fitness to plead (or to stand trial) are complicated and rendered unpredictable by two sub-surface issues: (i) the question of the defendant's rationality as compared to the standard already judicially laid out, and (ii) the level or degree of incompetency required to halt criminal proceedings. Further, all fitness to plead evaluations should ideally ask these two main questions: (i) how cognitively deficient the accused is, and (ii) how functionally deficient the accused is. A distinction should, and must, be made between the factors of cognitive ability and functional ability. While both factors stand as separate testaments to a defendant's level of fitness, they are also intimately intertwined and must be seen as acting in symbiosis along a continuum line.

Ultimately, the determination of fitness to plead requires the mental health and legal professional to assess whether the defendant has a rational as well as factual understanding of the nature and consequences of criminal proceedings against him or her and/or the ability to assist his or her legal counsel for the defense (Ho, 2003). Undoubtedly, the severity of mental retardation becomes a crucial factor in determining a defendant's capability to progress to criminal proceedings (Ho, 2003).

1.4.4 A BRIEF HISTORY OF CRIMINAL RESPONSIBILITY:

The proposition that some criminal defendants should not be held responsible for their actions by reason of their mental state has been well established in Anglo law for centuries (Frontline, 2002). As early as 1581, William Lombard authored the legal treatise, *Eirenacha*, in which he distinguished between those who understood the difference between good and evil (or right and wrong) and those who did not:

“If a madman or a natural fool, or a lunatic in the time of his lunacy do [kill a man], this is no felonious act for they cannot be said to have any understanding will” (Lombard, as cited in Frontline, 2002).

By the 18th century, the British courts had elaborated on this distinction developing the ‘Wild Beast’ test: If a defendant was so bereft of sanity that he understood the ramifications of his behavior "no more than in an infant, a brute, or a wild beast" (Perlin, as cited in Frontline, 2002) he would not be held responsible for his crimes.

1.4.4.1 THE M'NAUGHTEN RULE:

The earliest guidelines for evaluating the criminal responsibility of defendants claiming to be insane were codified in the British courts in 1843 as a result of the case of Daniel M'Naughten. M'Naughten was a Scottish woodcutter who murdered Edward Drummond the private secretary to Sir Robert Peel the British Prime Minister, in a failed attempt to assassinate the Prime Minister. M'Naughten apparently believed that the Prime Minister was the architect of the numerous misfortunes that had befallen him. During his trial, nine witnesses testified to the fact that he was insane, and the jury acquitted him, finding him "not guilty by reason of insanity" (Frontline, 2002).

Queen Victoria, the British monarch, was displeased with the outcome of M'Naughten's trial, and requested that the House of Lords debate the problems of criminality and insanity. In response to the questions concerning what specific guidelines could be used to determine whether a person could plead insanity as a defense against criminal responsibility, the reviewing committee stated:

“To establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act that he was doing, or if he did know it, he did not know he was doing what was wrong” (Sadock & Sadock, 2003, p. 1362).

Further, the committee elaborated by stating:

“Where a person labors under partial delusions only and is not in other respects insane and as a result commits an offense, he must be considered in the same situation regarding responsibility as if the facts with respect to which the delusions were real” (Sadock & Sadock, 2003, p. 1362).

Ultimately, the formulation that emerged from the House of Lords review – that a defendant should not be held responsible for his actions if he could not tell that his actions were wrong at the time he committed them (Frontline, 2002) – became the basis of the law governing legal/criminal responsibility in cases of insanity in England.

The M'Naughten Rule was embraced with almost no modification by American courts and legislatures for more than 100 years until the mid-20th century. In 1998, 25 States in the USA as well as the District of Columbia still used versions of the M'Naughten Rule to test for legal insanity (law.com, 2002).

The M'Naughten Rule is a traditional 'right and wrong' test of legal insanity in criminal prosecutions. According to the M'Naughten Rule, people are believed to be sane unless it can be proved that, at the time of committing the offence or act, they were labouring under such a defect of reason (from a disease of the mind) that they did not know the nature and quality of the act they were doing – or, if they did know they were committing the act, they did not know that what they were doing was wrong (Carson et al., 1996). Under the M'Naughten Rule, a defendant is legally insane if he or she cannot distinguish between right and wrong in regard to the crime with which he or she is charged (Judge M. Joffe, personal communication,

7 January 2004). If the judge finds that the accused could not tell the difference, then there could not be criminal responsibility or intent (law.com, 2002).

1.4.5 CRITICISMS OF THE M'NAUGHTEN RULE AND ADDENDUMS TO THE LAWS

REGARDING CRIMINAL RESPONSIBILITY:

The major criticism of the M'Naughten rule is that, in its focus on the cognitive ability to know right from wrong, it fails to take into consideration the issue of control (Carson et al., 1999). Mental health professionals agree that it is possible for an individual to understand that their behaviour is wrong, but still be unable to stop themselves from displaying the behaviour (the so-called 'sane automaton'). To address this issue, some countries have modified the M'Naughten test with an 'Irresistible Impulse' provision, which absolves a defendant who can distinguish right from wrong but is nonetheless unable to stop him/herself from committing an act he or she knows to be wrong (Carson et al., 1999; Frontline, 2002).

1.4.5.1 THE A.L.I. STATUTE:

In 1962, the American Law Institute (A.L.I.) set out a model insanity defense statute intended to soften the M'Naughten standard and allow for the introduction of medical and psychiatric evidence. The statute in effect consolidates the principles of the M'Naughten 'right and wrong' Rule and the 'Irresistible Impulse' test (Frontline, 2002; law.com, 2002). The A.L.I. formulation provides that a defendant will not be held criminally responsible if at the time of the behavior in question:

"as a result of a mental disease or defect, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law" (Perlin, as cited in Frontline, 2002).

The A.L.I. standard is a significant softening of the M'Naughten standard. Instead of requiring a defendant to have no understanding whatsoever of the nature of their acts or the difference between right and wrong, the A.L.I. standard requires merely that they lack a "substantial capacity" to understand right from wrong, and expands the M'Naughten Rule to include an 'Irresistible Impulse' component (Frontline, 2002; law.com, 2002). Most importantly, the A.L.I. standard excludes those defendants, whose mental illness or defect only manifests itself in criminal or antisocial conduct, thus addressing the conundrum of the

serial killer whose only symptom of mental illness is the killing of his victims (Judge M. Joffe, personal communication, 7 January 2003).

1.5 FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY IN SOUTH AFRICA:

1.5.1 PREFACE:

In terms of South African law, individuals who are charged with criminal offenses and who are suspected of being unfit to plead and/or not responsible for their actions, are referred by the courts for a 30 day period of forensic observation. Definitions of fitness to plead and criminal responsibility are explored below.

1.5.2 DEFINITIONS ACCORDING TO SOUTH AFRICAN LAW:

1.5.2.1 FITNESS TO PLEAD:

The Criminal Procedure Act 51 of 1977 of South Africa lists fitness to plead under Section 77 as the "capacity of accused to understand proceedings" (Vosloo, 1997, p.1-98). In part, Section 77 goes on to specify:

"If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defense, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79" (Vosloo, 1997, p.1-98).

As current South African law pertains to the discussion set out above for fitness to plead, it is somewhat evident that the legislation is consistent with the dual concepts espoused by Brakel (2003), that all fitness to plead evaluations should ideally ask two main questions, (i) what level of cognitive deficiency is displayed by the accused, and (ii) how functionally deficient is the accused.

Such account is evident in the phrase "If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defense ... "(Vosloo, 1997, p. 1-98).

However, such concepts only apply in the assessment phase of an observation period and not during the referral phase stipulated by the court.

1.5.2.2 CRIMINAL RESPONSIBILITY:

The Criminal Procedure Act 51 of 1977 of South Africa lists criminal responsibility under Section 78 as “mental illness or mental defect and criminal responsibility” (Vosloo, 1997, p.1-100). In part, Section 78 specifies:

“A person who commits an act which constitutes a offence and who at the time of such commissions suffers from a mental illness or mental defect which makes him incapable – (a) of appreciating the wrongfulness of his act; or (b) of acting in accordance with an appreciation of the wrongfulness of his act, shall not be criminally responsible for such act” (Vosloo, 1997, p.1-100).

A reading of the current South African law in regards to the provisions set out for the concept of criminal responsibility, points towards these laws being written in line the A.L.I. statute (see SECTION 1.4.5.1). Both cognitive and volitional or reactive elements have been tabled [“... (a) of appreciating the wrongfulness of his act; or (b) of acting in accordance with an appreciation of the wrongfulness of his act ...” (Vosloo, 1997, p.1-100)], and detailed guidelines exist as to appropriate means of referral and post-trial placement (see Vosloo, 1997, p.1-104 & p.1-106).

1.5.3 THE IMPLICATIONS OF FITNESS TO PLEAD AND CRIMINAL RESPONSIBILITY IN SOUTH AFRICA:

In the cases of those mentally retarded individuals who have committed criminal offenses, and who are found unfit to plead and/or criminally not responsible, the question remains as to appropriate means of referral and rehabilitation of such offenders.

In South Africa options are limited in this regard, with most such offenders being remanded as State Patients to psychiatric hospitals that specialise in the forensic paradigm, specifically in working to rehabilitate either mentally ill or mentally retarded offenders. Thus, especially in the case of the mentally retarded offender, there exists somewhat of a dearth of knowledge and practical options as to appropriate means of referral and rehabilitation, particularly in

terms of alternate forms of rehabilitation and treatment that are community rather than hospital-based.

