FAMILY VIOLENCE AND MENTAL ILLNESS
IN
LIMPOPO PROVINCE

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Submitted in partial fulfilment of the requirements for the degree Masters of Medicine Psychiatry (MMed Psych), University of Limpopo
DEDICATION

I dedicate this work to my late husband, Mr Reuben Sentlhwa Mogashoa, and to our children
Mahlatse, Tshepo and Mthuthuzeli.
DECLARATION

I, Nomsa Barnolia Mogashoa, hereby declare that this work submitted as a thesis for the Masters of Medicine degree in Psychiatry at the University of Limpopo, MEDUNSA Campus, has not been previously submitted for a degree at this university or any other university, and that it is my work in design and execution. Also, that all reference materials have been duly acknowledged.

December 2013

Nomsa Barnolia Mogashoa
ACKNOWLEDGEMENTS

I would like to express my heartfelt gratitude and thanks to

Prof. S.T Rataemane – my supervisor

Prof. E. A Weiss – my co-supervisor and for granting me the opportunity in the registrar training programme

Prof. F.R.S Maluleke from the Department of Community Health University of Limpopo

Drs. P.J. Mokoena-Molepo and E.M Malerotho – consultants in the Department of Psychiatry Polokwane/Mankweng Hospital Complex.

Mr. S. Ntuli for the statistical analysis of the data

Thank you to my children, my brothers and sisters, colleagues and friends and to my mother for the support and help you gave me throughout my studies

Most importantly I thank the Almighty God, Father of my Lord and my Saviour Jesus Christ for making all things to work together for my good.
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Definition of terms

Family Violence: includes physical, sexual, emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant’s residence without consent, where the parties do not share the same residence, any other controlling or abusive behaviour where such conduct harms, or may cause imminent harm to the safety, health or well-being of the complainant.

Mental Illness: DSM-IV defines mental illness as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual.

Serious/Severe mental illness: a diagnosable mental, behavioural or emotional disorder of sufficient duration and impairment in functioning to meet criteria specified within DSM-IV with the exception of "V" codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness; serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>DSM IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders Fourth Edition</td>
</tr>
<tr>
<td>MHCA</td>
<td>Mental Health Care Act</td>
</tr>
<tr>
<td>MHCU</td>
<td>Mental Health Care User</td>
</tr>
<tr>
<td>EP/Psych</td>
<td>Psychotic Disorder Secondary to Epilepsy</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>ASPD</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>MR</td>
<td>Mental Retardation</td>
</tr>
<tr>
<td>NOS</td>
<td>Not otherwise Specified</td>
</tr>
<tr>
<td>D/O</td>
<td>Disorder</td>
</tr>
<tr>
<td>SIPD</td>
<td>Substance Induced Psychotic Disorder</td>
</tr>
<tr>
<td>SMI</td>
<td>Severe Mental illness</td>
</tr>
<tr>
<td>GBH</td>
<td>Assault with Intent to Do Grievous Bodily Harm</td>
</tr>
<tr>
<td>CPO</td>
<td>Contravention of Protection Order</td>
</tr>
<tr>
<td>MDP</td>
<td>Malicious Damage to Property</td>
</tr>
<tr>
<td>PFVA</td>
<td>Prevention of Family Violence Act</td>
</tr>
<tr>
<td>DVA</td>
<td>Domestic Violence Act</td>
</tr>
<tr>
<td>sb</td>
<td>somebody</td>
</tr>
<tr>
<td>Ass</td>
<td>assault</td>
</tr>
<tr>
<td>Comm</td>
<td>common</td>
</tr>
<tr>
<td>SREC</td>
<td>School Research Ethics Committee</td>
</tr>
<tr>
<td>MREC</td>
<td>Medunsa Research Ethics Committee</td>
</tr>
</tbody>
</table>
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ABSTRACT

Introduction: Violence by adults with severe mental illness against their family members is estimated to be between 10% and 40%. The process of deinstitutionalization was followed by a reduction in psychiatric beds in Limpopo Province. As a consequence, there are limited facilities in the province to accommodate relapsed MHCU who exhibit violent and destructive behaviours. With the advent of the Domestic Violence Act, family members now lay charges following violent behaviours by their mentally ill family members, who are then arrested and dealt with through the Criminal Justice System.

Objective: This study aims to determine factors associated with family violence by MHCU referred for forensic psychiatric observation in Limpopo Province in 2010.

Method: This is a quantitative retrospective study; all 384 files with the data of forensic observations done in Limpopo Province between January and December 2010 were extracted from the data base. Data were summarized using numbers and percentages, categorical and numerical variable measurements, and were represented in graphs and tables.

Results: The study found that of the 384 accused who were referred by courts in 2010 to Limpopo Forensic Psychiatric Services for psychiatric observation, 121 (31.5%) had committed offences involving family violence. Of the 121 offenders who committed family violence, 52% were found not accountable and not fit to stand trial and referred to a psychiatric facility for management and 48% were returned to court. A diagnosis of severe mental illness was made in 53 (13.8%) of the offenders, 36/53 had a diagnosis of Schizophrenia. Only 11 accused with SMI were referred back to stand trial. The majority of these offences were committed by young, single and unemployed males. Single and widowed mothers and grandmothers were the most likely targets.

The most common crimes committed against family members were Assault GBH and Malicious Damage to Property. In 10/19 murder cases referred in 2010 the victim was a close family member, 6 offenders were found not accountable. Out of 88 cases of sexual assault referred in 2010 family members were the victims in 10 cases, with 4 offenders found not accountable.
Substances were the dominating factor in 68.6% of all offenders charged with family violence related crimes.

In those offenders not accountable (63/121), the following factors were found to be associated with family violence: Females (mostly mothers and grandmothers) were the most likely targets, only 4/48 previously treated offenders were on treatment at the time of the offence, 60.3% abused substances. Those not abusing substances acted on hallucinations and delusions or committed the offences in a state of psychosis induced disorganized behaviour.

Preceding violent and destructive behaviour was established in 73.6% of the 121 offenders with no significant difference between those found accountable and those found not accountable.

**Conclusion:** There is a high rate of family violence committed by the mentally ill in Limpopo Province, comparable to studies in different countries. This study, which deals only with those offenders who have been charged, is probably an indication of a much bigger problem which needs to be explored. The study suggests that the elements that contribute to family violence in Limpopo are related to the lack of adequate and effective mental health care services, especially in the field of substance abuse treatment and rehabilitation in those with and those without mental illness, which is the overriding contributing factor to family violence.

Interventions suggested are the provision of adequate and effective mental health care with short term holding facilities and medium term beds, specific training in risk assessment, and crisis teams on the ground involving the community, police and mental health professionals.

