

A STUDY OF THE
CHARACTERISTICS OF CRIMES COMMITTED BY
MENTALLY ILL OFFENDERS

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ABSTRACT

There is ongoing controversy concerning the relationship between crime, violence and mental illness. Studies from the first half of the century reported low arrest rates amongst the mentally ill. However recent researchers have suggested an increase in crime amongst the mentally ill since the advent of deinstitutionalisation, while other studies have implicated social factors, inadequate community facilities and prior criminality to account for this apparent trend.

A longitudinal prospective and descriptive study was therefore planned to investigate the relationship between crime and mental illness. All consecutive admissions to the Midlands Hospital Observation Unit during a six month period were included in this study. Relevant information was obtained from personal interviews by the author and from court records. The final study sample consisted of those in whom a final finding was made in terms of Section 78(2) of the Criminal Procedures Act 51 of 1977.

The significant findings were:

DEMOGRAPHIC CHARACTERISTICS

The majority of mentally ill offenders were young males in the age range 20-29 years.

CHARACTERISTICS OF CRIMES COMMITTED BY MENTALLY ILL OFFENDERS

The majority of mentally ill offenders were apprehended for property offences, theft being most common.

Chi square analysis produced the following statistically significant findings pertaining to mentally ill offenders:

- .1 Mentally ill offenders committed significantly more property offences. Crimes were significantly less dangerous and less physically violent.
- .2 Fewer crimes involved use of a weapon.
- .3 Significantly more crimes were seemingly without a motive or in response to an hallucination or delusion.
- .4 Offences were seldom planned.
- .5 Crimes were more visible, most occurring during the day, with little attempt made to conceal the act.

In conclusion most mentally ill offenders committed commonplace offences which due to their greater visibility may have predisposed them being channelled through the criminal justice system.

Investigation revealed a need for further research into this controversial sub-group of mentally ill patients.

SUPPORTING SERVICES

In this research the statistical planning and analyses, and recommendations arising from these analyses, have been done in consultation with the Institute for Biostatistics of the Medical Research Council.

PREFACE

This study represents original work by the author and has not been submitted in any form to another university. Where use was made of the work of other authors it has been duly acknowledged in the text.

The research described in this dissertation was carried out in the Department of Psychiatry, University of Natal from July 1990 to December 1990, under the supervision of Dr F B Mansoor.

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CHAPTER 1

INTRODUCTION

1.1 CRIME AND MENTAL ILLNESS

Interest in the relationship between mental illness, crime and violence is increasing amongst mental health professionals, law enforcement personnel and the general public. This may reflect society's general preoccupation with violence and a concern with the treatment of mentally ill patients following the shift from institutional to community based care over the past two decades (Grunberg et al 1977; Grunberg et al 1978; Pasewark et al 1979; Roth 1984 : 1-8). Mental illness is often perceived by the public as being associated with particularly violent or bizarre crimes. However according to Szasz (1955) this is a myth perpetuated by a tendency to ascribe mental illness to individuals who commit violent acts as they violate society's preference for a certain type of social and ethical order.

Up until the 1960's proponents of community based psychiatry assumed that the mentally ill were less prone to criminal acts, specifically acts of violence, than the general population. Rappeport and Lassen (1965) cite several studies ((Ashley (1922), Pollock (1938) and Fuller (1930)) reporting on the low arrest rates for psychiatric patients.

However these figures were based on studies of arrest rates in the 1930's and 1940's when large numbers of psychiatric patients were institutionalised and discharge policies were far more stringent than today (Grunberg et al 1977). This assumption has been challenged by findings in the recent literature. Notably that former psychiatric patients are more frequently arrested for certain offences than the general population (Rappeport and Lassen 1965; Giovannoni and Gurel 1967, Zitrin et al 1976; Grunberg et al 1977, Grunberg et al

1978, Sosowsky 1978, Steadman et al 1978a, Steadman et al 1978b).

In their thirteen year study of homicides committed in New York City, Grunberg et al (1978) found a significant increase in homicides committed by the mentally ill in the six years following the establishment of community based psychiatry.

In addition to the controversy surrounding the relationship between crime and mental illness the problem is further compounded by differences in the meaning of the term mental illness as used by the mental health and legal systems. The mental health and judicial systems use very different criteria in designating a person as mentally ill. The Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association 1987) states that the classification and diagnostic criteria used in the manual may not be relevant to legal determinations. Thus many of those diagnosed or diagnosable as mentally ill in terms of DSM-III-R (American Psychiatric Association 1987) are legally fit, sane and liable to be held criminally responsible (Freeman and Roesch 1989).

In addition the term "mental disease or defect" in the Criminal Procedures Act is not defined. It is for the court to decide what constitutes mental disease or defect on the basis of expert psychiatric opinion (Strauss 1984 : 120).

Guze et al (1974) studied 500 prisoners attending a psychiatric clinic and found the prevalence of offenders not much higher than matched controls. They concluded that while sociopathy, alcoholism and drug dependence were associated with serious crime, schizophrenia, affective disorders, neuroses and brain syndromes were not. This finding was further validated by studies of criminal populations which have found the prevalence of schizophrenia only marginally raised (Guze et al 1962, Spry 1984 : 125 - 137).

Traditionally mental health professionals have found that the vast majority of mentally ill patients manifest no criminal behaviour and that isolated acts of violence usually attract undue publicity and notoriety (Gunn 1977; Taylor 1982 : 271).

With the advent of deinstitutionalisation and the shift to community based care, many mentally ill patients have drifted into poverty, unemployment and homelessness or have been caught up in the criminal justice system. Due to their general social ineptitude and greater visibility they make a greater impression than their numbers warrant (Teplin 1984; Weller 1988).

Despite the above controversy concerning the relationship between criminal behaviour and mental illness, there are relatively few systematic studies available regarding mentally ill offenders (Gunn 1977).

1.2 AN EVALUATION OF THE CRITICAL VARIABLES IN THE MENTALLY ILL OFFENDER

From the above discussion it would be of value to study the characteristics of crimes committed by mentally ill offenders in terms of the following two variables:

1. Violence in the Mentally Ill
2. General Criminal Characteristics of Mentally Ill Offenders.

1.2.1 Violence in the Mentally Ill

Traditionally mental health professionals have assumed that the mentally ill are less prone to acts of violence than the general population. Recently this assumption has been challenged by several studies showing that for certain crimes of violence former psychiatric patients are more frequently arrested than the general population (Rappeport and Lassen

1965; Giovannoni and Gurel 1967; Zitrin et al 1976; Grunberg et al 1977; Grunberg et al 1978; Steadman et al 1978a; Steadman et al 1978b).

However mental health professionals have found that the vast majority of mentally ill patients manifest no criminal behaviour. Following the shift from institutional to community based psychiatric care, it has been postulated that many psychiatric patients have drifted into poverty, homelessness and unemployment or have been channelled into the criminal justice system (Teplin 1984; Weller 1988).

These patients often move between the criminal justice and mental health systems, making a far greater impression than their numbers warrant mainly because there are no adequate facilities for them. Most studies have found the typical mentally abnormal offender to be a young, single, unemployed male, often with multiple previous psychiatric hospitalisations and apprehended for a trivial offence (Gunn 1977; Teplin 1984; Addington and Holley 1987; Freeman and Roesch 1989). Thus it is usually rare isolated acts of violence within a small subgroup of multiply arrested mentally ill offenders which attract undue publicity (Gunn 1977).

Thus a comparison of the nature and severity of crimes committed by the mentally ill and those found not mentally ill would provide valuable insight into the mentally ill and their propensity to committing violent or dangerous acts.

1.2.2 General Criminal Characteristics of Mentally Ill Offenders

Much controversy surrounds the relationship between crime and mental illness. Recent studies have shown both an increase in arrest rates and acts of violence in former psychiatric patients (Rappeport and Lassen 1965; Giovannoni and Gurel 1967; Zitrin et al 1976; Grunberg et al 1977; Sosowsky 1978).

Other studies suggest that variables such as prior criminality, unemployment, social ineptitude and greater visibility in the community may account for the apparent increase in arrest rates amongst former psychiatric patients (Steadman et al 1978a; Steadman et al 1978b; Teplin 1984; Addington and Holley 1987; Weller 1988; Freeman and Roesch 1989).

It is clear from the above that a study of the general characteristics of crimes committed by mentally ill offenders would increase our understanding of the relationship between crime and mental illness.

1.3 MOTIVATION

A study of the above two variables, viz.:

- 1.3.1 Violence in the Mentally Ill and
- 1.3.2 General Criminal Characteristics of Mentally Ill Offenders, would be of relevance to the following:

- .1 To provide additional knowledge and insight into this controversial sub-group of mentally ill patients.
- .2 To enhance our understanding of the relationship between crime and mental illness.
- .3 To provide data which may assist the psychiatrist in the assessment of forensic observation cases.

In view of the ongoing controversy concerning the relationship between crime and mental illness, and the above motivating factors, a study of the relationship between violence amongst mentally abnormal offenders and general criminal characteristics was planned.

1.4 AIM

To investigate the relationship between:

1.4.1 Violence in the Mentally Ill

To investigate the relationship between mentally ill offenders and violence in terms of the following variables:

- .1 Charge against Accused
- .2 Crime against Person/Property
- .3 Dangerousness
- .4 Use of Weapons
- .5 Past Convictions

1.4.2 General Criminal Characteristics

To investigate the relationship between mental illness and crime in terms of the following variables:

- .1 Motive
- .2 Premeditation
- .3 Timing
- .4 Attempt to Conceal Crime
- .5 Intoxication
- .6 Confession

1.5 HYPOTHESES

The following hypotheses will be tested:

- .1 Mentally ill offenders are less prone to committing acts of violence than those found not mentally ill in terms of the Criminal Procedures Act.

- .2 The general criminal characteristics of mentally ill offenders differ significantly from those found not mentally ill in terms of the Criminal Procedures Act.

CHAPTER 2

REVIEW OF LITERATURE

2.1 CRIMINAL LAW AND PSYCHIATRY

2.1.1 Determinism and Free Will - The Controversy

Of all the points of contact between psychiatry and the law, criminal law is one of the most important and perhaps the most problematic. The performance of psychiatrists has been subject to criticisms both from within and outside the legal professions and there is a certain amount of mutual suspicion between these two disciplines (Strauss 1984 : 102-103).

The mental health and legal systems are two disciplines divided by a common language. The problems encountered with mentally ill offenders arise partly from their unique position at the intersection of the mental health and legal systems. The mental health and judicial systems use very different rules in designating a person mentally ill. Fitness to stand trial and criminal responsibility are legal terms. Thus many patients diagnosed as mentally ill in terms of DSM-III-R (American Psychiatric Association 1987) are fit, sane, and liable to be held criminally responsible. This difference in the meaning of the term mental illness as used by the two systems has led to the growth of a population who fall at the semantic disjunction of the two frameworks (Freeman and Roesch 1989; Shah 1989).

The dialogue between these two disciplines has not always been a constructive one and Glueck summed it up as follows: "Lawyers tend to look upon psychiatrists as fuzzy apologists for criminals, while psychiatrists tend to regard lawyers as devious and cunning phrase-mongers" (Strauss 1984 : 103).

The fundamental difference in approach of the two disciplines is that the law is primarily concerned with the assessment of individual responsibility whilst psychiatry is essentially therapeutic. Traditionally the law has assumed the standpoint of indeterminism or freedom of will. *Mens rea* presupposes that man can exercise control over his behaviour and that he is capable of making his own decisions for which he will be held liable (Snyman 1984 : 112-113; Whitlock 1990 : 226).

Some psychiatrists tend in the direction of determinism which holds that man's actions are largely governed by factors beyond his control. In its extreme form the deterministic philosophy would argue that individual responsibility does not exist. The proponents of this standpoint suggest that a person is subject to influences, drives and hereditary factors beyond his control. According to the extreme view of determinism all criminal acts would be regarded as socially deviant, requiring therapeutic treatment rather than incarceration (Snyman 1984 : 113; Strauss 1984 : 103).

However this is the extreme view of determinism and most would agree that the truth lies between the two extremes of determinism and freedom of will - that people can, and do, control their conduct (Snyman 1984 : 112).

Part of the conflict between psychiatry and the law is that psychiatry is essentially therapeutic and therefore not orientated towards morality or the law. The Rumpff Commission (The Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters RP69/1967) as cited by Gillis (1961) and Goldstein (1967 : 4) commented that this difference between the purpose of the law and psychiatry has resulted in a lack of mutual appreciation between the two disciplines. While the law is indicted for its punitive cast, psychiatry has been accused of undermining the social order.

The Rumpff Commission as cited by Gillis (1961) and Goldstein (1967 : 4), appealed for a cool-headed approach on both sides and added "What is required of the psychiatrist and the psychologist is a sense of responsibility towards the views of society and the purpose and essence of punishment, and what is required of the jurist and of the public is an appreciation for the development of psychiatric and psychological knowledge".

2.1.2 Legal Aspects of Mental Illness - an Historical Perspective

The legal issue of criminal responsibility refers to the conditions under which persons charged with crimes are to be held criminally liable or culpable for their alleged acts or omissions. The mere fact that a person has committed an unlawful act is not sufficient to render him criminally liable. Before one can be found guilty of a criminal offence, the law must establish the moral blame-worthiness or culpability of the accused (Snyman 1984 : 112; Shah 1986 : 171).

There are three basic defences against a guilty mind : that the mind is innocent, that it is absent (automatism), or that it is insane. Before one can be found guilty, it must be proven that the accused was mentally competent at the time of the alleged offence, had a guilty state of mind (*mens rea*), committed an act (*actus*) as defined by the law and that the act was unlawful (*reus*) (Strauss 1984 : 118; Shah 1986 : 171-173; Leng 1990 : 237-238).

Not all human behaviour is regarded as an act in criminal law. The act must be voluntary, in that at the time of its commission the accused must be capable of exercising his powers of volition. A court cannot find that an accused has a blameworthy mind (*mens rea*) if he does not have the criminal capacity to be able to form the necessary intent.

The *mens rea* enquiry therefore cannot be made without first determining the criminal responsibility of the accused (Strauss 1984 : 118).

In South Africa the new Criminal Procedures Act 51 of 1977 repealed all previous statutory provisions contained in the old Mental Disorders Act 38 of 1916 and the old Criminal Procedures Act of 1955 pertaining to criminal capacity of mentally ill or defective persons and their capacity to stand trial. Following the new Criminal Procedures Act it was confirmed that criminal responsibility was an indispensable prerequisite for *mens rea* and criminal liability (Strauss 1984 : 120).

Historically English law acknowledged that the mentally ill should not be punished but the defence of insanity was rather narrowly construed and applied. In order to be exculpated the defendant needed to have gross mental impairment which was likened to a "wild beast" by Judge Tracy in 1724.

This rather narrow insanity defence was further broadened during Erskine's defence of James Hadfield in 1800, but the most significant attempts at formulation of general criteria of criminal responsibility were the M'Naghten rules of 1843. These rules were drawn up following the M'Naghten trial in 1843, when a young Scotsman Daniel M'Naghten mistakenly assassinated Edward Drummond in response to a persecutory delusion. Although later acquitted by reason of insanity, much public dissatisfaction was expressed causing the House of Lords to debate the problems of criminal responsibility and insanity (Shah 1986 : 174-175).

As a result, the M'Naghten rules were introduced, which read as follows:

1. "To establish a defence 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 he was doing, or if he did know it, he did not know he was doing what was wrong".

2. "Where a person labors under partial delusions only and is not in other respects insane and as a result commits an offence he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real" (Kaplan and Sadock 1988 : 668).

Although the M'Naghten rules still form the basis of the law relating to criminal responsibility in England, in many American States and to a certain extent in South Africa, certain criticisms have been raised especially regarding its disregard for any volitional factor. A major criticism of the test was that it focused exclusively on cognitive factors (ability to know the nature and quality of the act) but failed to consider impairments of volition (the ability to control one's actions) (Strauss 1984 : 106; Shah 1986 : 176).

