

ABSTRACTS OF PRESENTATIONS

MENTAL HEALTH IN OUR PRISONS: Judge D van Zyl Inspector General of Prisons

It is well known that our prisons are overcrowded and under-resourced. This talk will outline the general conditions and demands on our prisons, and then attempt to describe the needs of prisoners, especially those with mental illness, and then recommend possible remedies.

RESEARCH: AN OLD OBLIGATION WITH NEW IDEAS: Sean Kaliski Forensic Mental Health Service, Western Cape Department of Psychiatry, UCT

Forensic mental health has always been a dimension of general psychiatry, yet continues to lag in research output. This is due to many factors, such as the ethical difficulties of conducting research on forensic patients, and the artificiality of the legal concepts that have to married to psychiatric phenomena. In 2004 an international collaboration, SWANZDSAJCS, was formed under the leadership of Pamela Taylor (Wales) and Per Lindqvist (Sweden), which consisted of representatives from 9 countries. Initially the collaboration attempted to compare the rates of crime in their various countries, but then discovered that there were no universal definitions of crimes, including murder/ homicide. The next stage was to compare practices of assessment and practice of forensic mental health in each country. This was accomplished by using the case vignette method. I propose to introduce this method for SA as a means of not only conducting research but of practice audits as well.

THE WORD ON THE INSIDE: THE ETHICS AND CHALLENGES OF RESEARCH WITH FEMALE OFFENDERS A/Professor Lillian Artz Gender, Health & Justice Research Unit Faculty of Health Sciences University of Cape Town

There is a stark gap in South African criminological theory about female offenders as well as a critical absence of information about crime prevention, rehabilitation and social interventions in relation to female youth-at-risk and incarcerated women. Drawing on findings gained from a study of incarcerated women in South Africa, this presentation will describe a mixed-method ethnographic research process which culminated in 55 in-depth interviews with incarcerated women. The process included participatory methods such as life mapping, journaling, murals, poetry and the creation of a 'prison dictionary'. Facing numerous challenges such as systemic barriers (prison authorities), individual barriers (prisoner's struggles with HIV, drug addiction/withdrawal and illiteracy) and structural barriers (race, class and gender inequalities within and outside of the prisons), this presentation will also describe some of the ethical tensions of carrying out research with vulnerable and incarcerated populations. Issues such as access to prisons, privacy and disclosure, the structural and operational realities of working within prison contexts, inclusion and exclusion criteria, theoretical positioning - amongst others - will be specifically addressed.

THE FORENSIC AND CLINICAL PROFILE OF FEMALE OFFENDERS: Profs M. Nagdee, H. Erlacher & L. Kowalski Fort England Hospital & Walter Sisulu University, Eastern Cape

The demographic characteristics, pattern of offending behaviour, and mental health profile of female offenders differs in comparison to that of their male counterparts. Whilst women

offend much less than men, there is a lack of reliable data on their forensic and clinical profile, particularly in the context of developing countries such as South Africa. There is little published information on women who commit violent offences (especially the phenomenon of child killing), an area of particular interest to our research group. A review of aetiological factors, issues around women in prison, and medico-legal aspects of psychiatric disorder in women offenders will be outlined. A cross-sectional, retrospective analysis of the forensic clinical records of accused women referred for observation under the Criminal Procedure Act (1977) to Fort England Hospital (Grahamstown, Eastern Cape) has been conducted. The initial results of this descriptive analysis of demographic, clinical and forensic parameters will be presented. The current study forms the initial phase of a multi-centre, national study on the forensic and clinical profile of women referred to the larger forensic mental health units in South Africa.

WOMEN WHO MURDER VS MEN WHO MURDER: THE FORENSIC PSYCHIATRIC OBSERVATION PROCESS IN JOHANNESBURG, SOUTH AFRICA
R. Kader University of the Witwatersrand Sterkfontein Hospital, Gauteng

The act of killing is the most heinous of crimes, and often the context in which competence to stand trial and criminal responsibility arises. Much time has been spent trying to identify the characteristics of the murderer, the victim and the context in which the crime arises. This is especially true in cases where the perpetrator is a woman. When a woman kills it is an act of defence, and the victim is known to her. It is also thought that a woman is more likely to have a mental illness. Some studies have recently suggested that women murderers are beginning to resemble their male counterparts. 90% of murders are committed by men who are more often intoxicated at the time of the offence. When they are sent for forensic observation they are more likely to have a personality disorder rather than a primary psychiatric illness. The objective of this study is to compare the socio-demographic characteristics of the women and men who have been sent for psychiatric observation to Sterkfontein Hospital from 2004 to 2009. Of particular interest will be the outcome of the forensic observation process. The assumption is that women who kill are more likely to have a mental illness whereas men who kill are more likely to have a personality disorder. It is also assumed that women are more likely than men to be found unfit to stand trial and not criminally responsible for the crime. Some preliminary results of a comparison of 40 women and 40 men sent for observation will be discussed.