In order to retain the social, financial and emotional basis that families provide to their mentally ill relatives, ongoing support for families rendered by social workers and community health service providers needs to be part of the Primary Health Care Services.

The next step will be a prospective study of family violence perpetrated by MHCU in Limpopo Province which can address the complexities not identified in the current retrospective study.
CHAPTER 1

1.1 Introduction and Background

Positive association between serious mental illness and rates of violence has been proven in several studies (Edward & Mulvey, 1994). However, there is still limited research on violence of adults with severe mental illness against family care givers, yet, these families experience violence at a rate estimated to be between 10% and 40% (Phyllis et al., 2005). The majority of individuals with severe mental illness live in the community following the process of de-institutionalization, favouring care and rehabilitation in the community rather than long-term institutionalized care (Copeland, 2005).

Limpopo is one of the nine provinces of South Africa. It is divided into five districts: Mopani, Waterberg, Capricorn, Vhembe and Greater Sekhukhune. It has a population of 5.4 million (Statistics South Africa, 2012). The Province is one of the poorest regions of South Africa, especially in the rural areas (en.wikipedia.org/Wiki/Limpopo). It is marred by high poverty rates, inequalities in the distribution of income between various population subgroups, unemployment and poor housing with overcrowding (Statistics South Africa, 2001).

In Limpopo Province there are very few beds available for medium to long term care of patients with severe mental illness (WHO, 2007). There are no specialized community-based rehabilitation facilities, no half-way houses, no assisted living facilities and no alternative accommodation in the villages for individuals who suffer from severe mental illness. South Africa, like many other countries, has lagged behind in implementing this portion of the deinstitutionalization process (en.wikipedia.org/wiki/Deinstitutionalisation)

Like in other parts of the world, this lack of facilities places an enormous burden on families, particularly mothers, who have to deal with the vicissitudes of the behavioural manifestations of these disorders, which may include violent and destructive behaviours (Phyllis et al., 2007). Family members who become the care giver of a mentally ill person become targets when their mentally ill relative becomes violent (Monahan et al., 2007).
Aggression and violence that does occur, is usually within families rather than with strangers (en.wikipedia.org/wiki/Deinstitutionalisation, Vevera, et al., 2005).

Distances to hospitals and clinics are often far in Limpopo Province. Mobile phones have become widely available in recent years allowing people to seek for help, but the response of the police force to assist families when their mentally ill relative becomes violent, has remained slow. This is happening in spite of the legislation in the Mental Health Care Act No 17, 2002. The legislation states that, if a member of the South African Police Service has reason to believe, from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental status is likely to inflict harm to himself or herself or others, the member must apprehend the person (Mental Health Care Act, No 17 2002).

Limpopo Province is an almost entirely rural province. The high levels of unemployment force employable males and females to move to other provinces, leaving behind mothers, grandmothers, aunts, sisters and children to live with the mentally ill family member. These people become responsible for enforcing compliance with medication and have to find a way of getting the mental health care user to the nearest medical facility if he or she has relapsed.

Sub-Saharan Africa is home to 80% of all the children in the developing world who have lost a parent to HIV and AIDS (UNICEF, 2002). The estimated number of child-headed households in South Africa represents 7% of orphans but doubles to 14% of AIDS orphans (Shimelis, 2007). Since most violence by mental health care users is perpetrated by males, this puts particularly children and the elderly at risk for physical injuries and emotional trauma.

With each incident families become more reluctant to accept their relative back after a hospital admission (Phyllis et al., 2007). The tensions caused by the potential for future violent situations may affect the physical and emotional health of the family members, forcing them to dismiss their relative to the criminal justice system or the streets (Hyde, 1997; Solomon et al., 1995). There is also lack of financial and medical resources at family and community levels, making it difficult and stressful to provide adequate care for their ill relative (Seloilwe, 2006).
Family violence needs to be raised as a primary concern in the mental health field, otherwise essential family support for individuals with severe mental illness may be lost (Phyllis et al., 2007). These include the extended family structures that are common in rural villages and allow for distribution of caregiver responsibilities (Seloilwe, 2006). The first piece of legislation to specifically address domestic violence in South Africa was the Prevention of Family Violence Act (PFVA) no 133 of October 1993 (Government Gazette, 1993). The new Domestic Violence Act (DVA) No 116 of 1998 is an improvement on its predecessor (Government Gazette, 1998).

One of the key innovations of the DVA is its broad definition of domestic violence, which includes a range of behaviours within its ambit. Acts constituting domestic violence include physical, sexual, emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant’s residence without consent, where the parties do not share the same residence. The Act also includes any other controlling or abusive behaviour where such conduct harms, or may cause imminent harm to the safety, health or well-being of the complainant (Government Gazette, 1998). Under the Domestic Violence Act, a victim of domestic violence may apply for a protection order to stop the abuse and to stop the abuser from entering the mutual home, the victim’s residence, or the victim’s place of employment. Legislators placed particular obligations in the Domestic Violence Act upon the police in an effort to challenge their long history of neglect of domestic violence.

With the advent of the Domestic Violence Act, relatives in Limpopo caring for patients with mental illness and repeated violent behaviour have taken recourse to get protection orders against their violent mentally ill family members, since it has become increasingly difficult to find help in the health sector. As the mentally ill patient violates this order, he/she is arrested and dealt with by the Criminal Justice System, leading to a scenario of seriously mentally ill individuals being incarcerated in jails and by default therefore promoting the criminalization of the mentally ill (Fuller, 1992).

In Limpopo Province the categories commonly associated with violence by mentally ill persons are assault, malicious damage to property, intimidation, assault by threat and sexual assault. A category of violation of a protection order has been added in the past years to the
offences for which mental health care users are referred for forensic psychiatric observation according to the annual statistics compiled by the Department of Psychiatry Limpopo Province (Forensic Statistics Limpopo, 2010). These referrals have increased over the past years, possibly as an indication that the current mental health care system is failing to adequately assist and protect families and communities from violent and destructive mentally ill persons, when they have relapsed.

The Department of Psychiatry in Limpopo Province has been running a well-documented forensic psychiatric service for the past 13 years with an average of 350 – 400 accused referred annually for forensic psychiatric observation according to annual statistics (Forensic Statistics Limpopo, 2010). Between 40 – 50% of the accused referred were found to be mentally ill annually and were admitted to psychiatric institutions via the Justice system. No evaluation has ever been done to find out how many of those cases are in fact family violence perpetrated by mental health care users.

1.2 Problem Statement

Many patients suffering from severe mental illness in Limpopo Province commit violent acts against family members, who react by laying charges against the mental health care users as they find no assistance from the police or Mental Health Services.

1.3 Aims of the Study

The main aim of this study was to determine the relationship between mental illness and family violence committed by mental health care users in Limpopo Province who were referred for forensic psychiatric observation during the year 2010.