The irresistible impulse test was designed to address this gap. This test does not have a uniform formation but means that a person charged with a criminal offence is not responsible for his actions if the act was committed under an impulse that the person was unable to resist because of mental illness. This has also been called the policeman-at-the-elbow law. In other words the courts would only regard an impulse to be irresistible if the accused would have proceeded with the act even if he had had a policeman at his elbow. (Kaplan and Sadock 1988 : 669).

The irresistible impulse test has been criticised as it is too narrow a test and ignores the gradual disintegration of self control and personality which may accompany mental illness. The South African courts therefore expanded on the M'Naghten test

by adding a broader test of volition. Thus even where the accused was found to have realised the nature and quality of his act and the wrongfulness thereof, he was not criminally responsible if as a result of mental illness he was unable to control his conduct (Snyman 1984 : 176; Strauss 1984 : 105).

This law was regarded by many as unsatisfactory as it covered only a small group of those who were mentally ill and in 1871 New Hampshire became the first American State to reject the M'Naghten test. In State versus Jones the court held that a defendant was "not guilty by reason of insanity" if his crime "was the offspring or product of mental disease" (Shah 1986 : 177).

In 1954, in the case of Durham versus United States, the United States Court of Appeals for Columbia adopted a test modeled after this New Hampshire rule that resulted in the product rule of criminal responsibility. Judge David Bazelon wrote "An accused is not criminally responsible if his unlawful act was the product of mental disease or defect". The Durham test generated considerable controversy as it did not provide any specific legal definition for the term mental disease and mental defect. The rule also applied to defendants with a diagnosis of antisocial personality and thus a substantial number of offenders in the district who would not have been deemed so elsewhere, were found insane (Shah 1986 : 177; Diamond 1988 : 642).

In 1972 the United States abandoned the Durham test and adopted the test recommended in 1962 by the American Law Institute in its Model Penal Code (which is the law in the federal courts today). The American Law Institute recommended the following test of criminal responsibility:

1. "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate

the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law.

2. As used in this Article, the terms "mental disease or mental defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct."

Some United States jurisdictions have recently adopted a test proposed by the American Bar Association, which states:

"A person is not responsible for criminal conduct on the grounds of insanity only if at the time of that conduct, as a result of mental disease or defect, he is unable to appreciate the wrongfulness of that conduct" (Shah 1986 : 178).

During the past five years several United States jurisdictions have sought to further restrict the insanity defence. One approach has been to abolish the special defence of insanity and to limit consideration of the defendant's defence to those specific *mens rea* elements required for the particular offence. This is referred to as the "*mens rea* limitation" and has been formulated as follows:

"It is a defence to a prosecution under any statute or ordinance that the defendant, as a result of mental illness, lacked the mental state required as an element of the offence charged. Mental illness shall not otherwise constitute a defence" (Shah 1986 : 178-179).

In 1966 the Prime Minister of South Africa, Dr. Verwoerd, was assassinated by a mentally ill person. This brought about an intensive debate on the criminal responsibility of the mentally ill and as a result the Rumpff Commission was set up by the Government. On the recommendation of the Rumpff Commission the M'Naghten rules and the concept of irresistible impulse were replaced by a new, simplified test embodied in Section 78(1) of

the Criminal Procedures Act.

The new Act repealed all previous statutory provisions contained in the old Mental Disorders Act of 1916 and the old Criminal Procedures Act of 1955, pertaining to criminal responsibility of the mentally ill and capacity to stand trial. The Criminal Procedures Act broadened the test of criminal responsibility and the following was enacted in Section 78(1) of this Act:

"A person who commits an act which constitutes an offence and who at the time of such commission suffers from a mental illness or 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".

Of note is that "mental illness or defect" is not defined in the Criminal Procedures Act and thus the court is not bound by the definition of that concept in other statutes such as the Mental Health Act. It is for the court to decide what constitutes mental illness or defect on the basis of expert evidence (Strauss 1984 : 120).

The new legislation embodied in the Mental Health Act of 1973 and the Criminal Procedures Act of 1977 removed the previous confusion between fitness to stand trial and certifiability. These concepts are now completely unrelated. A person who is declared mentally ill in terms of the Mental Health Act may not be mentally ill for the purposes of Section 78(2) of the Criminal Procedures Act. Thus certifiability does not infer criminal incapacity (Snyman 1984 : 123; Strauss 1984 : 122).

Section 78(7) of the Criminal Procedures Act provides for a mentally ill patient who may not succeed in a defence of mental illness in terms of Section 78(2) of the Criminal Procedures

Act but may be found to have diminished responsibility. This sub-section confirms that there is no absolute demarcation between criminal responsibility and non-responsibility. Criminal responsibility is viewed by the court as a question of degree.

Thus a mentally ill person although criminally responsible, may find it more difficult than a normal person to act in accordance with the appreciation of right and wrong. A finding of diminished responsibility may result in a charge of murder being reduced to culpable homicide (Snyman 1984 : 128; Shah 1986 : 181; Whitlock 1990 : 266).

In addition Section 77 of the Criminal Procedures Act makes provision for an enquiry into the capacity of an accused to understand court proceedings. In this instance it is the accused's mental condition at the time of his trial which is at issue.

The criterion for competency to stand trial embodied in Section 77(1) of the Criminal Procedures Act is whether the accused is "by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence". Thus a court cannot try a person who is incapable not only of giving proper evidence, but also of defending himself or instructing his legal representative (Snyman 1984 : 130).

If it is alleged during criminal proceedings that the accused was by reason of mental illness or mental defect not responsible at the time of the alleged offence or that he is unable to follow court proceedings, the court must direct that a psychiatric enquiry be held. In terms of Section 79 of the Criminal Procedures Act the court will then direct that the patient be sent for mental observation for a period not exceeding thirty days (Snyman 1984 : 130).

If after hearing expert psychiatric evidence, the court finds that an accused, on account of mental illness, was not criminally responsible for his act or alternatively, is unfit to stand trial, then the patient must be detained indefinitely in a mental hospital or prison pending the decision of the State President. However at the discretion of the Attorney-General, mentally ill offenders who commit non-violent crimes may be declared certified patients instead (Snyman 1984 : 130; Strauss 1984 : 140; Nair 1985 : 58).

In the case of Section 77(1) of the Criminal Procedures Act, the accused may subsequently be prosecuted and tried when he is capable of understanding court proceedings and in a position to make a proper defence (Strauss 1984 :140).

The Criminal Procedures Act makes provision for the discharge of State President's Detainees. For patients detained in connection with serious offences, a judge may upon application made to him by the Attorney-General, make a recommendation to the State President that the patient be discharged (Kruger 1980 : 230; Snyman 1984 : 130; Strauss 1984 : 140).

However, considerable difficulty is often experienced in discharging State President's Detainees back into the community because of difficulty in tracing relatives and lack of adequate alternative sources of placement (Nair 1985 : 59).

2.1.3 Mental Illness and the Criminal Justice System - Criminalisation of the Mentally Ill

Over the past thirty years treatment of the mentally ill has shifted from institutional to community based care. This was regarded as more humane and it was hoped that the patient would maintain his social support systems and not lose his social and vocational skills (Crawford and Conacher 1988; Weller 1988).

Many mentally ill patients have benefitted from this shift to community based care. However some have drifted into poverty, homelessness and unemployment or found themselves caught up in the criminal justice system. These patients often move from hospital to prison and back again making a greater impression than their numbers warrant, mainly because there are no adequate facilities for them (Roth 1984 : 4; Addington and Holley 1987; Weller 1988).

Roth (1969) as cited by Gunn (1977), found the typical abnormal offender to be a single man between thirty and fifty years of age, usually with no fixed abode and most often a schizophrenic who had committed a trivial offence. Addington and Holley (1987) studied 52 consecutive schizophrenics referred for forensic assessment. Typically the offenders were single males, unemployed, living on social security and with a history of multiple psychiatric admissions. In this study less than half had previous convictions and one third had previous incarcerations.

As shown by Teplin (1984) the mentally ill offender is also more likely to be remanded into custody than those found not mentally ill. Evidence supporting this comes from Gingell (in preparation) as cited by Freeman and Roesch (1989), who found mentally ill offenders far more likely to be awaiting trial for minor offences such as obtaining food under false pretences, trespassing, causing a public disturbance and failing to appear in court.

Penrose (1939) as cited by Weller (1988) showed that before the Second World War countries in Europe with a large prison population had a small mental hospital population and vice versa. Penrose's Law is often cited because as mental hospital populations have fallen with the move towards community care, so prison populations have risen.

Penrose's theory suggests that social standards for defining unacceptable behaviour change in relation to the facilities designed to control them. Depending on the prevailing laws and funding, the population of mental and correctional institutions change in an inverse manner. Society either defines unacceptable behaviour as mental illness and uses a mental health facility or as criminal, and employs the jail. However the actual size of the population remains stable, forcing people to transmigrate from one system to the other (Gunn 1977; Arboleda-Florez and Holley 1988; Freeman and Roesch 1989). According to Szasz (1955) both systems serve to rid society of those it finds bothersome by isolating them from the mainstream of society.

With increasing numbers of homeless, unemployed and poorly supervised mentally ill patients in the community, it seems inevitable that they will be channelled into the criminal justice system (Teplin 1984; Addington and Holley 1987; Weller 1988).

Although studies are conflicting, the weight of evidence seems to support this hypothesis. Teplin (1984) found that for similar offences, mentally disordered offenders have a significantly greater chance of being arrested than non-mentally disordered offenders. Her study also showed that when a civil remedy is unavailable (no hospital beds), a criminal solution (arrest and incarceration) is found. Comparing arrest rates for a pre- and post-reform period, Sosowsky (1978) found a significant increase in the arrest rates of psychiatric patients, suggesting that they are being diverted into the criminal justice system.

Criminalisation is also more likely to occur in this group because of their social ineptitude and occasional bizarre behaviour, hence they are more likely to be detected and arrested. Given the prevailing stereotype of the mentally ill as dangerous, citizens are more likely to invoke the criminal

justice system to handle these offenders especially when they manifest frightening signs of mental disorder (Teplin 1984).

The laws designed to protect the rights of the mentally ill may in practice predispose them being diverted into the criminal justice system. These patients may end up incarcerated yet untreated and find themselves outcasts of both systems (Crawford and Conocher 1988; Freeman and Roesch 1989; Shah 1989).

The dilemma posed by mentally ill offenders arises from their unique position at the interface of the mental health and legal systems. Fitness to stand trial and criminal responsibility in terms of Section 77(1) and 78(2) of the Criminal Procedures Act are legal terms. Hence the majority of mentally ill offenders are legally fit, sane and criminally responsible. They nevertheless constitute a needy minority within the judicial system and their needs may be ill served and their rights abrogated (Snyman 1984 : 183; Freeman and Roesch 1989; Shah 1989).

The legal consequences that follow being found mentally ill in terms of the Criminal Procedures Act may result in indeterminate detention and significant deprivation of liberty. Even for relatively minor offences, mentally ill offenders may suffer a more detrimental outcome than those found not mentally ill. The more protracted outcomes experienced by many mentally ill offenders raises serious questions regarding the rights of the disabled group. In addition, mental health care in the incarcerated mentally ill may be sporadic and inadequate (Kruger 1980 : 230; Teplin 1984; Freeman and Roesch 1989; Shah 1989).

A common public misperception is that the insanity defence is frequently raised. However Pasewark and Pantle (1981) as cited by Freeman and Roesch (1989) showed that the insanity defence is seldom used or effective. In their study a successful

defence on grounds of insanity occurred in only 0.01% of all felony trials.

Mentally ill offenders pose an enormous challenge to the judicial, correctional and mental health systems. As the law formally recognises the existence of the mentally ill only in terms of fitness to stand trial and criminal responsibility, it effectively ignores the vast majority of mentally ill offenders who appear in the courts and prisons. These patients present a challenge to both the criminal justice system and mental health professionals that is not easily met (Teplin 1984; Weller 1988; Shah 1989).

"Until the extent of the problem is better delineated and creative solutions found, it seems likely that mentally ill offenders will be as much at risk from society as they will be to society" (Freeman and Roesch 1989).

2.2 CRIME AND MENTAL ILLNESS

2.2.1 Schizophrenia

"There is no doubt that schizophrenics are capable of violent behaviour and, there, any certainty about the relationship between schizophrenia and violence ends" (Taylor 1982 : 269).

Both schizophrenia and crime are quite common events and thus probability alone would suggest a considerable proportion of people suffering from schizophrenia might also commit criminal offences (Spry 1984 : 127).

Criminal behaviour may have many different relationships to mental illness. Mental disorder may be only one of many factors in the life pattern of criminal behaviour, secondly criminal behaviour may occur in individuals without any evidence of mental disorder and lastly the behaviour may be a direct result of mental illness (Spry 1984 : 127).

Certifiability and criminal responsibility are unrelated and therefore people suffering from schizophrenia may commit a crime without their illness having any direct bearing on their offence (Trick and Tennent 1981 : 114; Mackay and Wight 1984 ; Shah 1989).

Numerous studies have attempted to determine the possible relationship between schizophrenia and crime especially as regards its association with acts of violence (Guze et al 1962; Taylor 1982 : 269).

In an American Study Guze et al (1962) examined 223 convicted male felons aged between 15 and 78 years. In this study sociopathy, alcoholism and drug dependence were over-represented while only 1% of the subjects were schizophrenic. However the sample consisted of convicted criminals and therefore many subjects with a formal mental illness may

already have been selected out.

Cloninger and Guze (1970) studied 66 female felons and found that sociopathy, alcoholism, drug dependency, hysteria and homosexuality were the most common mental disorders. In this study only one case of schizophrenia was found.

In a more recent study Faulk (1976) studied 72 consecutive males discharged from Winchester prison. Of his sample the majority suffered from alcoholism and a personality disorder. Two felons were diagnosed as schizophrenic but in neither was it the principal diagnosis.

From these and other studies it appears that the prevalence of schizophrenia in criminal populations is similar to the prevalence in the general population (Guze et al 1962; Cloninger and Guze 1970; Faulk 1976).

However when mental hospital populations are studied stronger associations between schizophrenia, violence and crime are seen. Almost invariably at least half the violent patients from mental hospitals are given a diagnosis of schizophrenia and it is within this sub-group that the most serious crimes occur (Taylor 1982 : 270; Taylor and Gunn 1984).

A large study was conducted in West Germany by Häfner and Böker (1973). These researchers studied the case histories of all mentally abnormal offenders convicted of serious violence against persons in the ten years between 1955 and 1964. In this study schizophrenia accounted for fifty-three percent of all mentally ill offenders.

A number of American studies support both negative and positive correlations between schizophrenia, violence and crime. Studies from the first half of this century showed that the mentally ill were less likely than the general population to commit violent offences while later studies showed a higher

rate for violent crimes amongst this group, the majority of whom were schizophrenic. This trend appears to have paralleled the shift in care from custodial to community based mental health care. Since the 1950's studies have found increasing rates of criminal behaviour in former psychiatric patients (Rappeport and Lassen 1965; Giovannoni and Gurel 1967; Grunberg et al 1978).

Rappeport and Lassen (1965) found that for certain offences such as robbery and rape psychiatric patients were more frequently arrested than the general population while for other offences no significant differences were found.

Giovannoni and Gurel (1967) studied a cohort of mentally ill offenders of which 73% were schizophrenic. They found a higher arrest rate for offences against person when compared to the general population.

Zitrin et al (1976) studied the arrest records of psychiatric patients from Bellevue Hospital in New York. In the two years following their discharge 10% of 403 schizophrenics were arrested for violent crimes and 11% for non-violent crimes.

Grunberg et al (1977) studied homicides committed in Albany County New York and found a significant increase in those committed by former psychiatric patients.

Sosowsky (1978) found that 25% of a cohort of 219 schizophrenics had been convicted for a violent offence and 23% for a non-violent offence in the eight year period following their index admission to hospital. In this study mentally ill offenders had higher arrest rates than the general population.