1.6 REHABILITATION PROGRAMS:

1.6.1 PREAMBLE:

The factor of mental retardation and in particular its level of severity, plays an extensive role in the overall decision making process and will influence recommendations made by mental health professionals to the court regarding fitness to plead and criminal responsibility (Cockram, Jackson & Underwood, 1998). Furthermore, such recommendations have crucial implications for the rehabilitation of individuals who are mentally retarded and who have been charged with criminal offenses. This is especially the case in the placement of individuals in programs that are community-based rather than those that fall within the mental health or legal systems (Murphy et al., 1983).

Several options for community-based treatment and intervention have been researched and implemented. Further, there is a strong advocacy to educate the general public and law-enforcement agencies about not just the mentally retarded offender, but about all mentally retarded individuals so that the behaviour of such individuals is seen within the correct context and interpreted as such, not as necessarily criminal or bizarre in nature (Davis, 1992). While such programs exist in the USA, they are not at present in place in South Africa.

1.6.2. GENERAL CHARACTERISTICS:

An analysis of the literature concludes that any form of rehabilitation program that is alternative to in-patient hospital treatment should include the following characteristics, (i) education, (ii) skills training, (iii) life-skills training, and (iv) public education concerning the mentally retarded individual (Reichard et al., 1980). Of great importance is that alternative rehabilitation programs be tailored to the mentally retarded individual's needs and level of adaptive functioning, or else it is doubtful that rehabilitation efforts will succeed (Reichard et al., 1980).

Therapeutically, the main emphasis of rehabilitation programs appears to be that clients learn throughout their daily interaction with therapists and other key members of multi-disciplinary teams, with emphasis placed on the concept that participation in their own treatment is the key to success (ten Wolde, n.d.). The idea is that the process of learning consists of four different phases which follow each other: (i) adjustment, (ii) commitment, (iii) performance and, (iv) testing of the treatment procedure. Each phase requires its own course of action of what is broadly referred to as ‘Social Therapy’ – the use of individuals (usually trained to work in mental health settings) who help the mentally retarded individual adjust their behaviour through the employment of processes such as mirroring (ten Wolde, n.d.).

Further, Reid (2001) maintains that some forms of rehabilitation, be they in-patient hospital-based treatment or community-based intervention, should be proposed no matter whether or not the mentally retarded individual is competent to consent to participation in such a program.

“Interventions that are not likely to harm the patient or that involve a great preponderance of benefit and very little risk are not generally seen as matters that justify much testing of competence. The level of competence required for consenting to them is often very low” (p.77).

What Reid proposes is that mentally retarded offenders, no matter whether they are found fit/unfit to plead and/or responsible/not responsible be remanded to a rehabilitation program, for the benefits of the individual’s involvement and participation in such a program would far out way the any of the minimal negative consequences brought about by their participation.

1.6.3 REHABILITATION PROGRAMS IN THE USA:

An analysis of the literature revealed that the following two programs, THE DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM and DEVEREUX KANNER PROGRAMS were being implemented in the USA. Both programs incorporate the key points listed under GENERAL CHARACTERISTICS (see SECTION 1.6.2). THE DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM (see SECTION 1.6.3.1) is expounded upon in an in-depth manner to provide a working example of a successful rehabilitative program in the USA, while the DEVEREUX KANNER PROGRAMS (see SECTION 1.6.3.2) salient features are described and problems with program implementation discussed.

1.6.3.1 THE DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM:

The Developmentally Disabled Offenders Program (DDOP) is one-of-a-kind program in the US State of New Jersey. It provides alternatives to incarceration on behalf of individuals with mental retardation who are defendants in the American criminal justice system. Additionally, the DDOP serves as a liaison between the Criminal Justice System (CJS) and Human Services System (HSS), thereby monitoring the quality of care and service provided to those with mental retardation as they move from one system to another. Its continuing mandate and challenge is to investigate how the linkages between these two systems and others can be established, strengthened and maintained (The Arc of New Jersey, 2003).

The DDOP comprises six main elements, those of (i) intervention, (ii) advocacy, (iii) case management, (iv) education, (v) training, and (vi) the Personalized Justice Plan (The Arc of New Jersey, 2003). Each element focuses on a separate issue with regard to the mentally retarded individual, and while each element is autonomous in its own right, they are also decidedly linked acting in mutual symbiotic process with each other.

- INTERVENTION:

Through its intervention process, the DDOP helps to overcome the American CJS's lack of understanding regarding the condition of mental retardation and those who suffer from it. Broadly, the DDOP aims to: (i) provide technical assistance to attorneys who represent mentally retarded individuals, and (ii) educate the CJS and HSS about mental retardation, the disadvantages faced by mentally retarded individuals and how appropriate community supports can address their habilitative needs (The Arc of New Jersey, 2003).

- ADVOCACY:

Advocacy services are provided to mentally retarded individuals who, because of their disability, may not understand the workings of the CJS. DDOP advocacy efforts help ensure that mentally retarded individuals are equally treated, and seek to ensure fair access to alternatives to incarceration and a more coordinated system of follow-up and aftercare through specialised community release programs and services. The DDOP also actively advocates for and supports legislation promoting the development of specialised programs

and services for offenders with mental retardation, as well as the protection of their rights (The Arc of New Jersey, 2003).

- CASE MANAGEMENT:

Case management services are provided to monitor individuals with mental retardation who become involved in the CJS. Once the DDOP receives a referral from any public or private agency, they develop a Personalised Justice Plan (PJP). This enables the referring agency to ensure accountability for the mentally retarded individual's behaviour while balancing the needs of the community (The Arc of New Jersey, 2003).

- EDUCATION:

Through education, the DDOP raises the level of understanding of the mentally retarded client, the service provider, the CJS, and the community about issues regarding persons with mental retardation and the CJS (The Arc of New Jersey, 2003).

Client Education – because of the numbers of persons with mental retardation living in the community, educating them about appropriate citizenship is paramount. The DDOP adheres to a prevention model, and strives to teach clients with mental retardation about ‘Citizenship and the Law’ (The Arc of New Jersey, 2003). Service Provider Information – through presentations to service providers, the DDOP provides specific educational programs on the special needs of persons with mental retardation and their ‘at risk’ status when involved in the CJS (The Arc of New Jersey, 2003).

Criminal Justice Education – through informational packets and advocacy letters, the DDOP educates the court system about the mentally retarded client's mitigating circumstances, and how the mentally retarded client can remain accountable for their criminal behavior while living in the community (The Arc of New Jersey, 2003). Community Education – the DDOP educates the community about the needs of mentally retarded defendants and about how the PJP can be utilised to assist persons with mental retardation who become involved in the CJS, and help to overcome the disadvantages faced by such persons (The Arc of New Jersey, 2003).

- TRAINING:

Due to the fact that a lack of basic knowledge concerning mental retardation exists in the CJS, the DDOP provides generic and specialised training sessions for any number of target audiences including defense and prosecuting attorneys, court officials, judges, police officers, parole officers and community service agencies. Training curricula are individually designed to meet the diverse needs and interests of the target audience (The Arc of New Jersey, 2003).

- THE PERSONALIZED JUSTICE PLAN (PJP):

The Personalized Justice Plan (PJP) is presented by the DDOP to the court system as an alternative to incarceration. It emphasises the use of the least restrictive community-based alternatives to incarceration as early as possible in the CJS process, while congruently holding mentally retarded individuals accountable for their behaviour. When presented as a special condition of probation or parole the PJP can help stabilise the mentally retarded individual in the community due to the way support systems are identified, coordinated and monitored. Once a mentally retarded individual is placed on probation or parole, the DDOP monitors the PJP until the individual completes their sentence. Every PJP increases the individual's accountability and responsibility in the community, with the goal in every case being to help the mentally retarded individual successfully complete probation or parole (The Arc of New Jersey, 2003).

1.6.3.2 DEVEREUX KANNER PROGRAMS:

The Devereux Kanner mission is to provide the highest-quality services to children, adults, and families with special needs, which derive from behavioural, psychological, intellectual or neurological impairments, such as mental retardation. Services are provided to foster human potential and to contribute to the individual's health, social, psychological, and educational well-being. Ultimately, the Devereux Kanner aim is to innovate and build programs of excellence that will act as models for other countries (Devereux Kanner, 2004).

- PROGRAM OVERVIEW:

Devereux Kanner's clinical and professional staffs are involved with each individual prior to

their participation in any program. Each customised program begins with a comprehensive needs assessment, integrating a thorough review of previous records (both psychological and legal), conducting standardised assessments, interviews and behavioural observations (Devereux Kanner, 2004). These are compiled into a core clinical record and treatment planning process. A multi-disciplinary team, headed by a Social Services Coordinator, carries out the assessment process. The multi-disciplinary team consist of some or all of the following members: (i) social workers, (ii) caregivers or guardians, (iii) mental health professionals including psychologists and psychiatrists, (iv) teachers, (v) occupational and speech therapists, and (vi) treatment managers and other professional staff as needed (Devereux Kanner, 2004).

The assessment process clarifies the specific role of team members in providing services. The treatment plan is individualised to meet each person's needs and is called the Individual Support Plan (ISP). Emphasis is on developing a functional curriculum that focuses on building new skills and creating environments to promote success (Devereux Kanner, 2004). Programming is monitored through a clinical team and administrative review procedures. The assessment and treatment plan focuses on promoting self-determination, improving quality of life, and developing transition plans that prepare individuals for future success (Devereux Kanner, 2004).