FORENSIC TELEPSYCHIATRY: A POSSIBLE SOLUTION IN SOUTH AFRICA?
M Mars, J Chipps, S Ramlall Depts of TeleHealth, Nursing and Psychiatry, University of KwaZulu-Natal

Forensic psychiatric services in South Africa are hampered by both a shortage of forensic psychiatrists as well as inpatient forensic observation facilities. The Department of Health's turnaround strategy to reduce the long waiting list for forensic psychiatric observations is to declare that it is "legally compatible to conduct single psychiatrist forensic observations in prisons or on an outpatient basis in health establishments." This paves the way for implementing/embracing/exploring innovative and cost effective solutions that reduce the demand for inpatient observations at mental health facilities. Tele-psychiatry, the use of video-conference technology, to conduct assessments is one such option. Tele-psychiatry is well established internationally and guidelines for practice in South Africa have been developed and are currently under review. Forensic tele-psychiatry, a cost-effective option in use in Australia, the United States and Britain, allows remote consultation between prisons,

courts and psychiatric services with distant specialist services. Empirical evidence exists to support its high diagnostic reliability, cost effectiveness and acceptability by patients. It can accommodate a wide variety of services which includes clinical and medico-legal assessments, clinical consultations and treatment, expert testimony as well as education and training. It has the potential to reduce inappropriate hospital admissions to scarce beds, decentralize services, improve access to psychiatrists and widen the pool of psychiatrists able to perform forensic assessments, thus reserving the specialist forensic psychiatrist for specialized/complex/serious offenders. It also obviates the need for lengthy, arduous, risky and costly transportation of patients with its inherent risk of patients escaping. Conducting assessments while patients remain in prison facilities will also reduce the demand for separate facilities for female and adolescent patients. While the benefits are many, challenges pertaining to local acceptability by the judicial system, patients and mental health professionals as well as ethical concerns will need to be explored. We present a model for remote forensic psychiatric assessments to be conducted in Southern Africa using videoconferencing technology that can complement face to face and inpatient forensic psychiatric assessments.

COERCION IN PSYCHIATRY: WHY HAS COERCION RESEARCH FAILED? I. S. Lewis: Department of Psychiatry UCT

Coercion is a controversial topic in psychiatry. Although legal coercion typically restricts patients' autonomy, it is often used by clinicians to ensure that the patient receives the required treatment, as well as to protect the community. Despite extensive research into coercion, published studies have failed to support what is 'known' clinically. For example, clinicians recognise that certain groups of patients, notably young aggressive males who are admitted to a hospital involuntarily are at high risk of being coerced. However, studies fail to detect such a relationship. This presentation looks at why research into coercion has failed and provides evidence for a fundamental flaw in the current approach to the study of coercion.

THE INTERFACE OF MORALITY, BIO-ETHICS AND THE LAW BY CASE DISCUSSION: Prof W. Pienaar Head of Clinical Unit, Stikland Hospital, Department of Psychiatry, University of Stellenbosch

Often the clinician is faced with a clinical dilemma of what would be the 'good moral action', or good clinical practice or mere duty to adhere to, or what the law prescribes. Good moral action, good clinical practice and the law need to be separated, weighed against each other and may finally leave the clinician with uncertain answers. To demonstrate this, a case will be presented where the clinician is confronted with justice versus respect for autonomy. Best result versus human rights, ethics of care against the ethics of duty and virtue versus casuistry. The eight contemporary moral theories will be discussed to build arguments that may guide the clinician to his/her final decision.