However Steadman et al (1978b) found the high arrest rates amongst former psychiatric patients to be entirely due to an increase in those with criminal records before admission and therefore a high risk of recidivism. They suggest that prior

criminality rather than schizophrenia may account for the higher re-arrest rates amongst former psychiatric patients. Thus many variables other than mental illness per se may interact to determine the nature of crimes committed by mentally ill offenders.

The characteristics of crimes committed by people suffering from schizophrenia fall into two main groups:

.1 Schizophrenia and Violence

Schizophrenia may be associated with violent crimes and certainly such acts when involving a famous person, lead to considerable notoriety and publicity. Violent crimes in patients with schizophrenia usually lack a clear motive and may have been committed in response to an hallucination or delusion. Delusions of persecution are especially likely to result in an unprovoked attack on the victim. It is commonly believed that this behaviour is impulsive but many schizophrenics with fixed delusional systems are capable of considerable premeditation (Trick and Tennent 1981 : 114). Schizophrenics occasionally commit bizarre crimes usually involving sexual perversions or acts of extreme violence or mutilation. These crimes tend to receive considerable publicity even though their true frequency is low (Taylor 1982 : 275; Spry 1984 : 129).

.2 Schizophrenia and Commonplace Offences

Commonplace offences are frequently found in patients with schizophrenia. Due to a general decline in social functioning, personality and competence, the offender may succumb to temptations that would normally be resisted. Commonplace offences include petty theft, begging, breaches of the peace and other minor offences, generally of a non-violent nature. Vagrancy may occur secondary to a general decline in social competence. These schizophrenics find themselves drifting into

inner city slums often homeless, unemployed and without adequate community support (Neustatter 1953 : 60; Mackay and Wight 1984; Teplin 1984; Weller 1988).

People suffering from schizophrenia may therefore commit a crime without their illness having any direct bearing on their offence. There are three main hypotheses concerning the relationship between schizophrenia and violent crime. Firstly schizophrenia may be directly related to violent behaviour. Secondly social factors may best correlate with the violence, and thirdly schizophrenia and violence may be related by a common underlying cause, whether that be mainly social, environmental or biological (Taylor 1982 : 273).

2.2.1.1 Schizophrenic Phenomenology and Violence

In persons suffering from schizophrenia an assault may be the direct result of an hallucination or persecutory delusion. In a study of severely violent schizophrenics sent for forensic assessment Virkkunen (1974a) found that approximately one third had committed the act in direct response to an hallucination or delusion. In the remaining two-thirds of schizophrenic patients neither the diagnosis nor symptoms appeared to be of direct relevance to the crime committed.

2.2.1.2 Social Factors and Violence

Although violent behaviour may occur in schizophrenics, there is not always an obvious relationship between the two and the majority do not appear to be actively psychotic at the time of the offence. (Virkkunen 1974a; Virkkunen 1974b; Silverton 1988). Häfner and Böker (1973) showed that violent schizophrenics have much in common with violence in offenders found not mentally ill with regard to education, sex, intelligence and occupational status, while Steadman et al (1978b) concluded that prior criminality rather than mental illness may account for the high re-arrest rates amongst former

psychiatric patients. Thus social and demographic factors may be influential in determining violent behaviour in these patients.

2.2.1.3 Schizophrenia and Violence - By-Products of a Common Aetiology

Both schizophrenia and violent behaviour may be symptomatic of certain patterns of damage, whether in the environment, the brain or both. Physical defects and cerebral dysfunction including ventricular enlargement and EEG abnormalities have been reported in both schizophrenics and violent offenders. These associations may be due to common underlying variables such as complications of pregnancy, perinatal insults and adverse socio-economic factors (Stafford-Clark and Taylor 1949; Taylor 1982 : 277-279; Kaplan and Sadock 1988 : 255-258).

Thus in studying the relationship between schizophrenia and criminal behaviour one needs to consider much more than the diagnosis per se. In addition to the content of the hallucinations or delusions the pattern of behaviour is likely to be modified by a complex interplay of cerebral dysfunction, personal, social and demographic factors (Taylor 1982 : 81).

The association between schizophrenia and crime is at best weak and in most cases cannot be explained directly in terms of the illness itself. The best general statement appears to be that it is unlikely that mental illness places people at any greater risk for committing acts of violence. The more violent crimes tend to attract undue publicity due to the sometimes bizarre circumstances surrounding them (Trick and Tennent 1981 : 116; Taylor 1982 : 241).

Within the mentally ill group schizophrenics are probably the most violence-prone. However the vast majority of those who suffer from schizophrenia show no tendency towards violent or criminal behaviour (Sosowsky 1978; Trick and Tennent 1981 :

116).

2.2.2 Mood Disorders

Criminal acts committed by offenders suffering from mood disorders are generally infrequent. Of the more serious offences associated with a major affective disorder, the extended suicide is regarded as the most typical. This almost exclusively occurs in severely depressed young mothers who in a delusional frame of mind, include their children in their suicide (Häfner and Böker 1973; Harrer and Kofler-Westergren 1986; Bourget and Bradford 1987; Higgins 1990 : 348).

Other criminal acts such as sexual or property offences may occur in milder forms of depression. Patients with mild depression or with masked symptomatology may be missed and hence the criminal significance of depressive conditions may be overlooked. Kunjukrishnan and Bradford (1988) in their study of 201 patients in a Forensic Psychiatric Department, found their schizophrenic sub-group to be more than three times the size of the major affective sub-group. They suggested that this might represent an under-diagnosis of mood disorders in mentally abnormal offenders.

Häfner and Böker (1973) analysed violent crimes committed by mentally abnormal offenders during a ten year period in Germany. This study showed that the violent crime rate in affective psychosis was 0.006%, while in comparison that of schizophrenic patients totalled 0.05% - more than eight times higher. In this study the violence was almost exclusively limited to young married women with severe melancholic depression, often with delusional thoughts of impending disaster. Manic syndromes in this study did not contribute significantly to crimes of violence.

Thus severe crime in depressed offenders most frequently involves young mothers who include their children in their

suicide. This killing of a child in order to avoid some imagined disaster due to a delusional frame of mind is referred to as altruistic suicide (Resnick 1969; Harrer and Kofler-Westergren 1986; Rosenbaum and Bennett 1986; Bourget and Bradford 1987).

Good (1978) studied 100 consecutive prisoners referred for psychiatric evaluation and concluded that both manic and depressive states especially among female offenders, are frequently under-diagnosed. Although widely held that the manic patient is most frequently euphoric, more recently the existence of irritability and aggression has been recognised. For example Carlson and Goodwin (1973) showed that 15 of 20 confirmed manic patients showed irritability, paranoid ideation and aggressive behaviour rather than the traditional elation and grandiosity.

The onset of the manic phase of a bipolar disorder may therefore be masked by a prodrome of antisocial behaviour or misdiagnosed as paranoid schizophrenia. The use of lithium carbonate in aggressive prisoners emphasises the need to clarify the relationship between affective disorder and aggression (Good 1978). Severe unipolar depression may also be associated with criminal or antisocial behaviour while feelings of depression may co-exist with mania. Good (1978) found a 10% incidence of primary affective disorder in his study of 100 consecutive prisoners. In only two cases was the affective disorder known prior to commitment to prison. Good (1978) suggests that primary affective disorder in prison populations is under-diagnosed and may be obscured by aggression, somatic complaints or alcohol and drug abuse.

Apart from being masked by antisocial behaviour, bipolar or unipolar patients may be mislabelled as schizophrenic, neurotic or personality disordered. It has been suggested that failure to recognise acute mania has resulted in an overdiagnosis of schizophrenia (Kunjukrishnan and Bradford 1988). Although

schizophrenia is generally cited as the mental illness most frequently related to violent crime, Herjanic et al (1977) found that female offenders suffering from affective disorders were charged with more serious crimes when compared to schizophrenics. Rosenbaum and Bennett (1986) studied six homicidal depressed patients and found the commonest crime in severely depressed offenders to be the maternal homicide of small children, often followed by suicide.

Depression in these offenders may be missed unless one enquires about early risk factors including difficulty in coping with aggression, certain personality variables and a disturbed relationship with the child, coupled with delusions of sinfulness and guilt (Rosenbaum and Bennett 1986; Bourget and Bradford 1987).

Rosenbaum and Bennett (1986) in their study of homicidal depressed patients, found these offenders more likely to have been physically abused as children, to have a personality disorder, to abuse alcohol or drugs and to be more actively suicidal than non-homicidal depressed patients. These studies suggest a strong relationship between severe mood disorder and homicide which appears to have been overlooked in forensic psychiatry (Resnick 1969; Good 1978; Rosenbaum and Bennett 1986).

In the forensic setting one needs to determine whether the mood disorder occurred prior to or after the alleged offence. The mood disorder may pre-date the crime or alternatively be in response to arrest and incarceration. In patients with severe depression, delusions related to guilt and worthlessness may also attract confessions from people who are totally innocent. Thus the relationship between mood disorder and crime is a complicated one requiring careful and accurate appraisal (Trick and Tennent 1981 : 111).

2.2.3 Epilepsy

The relationship between crime, epilepsy and mental illness has been widely debated in the literature. Writers in the early 1900's regarded crime and epilepsy as intimately related and most criminals were regarded as having an epileptoid constitution (Lishman 1987 : 241).

Despite the earlier stereotype of the epileptic being prone to acts of extreme violence, numerous studies of unselected populations (Alström 1950; Lennox 1960; Juul Jensen 1963) as cited by Flor-Henry (1976 : 268-269) show that there is no excess of violent crime when compared to control populations.

However in studies where the sampling proceeds from the general epileptic population through prisons to centres for the criminally insane, so the prevalence of epilepsy increases. Stafford-Clark and Taylor (1949) investigated the association between electroencephalogram (EEG) abnormalities and crime. Where the murder was in self-defence 9% were abnormal, where there was a clear motive 25% were abnormal, where the murder was motiveless, 73% were abnormal, while amongst those found unfit to plead or guilty but insane, 86% were abnormal.

Gunn (1969) surveyed the prison population of England and Wales in 1966. He found a prevalence of epilepsy of 7.2/1000 prisoners, which was much higher than the prevalence of epilepsy in the general population. Gunn concluded that epileptics do have a higher probability of being imprisoned but found nothing to suggest that these offenders were more prone to acts of violence.

Whitman (1984) as cited by Fenwick (1987 : 532) conducted a methodologically sound study and showed that the prevalence of epilepsy among prisoners was four times higher than expected. However almost half the prisoners with epilepsy had a post-traumatic etiology and they concluded that the high prevalence

was closely related to socio-economic status. Thus sociological factors rather than an intrinsic relationship between epilepsy and aggression, might best explain the high prevalence of epilepsy in prisons.

In the study of aggression and epilepsy clearer correlations emerge with temporal lobe epilepsy. Serafetinides (1965) in his study of 100 patients subjected to anterior temporal lobectomy, found that 36 patients showed overt physical aggression. The majority of these epileptics were young boys with an early age of onset and a left (dominant) temporal lobe focus. The finding that epileptics with temporal lobe seizure activity are more susceptible to aggressive outbursts may be related to this region of the brain being concerned with the integration and mediation of emotional behaviour (Taylor 1969).

Aggressive behaviour in epileptics is probably caused by many factors including low socio-economic status, increased perinatal morbidity, brain damage and infection - all of which are found in excess in this population (Fenwick 1987 : 531-537; Herzberg and Fenwick 1988).

Psychosocial factors including the stigma of epilepsy and poor social skills, also contribute to the relationship between crime and epilepsy. Specific discharges within the hippocampus, amygdaloid nucleus and hypothalamus contribute towards poor impulse control and aggressive outbursts. Aggression in a setting of clouding of consciousness may be due to spread of seizure activity in those structures involved in the control of aggression (Serafetinides 1965: Rodin 1973).

There is a complex interplay of organic and psychosocial factors underlying aggression in epilepsy. The association between aggression and epilepsy may be due to the seizure itself, to underlying brain damage or due to socio-economic variables (Rodin 1973; Fenwick 1987 : 531-537).

Two types of epileptic aggression occur - that due to the seizure itself or post ictal confusional state, and that due to interictal aggression (Herzberg and Fenwick 1988).

Aggressive acts may occur during a seizure as part of epileptic automatism. This is extremely rare as there is an associated disturbance of consciousness and the motor acts are carried out in an unco-ordinated and non-directed way (Lishman 1987 : 242; Fenwick 1990).

Delgado-Escueta et al (1981) studied 5400 videotaped seizures occurring in different psychiatric units throughout the world. They found only 13 cases of aggressive behaviour, most of which occurred post ictally in a setting of clouding of consciousness.

Rodin (1973) filmed 150 epileptics in hospital and none of these patients displayed any ictal violence. However the very rare occurrence of ictal violence in these studies may partly be due to the hospital setting, where provocation is unlikely to occur.

Legally epilepsy is regarded as a disease of the mind and a criminal act committed during an epileptic seizure is regarded as an insane automatism. Not infrequently psychiatrists are called upon to determine whether or not a crime has been committed during an epileptic seizure or in a post ictal confusional state and whether the defence of automatism can be substantiated. Patients suffering from an epileptic automatism will not automatically be found not guilty of an offence, and as with alcohol induced automatisms, the principle of antecedent liability applies. (Gunn 1971; Fenton 1972; Strauss 1984 : 118-119; Fenwick 1990).

The following points may help substantiate a diagnosis of epileptic automatism:

- .1 The patient should be a known epileptic and have a past history of unequivocal seizures. It is unlikely that a crime will be committed during a first seizure and without overwhelming evidence of epilepsy, this should be rejected. Vague symptoms such as depersonalisation or *deja vu* alone, should not be accepted as indicating temporal lobe epilepsy.
- .2 The case of epileptic automatism is strengthened if a previous history of automatism is elicited and if the behaviour described during the crime is consistent with behaviour that has previously occurred during an automatism.
- .3 The diagnosis of epilepsy must be a clinical one. An abnormal EEG merely lends support, but does not establish a diagnosis while a negative EEG proves nothing.
- .4 The act should be out of character for the individual and inappropriate to the circumstances.
- .5 The crime should always appear sudden and motiveless with no evidence of premeditation. An epileptic automatism must arise *de novo* from ongoing behaviour and if there is any evidence of pre-planning, one cannot substantiate a diagnosis of automatism.
- .6 Concealment after an automatism is unlikely. On regaining consciousness the patient emerges from a state of confusion. He is likely to be amnesic for the event and thus may seek help rather than attempt to conceal events.
- .7 A witness if present, should report impaired awareness including a dazed appearance, staring eyes, stereotyped

movements and confusion.

- .8 Memory for the act should be impaired. There is typically amnesia for the event, but no loss of memory antedating it. The memory loss starts with the onset of the seizure and not before it (Gunn 1971; Fenton 1972; Fenwick 1990).

2.2.4 Substance Abuse

Alcoholism and drug addiction have many associations with criminal behaviour and especially crimes of violence, although these are not always well defined (Öjesjö 1983 : 733).

It is well known that alcohol is a cerebral depressant and with increasing levels of blood alcohol there is a progressive impairment of central nervous system functioning. At a blood alcohol level of 80 mg/100 ml judgement and motor reaction time are severely impaired, while aggression and socially inappropriate behaviour commonly occur at blood alcohol levels of 150 mg/100 ml. With levels of 200 mg/100 ml there is blurring of vision, disturbance of balance and marked clouding of consciousness, while at blood levels over 600 mg/100 ml death is likely to result (Fenwick 1990).

Numerous writers have reviewed the complexity of the alcohol defence but generally the law has been extremely conservative in excusing intoxicated offenders. In most countries a person is criminally liable if the act constituting the crime was considered conscious and voluntary. However in the case of intoxication, if the ordinary rules or principles of criminal responsibility were applied, a person might have a complete defence, as inability to appreciate the wrongfulness of one's actions or to act in accordance with that appreciation, may certainly follow intoxication (Öjesjö 1983 : 134; Craft 1984b : 316; Whitlock 1990 : 267).