The ISP consists of service provisions such as: (i) counselling – in which services are provided by professionals who may include: psychologists, marriage, family and children counsellors, and licensed clinical social workers (Devereux Kanner, 2004); (ii) a Treatment Team – headed by a Social Services Coordinator who provides case management and serves as a liaison between the mentally retarded individual's family and government agencies, for example the Criminal Justice System (Devereux Kanner, 2004); (iii) mental health and medical services – which provide medical, nursing, dental and psychiatric services (Devereux Kanner, 2004); and (iv) ancillary services – such as speech, language and hearing screening (Devereux Kanner, 2004).

- PROGRAM IMPLEMENTATION DIFFICULTIES:

While Devereux Kanner programs are conventionally aimed at the non-criminally offending segment of the American population, plans are currently in motion to extend their services,

with some alterations and additions, to offenders with special needs. However, obstacles such as obtaining funding and premises, the employment of forensically-orientated personnel, and recognition from legal and government agencies, for example the American Criminal Justice System need to be overcome before a fully operational program may be put into place.

1.6.4 REHABILITATION PROGRAMS IN SOUTH AFRICA:

Current South African mechanisms in place with regard to the mentally retarded offender are limited as they offer only three practical options, specifically, (i) mentally retarded offenders who are found unfit to plead and/or not criminally responsible for their actions are certified under Section 28(3) of the Mental Health Act 1973, and are then placed at an appropriate psychiatric institution, for example Fort England Hospital (FEH), for rehabilitation, (ii) mentally retarded offenders who are found unfit to plead and/or not criminally responsible for their actions and who have been charged with crimes that are not of a violent nature, are remanded under Section 78(4) of the Criminal Procedure Act 1977 (as amended by the Criminal Matters Amendment Act, 1997), to an appropriate community setting in which they are treated as an out-patient at a suitable institution, pending eventual discharge which must be certified by the institutions superintendent, or (iii) mentally retarded offenders who are found fit to plead and criminally responsible are referred back to the legal system after their period of forensic observation so that the law may take its course.

In the cases of those mentally retarded individuals who have committed criminal offenses, and who are found unfit to plead and/or criminally not responsible, the question remains as to appropriate means of referral and rehabilitation of such offenders. In South Africa options are limited in this regard, with most such offenders being remanded as State Patients to psychiatric hospitals that specialise in the forensic paradigm, specifically in working to rehabilitate either mentally ill or mentally retarded offenders. The lack of appropriate specialist facilities that cater to the needs of the mentally retarded offender dictates that option (ii) mentioned above, that of diversion to a rehabilitation facility as an out-patient is currently unviable.

Thus, especially in the case of the mentally retarded offender, there exists a dearth of knowledge and practical options as to appropriate means of referral and rehabilitation,

particularly in terms of alternate forms of rehabilitation and treatment that are community rather than hospital-based.

1.6.4.1 IN-PATIENT PSYCHIATRIC HOSPITAL REHABILITATION – FORT ENGLAND HOSPITAL:

At FEH, mentally retarded State Patients are integrated into the general State Patient rehabilitation program, which is a typical example of rehabilitation programs in place at other South African forensic/psychiatric hospitals. The rehabilitative model utilised within the forensic (or State Patient) wards at FEH is relatively similar in manner to the two programs mentioned above (see SECTION 1.6.3.1 and 1.6.3.2) with the exception that it is run on an in-patient only basis. The rehabilitation model is operated by a multi-disciplinary team consisting of social workers, doctors, psychiatrists, psychologists and occupational therapists as well as the input of the nursing staff (Dr H. Erlacher, personal communication, 28 April 2004) who have the most interaction with the patients, thus making their contribution invaluable.

Medication is the principal form of rehabilitation, especially with those patients who have been diagnosed with a primary Axis I disorder. Additionally, a behaviour modification system is in place, which utilises a system of reward and punishment to reinforce desired behaviours (Dr H. Erlacher, personal communication, 28 April 2004), and further ancillary services such as Occupational Therapy and Psychoeducational Counselling are also available.

- THE BEHAVIOUR MODIFICATION PROGRAM:

Patients are assigned to groups (A through F), with each group symbolising varying levels in the rehabilitative process and with promotion to a higher group entailing following all ward rules and procedures and being compliant with medication as well as active participation in the rehabilitative process. Further, promotion to a higher group brings the added benefits of access to ground parole, ancillary hospital services and ultimately the final process of discharge, which only happens once several successful leaves-of-absence have been completed (Dr H. Erlacher, personal communication, 28 April 2004).

Demotion to a lower group usually occurs as a result of the flagrant infringement of ward rules, for example, attempting to abscond from the hospital grounds or physical violence

between fellow patients. Except in rare cases, both promotion and demotion are usually decided on by the particular ward's multi-disciplinary team once monthly (Dr H. Erlacher, personal communication, 28 April 2004). It does not appear as if any explicit adaptations are made to the current rehabilitation program with regards to the mentally retarded offender.

- OCCUPATIONAL THERAPY:

Occupational Therapy (OT) services two main purposes: (i) learning new skills that can be applied as job-related aids upon discharge in sheltered employment environments, for example, woodworking and machinist skills, and (ii) working in group settings, thereby allowing for the socialisation of the mentally retarded offender in communal settings (Dr H. Erlacher, personal communication, 28 April 2004).

- PSYCHOEDUCATIONAL COUNSELLING:

Psychoeducation entails both group and individual counseling on a weekly basis. Groups are run by psychologists and nursing staff with creative means such as art, games and music employed to achieve process and cohesion, thereby allowing the mentally retarded offender to: (i) learn skills such as the ability to delay gratification needs (for example, waiting in turn to use materials provided for the group) and, similar to OT, (ii) how to socialise appropriately in different settings (Dr H. Erlacher, personal communication, 28 April 2004).

Individual counseling provides a space in which offenders may address more directly those issues which affect them and has the added advantage of being on a one-on-one basis, meaning that especially for mentally retarded patients, therapy may be tailored to be commensurate with their specific level of cognitive and adaptive functioning (Dr H. Erlacher, personal communication, 28 April 2004).

- ANCILLARY SERVICES:

Ancillary services such as access to dental care and hygiene, appropriate vision screening, hearing testing, and specialist consults by doctors other than those working within FEH are also available.

1.7 RATIONAL FOR THE PRESENT STUDY:

While those people involved in the legal system who are mentally retarded constitute a small portion of all people with this disability (Noble & Conley, 1992) the number is significant enough to warrant the attention and concern of parents, criminal justice personnel, policy-makers, and mental health professionals who work within forensic settings (Davis, 1995). Consequently there is an increasing awareness among mental health professionals involved in forensic settings of the impact that mental retardation has on their work (O'Connor, 1996). However, as yet, the implications and repercussions of mental retardation in South African forensic settings, both in terms of overall decision making with regards to recommendations to the courts and in terms of rehabilitative programs, have not yet been fully researched or investigated.

1.8 RESEARCH GOALS:

The research aimed to explore three main areas, namely: (i) The prevalence and nature of crimes associated with of mental retardation in a South African forensic observation setting. (ii) The effectiveness of the current rehabilitation program in place for mentally retarded offenders at a South African forensic hospital. (iii) The implications that both goals (i) and (ii) have for psychologists in terms of current and future rehabilitation programs in both institutional and community settings.

CHAPTER II: METHODOLOGY

2.0 RESEARCH PARTICIPANTS:

Participants for the first research goal comprised all patients remanded to Fort England Hospital (FEH) for forensic observation over the period 1 January 2001 to 31 December 2003 (n=314) who were subsequently diagnosed as suffering from mental retardation (n=79). Regarding the second research goal, the files of several mentally retarded State Patients who were remanded to FEH for rehabilitation (n=24) were analysed to identify advantages and disadvantages in the current rehabilitation process.

The participants for the first two research goals came from a broad spectrum of racial, cultural and language backgrounds. The sole exclusion criteria for both goals was in relation to those patients who were diagnosed as being mentally retarded but who also had a primary Axis I diagnosis, for example Schizophrenia, to which their mental retardation was considered secondary (n=12).

No further exclusion criteria pertaining to race, sex or socio-economic status were applied on the grounds that such exclusions were biased, as mental retardation does not discriminate along racial or gender lines and reaches across all cultural, language and religious boundaries (American Psychiatric Association, 2000).

2.1 DATA COLLECTION INSTRUMENTS AND PROCEDURES:

The first aspect of the research was conducted in the Forensic Unit at FEH, which draws referrals for forensic observation from a broad judicial area of the Eastern Cape Province. The Forensic Unit at FEH has, since 2001, routinely gathered pertinent information, via the use of a formal data capture sheet, on all people referred by the courts for observation (see APPENDIX A). The data sheet includes details such as age, nature of charge, multi-axial diagnosis, history of substance use and recommendations to the court regarding fitness to plead and criminal responsibility.

The second aspect of the research was conducted utilising the files of those mentally retarded individuals who have been remanded to FEH as State Patients for rehabilitation and who were

currently in residence, as well as semi-structured interviews held with Principal Psychiatrist, Dr Helmut Erlacher of the Forensic Unit and State Patient wards to ascertain his views on the positives and negatives inherent in the current rehabilitation process. Dr Erlacher is an accepted expert with many years of working experience and practical knowledge in the field of Forensic Psychiatry.