1.4 Objectives of the Study

- To determine the proportion of accused individuals referred for forensic psychiatric observation for offences committed against family members.
- To determine the nature of offences committed against family members by an accused mental health care user.
To establish the relationship between the perpetrator and the victim(s).

To understand the involvement of substance abuse and other factors.

To find out what other interventions occurred before charges were laid.

1.5 Research question

What is the relationship between mental illness and family violence in Limpopo Province?
CHAPTER 2

LITERATURE REVIEW

Several recent large-scale research projects conclude that only a weak association (5.2%) between mental disorders and violence exists in the community (Swanson, 1990; Fazel, 2006; Stuart, 2003). Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number of all violence (5%), and it is especially apparent (10%) among those who use alcohol and other drugs (Monahan & Arnold, 1996), and 10-40% (of the 5.2%) has been shown to be violence against family members (Phyllis et al., 2005).

Research on the violence against family members by their psychiatric ill relative has been conducted primarily at the point of psychiatric hospital admissions, and has used chart reviews for the purpose of data collection (Phyllis et al., 2005). Binder and McNeil (1986) found that 15 % of patients admitted to the locked university-based short-term inpatient psychiatric unit had assaulted another person within two weeks of admission. More than half of these assaults were against family members, primarily parents and spouses, with a few being directed at children.

Greenberg et al. (2002) found that parents of adults with SMI (Severe Mental Illness) were found to be the most targeted group of caregivers, 39% of families were found to have been physically threatened since the ill relative had been diagnosed, and 83% of the threats were targeted at the primary caregiver. Additionally, 26% reported that their adult child had struck or injured someone in the household, and 80% of the victims were parents. In another study it was found that 40% of care givers had been threatened by violence at some point in their relative’s illness – 22% in the previous year. Forty percent had been hit or struck at some point – 24 % in the previous year; and 17 % had sustained physical injury – 4% in the previous year (Vaddadi et al., 2002).
In the MacArthur Violence Risk Assessment Study (Monahan et al., 2001), the most likely targets of violence were family members or friends (87%), and the violence typically occurred in the home. Discharged patients were less likely to target complete strangers (10.7%) compared to their community controls (22.2%). It appears that a conservative estimate of rates of violence towards family members by a relative with a psychiatric disorder is between 10 and 40% since diagnosis of the illness (Phyllis et al., 2005). Because a number of the prevalence estimates were based on short time frames, with few more than a year, and the likely tendency of families to under-report violent events, the annual rates are undoubtedly higher (Phyllis et al., 2005).

The significance of this problem is more apparent when placed in the current context of evidence. The evidence indicates that persons with SMI have a moderately elevated risk of violence compared to the general population when the family member is psychotic or is abusing substances; and consistently, 50% to 65% of these targets are family members (Steadman, 1998; Swanson & Lachicotte, 1998).

Other literature deals with the complexity of violence by mentally ill perpetrators towards the family since the majority of psychotic patients do not strike out at their family (Phyllis et al., 2005).

Violence is a complex phenomenon which needs to take social circumstances, life experiences of the individual and family relationships into consideration (Estroff et al., 1994; Mulvey, 1994; Hiday, 1995).

Three potential explanatory factors emerge:

(a) Psychiatric ill relative factors

(b) Family caregiver factors, and

(c) Quality of the interpersonal relationship between family caregivers and psychiatric ill relatives.

The following elements have been found to be related to violence in persons with SMI: Inherent individual characteristics, such as demographic and clinical characteristics; psychosocial factors not inherent to the individual, such as compliance with treatment and
social supports; as well as personal experience with and a history of violence (Estroff et al., 1994; Hiday, 1995). The two clinical factors most associated with violence among persons with psychiatric disorders have been active psychotic symptoms and substance abuse (Mulvey, 1994; Torrey, 1994; Hiday, 1995).

The combination of medication noncompliance and alcohol or substance abuse problems was significantly associated with serious violent acts in the community, after socio-demographic and clinical characteristics were controlled. Alcohol or other drug abuse problems combined with poor adherence to medication may signal a higher risk of violent behaviour among persons with severe mental illness. Reduction of such risk may require carefully targeted community interventions, including integrated mental health and substance abuse treatment (Marvin, 1998).

Whereas all of the above studies have been done in developed countries, no similar studies could be found for South Africa or the rest of the African continent.
CHAPTER 3

METHODOLOGY

3.1 Study Classification and Design

This is a quantitative retrospective study. Information was extracted from a database containing all the data of forensic observations done in Limpopo between January and December 2010.

3.2 Population and Sampling

A total of 384 offenders were referred for psychiatric observation in 2010. The documentation was reviewed and files of offenders charged with an offence relating to family violence were extracted to form the sample. The number of the sample is 121 (n=121).

3.3 Study Setting

The centre for this study was the Department of Psychiatry, Polokwane Mankweng Hospital Complex, where all forensic data for the whole province are archived.

3.4 Inclusion and Exclusion criteria

The following charges were included if perpetrated against family members or intimate partners:

- Assault with intent to do grievous bodily harm (GBH)
- Common assault
- Assault by threat/intimidation
- Malicious damage to property (MDP)/Arson
- Violation of protection order/domestic violence (CPO)
• Sexual assault (rape)
• Homicide or murder
• Housebreaking, theft and robbery

Offenders with a history of family violence but a charge not related to family violence were not included.

3.5 Data Collection

Data collection was done on an Excel spread sheet.

3.6 Data Analysis

Data were organized and summarized using numbers and percentages. Categorical and numerical variable measurements done were organized, analyzed and represented in tables or graphs.

3.7 Reliability and Validity

This is a quantitative retrospective study and therefore all the records that were used in the study remain available and any researcher can reproduce the study. The study uses a documented population sample with clearly defined parameters (charges from the courts), which cannot be manipulated, thus ensuring validity.

3.8 Bias

Selection bias was minimized because all available psychiatric observation records were used. Measurement bias was minimized by the fact that the same parameters were assessed on the records.
3.9 **Limitations**

All individuals in the sample had been charged with violent acts and therefore represent a preselected population as opposed to a general psychiatric population. Information bias occurred as the variables were not specifically collected for this study and certain information was not available or was open to interpretation. Since all of the documentation is available from reports and clinical notes the information can be reconciled.

3.10 **Ethical Considerations**

No names of people are mentioned in the study to ensure confidentiality. Ethical approval was obtained from the:

- SREC and MREC
- Chief Executive Officer of Polokwane-Mankweng Hospital Complex
- Polokwane-Mankweng Hospital Research and Ethics Committee
- Limpopo Research and Ethics Committee.
CHAPTER 4

PRESENTATION AND INTERPRETATION OF RESULTS

4.1 Analysis of offenders referred for psychiatric observation charged with violence against family in 2010

A total of 384 accused were referred for forensic psychiatric observation during the period of the study. Of these, 31.5% (121/384) committed offences against family members.