Consumption of alcohol may adversely affect a person's ability to appreciate the nature and consequences of his conduct and to resist the temptation to commit wrongful acts. Intoxication may induce impulsive behaviour, an overestimation of one's abilities and an underestimation of dangers (Snyman 1984 : 134-135).

The relationship between crime and alcohol can be divided into two categories. Firstly crimes committed by offenders who are intoxicated and secondly, crimes committed by people suffering from disorders following excessive alcohol intake over an extended time period (Trick and Tennent 1981 : 147; Mawson 1990 : 221).

Certain forms of mental illness such as delirium tremens and Korsakoff's psychosis, may result from the chronic consumption of alcohol. Here the accused is found not guilty according to the ordinary rules relating to mental illness but must be committed to a mental hospital or prison as a State President's Detainee (Snyman 1984 : 135).

Kruger (1980 : 185-186) points out that alcoholism itself is not a defence if it does not constitute a mental illness. Prior to 1981 the law on self-induced intoxication was quite clear. Self-induced intoxication did not absolve the accused from liability in crimes involving ordinary intent but excluded the specific intent required for crimes such as murder, which could then be reduced to culpable homicide (Craft 1984b : 316; Snyman 1984 : 137).

This was the position before 1981, when the South African courts refused to regard voluntary intoxication as a complete defence. This was referred to as the reduction rule whereby a serious crime could be reduced to a less serious one if it could be established that the person was too intoxicated to form the intent required (Strauss 1984 : 396).

Before 1981 it was accepted that an automatism induced by voluntary intoxication was no defence. However in the landmark case of Chretien (1981), the decision of the Appeal Court led to a radical change in the law relating to the defence of intoxication. The court held that : "Whenever a person who commits an act is so drunk that he does not realise what he has done was unlawful or that his inhibitions have disintegrated, he can be regarded as not being criminally responsible" (Surdut 1991). Thus the court found that where a person is so intoxicated as to be unaware of his actions and where his movements are involuntary, there can be no act on his part and he cannot be found guilty of any crime.

Much controversy followed this decision because the demands of society were no longer reconciled with the law. While it was a correct interpretation of modern jurisprudence it did not satisfy society's sense of justice, since it remained that a person who committed a crime while voluntarily intoxicated would be treated more leniently than a sober person who committed the same act (Snyman 1984 : 144; Surdut 1991).

"Chretien is certainly not good news for those who are concerned about the evils of liquor abuse and who look beyond the individual accused to the victims of that abuse. It came as no surprise that the judgement was coolly received by various commentators" (Snyman 1984 : 144).

These criticisms led to the Criminal Law Amendment Act No. 1 of 1988. This act provides that if a person on account of voluntary intoxication which impairs his faculties, is not criminally liable at the time of the commission of the Act, he will nevertheless be guilty of an offence and therefore liable for the same punishments he would have received had he been sober - except the death penalty (Surdut 1991).

Involuntary intoxication whereby a person becomes intoxicated against his will is regarded as a complete defence. Such cases however are extremely rare (Snyman 1984 : 115). In certain instances intoxication may be no defence nor grounds for mitigation, but grounds for increasing the punishment. This situation in practice is referred to as *actio liberia in causa* and describes the situation whereby a person drinks in order to build up the courage required to commit a crime (Snyman 1984 : 135-136; Strauss 1984 : 396).

Intoxication in certain instances rather than being grounds for the exclusion of *mens rea*, may actually confirm its presence. If a person is charged for drunken driving, the fact that he was intoxicated may be grounds for establishing negligence (Snyman 1984 : 141; Strauss 1984 : 396).

The legal concept of pathological intoxication is likewise a controversial one which includes people who are apparently extremely sensitive to small amounts of alcohol, leading to severely disruptive behaviour after minimal intake. Pathological intoxication is regarded as a mental illness and may thus be a total defence (Perr 1986a).

Perr (1986b) cites numerous cases in which the term has been used broadly and inaccurately especially in explosive outbursts following significant alcohol intake. He suggests that in the law courts, the term Alcohol Idiosyncratic Reaction should be used in strict conformance with the requirements of DSM-III-R (American Psychiatric Association 1987 : 129), as explosive outbursts of rage are not uncommon in sociopaths, hysterics and epileptics under the effects of alcohol.

According to DSM-III-R (American Psychiatric Association 1987 : 129), idiosyncratic intoxication is characterised by maladaptive behavioural changes occurring within minutes of ingesting an amount of alcohol insufficient to induce intoxication in most people. This behaviour is atypical of the

person when sober and is not due to any physical or other mental disorder. The duration is usually brief and during the episode the person appears out of contact with others.

Following severe head injury there may be reduced tolerance to alcohol and offenders with explosive rage following ingestion of alcohol may have associated soft neurological signs and minor CT scan or EEG abnormalities (Fenwick 1990).

The differential diagnosis includes amongst others, intoxication with other substances, epilepsy and brain damage and where criminal charges are pending simulation needs to be excluded (Perr 1986a).

2.2.5 Psychopathy

The Mental Health Act No. 18 of 1973 Chapter I, Sections 1 and 2, defines psychopathic disorder as "persistent disorder or disability of the mind, whether or not subnormality of intelligence is present, which has existed in the patient from an age prior to that of 18 years and which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient".

The main features of the psychopath are as follows:

a person who from an early age suffers from emotional instability, is unable to comply with accepted social or moral norms, acts impulsively, does not readily learn from experience, is egocentric and feels little remorse or compassion towards others (Craft 1984c : 384; Snyman 1984 : 129; Shah 1986 : 399).

According to DSM-III-R (American Psychiatric Association 1987 : 344-345) antisocial personality disorder is characterised by behaviour beginning before age 15 in which the rights of others are violated. It persists into adulthood with failure to conform to social norms with respect to lawful behaviour,

failure to sustain consistent work behaviour, recurrent aggression, failure to honour financial obligations, disregard for the truth and inability to function as a responsible person (Kaplan and Sadock 1988 : 437).

A review of the literature on psychopathic disorders reveals that as yet no-one has devised a satisfactory definition for the diagnosis or category. In addition some have questioned whether this disorder constitutes a valid diagnostic entity or is rather a moral judgement (Gunn 1977; Weinstock and Nair 1984; Roth 1990 : 437-440).

To further complicate matters there are two distinct uses of the term psychopath - legal and clinical. These different uses do not necessarily coincide even though they influence each other. Psychopathic disorder as defined by the Mental Health Act No. 18 of 1973, is referred to as Antisocial Personality Disorder in DSM-III-R (American Psychiatric Association 1987 : 342), even though the two definitions are not synonymous. This is further complicated by the circular definition of psychopathic disorder, as mental abnormality is inferred from antisocial behaviour, while antisocial behaviour is explained by mental abnormality. Gunn (1977) argues that if psychopathic disorder is a defect state then it would be more accurately viewed as a failure of learning rather than a disease process. However Kaplan and Sadock (1988 : 437) point out that even though the antisocial personality is characterised by participation in illegal activities that are grounds for arrest, it is not synonymous with criminality. It is rather an inability to conform to major age appropriate societal norms and values that involves many aspects of the patient's adolescent and adult development. Thus the concept of psychopathy has a wide range of application and is too broad to be of any value in the determination of criminal responsibility (Gunn 1977; Snyman 1984 : 129).

According to the Mental Disorders Act of 1916, the psychopath

was certifiable and hence not culpable. However with the new Mental Health Act of 1973 and the Criminal Procedures Act of 1977, certifiability and lack of criminal responsibility are no longer synonymous. Thus the mere fact that an accused is classified as a psychopath does not imply lack of criminal responsibility (Strauss 1984 : 110).

Psychopathy is not a mental illness leading to non-responsibility in terms of Section 78(2) of the Criminal Procedures Act. It is such a heterogenous disorder that psychopaths may range from those who are not criminally responsible in terms of the Act to those who are criminally responsible and will not even be entitled to lighter punishment in terms of Section 78(7) at the other extreme. Thus the ordinary tests for determining criminal responsibility apply equally to the psychopath (Snyman 1984 : 129; Strauss 1984 : 110; Whitlock 1990 : 268).

However as long as psychopathy is listed in the Mental Health Act as a mental disorder it will continue to cause controversy in forensic psychiatry. Much debate exists regarding whether psychopaths should be hospitalised or imprisoned. In view of the lengthy maturation of the psychopath, it has been much debated whether one should rely on finite sentences, short term treatment periods or long term commitment to a psychiatric hospital. It has been suggested that punishment has little deterrent effect and makes the psychopath more resentful to society (Roux 1975 : 185-196; Prins 1980 : 143-145; Roth 1990 : 449).

"From the Judge's viewpoint the repeatedly convicted, compulsive offender is an enigma because he does not respond to punishment, he gets little from his escapades and soon squanders his gains. He does not even appreciate the help people give him, often biting the hand that tries to feed him. What is one to do? The community has to be protected" (Craft 1984c : 384).

In South Africa provision exists for the detention of certified psychopaths in special prison hospitals. The Rumpff Commission recommended the establishment of such a hospital for the protection of the public, subsequently established at Zonderwater near Pretoria (Roux 1975 : 185-196; Kruger 1980 : 220-222).

2.2.6 Mental Retardation

A relatively high incidence of mental retardation has been found in the offender population. Shapiro (1968 : 77-90) in his 10 year study of all cases admitted to hospital through the courts or on transfer following conviction, found an average intelligence quotient(IQ) of 73 in women and 81 in men. While it is most unlikely that profoundly mentally retarded offenders will come to the attention of the forensic psychiatrist, it is quite common for the courts to question the criminal responsibility of the accused or his ability to understand court proceedings, especially where mild mental retardation is suspected (Prins 1980 : 90-92).

Estimations as to how many criminals are mentally retarded is not only complicated by problems of definition but also by lack of standardised culture fair intelligence tests. Poor conditions of upbringing, poverty, inadequate schooling and parental illiteracy compound the problem. Low intelligence is just one of the many factors which determine delinquent behaviour. Although low intelligence may modify one's attitude towards antisocial acts, delinquency is determined more by personality and social factors than by intellectual endowment per se (Prins 1980 : 90-92; Reid 1990 : 394-395).

In the Criminal Procedures Act 51 of 1977 there is no definition of the term mental defect in terms of an intelligence quotient. Thus mental retardation alone is not sufficient to absolve one of criminal responsibility. The degree of mental sub-normality must be severe enough to prevent

the offender from being able to appreciate the wrongfulness of his actions or act in accordance with that appreciation (Prins 1980 : 90-92; Strauss 1984 : 120).

In terms of Section 77(1) of the Criminal Procedures Act, competency to stand trial focuses primarily on the degree to which the accused is able to understand court proceedings so as to make a proper defence. The accused must be able to understand the nature of the charge against him and to instruct his counsel. Competency focuses primarily on the functional abilities of the accused as they relate directly to the demands of the trial and therefore the defendant's intellectual capacity alone is not sufficient to determine fitness to stand trial. The presence of mental retardation is therefore not sufficient to support a finding of incompetency (Grisso and Seigel 1986 : 146-147).

Apart from sexual offences low intelligence per se is not associated with criminal behaviour. When mental retardation is severe (IQ below 60), behaviour is often impulsive and irritable. This behaviour is not truly delinquent but rather symptomatic of the underlying disorder. Delinquency is especially common in mentally retarded offenders as the IQ rises above 65. This has been attributed to their increased capacity to exist in the community where they frequently become involved in criminal behaviour at the instigation of others (Shapiro 1968 : 78; Prins 1980 : 91-92; Reid 1990 : 395-396).

Sexual offences appear to be especially frequent among mentally retarded offenders. Shapiro (1968 : 78) found 33% of mentally retarded offenders to have convictions for sexual offences, the commonest offence being sexual assault on young girls, followed by indecent exposure and homosexual acts.

Mental retardation may be secondary to numerous organic factors which may predispose to impulsive or unpredictable behaviour. Organic brain dysfunction may co-exist or exist independently

of mental retardation. Travin et al (1985) in their study of patients in a forensic psychiatry clinic, were impressed by the significant mixture of both intellectual and neuropsychological impairment. In this study head trauma and substance abuse together with severe psychosocial deprivation, were found in association with a high degree of subnormal intellect or functioning. The issue of mental retardation is an extremely complicated one in view of the varying degrees of organic impairment that may be associated with it (Prins 1980 : 92; Travin et al 1985).

Organic brain syndromes may result in isolated handicaps in offenders with normal intelligence who do not show an overall decline in general intellectual functioning. In addition to a comprehensive neurological examination including an EEG and brain CT scan, formal neuropsychological assessment batteries such as the Halstead-Reitan and Luria-Nebraska may help the forensic psychiatrist in the assessment of mental retardation and organic brain syndromes (Travin et al 1985; Day 1990 : 401).

2.2.7 Senescence and Dementia

Crime is largely a phenomenon of youth and antisocial acts decline sharply in the fourth decade. The elderly are generally responsible for a very small proportion of the crimes that lead to conviction and a criminal act in an aged first offender should always raise the suspicion of an organic mental disorder (Roth 1968 : 35-37; Lishman 1987 : 17).

Dementia, chronic epilepsy and traumatic brain damage are among the commonest causes of an organic mental disorder. The end result of severe progressive cerebral damage is the syndrome of dementia characterised by a disintegration of memory, intellect and personality. The behaviour which results from these changes may bring patients into conflict with the law.

Even in non-demented elderly subjects, cerebral degenerative changes may give rise to coarsening of the emotions and a general tendency towards impulsivity and aggression. However the number of offenders suffering from organic mental disorders appears to be small (Roth 1968 : 35 - 37; Prins 1980 : 78; Lishman 1987 : 370; Toone 1990 : 385).

Presenile dementia may similarly be associated with antisocial acts and as this develops in a younger age group, a wider range of criminal activities is possible. There may be a clear family history of presenile dementia as in Huntingtons Disease, which has a strong correlation with antisocial behaviour and social decline (Trick and Tennent 1981 : 126-127; Toone 1990 : 386).

Of the treatable secondary causes of dementia, general paresis of the insane is common, leading to an insidious dementing illness. For this reason all observation cases should have a Wasserman reaction performed as a routine screening test. Where dementia is suspected, psychometric testing may give an accurate assessment of the magnitude of the intellectual deficit. In selective cases an EEG, skull X-Ray and brain CT scan may help confirm the diagnosis or be of value in detecting reversible causes (Lishman 1987 : 417).

2.2.8 Head Injury

Severe head injury is associated with a high incidence of mental disorder and adverse personality disturbance including impulsivity, irritability and aggression. This has important social and medicolegal implications especially in view of the mounting rate of traffic accidents and improved chances of survival with adequate medical care (Lishman 1987 : 370-404).

In contrast to parietal, occipital and cerebellar lesions, injury to the frontal and temporal lobes appears to be associated with the greatest psychiatric morbidity. Frontal

lobe lesions are a common cause of an organic personality syndrome characterised by affective instability, recurrent outbursts of rage, paranoid ideation and impaired social judgement, leading most often to sexual misdemeanours (Lishman 1987 : 154; Kaplan and Sadock 1988 : 200-202).

Criminal behaviour is especially common following traumatic damage to the orbital portion of the frontal lobe and usually involves sexual offences. Changes in personality are far more common than changes in intellect, and relatively circumscribed brain damage may lead to undue violence following rather minor provocation (Lishman 1987: 154; Adams and Victor 1989 : 352-358).

There appears to be a growing number of brain injured individuals with a high incidence of mental disorder and personality change, who constitute both a danger to themselves and to the community (Roth 1968 : 49).

2.2.9 Hypoglycaemia

Crimes committed during hypoglycaemic automatisms have been reported in criminal law. These states of clouding of consciousness need to be differentiated from automatisms due to alcohol, epilepsy, or hysterical fugue states.