THE INVOLUNTARY ADMISSION OF ADOLESCENT PSYCHIATRIC PATIENTS: A LEGISLATIVE CONUNDRUM: Susan Hawkrige Head: Metro East Child and Adolescent Mental Health Services, Western Cape Department of Psychiatry, University of Stellenbosch

The autonomy of adolescents in the health system has changed significantly over the last 15 years. In 1996 "minors" were given the right to give consent to termination of pregnancy. For

other medical interventions, the operative legislation remained the Child Care Act, which provided for children over the age of 14 years to consent to medical treatment. When the Mental Health Care Act was promulgated in 2004, there was confusion over the provisions made for involuntary /assisted patients under the age of 18 years. The only reference to these users states that application must be made by the parent/guardian. In circumstances in which the parent/guardian is unavailable or unwilling to make the application, no guidance is given. Since the promulgation of the Children's Act in 2010, children over the age of 12 years are able to consent to medical treatment if deemed to be competent. Should they not be competent to consent, a parent, guardian or caregiver may give consent. There is now some confusion as to which Act should apply to mentally ill adolescents. This paper will attempt to unravel the legal, ethical, clinical and practical implications of the various possibilities followed by contributions from the audience.

MENTAL IMPAIRMENT AS BASIS FOR DISABILITY CLAIMS: Helmut Erlacher, Mo Nagdee Fort England Hospital & Walter Sisulu University, Eastern Cape

In many cases insurance companies and employers do not accept reports by treating psychiatrists and other mental health care professionals without the opinion of an "independent" psychiatrist. This study conducted over 2 years tries to establish the pattern where these assessments differ. This may help to eliminate the adversarial stance that prevails when these cases go to court or to compensation commissions. This should be an extension to a previous study, and a precursor of a much larger study in the years to come.

THE DEFENCE OF NON-PATHOLOGICAL INCAPACITY IN THE SOUTH AFRICAN CRIMINAL LAW: ALMOST BACK TO WHERE WE STARTED: Professor Jonathan Burchell Faculty of Law, University of Cape Town

In this paper I pose ten questions, the answers to which will, I hope, unravel or at least explain some of the current tangled state of the law on 'non-pathological incapacity': (i) How is capacity defined for the purposes of determining criminal liability? (ii) Where does the concept of criminal capacity originate? (iii) What is meant by the defence of pathological incapacity? (iv) What is included in the defence of non-pathological incapacity? (v) What are the legal differences between pathological and non-pathological incapacity? (vi) What type of psychiatric/psychological evidence is generally led in support of the defence of non-pathological incapacity? (vii) How have the South African courts over the years approached the idea of non-pathological incapacity? (viii) Are there any alternative legal ways for dealing with situations of lack of non-pathological criminal capacity? (ix) What is the effect of the Eadie (road rage) judgment? (x) Is there a future for the defence of non-pathological incapacity in South Africa?

THE EXPERT PSYCHIATRIC WITNESS - ATTRIBUTES, EFFICACY AND REQUIREMENTS: Emeritus Professor Tuviah Zabow Department of Psychiatry, UCT

Providing testimony by expert reports and court testimony are an important part of the forensic psychiatrist's duties. The role of the expert is essential to the process and presentation, attitude and opinions are in the public domain. Testimony is often reported by the media and special skills are necessary to understand and appreciate the scrutiny of the professional occurring from such reports. A treating psychiatrist may testify on the patient's clinical state and course of treatment but the expert witness is required to participate in a legal

process relatively unfamiliar to other clinicians. Important issues must be understood and applied to present effective assistance and opinion to the court. This paper will discuss the attributes, the principles to be adhered to and the qualifications for efficient participation in this specific legal procedure. Ethical issues, common difficulties and errors will be addressed including the adversary system effects on the expert-clinician.

PTSD AND FORENSIC PSYCHIATRY: ANOTHER “GET OUT OF JAIL FREE CARD?” Ugash Subramaney Principal Specialist, Sterkfontein hospital Department of Psychiatry, WITS

PTSD as a diagnostic entity represents a conundrum to the psychiatric fraternity. Despite being the only psychiatric disorder that has a direct aetiology (the presence of a traumatic event is a necessary specifier according to current classification systems) it is fraught with difficulties and has drawn much debate in various circles. The forensic setting is certainly not exempt: the detection of malingering in PTSD is of utmost importance to establish fitness, as well as to cast opinion on criminal responsibility. As well, in civil cases and issues of compensation, ethical issues abound. This presentation will focus on a review of the current literature pertaining to these and related aspects of PTSD.