2.1.1 DATA ANALYSIS:

Data analysis comprised addressing the following questions in order to shed light on the main research goals:

2.1.1.1 IN A SOUTH AFRICAN FORENSIC OBSERVATION SETTING:

- (i) What percentage of observation cases are diagnosed with mental retardation?
- (ii) Are some types of charges more frequently associated with a diagnosis of mental retardation?
- (iii) Is there a link between the severity of mental retardation and type of charge?
- (iv) What percentage of mentally retarded observation patients were deemed unfit to plead and/or not responsible for their actions?

2.1.1.2 IN A SOUTH AFRICAN FORENSIC REHABILITATION SETTING:

- (i) How many mentally retarded offenders are currently in Fort England Hospital for rehabilitation purposes?
- (ii) What proportion of these mentally retarded offenders are being successfully rehabilitated?
- (iii) What are the impediments to successful rehabilitation inherent in the current process?

2.1.2 DATA PROCESSING:

Data collected during the course of the research, that was used to answer the questions listed under SECTION 2.1.1.1, was interpreted through the use of descriptive statistics, such as frequency tables and frequency histograms. Microsoft ® Excel was used to code the data as well as perform the required statistical evaluation. Additionally, the coded data was imported into a suitable statistical computer program (Statistica, Version 6.1, 2004 Edition) so that the statistical evaluations performed using Microsoft ® Excel could be checked and verified.

The questions listed under SECTION 2.1.1.2 were answered utilising individual patient files of those State Patients who are mentally retarded and are currently in residence at FEH for rehabilitation. Files were consulted to analyse both impediments to and supports of successful rehabilitation inherent in the current process. In terms of the number of mentally retarded State Patients who were in residence at FEH, it was only possible to estimate the state of their progress through the rehabilitation program. Several factors were examined to determine such progress:

- (i) ADAPTABILITY TO THE BEHAVIOUR MODIFICATION PROGRAM – The first indication was to explore each individual patient's adaptability to the hospital environment by examining which Behaviour Modification group (A to F) each individual patient was in, on average how long it took each patient to reach that group and the average length of time each patient had been in a particular group without demotion due to infraction of the rules.
- (ii) LEAVE-OF-ABSENCE – Second, an examination of each individual patient's file was undertaken to see if they had been granted Leave-Of-Absence (LOA), whether their LOA had been successful or unsuccessful, and if any further LOA's were planned.
- (iii) POSSIBLE RECLASSIFICATION OR DISCHARGE – Thirdly, each individual patient's file was examined to determine if reclassification (to another section as mandated by the Criminal Procedure Act 51 of 1977 or the Mental Health Act 18 of 1973) was possible, or if a discharge date had been discussed or set.

The above information was integrated with the information obtained from the semi-structured interviews conducted with Dr H. Erlacher, in which the following broad questions were asked as the basis for the interviews.

(i) What, in your view, are the major problems that the mental health system and the professionals who work within it experience when working with or rehabilitating the mentally retarded State Patient? (ii) What changes to the current system would make rehabilitating mentally retarded State Patients easier and more beneficial? (iii) What suggestions do you have for alternate forms of rehabilitation? (iv) What, in your view, would an ideal rehabilitative program for mentally retarded offenders consist of? (v) What more can be done in the current rehabilitative program to assist both staff and patients?

From the information obtained, key themes relating to impediments inherent in the current rehabilitation process were then identified and expounded upon.

2.2 ETHICS:

It should be emphasised that at no time during the course of the research were any patients in residence at FEH in State Patient wards consulted or approached in a personal manner. Individual people referred by the court for forensic observation were also not approached directly and were therefore not directly involved with the research in any manner.

All ethical considerations in particular the right to confidentiality and anonymity of people whose data was included in the study were strictly adhered to. In addition, access to the data collected was limited to only those people who were directly involved or consulting on the research process, which included the author, the author's supervisor, Mr I.R. Reid, and Dr H. Erlacher.

Consent to undertake the research was obtained in writing from Dr H. Erlacher, Principal Psychiatrist and Head of the Forensic Unit at FEH and was approved by Professor D.D. Swingler, Principal Psychiatrist and Clinical Head of FEH, and Dr A.I Schultz, Senior Medical Superintendent of FEH.

CHAPTER III: RESULTS

3.0 INTRODUCTION:

The following is the descriptive statistical data that arranges the collected data samples in tabular form as a means to answer the questions set out in SECTION 2.1.1.1. The data is laid out according to the order in which the questions were posed in the above listed section. Due to the limited data available, especially for the years 2001 and 2002, a category labelled MENTAL RETARDATION (UNSPECIFIED) was created, which broadly refers to all those observation patients who were diagnosed as having mental retardation without any indication of the severity of the retardation. For ease of convenience, key themes that were identified with regard to the rehabilitation process are presented in SECTION 2.1.1.2, and are also laid out according to the order in which they were posed.

3.1 PERTAINING TO SECTION 2.1.1.1:

3.1.1 QUESTION I:

- What percentage of observation cases are diagnosed with mental retardation?

TABLE I: TOTAL SAMPLE SIZE AND INDICATION OF THE NUMBER OF MENTALLY RETARDED REFERRALS

	2001	2002	2003	TOTAL
TOTAL OBSERVATION CASES	74	128	182	314
MENTAL RETARDATION (UNSPECIFIED)	12	21	1	34
MILD MENTAL RETARDATION	-	3	33	36
MODERATE MENTAL RETARDATION	-	-	9	9
TOTAL	12	24	43	79

As may be seen from TABLE I, there were 12, 24 and 43 mentally retarded offenders referred for forensic observation during the years 2001, 2002 and 2003 respectively, ultimately leaving an overall sample size of 79 (25.16%) mentally retarded offenders who have been sent to Fort

England Hospital (FEH) for a formal period of assessment and observation out of a grand total of 314 (100%).

TABLE II: PERCENTAGE OF MENTALLY RETARDED OBSERVATION CASES STRATIFIED BY YEAR

	2001	2002	2003	TOTAL
MENTAL RETARDATION (UNSPECIFIED)	16.22	16.41	0.55	33.18
MILD MENTAL RETARDATION	-	2.34	18.13	20.47
MODERATE MENTAL RETARDATION	-	-	4.95	4.95
TOTAL (%)	16.22	18.75	23.63	

TABLE II's results are indicative of the breakdown percentages of observation patients, stratified by year, who have been diagnosed with mental retardation. The severity of retardation has also been included where possible. Of specific note is the increase in the number of mentally retarded forensic observation patients over time, from 16.22 percent in 2001 to 23.63 percent in 2003.

3.1.2 QUESTION II:

- Are some types of charges more frequently associated with a diagnosis of mental retardation?

**TABLE III: CHARGES AGAINST MENTALLY RETARDED OFFENDERS AS CATAGORISED
PER YEAR**

CHARGE	2001	2002	2003	TOTAL
ARSON	1	1	-	2
RAPE	3	11	16	30
ATTEMPTED RAPE	1	2	2	5
ROBBERY	2	-	-	2
MURDER	5	1	8	14
HOUSEBREAKING	-	3	-	3
KIDNAPPING	-	1	1	2
POSSESSION OF STOLEN GOODS	-	1	-	1
INTIMIDATION	-	1	-	1
ASSAULT	-	1	8	9
INDECENT ASSAULT	-	1	3	4
THEFT	-	1	2	3
ATTEMPTED MURDER	-	-	1	1
STOCK THEFT	-	-	1	1
MALICIOUS DAMAGE TO PROPERTY	-	-	1	1
TOTAL	12	24	43	79

An analysis of the charges against individuals, who were sent to FEH for forensic observation and who were subsequently diagnosed as being mentally retarded, into categories, indicates that violent crimes, for example murder (14 17.72%), rape (30 37.97%) and assault (9 11.39%), appear to be most prevalent or associated with a diagnosis of mental retardation. A similar analysis indicating percentages may be found in TABLE IV below.

**TABLE IV: CHARGE PERCENTAGES OF MENTALLY RETARDED OFFENDERS AS
CATAGORISED PER YEAR**

CHARGE	2001 (%)	2002 (%)	2003 (%)	~ 2001-2003 (%)
ARSON	8.33	4.17	-	2.53
RAPE	25.0	45.83	37.21	37.97
ATTEMPTED RAPE	8.33	8.33	4.65	6.33
ROBBERY	16.67	-	-	2.53
MURDER	41.67	4.17	18.6	17.72
HOUSEBREAKING	-	12.5	-	3.8
KIDNAPPING	-	4.17	2.33	2.53
POSSESSION OF STOLEN GOODS	-	4.17	-	1.27
INTIMIDATION	-	4.17	-	1.27
ASSAULT	-	4.17	18.6	11.39
INDECENT ASSAULT	-	4.17	6.98	5.06
THEFT	-	4.17	4.65	3.8
ATTEMPTED MURDER	-	-	2.33	1.27
STOCK THEFT	-	-	2.33	1.27
MALICIOUS DAMAGE TO PROPERTY	-	-	2.33	1.27

3.1.3 QUESTION III:

- Is there a link between the severity of mental retardation and type of charge?

As there was a dearth of data specifying the severity of mental retardation in both 2001 and 2002, it was not possible to ascertain whether any links existed between the severity of mental retardation and type of charge in those years. However, as adequate data was available for the year 2003, a table indicating any possible links for that year may be found below.