According to the law hypoglycaemic automatisms due to an external factor such as injection of insulin are regarded as sane automatisms and a successful plea will result in an acquittal. However a hypoglycaemic automatism due to an internal factor such as a pancreatic tumour is regarded in law as an insane automatism which will result in the patient being declared a State President's Detainee (Strauss 1984 : 119; Fenwick 1990).

Hypoglycaemic automatism is not an automatic defence as the principle of antecedent liability still pertains. If a diabetic wishes to use hypoglycaemia as a basis for a defence, he must firstly show that the hypoglycaemia was not due to his own negligence and secondly that the hypoglycaemia was caused by an external factor for example injected insulin (Strauss 1984 : 119; Fenwick 1990).

2.2.10 Genetic Endowment and Chromosomal Abnormality

There has been considerable debate surrounding the relationship between chromosomal abnormality, mental illness, antisocial behaviour and criminal responsibility (Dorus et al 1977; Prins 1980 : 83; Craft 1984a : 122).

In all population studies approximately one in every four hundred live births have an extra sex chromosome. While the relationship between karyotype abnormality and crime may be one of chance, research has shown the prevalence of offenders with chromosomal abnormalities to be higher than would be expected in the general population. Patients with body chromosome abnormalities occur more commonly in mental hospitals, while sex chromosome abnormalities are over-represented in penal institutions and maximum security hospitals (Shapiro 1968 : 82; Dorus et al 1977; Craft 1984a : 122).

Much debate surrounds the question of whether the 47 XYY karyotype is associated with criminal behaviour especially of a violent nature. However many studies have not controlled for social class. In addition the criteria for violent behaviour have often been vague (Dorus et al 1977; Craft 1984a : 122).

Although chromosomal abnormality has been used as grounds for acquittal, usually it does not of itself affect criminal liability. It may however support a diagnosis of subnormality or be raised as grounds for hospitalisation rather than imprisonment (Trick and Tennent 1981 : 145).

2.2.11 Dissociative Disorders and Simulation of Mental Illness

In forensic psychiatry it may be extremely difficult to distinguish a true dissociative disorder from simulation. According to DSM-III-R (American Psychiatric Association 1987 : 269), the dissociative disorders (or hysterical neuroses) represent a disturbance in the normally integrative functions of identity, memory and consciousness. Mental illnesses falling into this category include multiple personality disorder, psychogenic fugue, psychogenic amnesia, depersonalisation disorder and the Ganser syndrome (Kaplan and Sadock 1988 : 345).

Psychogenic automatisms may be associated with dissociative disorders especially in hysterical fugue states. In crimes committed during periods of hysterical dissociation the defence of automatism is only available if the defendant wishes to plead insanity. These trances are regarded as insane automatisms according to Section 78(2) of the Criminal Procedures Act. The correct verdict in such cases would be a declaration as a State President's Detainee and not an unqualified acquittal (Kruger 1980 : 194; Fenwick 1990).

The Ganser syndrome is an hysterical dissociative reaction most often seen among prisoners awaiting trial. The unconscious motivation is to avoid responsibility for the crime by appearing insane and it may be virtually indistinguishable from conscious simulation. The chief symptom is often referred to as *vorbeireden* or talking past the point. The response to questions although often absurdly inaccurate, betrays a knowledge of the purpose of the question. Features include disorientation, fluctuating levels of consciousness, delusions and hallucinatory experiences. Typically resolution of the illness is abrupt and the hysterical conversion clears leaving a complete amnesia. The full syndrome as originally described by Ganser is extremely rare, whilst the Ganser symptom of

approximate answers is very common especially in prisoners awaiting trial (Lishman 1987 : 404-408; Enoch 1990 : 812).

Simulation of mental illness in order to be absolved of criminal responsibility may be extremely difficult to distinguish from hysteria. Simulation is more likely in serious offences when a suspect faces the death penalty and in these cases symptoms are consciously produced and maintained (Lishman 1987 : 408).

The following points as cited by Prins (1980 : 73-74), Lishman (1987 : 404-408) and Enoch (1990 : 804) may help distinguish true hysteria from simulation:

- .1 In simulation the suspect is often suspicious and ill at ease. His motivation is conscious and he is therefore more careful in choosing his words.
- .2 The hysteric usually revels in examination while a person simulating mental illness attempts to avoid it.
- .3 In simulation the offender is more likely to slip into inconsistencies with resultant embarrassment while the hysteric when accused of inconsistency usually displays a bland indifference.
- .4 In simulation symptoms are exaggerated and extreme, rarely resembling true mental illness but rather the patient's own concept of insanity.
- .5 In simulation symptoms are usually exaggerated during observation and the degree of disability displayed is inconsistent with the patient's general functioning.

2.2.12 Impulse Control Disorders

Impulse control disorders relevant to the forensic psychiatrist

include intermittent explosive disorder, kleptomania, pyromania and pathological gambling. These disorders are characterised by failure to resist a sudden impulse to perform a harmful act, with increasing arousal prior to the act and a sense of relief when committing the act (Kaplan and Sadock 1988 : 400). These disorders of impulse control have on occasion been successfully used as legal exculpation for violent crimes (Monopolis and Lion 1986 : 411).

Intermittent explosive disorder is a controversial diagnostic category. There is little statistical or systematic empirical basis for the disorder and many critics feel these offenders belong in the domain of the criminal justice system rather than clinical psychiatry. The disorder describes discrete outbursts of extremely aggressive behaviour grossly out of proportion to any precipitant and generally out of character for the person concerned. Certain neurological abnormalities for example head injury or EEG dysfunction may pre-date these outbursts. Thus many authorities doubt the existence of this syndrome and feel it can be explained by one of the disorders that must be excluded before the diagnosis can be made (Kaplan and Sadock 1988 : 401-402).

It is nevertheless listed as a mental disorder and has been used as exculpation for violent offences. Court mandated therapy may be useful in propelling these offenders into a treatment facility. Males are most likely to be found in correctional institutions, while females are most frequently found in mental health facilities (Monopolis and Lion 1986 : 409-414).

Patients claiming to suffer from pyromania, kleptomania or pathological gambling may also attempt to use these as a defence. Mental retardation may co-exist with pyromania or kleptomania thus complicating the issue (Monopolis and Lion 1986 : 410).

Offenders convicted of shoplifting may claim to be suffering from kleptomania. With criminal stealing there will usually be clear planning and an obvious gain. With kleptomania objects stolen are not needed for personal gain or monetary value. Criminals convicted of theft may simulate kleptomania in order to avoid prosecution. Thus simulation and other disorders such as a conduct disorder and antisocial personality must be excluded (Kaplan and Sadock 1988 : 402-403; Bluglass 1990 : 792-793).

The essential feature of pyromania is deliberate fire setting purely for relief of tension and not for any monetary or retributive gain. Associated features may include truancy, stealing, aggression, learning disabilities and mental retardation. These patients are usually resistant to treatment and probationary supervision for long periods may be necessary in order to prevent a recurrence (Kaplan and Sadock 1988 : 405-406).

Pathological gambling is regarded by many as an extremely questionable concept especially when offered as an insanity defence. In pathological gambling there is usually no history of antisocial behaviour and the patient is generally conscientious in all other aspects. Simulation, mood disorders and conduct disorders need to be excluded. Once identified as a pathological gambler the patient usually requires court supervision in order to remain in treatment (American Psychiatric Association 1987 : 324-325; Monopolis and Lion 1986 : 419-421).

2.2.13 Sexual Disorders

Paraphilias are sexual disorders which are characterised by recurrent intense sexual urges and fantasies involving either non-human objects, the suffering or humiliation of oneself or one's partner, a child or other non-consenting person. Since some of these disorders are associated with non-consenting

partners they are of legal and social importance. People with these disorders typically do not regard themselves as mentally ill and usually only come to the attention of mental health professionals when their behaviour has brought them into conflict with sexual partners or the law. Exhibitionism, frotteurism, paedophilia and sexual sadism are the paraphilias most often leading to arrest and incarceration. Sexual offences against children constitute a significant proportion of reported criminal acts. The most commonly apprehended sex offenders are exhibitionists, voyeurs and paedophiles (American Psychiatric Association 1987 : 279-290; Kaplan and Sadock 1988 : 358-363).

95% of paedophiles are heterosexual and 5% have consumed excess alcohol at the time of the offence. A significant number have also been involved in exhibitionism, voyeurism or rape. Recidivism is generally high, with unsatisfactory success rates following repeated attempts at therapy (Kaplan and Sadock 1988 : 360-361).

Sexual sadism is the most dangerous of the paraphilias and when associated with an antisocial personality or with sadistic personality traits, these people may seriously injure or kill their victims (Kaplan and Sadock 1988 : 360).

The diagnosis of a paraphilia does not lead to non-responsibility in terms of Section 78(2) of the Criminal Procedures Act. In offences such as exhibitionism the courts may direct that the patient receive treatment as part of the sentence (Abel et al 1986 : 308-310).

2.2.14 Sleep Disorders

Crimes are committed and also purported to be committed during sleep automatisms. Crimes allegedly committed during periods of somnambulism and sleep drunkenness include serious offences such as murder and assault. Sleepwalking and sleep terrors

have a marked genetic component yet despite these internal factors, they are regarded as sane automatism by the law. Thus a successful plea of not guilty will lead to an acquittal (Kaplan and Sadock 1988 : 393; Fenwick 1990).

The forensic psychiatrist may be required to give evidence in court regarding offences allegedly committed during sleep. Certain factors are required for the establishment of a diagnosis of sleepwalking and a defence of sleep automatism. There is often a family history of sleepwalking or night terrors and the onset is usually in early childhood.

Specific factors as cited by Gunn (1971) and Fenwick (1990), are required for the diagnosis and include the following:

- .1 Episodes only occur during slow wave sleep and therefore usually occur within two hours of sleep onset.
- .2 The nature and quality of the previous sleep mentation must be that of stage IV sleep. It should be non-dreamlike, non-narrative and with only vague visual content.
- .3 There is generally disorientation on awakening from a sleep automatism.
- .4 There must be amnesia for the event.
- .5 If a witness is present, confusion and inappropriate automatic behaviour should be reported.
- .6 There should be no attempt to conceal the crime.
- .7 The crime should be motiveless.
- .8 If there is a sexual element to the offence, physical evidence of sexual arousal makes sleep automatism highly

unlikely.

- .9 There may be a previous history of violence during sleep automatism.
- .10 Trigger factors especially fatigue, alcohol and stress may be present.

2.3 VIOLENCE IN THE MENTALLY ILL - PREDICTING DANGEROUSNESS

The belief that mental disorder predisposes to dangerous behaviour is an ancient one and mental illness is often perceived by the general public as being associated with particularly violent or bizarre crimes. This perception is fuelled by certain mental disorders being characterised by bizarre, impulsive and sometimes frightening behaviour. This, together with the view that impulse and action are interchangeable has fostered the belief that all mental disorder must lead to inappropriate, antisocial, or dangerous acts. During the past decade there has been renewed interest among mental health professionals, law enforcement personnel and the general public in the occurrence of violent behaviour in psychiatric patients. This is linked to concerns that deinstitutionalisation and the expansion of community treatment programmes has placed into the community more persons who are violent and likely to be involved in criminal activity (Rubin 1972).

This concern has been fuelled by findings in the recent literature that former psychiatric patients are more frequently arrested for certain offences than the general population (Rappeport and Lassen 1965; Giovannoni and Gurel 1967; Zitrin 1976; Grunberg et al 1977; Grunberg et al 1978; Sosowsky 1978; Steadman et al 1978a; Steadman et al 1978b).

Added to this concern is the ongoing controversy over the use of the dangerousness standard in the involuntary hospitalisation of psychiatric patients. The Butler Committee in reviewing the concept of dangerousness in relationship to mentally disordered offenders defined it as "a propensity to cause serious physical injury or lasting psychological harm (Mullen 1984; Prins 1990 : 500).

From the forensic psychiatrist's perspective Scott (1977) defined dangerousness as "an unpredictable and untreatable

tendency to inflict or risk irreversible injury or destruction, or to induce others to do so." The key element according to Scott (1977) is the risk of repetition. However others have questioned the inclusion of unpredictability and untreatability, since the anticipation of a danger does not necessarily minimise its risk (Whitlock 1990 : 500). In predicting or regarding an act as dangerous Walker (1980) as cited by Whitlock (1990 : 500) has provided the following guidelines:

- .1 Most property offences should be excluded since most loss or damage to property can be remedied by compensation.
- .2 Certain offences against persons causing temporary alarm should be excluded eg. indecent exposure and other minor threats.
- .3 All serious assaults should be regarded as dangerous eg. murder, attempted murder, culpable homicide, rape and kidnapping.
- .4 Harm need not occur - if the offender intended harm or must have appreciated that harm was a highly likely result of his actions, the concept of dangerousness would apply.
- .5 In predicting future dangerousness, the behaviour should not be an isolated out of character episode. Previous similar offences or declared intention of future vengeance would add weight to such prediction.
- .6 Lastly if the incentives for the initial offence have ceased to exist then repetition of the behaviour is unlikely to occur.

Thus dangerousness refers to both actual and intended acts involving physical injury or lasting psychological harm (Rubin 1972; Mullen 1984; Prins 1990 : 502).

Violence is a similar concept and refers to assaultive or destructive acts or ideation, because patients with fantasies of violence may occasionally act them out (Rubin 1972; Mullen 1984).

The prevalence of mental disorder amongst violent offenders depends on how wide a definition of mental illness is employed. When various forms of psychopathic disorders are included, with their circular definitions, then a significant proportion of offenders will fall within the category of mentally disordered.

Guze et al (1962) studied 223 convicted male criminals and found that 48% received no psychiatric diagnoses exclusive of sociopathic personality. In the remaining 52% the following prevalence for individual psychiatric disorders was found: alcoholism 43%; anxiety neuroses 12%; drug addiction 5%; homosexuality, schizophrenia and epilepsy each 1%; mental deficiency, dementia and other psychiatric illnesses; less than 1% each.

Where personality disorders are concerned there may be considerable disagreement on the diagnosis. Rogers et al (1984) studied 316 subjects under the jurisdiction of the Psychiatric Review Board. Of those given a final diagnosis, 70% were judged to be psychotic, 18% as personality disordered and 12% as retarded, organically impaired or neurotic. Of those who received a final diagnosis of psychosis there was diagnostic agreement in 97% of cases. In those diagnosed as personality disordered there was diagnostic agreement in only 28% of cases. It appears that criminal behaviour and violence are more frequent in patients with personality problems, social problems, mental handicap and drug addictions.

Guze et al (1974) studied 500 patients attending a psychiatric clinic and found the prevalence of offenders not much higher than matched controls. They concluded that while sociopathy,

alcoholism and drug dependence were associated with serious crime - schizophrenia, affective disorders, neuroses and brain syndromes generally are not. In other words, criminality overlaps with those aspects of the psychiatric spectrum that border on social inadequacy and habit disorders (Gunn 1977).

Early studies initially suggested that conviction rates amongst the mentally ill were similar to the general population. More recent studies question the traditional low re-arrest rate, suggesting that ex-psychiatric patients may be more dangerous than the general population (Rappeport and Lassen 1965; Giovannoni and Gurel 1967; Zitrin et al 1976; Grunberg et al 1978).

However these studies have been criticised for methodological flaws including failure to control for previous arrest records and insufficient follow up. In addition, different definitions for mental illness and violence were used (Steadman et al 1978a; Steadman et al 1978b).

Steadman et al (1978a) in their analysis of New York State data suggested that prior criminality rather than mental disorder per se might account for the higher re-arrest rate among ex-psychiatric patients. Despite the increasing number of studies concerning arrest rates of these patients none had provided such comparisons.

This study showed that former psychiatric patients with no previous criminal record have arrest rates comparable with the general population. The study showed that the trend towards higher arrest rates and violence is consistent with a higher number of prior arrests. In this study mentally ill patients with no previous criminal record (representing about 75% of all released psychiatric patients in New York) were arrested about as often or even less frequently than the general population.