Figure 1: Distribution of offenders referred for family violence per district

<table>
<thead>
<tr>
<th>District</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap</td>
<td>23</td>
</tr>
<tr>
<td>Sekh</td>
<td>24</td>
</tr>
<tr>
<td>Vhembe</td>
<td>24</td>
</tr>
<tr>
<td>Mopani</td>
<td>24</td>
</tr>
<tr>
<td>Waterberg</td>
<td>20</td>
</tr>
<tr>
<td>Bothlabelo</td>
<td>6</td>
</tr>
</tbody>
</table>

The graph shows an even distribution of offenders referred. Capricorn, Sekukhune, Vhembe and Mopani are more densely populated. Waterberg is a large but less densely populated district.

Cases from Bothlabelo were still seen in Limpopo after the integration into Mpumalanga pending the re-demarcation of the courts.
4.2 Demographic data of offenders

4.2.1 Gender

There were 119 male offenders and 2 female offenders.

4.2.2 Age distribution

Figure 2: Age distribution (N 121)

The majority of offenders were between 20 and 40 years old. The mean age was 35 years (range 15-70 years).

4.2.3 Education

More than 60% (76/121) had secondary education, 23% (28/121) had primary education. Seven percent (9/121) of the offenders had no formal education and only 6% (8/121) had tertiary education.
4.2.4 Marital Status

Figure 4: Marital Status (N 121)

In this study 63.6% (77/121) of the accused were single, 20.6% (25/121) were married or in a steady relationship. Five accused were adolescents.

4.2.5 Employment status

Figure 5: Employment Status (N 121)

Of the accused 47.9% were unemployed, 35.5% received a disability grant from the State. The unemployment rate in Limpopo was 26.9% in 2010 (www.info.gov.za, 2013).
4.3 Findings during Evaluation of Offenders

4.3.1 Results overview

Table 1: Results overview

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Observation referrals 2010</td>
<td>384</td>
<td></td>
</tr>
<tr>
<td>Offences against family identified</td>
<td>121</td>
<td>31.5 %</td>
</tr>
<tr>
<td>Previous history of psychiatric treatment</td>
<td>86/121</td>
<td>71.1 %</td>
</tr>
<tr>
<td>Never received psychiatric treatment</td>
<td>35/121</td>
<td>28.9 %</td>
</tr>
<tr>
<td>Not accountable, not fit to stand trial</td>
<td>63/121</td>
<td>52 %</td>
</tr>
<tr>
<td>Accountable, fit to stand trial</td>
<td>58/121</td>
<td>48 %</td>
</tr>
</tbody>
</table>

4.3.2 Nature of offences constituting family violence in 2010

Table 2: Nature of offences (N 121)

<table>
<thead>
<tr>
<th>Offence Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault GBH (plus common robbery, crimen injuria, arson, and MDP in 4 instances)</td>
<td>33</td>
</tr>
<tr>
<td>Malicious Damage (plus intimidation, GBH and common assault in 3 instances)</td>
<td>26</td>
</tr>
<tr>
<td>CPO (plus intimidation, malicious damage, common assault in 4 instances)</td>
<td>15</td>
</tr>
<tr>
<td>Common assault (plus crimen injuria and 2x MDP in 3 instances)</td>
<td>12</td>
</tr>
<tr>
<td>Murder</td>
<td>10</td>
</tr>
<tr>
<td>Rape, Rape x 2 (plus indecent assault in one case)</td>
<td>10</td>
</tr>
<tr>
<td>Assault by threat, intimidation (plus crimen injuria), crimen injuria (plus intimidation)</td>
<td>6</td>
</tr>
<tr>
<td>Arson</td>
<td>2</td>
</tr>
<tr>
<td>Robbery (plus MDP in both cases)</td>
<td>2</td>
</tr>
<tr>
<td>Attempted Rape (plus housebreaking in 1 case)</td>
<td>2</td>
</tr>
<tr>
<td>Pointing somebody as a witch (plus crimen injuria and assault, and MDP)</td>
<td>2</td>
</tr>
<tr>
<td>Theft (MDP and assault)</td>
<td>1</td>
</tr>
</tbody>
</table>

The Charges were documented as primary and additional charges as indicated on the referrals from Court.
4.3.3 Family Violence offences compared to all offences of a similar nature referred for forensic psychiatric observation during 2010

Figure 6: Family Violence Offences compared to total referrals for observation for the same range of offences in 2010 (N 340)

<table>
<thead>
<tr>
<th>Offence</th>
<th>Total Referrals N 340</th>
<th>Domestic Violence N 121</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft and others</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Pointing somebody as a witch</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Attempted Rape</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Robbery</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Arson</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Assault by threat, intimidation, crimen injuria</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Rape and others</td>
<td>10</td>
<td>88</td>
</tr>
<tr>
<td>Murder</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Common assault and others</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>CPO</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>MDP and others</td>
<td>26</td>
<td>47</td>
</tr>
<tr>
<td>GBH and others</td>
<td>33</td>
<td>78</td>
</tr>
</tbody>
</table>

Almost half (42.3%) of all Assault GBH cases were directed against family members. More than half (55.3%) of the Malicious Damage charges were related to family violence. Few Sexual Offences (11.4%) involved family members, but 52.7% of the murder victims were close family members.
4.3.4 Family Violence Offences and accountability

Assault GBH and Malicious damage outweighed any other offences, with more than half (61.5%) of the accused for MDP and for GBH (66.7%) found not accountable.

There were 15 accused on charges of contravening a protection order of which 14 were found accountable. Six accused were charged with domestic violence related offences (intimidation, threat), 4 were found not accountable and 6/10 (60%) of murder accused were mentally ill at the time of the offence.