START: EXPERIENCE WITH A 3RD GENERATION RISK ASSESSMENT TOOL: Marc Roffey Valkenberg Hospital Department of Psychiatry, UCT

Risk assessment methods have undergone many transformations, each eventually failing the ultimate test of sensitivity. About 25% of decisions made with any risk assessment tool will prove to be wrong. The Short Term Assessment of Risk and Treatment (START, which relies on structured clinical judgment, was developed in Vancouver by Brink et al, and is novel in combining actuarial as well as clinical judgment in reaching a final assessment of risk. It is useful in identifying risk factors in particular patients, such as signature and unique factors, and using these to follow the patient at regular intervals to monitor progress in rehabilitation and risk management. This talk will describe our experience with this instrument in patients in a medium secure ward at Valkenberg Hospital.

A FAMILY SYSTEMS ANALYSIS OF SERIAL MURDER IN SOUTH AFRICA: Giada Del Fabbro Department of Psychiatry, Wits

This paper explores the phenomenon of serial murder from a systems theory perspective. Its purpose is to develop an understanding of serial murder in a South African context from a family systems approach. Utilizing a family systems theoretical framework and the genogram method, information about the family systems of individuals who committed serial murder was analyzed via a content analysis. The investigation focused mainly on emotional processes, multigenerational and relationship patterns in family systems. Information was gathered from numerous sources and included interviews conducted inter alia with individuals currently incarcerated for serial murder and their family members, and with professionals involved with such individuals; as well as information obtained from clinical observations and archival data. The results of the content analysis demonstrated considerable similarities but also differences in the organization and functioning of the family systems of individuals who committed serial murder. Importantly, the analysis shed novel theoretical light on the role of serial murder within family systems and challenged established dominant theoretical perspectives on serial murder that have emphasized linear, causal and/or individual-focused explanations. This paper opens up considerable opportunities for further

exploration of the phenomenon from a systemic perspective, specifically with the focus on the meaning of serial murder in relatively smaller (e.g., parent-child or peer relationships) or larger (e.g., political, cultural and societal) systems. It also provides opportunities for alternative vistas from which the phenomenon of serial murder can be viewed in terms of theoretical, definitional, typological, investigative and correctional approaches.

STATE PATIENTS AND THEIR FAMILIES Siviwe Mdunyelwa Valkenberg Hospital

The Regulations of the Mental Health Care Act require that state patients be supervised by identified family members whenever granted leaves of absence, and ultimately discharge. Unfortunately many state patients do not have good enough social circumstances to be given periods of leave into the community, and those who do have families willing to take them often find that their families have limited means to deal with them, or have conflictual relationships with some, or all family members. This study set out to explore the reasons that caused families to reject the index patient. Family members were interviewed personally using a semi-structured interview. The factors that families highlighted that they were unable to cope with their substance abuse, especially as intoxication resulted in difficult behaviours and was associated with other antisocial behaviour (such as stealing from them). They also complained that patients seldom made a financial contribution to their expenses. The index offence was also an issue, especially if violent and involved family members. Most did not understand the nature of the patient's illness, and felt that the mental health team did not support them adequately. Consequently there was a great deal of ambivalence expressed about the patient. It is recommended that families be encouraged to engage more with the forensic mental health teams via psychoeducation, family therapy and support groups.

A RETROSPECTIVE STUDY OF FILICIDE AT STERKFRONTEIN PSYCHIATRIC HOSPITAL

Abe Dolo Sterkfontein Psychiatric Hospital, Krugersdorp Department of Psychiatry, Wits

Filicide is the tragic crime of murdering one's own child. Research has found that offending parents often had prior use of psychiatric services and suicide is usually an associated act. Yet a dearth of knowledge still exists about the phenomenon in developing countries. Aim of the study is to profile filicide perpetrators who are referred for forensic observation and therefore aid to identify risk factors in clinical setting. The study is a retrospective records review of awaiting trial detainees referred to Wits University-affiliated Sterkfontein forensic psychiatric unit for observation from 1996-2010.