It is therefore the multiply-arrested psychiatric patient who

is most often re-arrested after release. They conclude "the issue is not so much that there are more mentally ill people at risk for criminal activity in the community; more accurately, the problem seems to be that there are more criminals in mental hospitals in the first place".

From a review of the literature it appears that arrest rates for ex-psychiatric patients during the 1930's and 1940's were lower than those for the general population, while more recent studies have shown higher arrest rates especially for violent crimes. However the higher arrest rates are largely accounted for by a small sub-group of mentally ill patients with previous convictions while those without such records have post-discharge arrest rates equivalent to that of the general population (Steadman et al 1978b; Stokman 1984).

Teplin (1984) in her study of 1382 police-citizen encounters showed that for similar offences mentally disordered offenders have a significantly greater chance of being arrested. It has been suggested that due to their general social ineptitude and bizarre behaviour, the mentally ill are more conspicuous and hence more likely to be arrested.

Thus the public's common perception concerning violence in the mentally ill is a response to high arrest rates and highly publicised violent crimes involving a relatively small number of ex-psychiatric patients (Steadman and Keveles 1972; Steadman et al 1978a; Steadman et al 1978b; Stokman 1984).

Although these recent studies suggest that psychiatric patients do not contribute significantly to offending, it is nevertheless important to know if the presence of such disorder has any predictive value in determining dangerousness. Determination of dangerousness is a core issue in forensic psychiatry, yet the accuracy of predicting future dangerous behaviour is very low (Trick and Tennent 1981 : 193; Rossi et al 1986).

In reviewing the literature Monahan (1988) reached the following conclusions:

- .1 The upper bound of accuracy achieved in risk assessment is about 0.33. Thus for every three persons predicted to be dangerous there will be two wrong judgements for every one correct judgement.
- .2 The best predictors of violence among the mentally disordered are the same demographic factors that best predict violence in non-disordered criminal populations viz. age, gender, social class and a history of previous violence.
- .3 Amongst mentally disordered offenders the poorest predictors of violence are psychological factors such as diagnosis, severity of disorder or personality traits.

Therefore the strongest predictors of future violence appear to be a previous record of violent acts and offending together with youth. Mental abnormality as a global designation adds little to the prediction of future dangerousness (Trick and Tennent 1981 : 195; Monahan 1988).

Monahan (1988) points out that each of these assumptions has been both supported and challenged, confirming the difficulty in making accurate clinical judgements concerning dangerousness and mental disorder.

Despite this problem several laws concerning mentally disturbed offenders depend upon expert psychiatric testimony as to the likely recurrence of serious crime or dangerous behaviour. The difficulty in such predictions is especially increased in those patients who have never actually performed an assaultive act (Rubin 1977).

A prediction of dangerousness may substantially deprive a

person of his liberty and result in a lengthy involuntary confinement in a mental hospital as a State President's Detainee. Release will then depend on a determination that he is no longer dangerous.

Psychiatrists are therefore faced with an ethical dilemma where predicting future dangerousness becomes a decision of social policy. This brings about a change in the function of psychiatrists from that of treatment to social control, where the patients interests may be sacrificed to the general good of the community (Kruger 1980 : 230; Brooks 1984 : 295-300; Crawford and Conacher 1988).

Szasz (1955) rejects the concept of dangerousness and believes that the tendency to label people as mentally disordered and therefore dangerous is an attempt to control those people who violate society's preference for a certain type of social and ethical code.

Although mental disorder per se does not help predict the predisposition to violent behaviour, there may well be definable sub-groups within the spectrum of mental disorder for whom there is a risk of future violence (Taylor and Gunn 1984).

Häfner and Böker (1973) in their 10 year study of mentally abnormal offenders in Germany, found particular clinical features within a narrow spectrum of the mentally ill which may be associated with an increased risk of violent behaviour.

Organised persecutory delusions especially in young males with paranoid schizophrenia, may increase the risk of violent behaviour. Morbid jealousy and high emotional arousal especially in the context of intimate emotional relationships is associated with high levels of aggression towards the partner.

Thus there appears to be an increased risk of aggression

amongst acutely disturbed and deluded paranoid schizophrenics, while chronic schizophrenics are unlikely to behave in this manner (Mullen 1984; Taylor and Gunn 1984).

Criminal acts committed by people suffering from mood disorders are uncommon. A small sub-group of offenders with severe melancholic depression especially when associated with psychotic features show a tendency to become involved in homicide accompanied by attempted suicide (Häfner and Böker 1973; Good 1978; Harrer and Koffler-Westergren 1986).

Rossi et al (1986) in their study of violence amongst psychiatric hospital admissions concluded that high risk patients consist of those having disorders involving recurrent loss of impulse control or a history of repeated involuntary hospital admissions.

Although there may be small sub-groups of offenders within the spectrum of mental disorders with a tendency towards acts of violence, mental disorder itself does not help predict predisposition towards violent acts. The vast majority of mentally ill patients manifest no criminal behaviour and it is usually isolated acts of violence which cause unwarranted publicity (Gunn 1977).

A review of the literature does not support the contention that mental illness per se increases the risk for violent or criminal behaviour. Public concern is a response to the high arrest rate and widely publicized violent crimes of a relatively small sub-group of psychiatric patients (Steadman et al 1978a; Steadman et al 1978b; Stokman 1984).

CHAPTER 3

PATIENTS AND METHODS

This descriptive and cross-sectional study was carried out on all forensic observation cases referred to the Midlands Hospital Observation Unit (Fort Napier Section) during the period 18 July 1990 to 18 December 1990. The final study sample consisted of those subjects in whom a final finding was made in terms of Section 78(2) of the Criminal Procedures Act. The author as registrar to four consultant psychiatrists, was personally involved in the assessment of these cases.

All relevant information was obtained from interviews with the subjects and where possible their relatives. This information was used together with reports from social workers, psychiatrically trained nursing staff, court records and from the final reports submitted by the psychiatrists to the court.

Permission to conduct the study was obtained from the Senior Medical Superintendent at Midlands Hospital Complex. All observation cases were requested to consent to the inclusion of their data in the study and signed a written consent form (see Appendix). Where subjects were unable to give consent, permission to include their data in the study was obtained from the Senior Medical Superintendent.

The following variables were recorded:

3.1 DEMOGRAPHIC CHARACTERISTICS

3.1.1 Age

3.1.2 Sex

3.2 VIOLENCE IN THE MENTALLY ILL

In order to determine how violent mentally ill offenders are the following variables were studied:

3.2.1 Charge against Accused

Where there were multiple charges against the accused, the most serious charge was entered and described.

3.2.2 Crime against Person/Property

The following crimes were included in the classification Crime against Person:

- .1 Murder
- .2 Attempted murder
- .3 Culpable homicide
- .4 Rape
- .5 Assault with intent to do grievous bodily harm
- .6 Indecent assault
- .7 Common assault
- .8 Crimen injuria
- .9 Perjury

The following were regarded as Property Offences:

- .1 Theft/attempted theft/possession of goods believed to be stolen/house breaking
- .2 Malicious injury to property
- .3 Arson
- .4 Unlawful possession of firearms/ammunition/dangerous weapons
- .5 Armed robbery
- .6 Unlawful possession of drugs

3.2.3 Dangerousness

For the purposes of this study, dangerous crimes included all crimes fulfilling the concept of dangerous as defined by the Buttler Committee, viz. "a propensity to cause serious physical injury or lasting psychological harm". In keeping with the guidelines of Walker (1980) as cited by Prins (1990 : 502), all crimes which involved serious physical or psychological harm, or alternatively where the offender intended harm, or must have appreciated that harm was highly likely to occur, were classified as dangerous.

In accordance with these guidelines the following crimes against person were regarded as dangerous:

- .1 Murder
- .2 Attempted murder
- .3 Culpable homicide
- .4 Rape
- .5 Assault with intent to do grievous bodily harm
- .6 Common assault
- .7 Indecent assault

The following crimes against person were not regarded as dangerous:

- .1 Crimen injuria
- .2 Perjury

The following crimes against property were regarded as dangerous:

- .1 Arson
- .2 Armed robbery
- .3 Unlawful possession of firearms/ammunition/dangerous weapons
- .4 Malicious injury to property (only where extensive damage to property or dangerous behaviour occurred)

The following property offences were not regarded as dangerous:

- .1 Theft/attempted theft/possession of goods believed to be stolen/housebreaking
- .2 Malicious injury to property involving minor damage. eg. broken window pane
- .3 Unlawful possession of drugs

3.2.4 Use of Weapons

Where no actual weapon was used, but injury was inflicted by punching, hitting or strangulation, the fist was regarded as a weapon. The following weapons were categorised:

- .1 Stick or other rod shaped object
- .2 Fist
- .3 Knife or other sharp object
- .4 Gun
- .5 Stone or other round object
- .6 Other

3.2.5 Past Criminal Record

3.3 GENERAL CRIMINAL CHARACTERISTICS

In order to gain insight into the general characteristics of mentally ill offenders the following variables were studied:

3.3.1 Motive

Crimes were classified according to the following motives/causes:

- .1 Quarrel
- .2 Self defence
- .3 Revenge
- .4 Monetary gain

- .5 In response to an hallucination or delusion
- .6 Apparently motiveless
- .7 Unknown/unclassifiable

3.3.2 Premeditation

Premeditated crimes involved those with evidence of a plan. Unplanned crimes generally involved crimes of opportunity.

3.3.3 Timing

Crimes committed between 06h00 and 18h00 were regarded as daytime crimes. Those committed between 18h00 and 06h00 as evening crimes.

3.3.4 Attempt to Conceal Crime

Hiding goods, burning/burying the victim, etc were regarded as attempts to conceal. Where the offender fell asleep at the scene of the crime, or committed the offence in full view of witnesses or in a public place, it was regarded that no such attempt was made. This was an attempt to determine whether crimes committed by mentally ill offenders are more visible.

3.3.5 Alcohol Intoxication

This information was obtained from court records and from the subjects themselves. A history of intoxication was required for inclusion in this category, not merely being mildly under the influence of intoxicating substances.

3.3.6 Confession

This was recorded according to whether the subject admitted/denied the alleged offence.

CHAPTER 4

RESULTS

Of 115 subjects entered into the study, a finding in terms of Section 78(2) of the Criminal Procedures Act was made in 105 cases who thus constituted the final study sample. Of these subjects 41 (39.05%) were mentally ill, while 64 (60.95%) were not mentally ill in terms of the Act. Further comparisons of demographic characteristics, violence and general criminal characteristics, were made between these two groups.

To compare categorical data the chi square test was used. Where expected cell sizes were less than 5 in the 2x2 case Fishers exact test was used. The significance level was 0,05. In this chapter the terms mentally ill and not mentally ill refer to the legal findings in terms of Section 78(2) of the Criminal Procedures Act and not mental illness in terms of DSM-III-R (American Psychiatric Association 1987).

4.1 DEMOGRAPHIC CHARACTERISTICS

4.1.1 Age

Age was sub-divided into the following categories: 10-19 years, 20-29 years, 30-39 years, 40-49 years, 50-59 years and over 60 years. As shown in Figure 2 both mentally ill offenders and those found not mentally ill cluster around the age range 20-29 years.

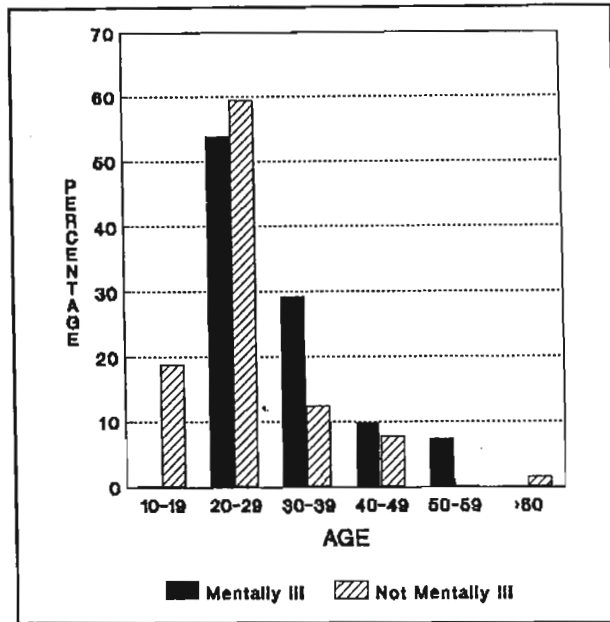


Figure 1: Histogram illustrating Age Distribution of Subjects

For the purpose of statistical comparison all subjects over 40 were combined. Chi square analysis of Table II revealed a significance level of 0,005. The bulk of significance was due to the larger percentage of mentally ill subjects in the age group 30-39 years and over 40 years (see Table I).

TABLE I
Frequency Distribution of Subjects according to Age

Mental Illness	Age				x ²	p
	10-19	20-29	30-39	>40		
Mentally Ill	0 0%	22 53.66%	12 29.27%	7 17.07%	12.716	0.005
Not Mentally Ill	12 18.75%	38 59.38%	8 12.5%	6 9.38%		
Total	12 11.43%	60 57.14%	20 19.05%	13 12.38%		

4.1.2 Sex

During the six month observation period only 1 female subject was referred for forensic assessment, thus no valid statistical analysis was possible (see Figure 2 and Table II).

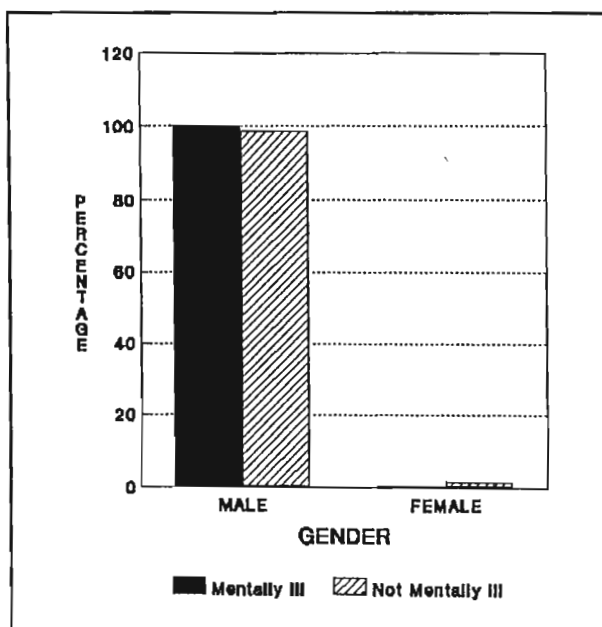


Figure 2: Histogram illustrating Sex Distribution of Subjects

TABLE II

Frequency Distribution of Subjects according to Sex

Mental Illness	Male	Female
Mentally Ill	41 100%	0 0%
Not Mentally Ill	63 98.44%	1 1.56%
Total	104 99.05%	1 0.95%

4.2 VIOLENCE IN THE MENTALLY ILL

In order to establish whether mentally ill offenders are prone to violent acts the following variables were studied:

4.2.1 Charge Against Accused

Figure 3 illustrates the different offences for which the subjects were charged. The majority of mentally ill offenders were convicted of theft, while in those found not mentally ill theft, assault with intent to do grievous bodily harm and murder were the most common.