Figure 7: Accountability in relation to family violence offences
4.3.5 Diagnoses of Offenders

Figure 8: Diagnoses of offenders (N 121)

Schizophrenia 36/121 (29.8%) was the most common diagnosis followed by SIPD plus Substance Abuse 28/121 (23.1%), and Substance Abuse 18/121 (14.9 %). Schizo-affective disorder was diagnosed in 8.3% of offenders.
The majority of offenders found *not* accountable suffered from schizophrenia 30/36 (85.3%), SIPD plus substance abuse 16/30 (53.3%) and Schizo-affective disorder 9/10 (90%). Substance abuse (100%) and a previous or current diagnosis of SIPD 14/30 (46.7%) were the most common diagnoses in those offenders found accountable for their actions. Considering the high prevalence of epilepsy and mental retardation in Limpopo Province, there were few amongst the referrals with family violence offences.
4.3.7 Substance use by offenders

Figure 10: Distribution of substances used by offenders

4.3.8 Substance abuse in relation to diagnosis and accountability

Table 3: Diagnosis, substance abuse and accountability

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Substance Abuse/Not accountable N 63</th>
<th>Substance Abuse/Accountable N 58</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>36</td>
<td>12/30</td>
<td>2/6</td>
</tr>
<tr>
<td>Schizo-affective disorder</td>
<td>10</td>
<td>9/9</td>
<td>1/1</td>
</tr>
<tr>
<td>SIPD (previous and current)</td>
<td>30</td>
<td>16/16</td>
<td>14/14</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>5</td>
<td>0/3</td>
<td>0/2</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>4</td>
<td>0/2</td>
<td>1/2</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>6</td>
<td>1/2</td>
<td>1/4</td>
</tr>
<tr>
<td>Mood disorder due to GMC</td>
<td>1</td>
<td>0/1</td>
<td>0</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>19</td>
<td>0</td>
<td>19/19</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>6</td>
<td>0</td>
<td>6/6</td>
</tr>
<tr>
<td>BMD</td>
<td>2</td>
<td>0</td>
<td>½</td>
</tr>
<tr>
<td>No mental illness</td>
<td>2</td>
<td>0</td>
<td>0/2</td>
</tr>
<tr>
<td><strong>Offenders abusing substances</strong></td>
<td><strong>38 (60.3%)</strong></td>
<td><strong>45 (77.6%)</strong></td>
<td></td>
</tr>
</tbody>
</table>
Substance abuse played a major role in both the accountable and not accountable groups. In 18/30 schizophrenic patients without substance abuse the violent acts were due to delusions and disorganized behaviour.

4.3.9 Treatment history of accused

Table 4: Treatment history of accused

<table>
<thead>
<tr>
<th></th>
<th>Previous History</th>
<th>Never treated</th>
<th>Defaulters</th>
<th>On treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable N 58</td>
<td>34</td>
<td>24</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>Not accountable N 63</td>
<td>52</td>
<td>11</td>
<td>48</td>
<td>4</td>
</tr>
</tbody>
</table>

In the group found accountable 24 were never treated before. This number comprises all of the substance abusers (19) with no psychiatric diagnosis. Three offenders had diagnoses of Personality Disorders and Mental Retardation, two were found not to be suffering from any form of mental illness or disorder.

In the not accountable group, 11 offenders never received treatment before, 5 of them were newly diagnosed as Schizophrenia, 3 as SIPD, 2 Psychosis NOS. One was mentally retarded with behavioural problems. Only 4 of the accused found not accountable with a psychiatric history were on treatment at the time of the alleged offences.

Of a total of 86 accused with a previous history of psychiatric treatment only 18 (23.3%) were on treatment at the time of the offence.

4.3.10 Relationship with the victims

There were 135 victims affected by the acts of the 121 offenders. 56.2 % were the victims of offenders found accountable, 55.4% were affected by those found mentally ill. 101 victims consisted of one or both parents and grand-parents, sisters and brothers. Children were the primary target in 2 instances of violence, with one offender found psychotic. Sexual offenders abused 8 children and 2 adults.
Figure 11: Offenders’ relationships with the victims

This figure indicates the vulnerability of parents and grandparents who are the primary caregivers in rural communities, as well as the sisters who would be giving care, especially to the elderly parents. Female family members are at highest risk for violence. Single, separated or widowed mothers were the largest group of victims. Extended family members frequently reside within the primary home.
4.3.11 Living arrangements between accused and victims

This graph shows that many of those found not accountable and a great number of those found accountable (45.5%) do live in their mothers’ or grandmother’s home (single, divorced, widowed) or their parents’ home (21.5%), which commonly includes a number of other family members, especially one or both grandparents and children of immediate and extended family members. More offenders found accountable live on their own or with their spouse. Fathers who leave home or re-marry usually do not accommodate adult children.
### 4.3.12 Preceding behaviour patterns and forensic history

Table 5: Analysis of preceding problematic behaviours

<table>
<thead>
<tr>
<th></th>
<th>Aggression or violence</th>
<th>Damage to property</th>
<th>Emotional and verbal abuse</th>
<th>Sexual threats</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable N 58</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric history co-</td>
<td>10 (17.2%)</td>
<td>5 (8.6%)</td>
<td>2 (3.4%)</td>
<td>1 (1.7%)</td>
<td>18 (31%)</td>
</tr>
<tr>
<td>morbid substance abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse, no</td>
<td>7 (12.1%)</td>
<td>1 (1.7%)</td>
<td>8 (13.8%)</td>
<td>0</td>
<td>16 (27.5%)</td>
</tr>
<tr>
<td>history</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history, no</td>
<td>3 (5.1%)</td>
<td>1 (1.7%)</td>
<td>0</td>
<td>0</td>
<td>4 (6.8%)</td>
</tr>
<tr>
<td>substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric history, no</td>
<td>2 (3.4%)</td>
<td>0</td>
<td>5 (8.6%)</td>
<td>0</td>
<td>7 (12.1%)</td>
</tr>
<tr>
<td>substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>22</td>
<td>7</td>
<td>15</td>
<td>1</td>
<td>45 (77.6%)</td>
</tr>
</tbody>
</table>

|                         |                        |                    |                             |               |           |
| **Not Accountable N 63**|                        |                    |                             |               |           |
| Psychiatric history co-| 18 (28.5%)             | 5 (7.9%)           | 3 (4.7%)                    | 0             | 26 (41.3%)|
| morbid substance abuse  |                        |                    |                             |               |           |
| Substance abuse, no     | 0                      | 2 (3.2%)           | 0                           | 1             | 3 (4.7%)  |
| history                 |                        |                    |                             |               |           |
| No history, no          | 2 (3.2%)               | 1 (1.6%)           | 2 (3.2%)                    | 0             | 5 (7.9%)  |
| substances             |                        |                    |                             |               |           |
| Psychiatric history, no| 6 (9.5%)               | 1 (1.6%)           | 2 (3.2%)                    | 1 (1.6%)      | 10 (15.9%)|
| substances             |                        |                    |                             |               |           |
|                         | 26                     | 9                  | 7                           | 1             | 44 (69.8%)|
Of 121 offenders charged with an offence against family, 89 (73.6%) had shown behaviour previously, recently or over time, for which they could have been charged. In the group found accountable, 22.4 % had **not** shown any of above mentioned behaviours previously vs. 30.2 % in the not accountable group. These figures indicate that a history of previous abusive behaviour points towards more abusive behaviour in the future, and this applied to both groups (accountable and not accountable) in this research. Co-morbid substance abuse and substance abuse without psychiatric illness are the major risk factors for family violence.