RETROSPECTIVE REVIEW OF INDIVIDUALS CHARGED WITH SEXUAL OFFENCES AGAINST MINORS Navanthree Govender Sterkfontein Psychiatric Hospital, Krugersdorp Department of Psychiatry, Wits

Background: Sexual offences against children has been an escalating problem in South Africa. Several international studies have found links between mental illness and sexual offenders. However, no South African studies have been done on those who commit these crimes. Objectives: To measure the number of individuals charged with sexual offence(s) against a minor(s), admitted for forensic observation to Sterkfontein Psychiatric Hospital; determine the demographic profiles of these individuals; the number of these individuals assessed as fit to stand trial and criminally responsible, and the number found not fit and/or not criminally responsible; and whether psychiatric diagnoses were present in these

individuals. Methods: This study took the form of a retrospective record review at Sterkfontein Hospital between January 2007 and December 2009. It included all individuals charged with a sexual offence against a minor. Ethics clearance was obtained from Wits HREC. Data was collected from the Criminal Procedure Act reports and clinical files. Results (preliminary descriptive): indicate that rape was the most common charge. More than half the sample was found fit to stand trial and criminally responsible. The results will be discussed with a view to expand upon the indepth analysis.

THE SEXUAL OFFENDER REHABILITATION PROGRAM: THE SEXUAL OFFENDER PROFILE AT FORT ENGLAND PSYCHIATRIC HOSPITAL: Lauren Fike Fort England Hospital & Walter Sisulu University, Eastern Cape

The sexual offender's rehabilitation program forms a central part of the forensic rehabilitation aspect at Fort England Psychiatric Hospital in the Eastern Cape. This presentation describes the typical sexual offender profile drawn from the assessment and subsequent treatment of all sexual offender state patients from 2008 - present at Fort England Psychiatric Hospital. Information pertaining to the most common distribution of multi-axial diagnoses, sexual offences, relationship to and age of victim, previous convictions and the presence or absence of violence, denial, and expression of remorse will be highlighted and discussed.

**FORENSIC STATE PATIENTS AT STERKFRONTEIN PSYCHIATRIC HOSPITAL: A 3-YEAR FOLLOW-UP OF STATE PATIENTS ADMITTED IN 2004 & 2005
Belinda Marais**

A State Patient is someone who, following a period of forensic psychiatric observation, has been found "unfit to stand trial" and/or "not criminally responsible" for that crime as a result of a mental illness and/or defect. They are then referred, by the courts, for detention at a forensic mental institution, such as Sterkfontein Psychiatric Hospital. The purpose of this detention is not for punishment, but for treatment & rehabilitation. Thus these patients may ultimately be released back into the community once they are stable and well. In comparison to international literature, there is a paucity of published local research. Not much found regarding long-term outcome of "mentally ill offenders" in South Africa. The aim of this study was to examine the 3 year outcome of forensic State Patients who were admitted to Sterkfontein Hospital during the years 2004 and 2005. This was done as a retrospective clinical file review. Specific research questions which were posed: Firstly, what proportion of State Patients are still detained at Sterkfontein Hospital and what proportion have been released back into the community after 3 years? Secondly, what are the most common reasons for these State Patients being still admitted after 3 years? Thirdly, of the State Patients who are out in the community after 3 years, what proportion are out on leave of absence, have been discharged, have been reclassified, or have absconded? And lastly, what is the documented recidivism rate in this population of State Patients after 3 years? The results of my research, as well as the limitations, will be discussed in this presentation.

A BRIEF GROUP ANGER MANAGEMENT PROGRAMME DEvised FOR A FORENSIC PSYCHIATRIC UNIT AT FORT ENGLAND PSYCHIATRIC HOSPITAL: Andrea Wong Fort England Hospital & Walter Sisulu University, Eastern Cape

Anger is commonly a precursor to acts of aggression and violence and, in people with psychiatric illnesses, aggressive behaviour is often one of the most common reasons for

institutionalisation. Anger management programmes in forensic psychiatric settings are therefore of utmost importance. However, existing programmes have been devised for prison populations or better resourced, international psychiatric institutions. Such interventions are usually lengthy (a minimum of 12 weeks) and require high levels of participation from well-trained clinical staff. This is not possible in South Africa, where even the highest quality institutions do not have sufficient resources or bed space to treat the number of forensic patients requiring anger interventions at such an intensive level and for such a long duration. A brief group anger management programme, devised specifically for use in a forensic unit in Fort England Psychiatric Hospital will therefore be presented as an alternative to existing programmes. This intervention is brief (eight sessions) and incorporates cognitive behavioural therapeutic principles as well as a simple mindfulness technique. The experience of running such a programme and information gained from this experience will be

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