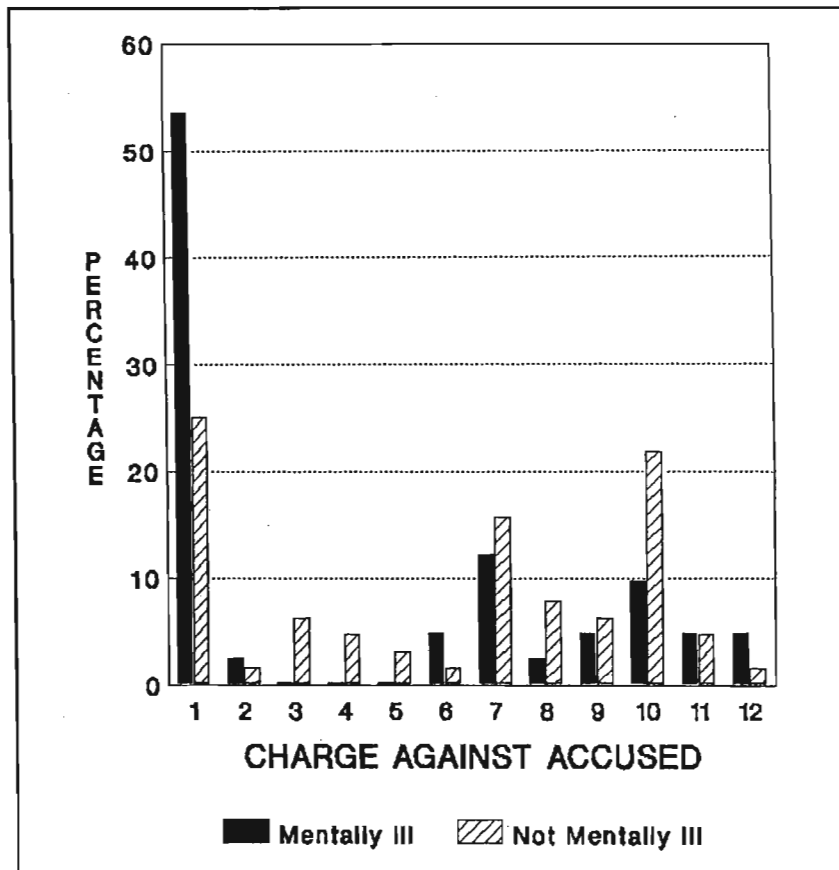


Figure 3: Histogram illustrating Distribution of Charges amongst Subjects

Key (see Figure 3):

- 1 - Theft
- 2 - Illegal Possession of Drugs
- 3 - Illegal Possession of Firearms
- 4 - Culpable Homicide

- 5 - Perjury
- 6 - Common Assault
- 7 - Assault with Intent to do
Grievous Bodily Harm
- 8 - Indecent Assault
- 9 - Rape
- 10 - Murder
- 11 - Malicious Injury to Property
- 12 - Arson

Chi square analysis of Table III distribution revealed a significance level of 0,013 for the combined categories shown below. The bulk of significance is due to the higher percentage of mentally ill offenders committing theft compared to the higher percentage of violent crimes committed by those found not mentally ill.

TABLE III
Frequency Distribution of Subjects according to
Charge Against Accused (see key above)

Mental Illness	Category 1 and 2	Category 3,11 and 12	Category 4,6,7,8,9, and 10	x^2	p
Mentally Ill	23 56.10%	4 9.76%	14 34.15%	8.685	0.013
Not Mentally Ill	17 27.42%	8 12.90%	37 59.68%		
Total	40 38.83%	12 11.65%	51 49.51%		

4.2.2 Crime Against Person/Property

Figure 4 and Table IV illustrate the distribution of offences according to the classification Person/Property.

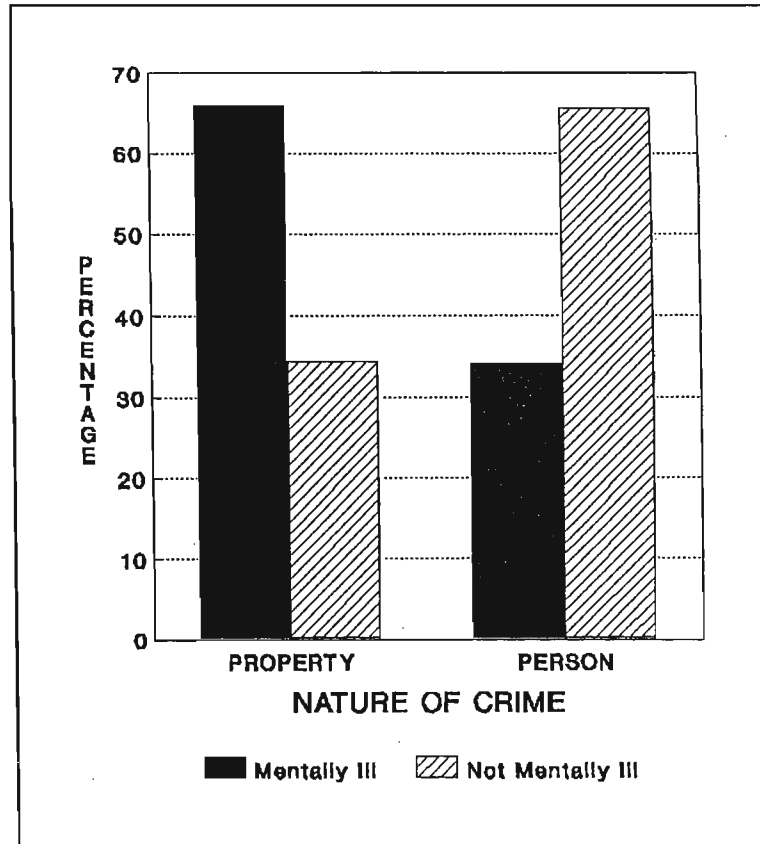


Figure 4: Histogram illustrating the Nature of Crime

Chi square analysis of Table IV distribution revealed a significance level of 0,002. Thus significantly more mentally ill offenders committed property offences while the majority of those found not mentally ill committed crimes against persons.

TABLE IV
Frequency Distribution of Subjects according to Nature of
Crime

Mental Illness	Crime Against Property	Crime Against Person	x^2	p
Mentally Ill	27 65.85%	14 34.15%	9.950	0.002
Not Mentally Ill	22 34.38%	42 65.62%		
Total	49 46.67%	56 53.33%		

4.2.3 Dangerousness

Crimes were further studied and categorised according to whether they were dangerous as discussed in Chapter II. In the mentally ill group 43.90% of crimes were regarded as dangerous compared to 68.75% of those committed by offenders who were not mentally ill (see Figure 5).

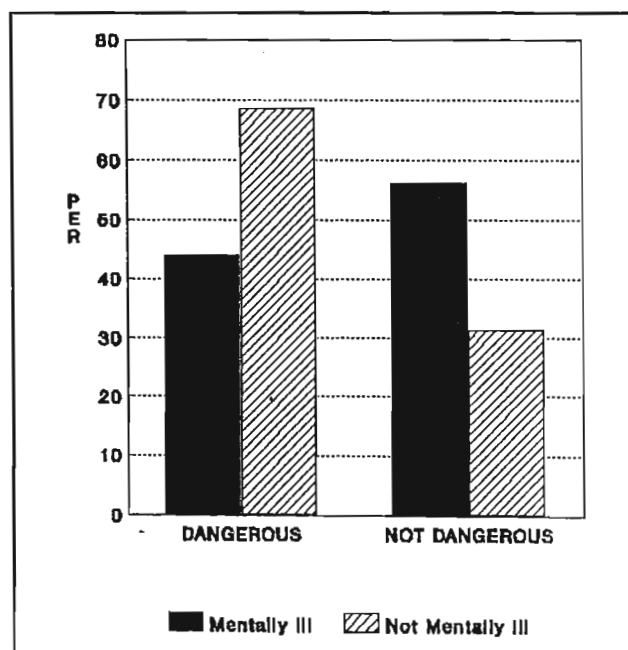


Figure 5: Histogram illustrating Dangerous Crimes

Chi square analysis of Table V distribution revealed a significance level of 0,012. Thus in this study the mentally ill group were significantly less prone to committing dangerous crimes.

TABLE V

Frequency Distribution of Subjects according to Dangerousness

Mental Illness	Dangerous	Not Dangerous	χ^2	p
Mentally Ill	18 43.90%	23 56.10%	6.381	0.012
Not Mentally Ill	44 68.75%	20 31.25%		
Total	62 59.05%	43 40.95%		

4.2.4 Use of Weapons

Figure 6 illustrates the different weapons used by the subjects during the alleged offence. It is interesting to note that none of the mentally ill offenders used guns compared to 10.94% of those who were not mentally ill.

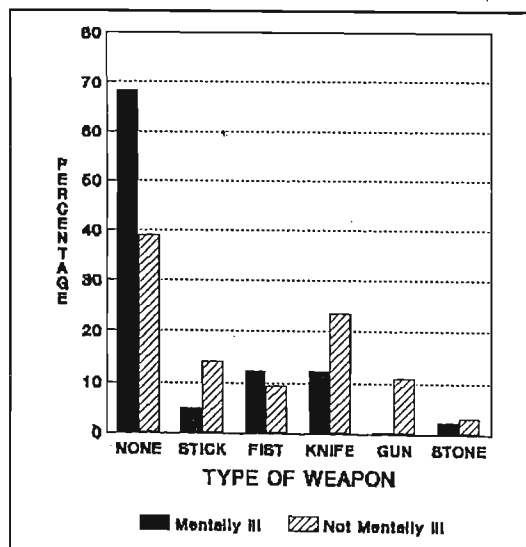


Figure 6: Histogram illustrating Types of Weapons

Table VI compares the use of weapons in the two categories. In the mentally ill group 31.71% used some form of weapon compared to 60.94% of those found not mentally ill. Chi square analysis of Table VI distribution revealed a significance level of 0,003 thus significantly less of the mentally ill offenders used a weapon during the alleged offence.

TABLE VI
Frequency Distribution of Subjects according to usage of
Weapons

Mental Illness	Weapons	No Weapons	x^2	p
Mentally Ill	13 31.71%	28 68.29%	8.542	0.003
Not Mentally Ill	39 60.94%	25 39.06%		
Total	52 50.48%	53 49.52%		

4.2.5 Past Criminal Record

The criminal records were unavailable in 11 of the 105 subjects. Of the remaining 94 subjects, 46.15% of the mentally ill had past convictions compared to 49.09% of those found not mentally ill. Although fewer mentally ill offenders had a past criminal record this was not statistically significant (see Figure 7 and Table VII).

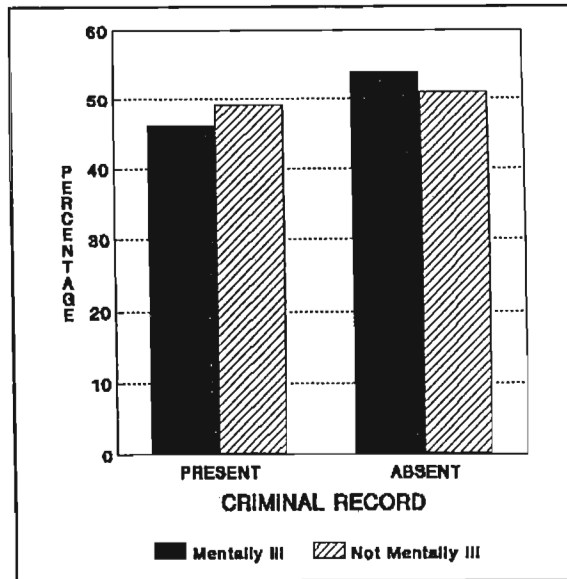


Figure 7: Histogram illustrating Past Criminal Records

TABLE VII
Frequency Distribution of Subjects according to
Past Criminal Record

Mental Illness	Criminal Record	No Criminal Record	χ^2	p
Mentally Ill	18 46.15%	21 53.85%	0.079	0.779
Not Mentally Ill	27 49.09%	28 50.91%		
Total	45 47.87%	49 52.13%		

4.3 GENERAL CRIMINAL CHARACTERISTICS

4.3.1 Motive

In the mentally ill group 41.46% committed the crime in direct response to an hallucination or delusion. In 9.76% the crime was apparently motiveless while in 19.51% no cause could be found.

In those found not mentally ill the commonest motives were monetary gain (34.38%) and provocation (28.12%) while in 23.44% the cause was unknown as shown in Figure 8.

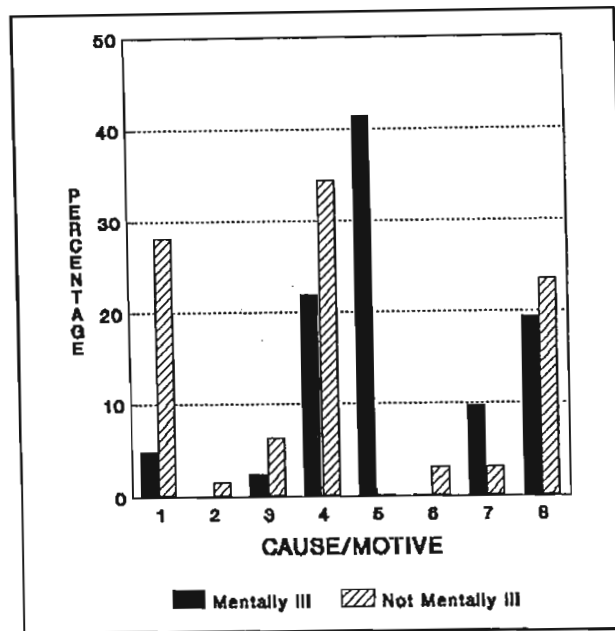


Figure 8: Histogram illustrating the Different Motives in Crimes Committed by the Subjects

- Key: 1 - Quarrel/Provocation
 2 - Self Defence
 3 - Revenge
 4 - Monetary Gain
 5 - Hallucination/Delusion
 6 - Cultural Beliefs
 7 - No Apparent Motive
 8 - Unknown/Unclassified

When all crimes with a motive (categories 1, 2, 3, 4 and 6) were compared to those with no apparent motive/hallucination/delusion (categories 5 and 7) significant results were obtained. Chi square analysis of Table VIII distribution revealed a significance level of 0,000. Thus significantly more mentally ill offenders committed crimes for which no apparent motive could be found.

TABLE VIII
Frequency Distribution of Subjects according to Motive

Mental Illness	Motive Categories 1,2,3,4 & 6	Motiveless Categories 5 & 7	Unknown Category 8	χ^2	p
Mentally Ill	12 29.27%	21 51.22%	8 19.51%	35.242	0.000
Not Mentally Ill	47 73.44%	2 3.12%	15 23.44%		
Total	59 56.19%	23 21.90%	23 21.90%		

4.3.2 Premeditation

As seen in Figure 9 only 21.95% of mentally ill offenders committed crimes which were premeditated compared with 51.56% of those who were not mentally ill.

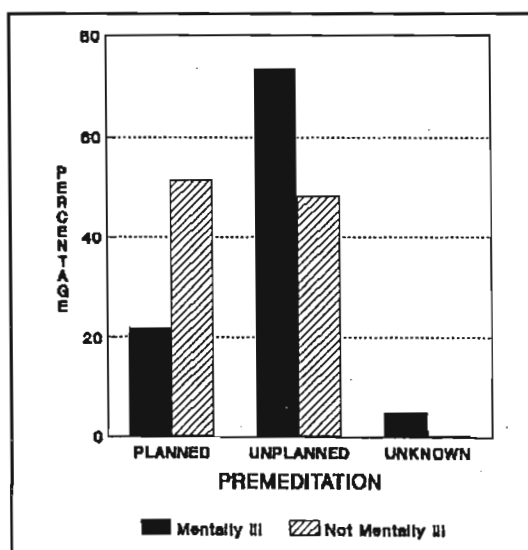


Figure 9: Histogram illustrating Premeditation

Chi square analysis of Table IX revealed a significance level of 0,004.

TABLE IX

Frequency Distribution of Subjects according to Premeditation

Mental Illness	Planned	Unplanned	Unknown	x^2	p
Mentally Ill	9 21.95%	30 73.17%	2 4.88%	11.231	0.004
Not Mentally Ill	33 51.56%	31 48.44%	0 0.00%		
Total	42 40.00%	61 58.10%	2 1.90%		

4.3.3 Timing

The majority of mentally ill offenders (73.17%) committed the alleged offence during the day compared to 53.13% of those found not mentally ill as shown in Figure 10.