Previous convictions are not disclosed in forensic reports, and files of offenders admitted to various psychiatric units in the Province were not available. Therefore the analysis of previous convictions was limited to 3 previous convictions out of 63 accused found not accountable (data not available for 22 accused), and 11 previous convictions out of 58 accused found accountable (data not available in 8 cases).

Figure 13: Preceding violent and destructive behaviour
Figure 13 shows the overwhelming role substances play with behaviour over time in both groups before charges are laid. It also highlights the role of mental illness in aggression and destructive behaviours preceding being charged for an offence even without substances.

4.3.13 Complaints about lack of intervention

Table 6: Complaints about lack of intervention

<table>
<thead>
<tr>
<th>Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges are laid and are withdrawn.</td>
</tr>
<tr>
<td>Charges are laid and the offender is released on bail without psychiatric</td>
</tr>
<tr>
<td>attention.</td>
</tr>
<tr>
<td>Police refuse to open dockets because the offender is a MHCU.</td>
</tr>
<tr>
<td>Police was called and did not respond.</td>
</tr>
<tr>
<td>MHCU is taken to hospital, turned away or discharged after a few days if</td>
</tr>
<tr>
<td>admitted.</td>
</tr>
<tr>
<td>If a case comes to court it is thrown out, sentences are usually suspended.</td>
</tr>
<tr>
<td>There are very few cases that are referred for substance rehabilitation.</td>
</tr>
<tr>
<td>Mental Health Care Users are discharged from hospital even if they are</td>
</tr>
<tr>
<td>abusing the family, with no interaction with the family.</td>
</tr>
</tbody>
</table>

This information is indicating the deficiencies of all systems which are meant to protect MHCU, their families and communities.
CHAPTER 5

DISCUSSION

The purpose of this study was to analyse the relationship between family violence and mental illness in Limpopo Province, using data of forensic observations referred during the year 2010. A total of 384 offenders were referred to the Limpopo Forensic Psychiatric Services by the courts for psychiatric observation. Of the charges, 31.5 % (121) were identified as “domestic violence which includes physical, sexual, emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant’s residence without consent, where the parties do not share the same residence. The Act also includes any other controlling or abusive behaviour where such conduct harms, or may cause imminent harm to the safety, health or well-being of the complainant” (Government Gazette, 1998).

Figure 1 shows the referrals per district. It shows that the referrals were evenly distributed with fewer referrals from Waterberg and Bothlabelo, which are less densely populated districts.

Overall 52% (63/121) of offenders were found not accountable and not fit to stand trial. Charges against them would be withdrawn and they would be admitted as involuntary mental health care users in various units and psychiatric hospitals, 48% (58/121) were referred back to court, with no evidence that any psychiatric condition contributed to their behaviour at the time of the offence.

Table 2 indicates that Assault GBH, Malicious Damage to property and Common Assault were the most frequent offences. Almost half of all Assault GBH offences and more than half of Malicious Damage charges were directed against family during 2010 (Figure. 6). In a study of a non-forensic population by Mullen (2006), minor forms of assault in schizophrenia were found to be at 5–15% per year. It can be inferred that the findings in this study in respect of the minor offences are a reflection of the bigger picture as seen in the acute admissions in Limpopo Province with many patients having committed similar offences without being charged.
In a community where most people live in poor circumstances and far from protective resources, repetitive trauma through assault by MHCU causes families to flee their homes, leaving the offender alone in the house. The fear of being killed one day by their mentally ill relative is frequently expressed by the female care givers. To replace damaged windows, doors and other belongings with limited means is adding to the burden of the care givers.

Of 121 offenders charged with an offence against family 89 (73.6%) had shown behaviour previously, recently or over time, for which they could have been charged (Table 5). There is no significant difference between the accountable and the not accountable group. This has been expressed by Gondolf et al. (1990) in his findings that violence against family members were not isolated incidents, as patients who were involved in a recent family assault were likely to have engaged in other incidents of family violence. Lefley (1996) found that 33% of family members reported calling the police for assistance. Solomon et al (1995) found that 8.4% of family members reported taking out restraining orders against their relative because of violent and threatening behaviour.

In this study there were 21 (18.2%) families with protection orders against offenders, but only 15 were charged with Contravention of Protection Order; the others were charged with different offences. It is evident that families are becoming aware of the availability of such a mechanism and do use it to get assistance from the police if everything else has failed. Only one of the offenders charged with CPO was found to be mentally ill in relation to the alleged offence. Looking more closely at the protection orders taken out, it becomes obvious that families resort to this action after serious repetitive provocation, threat, damages and injuries sustained, which is consistent with maladaptive behaviour of perpetrators when under the influence of substances. In most cases families can recognize symptoms of relapse of mental illness and try to take appropriate action, rather than asking for a protection order. Only 3 of the offenders with a protection order were suffering from SMI, and they were charged with other offences.

The total of murder cases amounted to 19 during 2010, with 10 victims being family members and 6/10 accused found not accountable. Annual statistics in the Department of Psychiatry of offenders referred for murder over a period of 6 years showed that there has
been no increase in the incidents of murder by a mentally ill person in spite of an overall increase in referrals for observation.

There were few incidents of sexual assault against family members (10/88) in 2010, and perpetrators were found not accountable in 4 instances. In these cases the sexual assault was directed against mother, aunt, sister and a 3 year old daughter.

The other 6 sexual assaults were fathers or stepfathers’ assaults of their older children (10 -15 years old) and perpetrators were found accountable. In an unpublished analysis of sexual offenders referred for observation in Limpopo Province, covering 6 years (2003-2009), it was found that 29% of offenders were close family members (Leputu, 2011).

The majority of the accused seen were males. Only 3 family violence offenders (out of a total of 8/384 female observation cases referred) were females, and all 3 had psychotic symptoms at the time of the offence.

The mean age of all offenders was 35 years (Figure 2).

Seven percent (9/121) of the offenders had no formal education, 23% (28/121) had a primary education. More than 60% (76/121) had a secondary education and only 6% (8/121) had tertiary education.

In this population of offenders 62.8% (76/121) were single (Figure 4), 47.9% (58/121) were unemployed, and 42.6% (43/121) were disability grant recipients (Figure 5). In the not accountable (mentally ill) group, only 27/63 offenders received disability grant.

The above findings are comparable to findings by Jeremy et al. (2006) and Copeland et al. (2007) that the impact of the mental conditions ultimately depends on the base rate of violence in the general population, where being young, male, single and of low social class increases the risk of violence significantly irrespective of psychiatric morbidity (P<0.001). Heather Stuart (2003) found that more recent studies have reported a modest association between mental illness and violence, even when risk factors such as being young, male, single, or of lower socio-economic status have been controlled.
In this study the offenders were young males, single, unemployed or on a disability grant, with secondary education and little prospect of a bright future. In rural Limpopo, this would amount to living at home, doing odd jobs, socializing with people in similar position and abusing substances.