**TABLE V: NUMBER OF CHARGES PER CATEGORY AS DEFINED BY SEVERITY OF
MENTAL RETARDATION IN 2003**

2003 n=43	MENTAL RETARDATION (UNSPECIFIED), n=1	MILD MENTAL RETARDATION, n=33	MODERATE MENTAL RETARDATION, n=9	TOTAL (%)
CHARGE				
RAPE	1	13	2	16 (37.21)
ASSAULT	-	7	-	7 (16.28)
MURDER	-	5	3	8 (18.6)

TABLE V contains the most prevalent charges, across all groups, against mentally retarded offenders, as categorised by severity, in 2003. Violent crimes, particularly rape, predominate, especially when taking into account that the 31 charges listed (16+7+8=31) comprise more than half of the sample (n=43) of mentally retarded offenders who were assessed during the time period (see TABLE I, SECTION 3.1.1). A link may therefore be drawn between violent crimes, especially rape and assault, and the mildly mentally retarded offender. However, no similar links may be drawn for the moderately mentally retarded offender, due to the limited numbers involved in this study.

3.1.4 QUESTION IV:

- What percentage of mentally retarded observation patients were deemed unfit to plead and not responsible for their actions?

The data utilised in regards to fitness to plead and criminal responsibility is being presented by year, with an overall indication following. All tables provide percentages and not statistical descriptions of the data.

**TABLE VI: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN
2001**

2001	FIT TO PLEAD (%)	UNFIT TO PLEAD (%)
MENTAL RETARDATION (UNSPECIFIED)	4 (33.33)	8 (66.67)

**TABLE VII: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL
RESPONSIBILITY IN 2001**

2001	RESPONSIBLE (%)	NOT RESPONSIBLE (%)	DIMINISHED RESPONSIBILITY (%)	INSUFFICIENT INFORMATION (%)
MENTAL RETARDATION (UNSPECIFIED)	2 (16.67)	7 (58.33)	3 (25.0)	0

TABLES VI and VII provide the percentage breakdowns of recommendations to the court regarding fitness to plead and criminal responsibility for the year 2001. Of note is that two-thirds (66.67%) of referred observation patients who were subsequently diagnosed as being mentally retarded were found unfit to plead and over 83 percent (58.33 + 25.0 = 83.33%) of the same group were found to either be not responsible for their actions or as having diminished responsibility.

**TABLE VIII: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN
2002**

2002	FIT TO PLEAD (%)	UNFIT TO PLEAD (%)
MENTAL RETARDATION (UNSPECIFIED)	13 (54.17)	11 (45.83)

**TABLE IX: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL
RESPONSIBILITY IN 2002**

2002	RESPONSIBLE (%)	NOT RESPONSIBLE (%)	DIMINISHED RESPONSIBILITY (%)	INSUFFICIENT INFORMATION (%)
MENTAL RETARDATION (UNSPECIFIED)	4 (16.67)	14 (58.34)	5 (20.83)	1 (4.17)

TABLES VIII and IX provide the percentage breakdowns of recommendations to the court regarding fitness to plead and criminal responsibility for the year 2002. Contrary to the figures for 2001, almost 55 percent (54.17%) of referred observation patients who were subsequently diagnosed as being mentally retarded were found unfit to plead. However,

similarly to 2001 almost 80 percent ($58.34 + 20.83 = 79.17\%$) of the same group was found to be either not responsible for their actions or as having diminished responsibility.

**TABLE X: RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD IN
2003**

2003	FIT TO PLEAD (%)	UNFIT TO PLEAD (%)
MENTAL RETARDATION (UNSPECIFIED)	0 (0)	1 (2.33)
MILD MENTAL RETARDATION	30 (69.77)	3 (6.98)
MODERATE MENTAL RETARDATION	1 (2.33)	8 (18.6)
TOTAL	31 (72.1)	12 (27.91)

**TABLE XI: RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL
RESPONSIBILITY IN 2003**

2003	RESPONSIBLE (%)	NOT RESPONSIBLE (%)	DIMINISHED RESPONSIBILITY (%)	INSUFFICIENT INFORMATION (%)
MENTAL RETARDATION (UNSPECIFIED)	0 (0)	1 (2.33)	0 (0)	0 (0)
MILD MENTAL RETARDATION	9 (20.93)	2 (4.65)	20 (46.51)	2 (4.65)
MODERATE MENTAL RETARDATION	0 (0)	2 (4.65)	5 (11.63)	2 (4.65)
TOTAL	9 (20.93)	5 (11.63)	25 (58.14)	4 (9.3)

TABLES X and XI provide the percentage breakdowns of recommendations to the court regarding fitness to plead and criminal responsibility for the year 2003. Where possible, the severity of retardation has also been included. Continuing the trend of an increase in the number of mentally retarded offenders who are found fit to plead, and in line with the figures from 2001 and 2002, just under thirty percent (27.91%) of referred observation patients who were subsequently diagnosed as being mentally retarded were found unfit to plead. However, similarly to 2001 and 2002 over two-thirds ($11.63 + 58.14 = 69.77\%$) of the same group was found to either be not responsible for their actions or as having diminished responsibility.

TABLE XII: OVERALL RECOMMENDATIONS TO THE COURT REGARDING FITNESS TO PLEAD

~ 2001 – 2003	FIT TO PLEAD (%)	UNFIT TO PLEAD (%)	TOTAL (%)
MENTAL RETARDATION (UNSPECIFIED)	17 (35.42)	20 (64.52)	37 (46.84)
MILD MENTAL RETARDATION	30 (62.5)	3 (9.68)	33 (41.77)
MODERATE MENTAL RETARDATION	1 (2.08)	8 (25.81)	9 (11.39)
TOTAL	48 (60.76)	31 (39.24)	79 (100)

TABLE XII provides an over-arching indication of the data collected for 2001, 2002 and 2003, finding that 39.24 percent of all individuals who were referred to FEH for a period of forensic observation and who were subsequently diagnosed with mental retardation were found unfit to plead. FIGURE I provides a limited visual representation of the percentages indicated above.

FIGURE I: A GRAPHICAL REPRESENTATION OF THE OVERALL PERCENTAGES LISTED IN TABLE XII

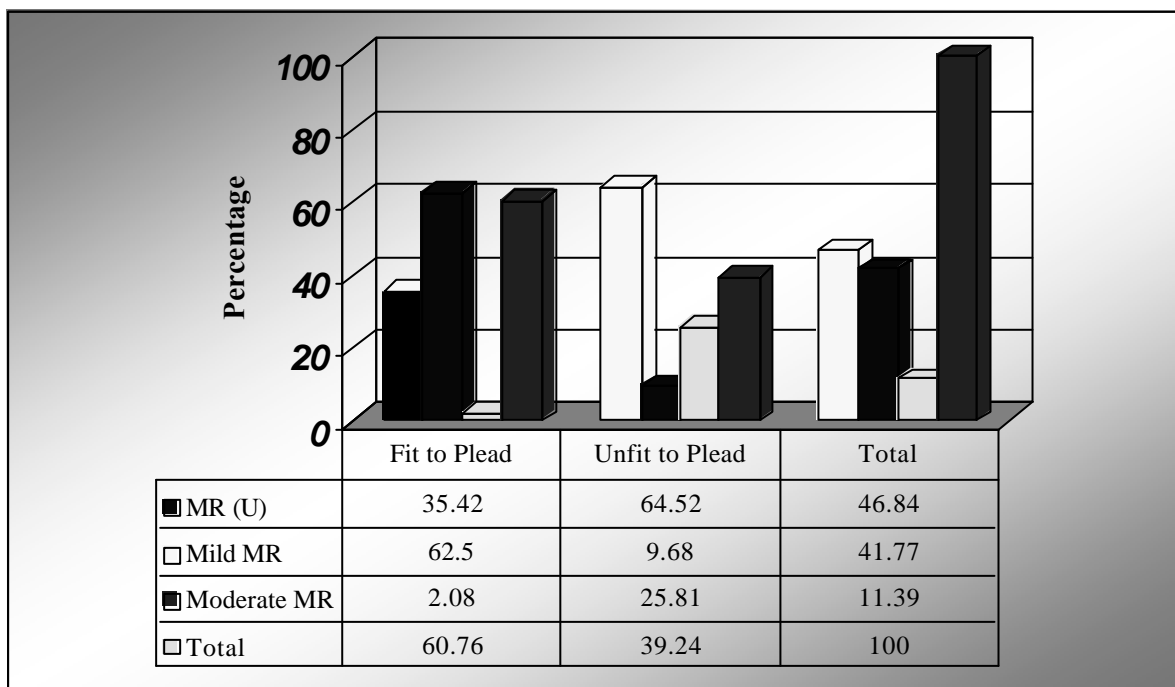
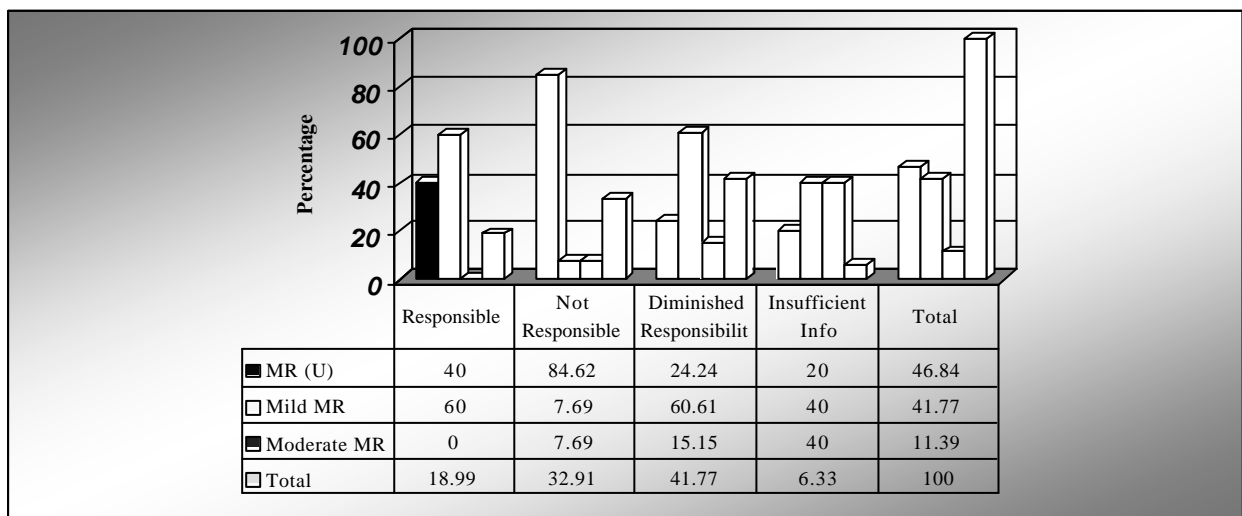