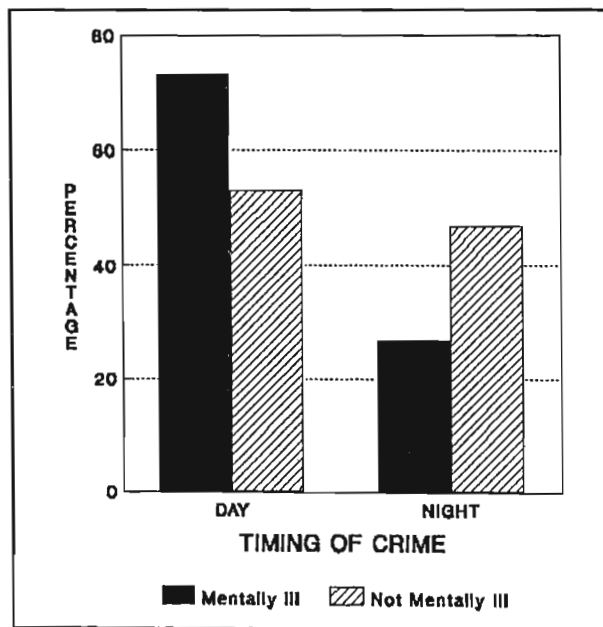


Figure 10: Histogram illustrating Timing of Crime

TABLE X
Frequency Distribution of Subjects according to Timing

Mental Illness	Day	Night	χ^2	p
Mentally Ill	30 73.17%	11 26.83%	4.219	0.040
Not Mentally Ill	34 53.13%	30 46.88%		
Total	64 60.95%	41 30.95%		

4.3.4 Attempt to Conceal Crime

As shown in Figure 11 the majority of mentally ill offenders made no attempt to conceal their crime (75.61%). This contrasted with those found not mentally ill, the majority of whom did attempt to do so (65.62%).

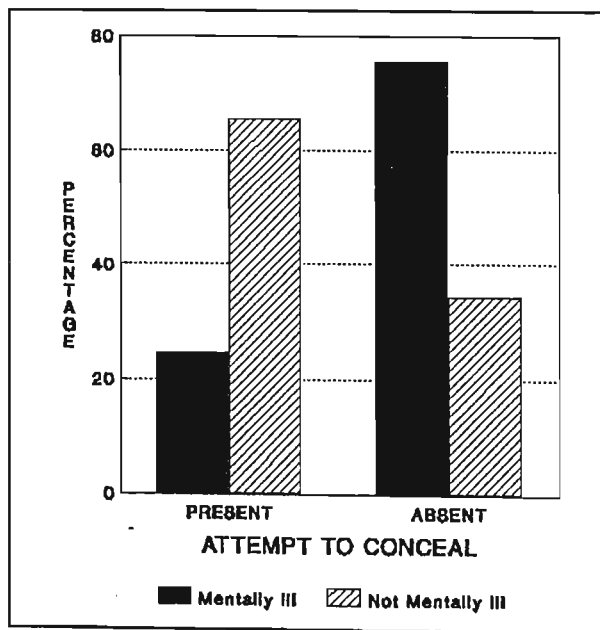


Figure 11: Histogram illustrating Attempt to Conceal Crime

Chi square analysis of Table XI revealed a significance level of 0,000. Thus significantly more mentally ill offenders committed visible offences.

TABLE XI
Frequency Distribution of Subjects according to
Attempt to Conceal Crime

Mental Illness	Concealed	Not Concealed	χ^2	p
Mentally Ill	10 24.39%	31 75.61%	16.998	0.000
Not Mentally Ill	42 65.62%	22 34.38%		
Total	52 49.52%	53 50.48%		

4.3.5 Intoxication

In the mentally ill group 21.62% were intoxicated at the time of the alleged offence compared with 78.38% of those found not mentally ill as shown in Figure 12.

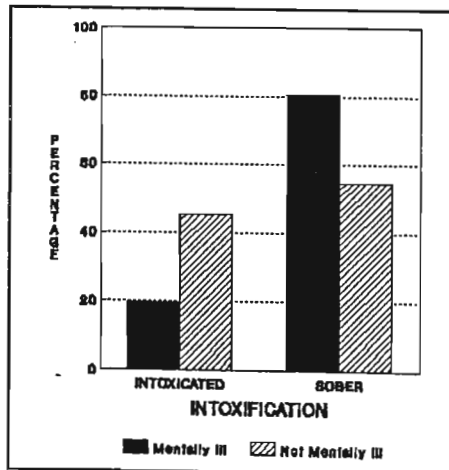


Figure 12: Histogram illustrating Intoxication

Chi square analysis of Table XII distribution revealed a significance level of 0,007. Thus significantly less mentally ill offenders were intoxicated at the time of the crime.

TABLE XII
Frequency Distribution of Subjects according to
Alcohol Intoxication

Mental Illness	Intoxicated	Sober	x^2	p
Mentally Ill	8 21.62%	33 48.53%	7.289	0.007
Not Mentally Ill	29 78.38%	35 51.47%		
Total	64 60.95%	41 39.05%		

4.3.6 Confession

63.41% of mentally ill offenders admitted the crime compared with 60.94% of those found not mentally ill. These results were not statistically significant (see Figure 13 and Table XIII).

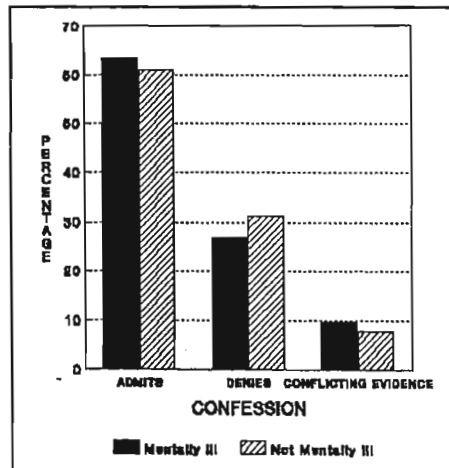


Figure 13: Histogram illustrating Confession of Crime

TABLE XIII

Frequency Distribution of Subjects according to Confession

Mental Illness	Admitted Crime	Denied Crime	Conflicting Evidence	χ^2	p
Mentally Ill	26 63.41%	11 26.83%	4 9.76%	0.300	0.861
Not Mentally Ill	39 60.94%	20 31.25%	5 7.81%		
Total	65 61.90%	31 29.52%	9 8.57%		

CHAPTER 5

DISCUSSION OF RESULTS

The results presented in Chapter 4 will be discussed in terms of the following three variables:

- .1 Demographic Characteristics
- .2 Violence in the Mentally Ill
- .3 General Criminal Characteristics

5.1 DEMOGRAPHIC CHARACTERISTICS

The following variables were studied and scores obtained for the two groups of offenders were statistically analysed.

5.1.1 Age

In this study the majority of subjects were in the age range 20-39 years (76.19%) (see Table I, p 69). This is in keeping with other studies both in South Africa and abroad in which youth is a consistent finding both in criminal and forensic populations (Häfner and Böker 1973; Van Rensburg 1979 : 58; Nair 1985 : 29; Addington and Holley 1987).

5.1.2 Sex

In this study only one female offender was referred for forensic assessment during the six month study period. Thus 99.05% of the sample consisted of males (see Table II, p 70). This finding is consistent with other studies reporting on the low prevalence of females in offender populations (Häfner and Böker 1973; Van Rensburg 1979 : 41; Nair 1985 : 31; Addington and Holley 1987).

5.2 VIOLENCE IN THE MENTALLY ILL

In order to determine whether mentally ill offenders are more prone to committing physically violent or dangerous crimes, the following variables were studied: Charge against Accused, Nature of Charge, Dangerousness, Use of Weapons and Past Convictions.

5.2.1 Charge against Accused

An analysis of the different charges revealed that the majority of mentally ill offenders were apprehended for theft (see Table III, p 72). 56% of mentally ill offenders fell into the combined category theft/illegal possession of drugs, while in contrast the majority of offenders who were not mentally ill committed crimes involving physical violence against persons (59.68%).

In this study mentally ill offenders were significantly less prone to acts of physical violence against persons and appeared less dangerous to the public than offenders who were not mentally ill.

This is in keeping with numerous recent studies and literature reviews which have found the vast majority of mentally ill offenders to commit trivial or commonplace offences (Gunn 1977; Teplin 1984; Addington and Holley 1987; Weller 1988; Freeman and Roesch 1989).

5.2.2 Crime against Person/Property

In the present study the majority of mentally ill offenders (65.85%) committed property offences (see Table IV, p 74). This is similar to Van Rensburg's study (1974 : 54) of forensic observation cases in which 55.1% committed property offences. Addington and Holley (1987) studied 52 schizophrenics referred for forensic assessment and found property offences to be most frequent. In this sample 47% of the crimes were against property, 28% against persons, 5% traffic offences and 6%

victimless.

These findings contrast with Nair (1985 : 37) who found the majority of mentally ill offenders committed crimes against persons. However this score was less than that obtained in those who were not mentally ill. Thus the mentally ill offenders appeared less prone to acts of violence when compared with offenders who were not mentally ill.

In the present study the significantly higher proportion of property offences within the mentally ill group is in keeping with recent studies and literature reviews. Notably that mentally ill offenders usually commit commonplace offences of a non violent nature (Roth 1977; Teplin 1984; Addington and Holley 1987; Weller 1988; Freeman and Roesch 1989).

5.2.3 Dangerousness

In this study crimes were further categorised into dangerous/not dangerous according to the criteria discussed in chapter III.

The mentally ill offenders in this study committed crimes which were significantly less dangerous than offenders who were not mentally ill, as shown in Table V, p 75. 43.9% of the mentally ill offenders committed dangerous crimes which contrasted with 68.75% in offenders who were not mentally ill.

These findings lend further support to recent findings in the literature that the majority of mentally ill offenders are not dangerous. Gingell (in preparation) as cited by Freeman and Roesch showed that the mentally ill remanded in custody are likely to be awaiting trial for trivial or commonplace offences.

5.2.4 Use of Weapons

In this study only 37.71% of mentally ill offenders used a weapon which was significantly less than the finding of 60.94%

for offenders found not mentally ill. It is also of interest to note that no mentally ill offenders used guns in this study (see Figure 6, p 75). This further supports the contention in recent literature that due to their greater visibility mentally ill patients are prone to arrest for minor offences of a non violent nature (Teplin 1984; Addington and Holley 1987).

5.2.5 Past Criminal Record

In this study very similar past conviction rates were obtained for the two groups. 46.15% of the mentally ill offenders had a previous criminal record which did not differ significantly from the finding of 49.09% in those offenders who were not mentally ill (see Table VII, p 77).

This finding is very similar to a study conducted by Addington and Holley (1987) who found a previous conviction rate of 46% in a consecutive series of 52 schizophrenics referred for forensic assessment. In this study 35% had 1-5 previous convictions, 10% had 6-10 previous convictions and 1% more than 10 convictions. 54% had no previous convictions. Similarly Rollin (1969) as cited by Gunn (1877) found 40% of mentally ill offenders had a previous criminal record.

The similar conviction rates between the mentally ill offenders and those found not mentally ill is of importance. Steadman et al (1978b), comparing arrest rates of mentally ill patients and criminal offenders showed that the apparent increase in the arrest rate amongst mentally ill offenders was almost entirely related to their previous conviction rate. They concluded that prior criminality rather than mental illness per se explained the higher arrest rates amongst ex-psychiatric patients.

5.3 GENERAL CRIMINAL CHARACTERISTICS OF MENTALLY ILL OFFENDERS

5.3.1 Motive

In this study 41.46% of mentally ill offenders committed the offence in response to an hallucination or delusion while in a

further 9.76% no apparent motive was found (see Table VIII, p 79). This finding is similar to Virkkunen's (1974a) who in a study of schizophrenics sent for forensic assessment, found that approximately one third had committed the act in response to an hallucination or delusion.

5.3.2 Premeditation, Timing and Attempt to Conceal the Crime

Significantly more mentally ill offenders committed daytime offences which showed no evidence of premeditation or any attempt to conceal the crime (see Figures 9, 10, and 11, p 79-81).

These characteristics in the mentally ill group lend support to Teplin (1984) who in her study of 1382 police-citizen encounters showed that for similar offences mentally disordered offenders have a significantly greater chance of being arrested than those who are not mentally ill. Teplin (1984) suggests that symptoms of mental illness may increase their visibility in the community and provoke a harsher response in law enforcement personnel. Alternatively the criminal justice system may become a default option for mentally ill offenders when treatment within the mental health system is not readily available (Teplin 1984; Weller 1988; Freeman and Roesch 1989).

5.3.3 Intoxication

In this study 35.24% of all subjects were intoxicated at the time of the alleged offence. In no case was the diagnosis pathological intoxication made.

Significantly less of the mentally ill offenders were intoxicated during the crime. When compared with those who were not mentally ill (see Table XII, p 83).

This finding based both on court records and case histories, is more difficult to explain since both groups gave very similar histories of past substance abuse.

CHAPTER 6

CONCLUSION

This descriptive and cross-sectional study was conducted to gain insight into the characteristics of crimes committed by mentally ill offenders in terms of the following two variables:

- .1 Violence in the Mentally Ill
- .2 General Criminal Characteristics of Mentally Ill Offenders

In this study the following hypotheses were postulated:

- .1 Mentally ill offenders are less prone to committing acts of violence than those found not mentally ill in terms of the Criminal Procedures Act.
- .2 The general criminal characteristics of mentally ill offenders differ significantly from those found not mentally ill in terms of the Criminal Procedures Act.

The following significant conclusions emerged:

6.1 DEMOGRAPHIC CHARACTERISTICS

The majority of mentally ill offenders in this study were young males in the age range 20-29 years.

6.2 VIOLENCE IN THE MENTALLY ILL

- 6.2.1 Mentally ill offenders committed significantly more property offences than those who were not mentally ill.
- 6.2.2 Crimes committed by mentally ill offenders were less dangerous.

- 6.2.3 Fewer mentally ill offenders used a weapon during the alleged offence.
- 6.2.4 Mentally ill offenders had similar past conviction rates to those who were not mentally ill.
- 6.3 GENERAL CRIMINAL CHARACTERISTICS OF MENTALLY ILL OFFENDERS
- 6.3.1 Mentally ill offenders were more likely to commit crimes for which no apparent motive could be found or in response to an hallucination or delusion.
- 6.3.2 The majority of mentally ill offenders committed crimes which were unplanned.
- 6.3.3 The crimes committed by mentally ill offenders were significantly more visible. Most were committed during the day with no attempt made to conceal the offence.
- 6.3.4 Significantly less mentally ill offenders were intoxicated at the time of the alleged offence.

Both hypotheses were confirmed. These findings lend support to the contention that the majority of mentally ill offenders commit trivial offences. Due to their social ineptitude and greater visibility they are more likely to be detected and arrested.

6.4 RESEARCH POSSIBILITIES

The following research possibilities emanate from this study:

- .1 A comparative study of the arrest rates of psychiatric patients involved in a community treatment programme with those who have defaulted follow up. This would provide valuable insight into the impact of deinstitutionalisation on crime in the mentally ill.

- .2 A longitudinal and prospective study of the prevalence of major mental disorder in the prison population over an extended period of time. This would determine whether the mentally ill are being increasingly diverted into the criminal justice system.

6.5 CONCLUSION

In conclusion it appears that the traditional assumption pertaining to crime in the mentally ill still holds - the vast majority of mentally ill patients present no danger to the general public. Due to their greater visibility in the community they may be more easily detected and arrested. It is the rare acts of violence amongst a small sub-group of the mentally ill that attract undue publicity.

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APPENDIX
CONSENT FORM

I,hereby
declare that I give my permission for the investigation set out
below.

I am fully informed by DR. S.W. BOYES in respect of the nature
and confidentiality of the study mentioned below. I understand
and accept that the information collected will be used for
research purposes and for publication in scientific journals and
for teaching purposes.

The nature of the investigation is:

A study of the Characteristics of Crimes committed by forensic
observation cases.

The interview will be conducted by: DR. S W BOYES

My permission is granted of my own free will and I am aware that
I can revoke such permission at any time.

SIGNED:

.....

PATIENT

.....

DATE

WITNESSES:

1.

AUTHOR - who informed patient and conducted the interview

2.

INTERPRETER