Substances commonly abused in Limpopo Province are cannabis, alcohol, alcohol and cannabis combined and glue. Substance use and abuse in this study were found to feature significantly as contributing factors to domestic violence, with 83/121 (68.6%) offenders abusing substances, 30/83 diagnosed previous or current SIPD and were currently abusing substances. 45/83 were referred back to court amongst them all 19 substance abusers with no psychiatric co-morbidity. 38/83 were not accountable, of the 38 not accountable 16 were diagnosed with previous and current SIPD. In the not accountable group 60.3% were abusing substances vs. 77.6% in the accountable group.

According to Fazel et al. (2009), the widespread public perception that psychiatric disorders alone make people more prone to commit violent acts, is flawed. In her words: “Substance abuse is really the key mediator of violent crime. If you take away the substance abuse, the contribution of the illness . . . is very minimal“(Kelland, Reuters, 2010). Reviewing all the available evidence suggests that the risk of violent crime among the general population who abuse drugs or alcohol when compared to that among those with bipolar disorder who abuse drugs or alcohol is raised by the same value, suggesting that the mental illness has little or no role (Fazel et al., 2009). The association between schizophrenia and violent crime is minimal unless the patient is also diagnosed as having substance abuse comorbidity (Fazel et al., 2010).

A critical review of the literature concerning crime and mental illness reported that alcohol use was often a confounding factor in this area of research (Cohen, 1980). Patricia et al. (2000) found that the presence of an alcohol or drug use disorder increased the already elevated risks for violent crime among men and women in all diagnostic categories, except women with organic psychosis and men and women with affective psychoses. These results are consistent with a large number of studies showing that among both persons with and without major mental disorders, substance abuse increases the risk of violent crime (Stuart, 2003). These findings have been confirmed in this study.
Non-compliance with medication is a ubiquitous problem with psychiatric patients. Substance abuse in the context of medication non-compliance is a particularly volatile combination and poor insight also may be a factor (Swartz, 1998).

There were 86/121 (71.1%) accused who had received previous psychiatric treatment (Table 4) and were meant to be on medication. Only 18 (23.3%) were on treatment at the time of the offence. Only 4/63 offenders found not accountable were on treatment at the time of the alleged offence (Table 4).

In the accountable group 24 had never been treated. These would include the accused abusing substances with no psychiatric co-morbidity and accused with Personality Disorders (Table 4). In the not accountable group 11 offenders never received treatment before, coming into the health system unattended or from a traditional or faith healing background. Six of them were newly diagnosed as Schizophrenia, 3 as SIPD, and 2 Psychosis NOS. One was mentally retarded with behavioural problems.

Vaddadi et al. (1997) conclude that individuals with schizophrenia have higher levels of abuse toward others than those depressed or those with nonpsychotic disorders.

Within the sample population of 384 forensic referrals in this study, 53 (13.8%) offenders suffering from SMI were identified as having committed crimes of domestic violence. The majority of offenders, 36/121 (29.8%) suffered from schizophrenia with 30 found not accountable. 18/30 were not abusing substances and their violent behaviour could directly be linked to the positive symptoms of delusions, hallucinations and disorganized behaviour during a psychotic state.

Only 11/53 accused with a diagnosis of SMI were found accountable. Co-morbid substance abuse was identified in 14/36 (38.9%) accused with schizophrenia. 10/121 (8.3%) had a diagnosis of schizo-affective disorder with co-morbid substance abuse in all cases, 9/10 were assessed as not accountable.
Fazel & Grann, (2006) conclude: "Overall, the population attributable risk fraction (the proportion of violent crimes that can be attributed to individuals with mental illness) was 5.2%, suggesting that patients with severe mental illness commit 1 in 20 violent crimes.

In the MacArthur Violence Risk Assessment Study (2001) the most likely targets of violence were family members or friends (87%). The majority of individuals with SMI live in the community. As a result, families have assumed the major responsibility for the care of their mentally ill relatives whether the relative resides in the same or separate domicile (Carpentier et al., 1994; Swartz, 1998)). It is estimated that 50% of persons with SMI live with their families (Beeler, 1999).

In this study it emerged that 45.5% of all offenders reside in their mothers’ house and 21.5 % with both parents (figure 12). This is in keeping with the culture of close extended family relationships seen especially in the rural areas of Limpopo Province. Adult children leave home to work or seek work, to attend school or to get married. In a case of adversity like unemployment, illness or mental illness the adult child commonly returns home.

There were 135 victims of 121 offenders, 101 victims consisted of one or both parents and grand-parents, sisters and brothers (Figure 11). Greenberg (2002) found that 80% of the victims most commonly targeted are the parents.

Phyllis et al. (2005) contends that violence perpetrated by persons with SMI against their family caregiver cannot be explained by simply attributing incidents to psychotic symptoms because the majority of individuals with these symptoms do not strike out at their family caregivers. Rather, violence is a complex phenomenon that is imbedded within the social circumstances and life experiences of the individual. One of the potential explanatory factors identified is family caregiver factors.

This study found that female family members are at highest risk for violence by those found not accountable. Single, separated or widowed mothers or grandmothers were the largest group of victims in this study (Figure 11). With the exception of sexual assaults involving 8 children, only 2 children were the primary target for violence, with one offender found to be psychotic.
CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

From the histories obtained, a number of system failures contributing to the high rate of family violence were identified (Table 6).

The failure to deal with the described scenarios lies firstly with the health system:

- Lack of facilities, lack of community mental health services;
- Lack of skills of health professionals not trained in mental health;
- Failure to do a proper risk assessment. Blatant violations were observed in some cases;
- Refusal to admit/assess a violently psychotic patient;
- Non-assistance by the police keeps violent patients in the community;
- Unavailability of medication/health care services during certain periods;
- Discharge of patients that are still psychotic;
- Failure to consult with or seek advice of mental health professionals, and
- Lack of facilities for substance rehabilitation in Limpopo.

The inconsistent assistance by police has presented as another system failure repeatedly in spite of the provision in the MHCA (Criminal Procedure Act, 1998). The following are examples:

- Refusal to assist with taking a MHCU to hospital;
- Refusing family members to lay charges, and discouraging protection orders;
- Police are not trained in dealing with MHCU;
- Unfortunate incidents deterring the police to render assistance, and
- Poor collaboration between Health, Police and EMS.