TABLE XIII: OVERALL RECOMMENDATIONS TO THE COURT REGARDING CRIMINAL RESPONSIBILITY

~ 2001 – 2003					
	RESPONSIBLE (%)	NOT RESPONSIBLE (%)	DIMINSISHED RESPONSIBILITY (%)	INSUFFICIENT INFORMATION (%)	TOTAL (%)
MENTAL RETARDATION (UNSPECIFIED)	6 (40.0)	22 (84.62)	8 (24.24)	1 (20.0)	37 (46.84)
MILD MENTAL RETARDATION	9 (60.0)	2 (7.69)	20 (60.61)	2 (40.0)	33 (41.77)
MODERATE MENTAL RETARDATION	0 (0)	2 (7.69)	5 (15.15)	2 (40.0)	9 (11.39)
TOTAL	15 (18.99)	26 (32.91)	33 (41.77)	5 (6.33)	79 (100)

TABLE XIII provides an over-arching indication of the data collected for 2001, 2002 and 2003, finding that almost 75 (32.91 + 41.77 = 74.68%) percent of all individuals who were referred to FEH for a period of forensic observation and who were subsequently diagnosed with mental retardation were found not responsible for their actions or as having diminished responsibility. FIGURE II provides a limited visual representation of the percentages indicated above.

FIGURE II: A GRAPHICAL REPRESENTATION OF THE OVERALL PERCENTAGES LISTED IN TABLE XIII



3.2 PERTAINING TO SECTION 2.1.1.2:

3.2.1 QUESTION I:

- How many mentally retarded offenders are currently in Fort England Hospital for rehabilitation purposes?

An analysis of the State Patient Data Base at FEH on 29 April 2004 indicated that as at 1 January 2004, there were 24 mentally retarded offenders remanded as State Patients under Section 28(3) of the Mental Health Act 18 of 1973 to FEH for rehabilitation. Of those 24 patients, two were females and 22 were males. The patients were split over six wards, with only one residing in the Forensic Unit under maximum security. In terms of the behavioural modification program (see CHAPTER I, SECTION 1.6.4.1), 13 of the patients were in Group A, two were in Group B and five were in Group C. Of the remaining four patients, three had absconded and one was on leave-of-absence. It should be noted that six of the patients included in the sample of 24 were first remanded to FEH as State Patients before 1 January 2001.

3.2.2 QUESTION II:

- What proportion of these mentally retarded offenders are being successfully rehabilitated?

(i) ADAPTABILITY TO THE BEHAVIOUR MODIFICATION PROGRAM – Of the 13 State Patients in Group A, 11 were Group A members as of 1 January 2004, with only two being promoted to Group A in 2004. On average, each individual patient took approximately four to five months to be promoted to Group A, as with the exception of two patients, the other 11 patients were put into Group C upon arrival at FEH. One of the two patients in Group B was scheduled for promotion to Group A, while the other patient in Group B was demoted from Group A due to an infraction of the ward rules. All five patients in Group C were considered to be difficult to manage within the hospital setting and according to their files had experienced numerous promotions and demotions due to poor internal behavioural controls. None of the patients in Group C were being considered for promotion.

(ii) LEAVE-OF-ABSENCE – Data collected from the individual State Patient files indicated that 12 of the 13 patients in Group A had been granted Leave-of Absence (LOA) at some point, with eight of the patients considered to have had successful LOA's as their LOA was extended due to good behaviour and laudable progress reports from their custodians. The one remaining patient in Group A was scheduled for LOA; however difficulties were encountered by social workers in terms of finding the patient an appropriate custodian. All 13 patients in Group A had either further LOA's planned for them or were being considered for reclassification or discharge. One of the patients in Group C had been granted several LOA's; however numerous behavioural disturbances similar to those that led to his demotion to Group C were reported by his custodian. As of 4 May 2004, none of the patients in Group B and only one of the patients in Group C were scheduled by their respective multi-disciplinary teams for LOA in the near future.

(iii) POSSIBLE RECLASSIFICATION OR DISCHARGE – In Group A, five of the patients were being considered for some form of discharge (whether it was conditional or unconditional), two were being considered for reclassification, while the remaining six patients future management would be considered after further positive reports were received about their level of adaptability while on LOA. In Group C, two of the patients were being considered for reclassification. The remaining three patients in Group C as well as the two patients in Group B were not yet being considered for any form of reclassification or discharge.

3.2.3 QUESTION III:

- What are the impediments to successful rehabilitation inherent in the current process?

With regard to the mentally retarded State Patient, several problems arise that are not usually faced when working with or rehabilitating the non-mentally retarded State Patient. Specifically the following themes were identified:

(i) LACK OF A 'TRADITIONAL' MEDICAL SOLUTION – Unlike a State Patient with a primary Axis I DSM diagnosis, for example Schizophrenia, there is no appropriate treatment protocol or medication indicated that will lessen an individual's level or severity of retardation.

(ii) DEARTH OF COGNITIVE ABILITIES – Due to the fact that an individual is mentally retarded, and depending on the severity of the retardation, certain patients may be unable to comprehend or fully understand both ward and hospital rules, thereby resulting in frequent infringements usually in the form of undesirable behaviour. In the case of FEH, such undesirable behaviour (which is usually the result of the mentally retarded individual's inability to respond to positive and negative reinforcement) may result in the mentally retarded State Patient being transferred to the Forensic Unit and possibly prescribed neuroleptic medication in an attempt to control his or her behaviour.

(iii) LEGAL PROBLEMS WITH RECLASIFICATION OR DISCHARGE – The Director of Public Prosecutions may refuse applications by hospital staff, for the reclassification or discharge of mentally retarded State Patients, on the basis that such individuals are unable to function in the unstructured environment that is today's modern society.

(iv) ISSUES OF GENDER – In the case of female mentally retarded State Patients, a dearth of knowledge and facilities exists as to appropriate means of behavioural control and modification.

(v) MANAGEMENT PROBLEMS DUE TO THE SEVERITY OF RETARDATION – Despite several obstacles (as mentioned above) a significant portion of mentally retarded State Patients are ultimately rehabilitated and discharged from the psychiatric hospital setting. However, those mentally retarded State Patients who remain within the rehabilitative system are notoriously difficult to manage due to the severity of their retardation.

(vi) LACK OF APPROPRIATE FACILITIES – In general, there is no specialist facility or hospital setting within South Africa that caters specifically to the needs of mentally retarded State Patients.

CHAPTER IV: DISCUSSION

4.0 INTRODUCTION:

This study has aimed to add to the field of knowledge concerning the mentally retarded offender in South Africa, both in terms of the prevalence of such offenders and in terms of rehabilitation and the difficulties faced in regards to tailoring the rehabilitative process to such offenders specialised needs.

The literature review contained in CHAPTER I traces the origins of such concepts as fitness to plead and criminal responsibility, yet reveals little prior research, specifically within the South African context, concerning the application of these principles to the mentally retarded offender. Further, two options for alternate community-based intervention are discussed, in which the rehabilitation process is individually customised to suit the specialised needs of the mentally retarded offender.

CHAPTER III highlights some of the complexities faced in South Africa by the mental health system and the professionals who work within it in regards to the mentally retarded offender. The data is also in line with previous studies conducted in other countries (Hayes, 1996; Ho, 2003), which indicate that as a group, mentally retarded offenders pose significant challenges and obstacles to systems already in place.

The clinical implications of the results contained within this chapter serve to highlight the problems inherent in the forensic rehabilitative process and in particular the growing complexities of modern forensic rehabilitation, while concurrently illustrating the strengths, in terms of predictors of successful rehabilitation, intrinsic to current practice.

It is hoped that the findings of this study will augment our understanding of the specific needs of the mentally retarded offender and allow new techniques to be developed that will aid in not only the traditional rehabilitation of such offenders, but also in the application of alternate forms of rehabilitation, specifically within the South African context.

4.1 CLINICAL IMPLICATIONS OF THE FINDINGS:

4.1.1 IN A SOUTH AFRICAN FORENSIC OBSERVATION SETTING:

(i) **SIGNIFICANT NUMBER OF MENTALLY RETARDED OBSERVATION PATIENTS** – Over 25 percent (25.16%) of all forensic observation cases referred to Fort England Hospital (FEH) were subsequently diagnosed with mental retardation. Thus, similar to other countries (Barron et al., 2002), it is incumbent upon mental health professionals working within South African forensic observation settings to adapt their assessment methodology to the complex needs and requirements of such individuals. Such adaptation will entail researching a supplementary means of sensitive, accurate and culturally fair IQ assessment that is contextualised within the South African milieu, as well as additional training for those staff members within forensic settings who are unfamiliar with the condition of mental retardation.

(ii) **PREDOMINANCE OF SEXUAL OFFENSES** – An analysis of the charges against mentally retarded forensic observation patients indicated that violent crimes such as rape, murder and assault appear to be the most prevalent. Such results are in line with those found in the United States of America (USA), where sexual offences appear to predominate (Day, 1994; Murphy et al., 1983). The connotation of such a finding indicates that the rehabilitation of mentally retarded offenders charged with such crimes will be more complicated and lengthy than the rehabilitation of other mentally retarded offenders, as these individuals create concerns regarding the safety of community members if they are granted a leave-of-absence. Additionally, concerns that will arise from the community as to the presence of a violent and/or sex offender within their midst, will have to be addressed by mental health professionals.

(iii) **LINKS BETWEEN SEVERITY OF RETARDATION AND TYPE OF CRIME** – Within the South African context, a tenuous link may be drawn between violent crimes, especially rape and assault, and the mildly mentally retarded offender. However, due to a lack of pertinent data, other links between severity of retardation and type of crime were not able to be made.

(iv) **IMPLICATIONS FOR REHABILITATIVE PROGRAMS** – 39.24 percent of all individuals who were referred to FEH for a period of forensic observation and who were subsequently diagnosed with mental retardation were found unfit to plead, while 32.91 percent were found

not responsible for their actions. Consequently, a significant number of mentally retarded individuals will therefore be certified under Section 28(3) of the Mental Health Act 1973 and remanded as State Patients to an appropriate psychiatric institution for rehabilitation.

Further, 41.77 percent of mentally retarded forensic observation patients were found to have diminished responsibility. Accordingly, these patients will return to the legal system where they will face trial, where mitigating circumstances may be taken into account upon sentencing.

4.1.2 IN A SOUTH AFRICAN FORENSIC REHABILITATION SETTING:

- SIGNIFICANT NUMBER OF MENTALLY RETARDED STATE PATIENTS:

As at 1 January 2004, there were 24 mentally retarded offenders who have been remanded as State Patients under Section 28(3) of the Mental Health Act 18 of 1973 to FEH for rehabilitation, which comprises six and a half percent (6.5%) of the total State Patient population in residence at FEH. Thus, it is incumbent upon the mental health professionals working at FEH and other forensic rehabilitation facilities to adapt the rehabilitation program already in place to the complex needs and requirements of such individuals, especially when taking the mentally retarded individuals limited cognitive and adaptive functioning abilities into account.

- PREDICTORS OF SUCCESSFUL REHABILITATION:

(i) ADAPTABILITY TO THE BEHAVIOUR MODIFICATION PROGRAM – Of the 24 mentally retarded offenders remanded as State Patients to FEH for rehabilitation, 13 were in Group A, two were in Group B and five were in Group C. Of the remaining four patients, three had absconded and one was on leave-of-absence. Consequently, it may be inferred that over half of the mentally retarded State Patients at FEH were responding to the behaviour modification program in a desired manner, as exhibited in their adaptive behaviour (i.e. promotion to Group A) and that these individuals were able to comprehend to a satisfactory degree the structured environment in place at FEH. However, it should be noted that the remaining mentally retarded State Patients were struggling to adapt to the hospital environment as evidenced by the five patients in Group C who were considered to be difficult to manage

within the hospital setting as, according to their files, they had experienced numerous promotions and demotions due to poor internal behavioural controls.

(ii) LEAVE-OF-ABSENCE – 8 of the patients in Group A were considered to have had successful Leave-of-Absence (LOA), which were judged on the basis of positive reports from custodians and, where applicable, by extensions of the LOA time period. The remaining patients in Group A were all scheduled for further LOA, while none of the patients in Group B and only one of the patients in Group C was scheduled for LOA. Hence, successful LOA's provide an indication that the mentally retarded State Patient's advancement through the rehabilitative process is progressing in a satisfactory manner. However, some mentally retarded State Patients are deemed to have had unsuccessful LOA due, in part, to problems with acceptance or stigmatisation within the community, neglect by their custodians and an inability to transfer the gains they have made within the structured hospital setting to the unstructured community setting.

(iii) POSSIBLE RECLASSIFICATION OR DISCHARGE – In Group A, five of the patients were being considered for some form of discharge, while two were being considered for reclassification, as were two patients in Group C. Applications by hospital staff for the reclassification or discharge (whether conditional or unconditional) of a mentally retarded State Patient, dictates that a particular patient's progress through the rehabilitative system has been satisfactory, and that no further gains or improvements, specifically in their behaviour, may be made or expected. Accordingly, it may be assumed that these individuals are therefore equipped to rejoin society as productive, non-threatening persons.

The above three points form the basis on which the success of an individual's progress through the rehabilitative process may be judged. However, these points are by no means all encompassing as the only predictors of successful rehabilitation. Thus, it should be kept in mind that a mentally retarded State Patient may be progressing satisfactorily through the rehabilitative process (i.e. they have been promoted to Group A) without having been granted LOA or being considered for reclassification or discharge, due to factors beyond the scope of the individual's participation within the rehabilitation process. For example, difficulties in locating an appropriate custodian precludes the granting of LOA and indeed discharge, on the basis that the patient will be left unsupervised within the community and is therefore likely to re-offend.

- IMPEDIMENTS TO SUCCESSFUL REHABILITATION:

(i) LACK OF A 'TRADITIONAL' MEDICAL SOLUTION – The lack of a 'traditional' medical intervention for mental retardation, dictates that mental health professionals working with such offenders will have to adapt rehabilitative programs and methods that have already been implemented to suit the specialised needs of such offenders. Such adaptation would likely entail extending the time period that such offenders remain within the rehabilitative process as, for example, deficits in their cognitive abilities may increase the length of time needed for such individuals to comprehend the rules in place in the structured environment at FEH and thus their progress through the behaviour modification program will be slower.

(ii) DEARTH OF COGNITIVE ABILITIES – Mentally retarded offenders, particularly those individuals whose retardation is severe, have a limited ability to learn new behaviour and thus struggle to adapt to the rehabilitative process, as they strain to comprehend positive and negative reinforcement. Therefore special care and understanding must be taken into account when reviewing such offenders' progress through the rehabilitative process, especially in respect of behavioural performance.

(iii) LEGAL PROBLEMS WITH RECLASSIFICATION OR DISCHARGE – Refusal by the Director of Public Prosecutions to reclassify or discharge (whether conditionally or unconditionally) mentally retarded State Patients may place pressure on hospital staff and resources in terms of the growing numbers of mentally retarded State Patients, which may lead to difficulties in program implementation and follow through due to, for example, low patient : staff ratios.

(iv) ISSUES OF GENDER – a dearth of knowledge and facilities exist as to appropriate means of behavioural control and modification in the case of mentally retarded State Patients who are female. Thus, rehabilitative efforts with regards to such female State Patients are hampered as limited numbers preclude any evaluation or research into the efficacy of systems that are currently utilised. For example, as at 4 May 2004 only eight of the 369 State Patients in residence at FEH were female of which just three were diagnosed as being mentally retarded. Thus it is impractical to evaluate their progress through the rehabilitative process in comparison to their male counterparts.

(v) MANAGEMENT PROBLEMS DUE TO THE SEVERITY OF RETARDATION – Those mentally retarded State Patients who remain incumbent within the rehabilitative system are notoriously difficult to manage due to the severity of their retardation. As such, long-term planning that extends beyond the current processes already in place is needed to optimise the successful rehabilitation of these individuals. Such planning would possibly entail additional funding, housing, staff and ancillary services, as in the case of a limited number of mentally retarded State Patients their progress through the rehabilitative process will be prolonged in comparison to non-mentally retarded State Patients.

(vi) LACK OF APPROPRIATE FACILITIES – In general, there is no specialist facility or hospital setting within South Africa that caters specifically to the needs of mentally retarded State Patients. Thus, a lack of uniformity exists concerning the rehabilitative process and policies at work in differing institutions, which precludes uniformity thereby impacting negatively upon the rehabilitative success rate.

The above six points are illustrations of impediments to successful rehabilitation inherent in working with mentally retarded offenders. However, these points do not preclude the ultimately successful rehabilitation of such offenders. Rather they serve to demonstrate difficulties which may be encountered by mental health professionals when working to rehabilitate mentally retarded offenders within the current process. Accordingly, it should be noted that despite encountering such difficulties, the rehabilitation of mentally retarded State Patients does progress (if the factor of mental retardation is taken into account) albeit at a sometime slower rate than other non-mentally retarded State Patients.

Consequently, if the implications of the above six points are integrated into developing and tailoring the current rehabilitation process to the specialised needs of mentally retarded offenders, management and treatment should ideally consider the issues of (i) socialisation, (ii) poor internal controls, (iii) faulty social learning, (iv) educational underachievement, (v) lack of social and occupational skills, and (vi) poor self-image. Thus, if appropriate funding may be obtained, a pilot study along the lines of the DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM (The Arc of New Jersey, 2003) should be attempted and perhaps modified to suit South African conditions.

4.2 CONCLUSIONS:

This study shares many similarities with other studies concerning the implications, both positive and negative, of rehabilitating mentally retarded offenders (Beail, 2002; Jahoda, 2002; Lindsay et al., 2002), while at the same time placing such implications within the South African context. Overall, the results highlight the difficulties experienced by mental health and, to some extent, legal professionals when working with the mentally retarded offender.