The justice system does not provide mechanisms to deal with domestic violence in MHCU:

- There are no diversion programmes;
- No rehabilitative facilities or programmes for those committing domestic violence;
• Very seldom are offenders referred for substance rehabilitation, and
• If the offences are minor the accused is released back into the same situation.

It is the process after an arrest which takes long, which gives the family some relief, when they cannot find a bed in a psychiatric facility. However, the mentally ill offender usually does not receive treatment in the cells and is subjected to abuse by other inmates. These factors highlight the hardships that these family members live under, and support the need for interventions, including legislative interventions.

We as mental health care professionals need to face up to the fact that reducing violence is part of the legitimate aims of our services (Mullen, 2006). Current literature supports early identification and treatment of substance abuse problems, and greater attention to the diagnosis and management of concurrent substance abuse disorders among the seriously mentally ill as potential violence prevention strategies (Marvin et al., 1998).

This is obviously done concurrently with managing the mental illness itself, including non-compliance, and the psychosocial conditions, as alluded to by Estroff et al. (1994); Hiday, (1995) and Mulvey, (1994) that violence is a complex phenomenon which needs to take social circumstances, life experiences of the individual and family relationships into consideration. This will include empowering family care givers on how to deal with their mentally ill relative.

Since this study deals with already identified offenders, it should be seen as revealing the tip of an iceberg as far as family violence by the mentally ill and substance abusers in this province are concerned. The rate is comparable with literature’s rates of 10-40%; but a likely tendency of families to underreport violent events has been reported; as a result the annual rates are undoubtedly higher (Phyllis et al., 2005). Observations from admission centres have confirmed consistently the amount of violence and destructiveness preceding a relapsed MHCU’s admission to hospital.

The study highlights the detrimental effect of mental illness and substances on the physical, emotional and material well-being of families in Limpopo Province, who already shoulder additional burdens in the face of the AIDS epidemic, unemployment and poverty. Substances equally affect actions in those suffering from a mental illness, those not suffering from a
mental illness, and those reacting with psychosis to the intake of substances. Abuse of substances by the mentally ill increases the risk of family violence.

Non-compliance with medication is a major contributory factor especially in those not abusing substances. These are the MHCU who act on hallucinations, delusions and show disorganized behaviour as part of their psychosis. Non-compliance with medication is a volatile factor in those that have suffered from SIPD and are still abusing substances. Currently the information about the burden on families of MHCU is largely anecdotal in this province, and a comprehensive prospective study in a non-forensic context would be needed to document evidence about family violence and mental illness in Limpopo Province.

Being male, unemployed, young, living with family (mostly the mother) in the absence of a male parental figure, having a secondary education, no access to facilities for skills training, and living in rural Limpopo where dagga and alcohol are freely available appear to be the main risk factors for family violence, with mental illness either being an aggravating factor in those abusing substances, or being aggravated by substance abuse. This is a social and ultimately political problem, which can only be addressed by providing skills training opportunities and employment.

Victims are commonly female care givers in the household. Assault GBH, Malicious Damage, Assault, Intimidation and threats are the common charges associated with family violence, with rape and murder on the lower scale of offending, but being the most traumatizing of the offences, with two mothers recently having committed suicide after being raped by their mentally ill sons.

The social stressors for both the victims and the perpetrators associated with living arrangements in Limpopo Province are mostly financial. Disability grants are therefore needed for the common good, but these are used to purchase substances, leading to further stress in mostly female-driven households. When the MHCU relapses, there are no male family members to deal with the situation, and community resources are limited.
It must be borne in mind that households usually include various extended family members with overcrowding being a major problem. The AIDS epidemic has left the care for children in the hands of the often elderly, even in the hands of older children, thus compounding the problem.

The Department of Health is failing the victims by not providing the facilities for admission, not addressing the trauma experienced by the victims and not training enough professionals in risk assessment, risk management and intervention with family violence. The justice system and the police are equally failing the victims by not intervening as is provided for in the legislation.

The MHCA No 17 of 2002 was meant to improve the rights of MHCUs. Many very troublesome mentally ill patients now end up for short admissions in district hospitals and are never seen by a psychiatrist. This forms the basis for the criminalization of the mentally ill in the province. The latest annual forensic statistics for Limpopo Province reports that 540 accused (160 more than in 2010) were observed during 2012. Many MHCUs found not fit to stand trial are awaiting admission to a psychiatric hospital in police cells. This state of affairs needs further analysis in accordance with the findings of this study.

The present research was a retrospective study and information provided mostly came from brief assessments of accused sent for observation as has been the practice in Limpopo Province since 1998 in the absence of adequate resources. Therefore this did not allow for a more detailed analysis of family dynamics and other factors necessary to cover all aspects relevant to family violence. However, despite these limitations and the small population sample, the findings of this study are a valuable pointer to an existing epidemic of abuse of families by their mentally ill and/or substance abusing relative, which ultimately will lead to more mental health problems due to the trauma inflicted upon mostly helpless care givers. The next step will need to be a prospective study which can address the complexities not identified in the current retrospective study.
RECOMMENDATIONS

A number of factors have stood out in this study that raise concern: high rates of substance abuse and treatment non-compliance, mothers being the largest group of victims, poor interventions by the police and the justice system and inadequate mental health care services.

1  The role of Social Workers in mental health care needs to be intensified and training in this field needs to be provided. Psychiatric social workers will be better equipped to deal with the issues of the mentally ill and their families.

2  The disability grant situation in Limpopo Province deserves special attention with the propensity for being a source of conflict and misuse.

3  Consideration should be given to re-introducing community mental health care which was abolished with the introduction of integrated Primary Health Care. These teams previously were available to do home visits, follow-up high risk patients and deal with family issues.

4  The impact of family violence by a mentally ill person on the care givers needs to be studied and submitted at the highest government level to review the establishment of medium stay facilities as well as creating facilities for substance rehabilitation.

5  The collaboration between Mental Health Services and the Police needs to be improved at all levels. Training/in-servicing of the various categories of role players could be achieved at a low cost and could be of immediate benefit to communities.

6  In the meantime, Mental Health Care Providers must provide early identification and treatment of substance abuse problems, and diagnosis and management of concurrent substance abuse disorders among seriously mentally ill, as a violence prevention strategy.
Providers must educate families on their rights, on Policies, Regulations, Mental Health Care Services and police services that are presently in place for them to access when need arises.

There needs to be a major review of the impact of the MHCA No 17 2002 on the families and the communities. This Act did not take into consideration that Limpopo Province and other rural areas in South Africa have inadequate resources and different priorities; consequently, communities forced to reject and stigmatize the mentally ill who end up inevitably being inadequately treated or contained.

Lastly, studies of this nature need to be made available to advocacy groups and government agencies so that a plan can be formulated with the intention of finding a workable and efficient approach that would protect both the MHCU and their families.
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