Despite the significant population size of mentally retarded offenders, there remain substantial areas of deficit in service provision, and numerous unanswered questions regarding appropriate diversion and rehabilitation of such offenders, both pre-trial and post-trial (Barron et al., 2002).

Thus, while individuals who are mentally retarded make up a small percentage of the South African population and indeed an even smaller percentage of criminal offenders, the number is significant enough to dictate that more careful intervention, management and particularly rehabilitation methods are direly in need of further research (as the current rehabilitation system does not have full value for all mentally retarded State Patients) and the attention of not only mental health and legal professionals but the entire community too.

4.3 LIMITATIONS OF THE RESEARCH:

Four limitations of this research must be acknowledged:

(i) The lack of specifiers in regards to stratifying the data contained in CHAPTER 3, SECTION 3.1.3 limited the accuracy of the determination of correlations between the severity of retardation and type of charge.

(ii) Mentally retarded female patients may have different charges against them compared to mentally retarded male patients. For example, it is highly unlikely that mentally retarded females will commit rape. Thus the sample utilised for data analysis in CHAPTER 3, SECTIONS 3.1.2 and 3.1.3 is possibly skewed, which therefore casts doubt on any correlations obtained. However, the number of mentally retarded female observation patients included in this study was very small (n=5), thus the effect of this variable is negligible.

(iii) Specifically within the Forensic Unit and occasionally in the State Patient wards at Fort England Hospital (FEH), assessments of intelligence and the subsequent identification of mentally retarded offenders is undertaken via the use of a standardised test of intelligence, namely, the *Raven's Coloured Progressive Matrices* (RCPM), which is considered to be the least culturally biased of the general intelligence tests available in South Africa. However, the RCPM is composed of predominantly visuospatial items (Lezak, 1995), which may lead to discrepancies in test results (such as specifying the severity of mental retardation) and possible misdiagnosis, especially if a patient has unknown right hemisphere brain damage (Lezak, 1995). While such discrepancies are possible, it is important to remember that no diagnosis of mental retardation is made at FEH solely on the basis of IQ score. The gathering of collateral information is considered to be an integral part of the process, especially in determining levels of adaptive functioning.

(iv) The research contained within this study is focused solely on the mentally retarded offender. The inclusion of other categories of mental illness as well as co-morbid mental illness/mental retardation diagnoses would have been of use in identifying problems that are specific to the mentally retarded offender alone. Mentally retarded offenders are not the only individuals who struggle within the rehabilitative process as problems may be encountered by mental health professionals when working to rehabilitate, for example, individuals diagnosed with schizophrenia.

4.4 SUGGESTIONS FOR FUTURE RESEARCH:

(i) Local South African courts have long stressed the importance of psychological testimony in cases where the defense is one of a lack of criminal responsibility due to non-pathological reasons (Louw, 1995). The use of such testimony in the sentencing stage of criminal proceedings has also been recommended by the court (Louw, 1995) and should be investigated further in terms of the mentally retarded offender particularly since the condition of mental retardation is innate and therefore untreatable by traditional medical methods.

(ii) Within the legal context, scholars should investigate addendums to the laws governing criminal responsibility that would apply specifically to the mentally retarded individual. Such laws would ideally stipulate methods and controls that would ensure the mentally retarded individual fair and equal access to justice and remand to appropriate specialist rehabilitative

facilities where necessary. While this suggestion does not apply directly to the field of mental health, the outcomes of such research, i.e. possible changes to South African law, will have direct implications for the rehabilitative process and the mental health professionals who work within the forensic paradigm.

(iii) The efficacy of alternate forms of rehabilitation that would aid the mentally retarded offender is, in most parts, based on small-scale uncontrolled research studies, which lack any level of homogeneity (Barron et al., 2002). Thus the success of such alternate forms of rehabilitation remains questionable. However, interventions similar to the DEVELOPMENTALLY DISABLED OFFENDERS PROGRAM (The Arc of New Jersey, 2003) should still ideally be researched on a national scale in South Africa by mental health professionals, for despite difficulties with funding, cultural variations and general public misinformation and prejudice, the benefits of implementing such a program will likely outweigh the initial problems encountered when adapting it to South African conditions.

(iv) A long-term study should be conducted that incorporates regular follow-up of the progress of the mentally retarded offender both within the rehabilitation setting and within the community after discharge. Such studies would ideally assess the mentally retarded offender's (i) ability to adapt to new environments, (ii) ability to learn new life and socialisation skills, for example, some form of semi-skilled sheltered employment, and (iii) ability to benefit constructively both within the community, and financially.

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APPENDIX A: FORENSIC UNIT DATA CAPTURE SHEET

FORENSIC UNIT
DATA CAPTURE SHEET

1. HOSPITAL NUMBER
2. SURNAME
3. AGE
4. SEX M1 F2
5. HOME LANGUAGE (Specify)
6. CURRENT MARITAL STATUS

0	1	2	3	4	5	6
UNKNOWN	SINGLE	MARRIED	COMMON	DIVORCED	SEPARATED	WIDOW

7. HLE

0	1	2	3
UNKNOWN	NO FORMAL ED.	SPECIAL ED.	LESS THAN STD. 6
4	5	6	7
STD. 6-7	STD. 8-9	STD. 10	TERTIARY

8. EMPLOYMENT

UNKNOWN 0	YES 1	NO 2
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9. AREA WHERE PERSON RESIDES e.g. Grahamstown, Peddie

10. CRIMINAL CHARGE (List all charges as per Prosecutors report)

1	
2	
3	
4	

11. REFERRING MAGISTERIAL DISTRICT (see J138)

12. VICTIM (Accused's relationship in violent crimes)

1	2	3	4
SPOUSE	CHILD	RELATIVE	ACQUAINTANCE
5	6	7	8
STRANGER	POLICE	PARENT	UNKNOWN

13. IF VICTIM IS A CHILD SPECIFY

1	2	3
OWN CHILD	STEP CHILD	RELATIVE
4	5	6
FRIEND/ ACQUAINTANCE	STRANGER	UNKNOWN

14. PAST CRIMINAL RECORD

1	2	3
YES	NO	UNKNOWN

14. REASON FOR REFERRAL

PAST PSYCHIATRIC HISTORY	1
REQUEST BY FAMILY	2
REQUEST BY ACCUSED	3
REQUEST BY LEGAL DEFENCE	4
PRE-TRIAL PSYCHIATRIC EVALUATION	5
ODD BEHAVIOUR IN COURT	6
OTHER	7
UNKNOWN	0

15. PAST PSYCHIATRIC HISTORY

UNKNOWN	YES	1	NO	2
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UNTREATED	1
TREATED BY TRADITIONAL HEALER	2
TREATED BY MENTAL HEALTH PROFESSIONAL	3

16. PAST PSYCHIATRIC DIAGNOSIS (If diagnosed and treated by a mental health professional)

17. FAMILY PSYCHIATRIC HISTORY

UNKNOWN	0	YES	1	NO	2
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18. SUBSTANCE ABUSE

0	1	2	3
UNKNOWN	ALCOHOL	DAGGA	CRACK COCAINE
4	5	6	7
MANDRAX	OTC	PRESCRIPTION	OTHER
8	9		
MULTIPLE	NONE		

19. PAST MEDICAL HISTORY

1.
2.
3.
4.

20. PAST HEAD INJURY (Resulting in loss of consciousness and/or hospitalisation)

0. UNKNOWN	1. YES	2. NO
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21. PHYSICAL ILLNESS DIAGNOSED AND TREATED DURING THE OBSERVATION PERIOD

1.
2.

22. CURRENT MENTAL STATE

NORMAL	1.
PSYCHOSIS	2.
DEPRESSION	3.
MANIA	4.
DELIRIUM	5.
COGNITIVE FALL-OUT (in the absence of psychosis and delirium)	6.
MALINGERING	7.
OTHER	8.

23. MENTAL STATE AT TIME OF OFFENCE

NORMAL	1.
PSYCHOSIS	2.
DEPRESSION	3.
MANIA	4.
DELIRIUM	5.
COGNITIVE FALL-OUT (in the absence of psychosis and delirium)	6.
MALINGERING	7.
OTHER	8.

24. INVESTIGATIONS

25.1 LAB TESTS

YES NO-

	NORMAL	ABNORMAL	NOT DONE
1. FBC	1	2	0
2. U & E	1	2	0
3. LFT	1	2	0
4. GLUCOSE	1	2	0
5. ESR	1	2	0
6. URINE CANNABIS	1	2	0
7. RPR	1	2	0
8. TPHA	1	2	0
9. FTA	1	2	0
10. H.I.V.	1	2	0

25.2 FURTHER SPECIAL INVESTIGATIONS

YES NO

SPECIFY: (EG. CSF.TFT etc)

25. PSYCHOLOGICAL ASSESSMENT

	YES	NO
1. NEUROPSYCHOLOGICAL	1	2
2. PERSONALITY	1	2
3. INTELLIGENCE	1	2
4. MALINGERING	1	2

26. SOCIAL REPORT

 YES NO 2

27. OCCUPATIONAL THERAPY REPORT

 YES NO 2

29. PSYCHIATRIC DIAGNOSIS

AXIS I	
AXIS II	
AXIS III	

30. FITNESS TO PLEAD

FIT 1	NOT FIT 2
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31. CRIMINAL RESPONSIBILITY

RESPONSIBLE	1
DIMINISHED RESPONSIBILITY	2
NOT RESPONSIBLE	3
INSUFFICIENT INFORMATION	4

CASE MANAGER
DATE COMPLETED