

**FACTORS CONTRIBUTING TO THE CRIMINAL  
BEHAVIOUR OF PERSONS WITH MENTAL DISORDERS.**

**BY**

**ALLEN TEBOGO MBAKILE**

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**MSD (SOCIAL HEALTH CARE)**

**In the Faculty of Humanities, Department of Social Work and Criminology,  
University of Pretoria, South Africa**

**Supervisor: Dr J. Sekudu**

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FACULTY OF HUMANITIES  
RESEARCH PROPOSAL & ETHICS COMMITTEE

## DECLARATION

Full name : Allen Tebogo Mbakile

Student Number : 27229590

Degree/Qualification: MSW (HEALTH CARE)

Title of thesis/dissertation: **Factors contributing to the criminal behaviour of persons with mental disorders.**

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I understand what plagiarism is and am aware of university policy in this regard.

A.T. Mbakile

25/06/09

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## SUMMARY

**Department: Social Work and Criminology**

**Candidate: Allen Tebogo Mbakile**

**Supervisor: Dr J. Sekudu**

**Degree: MSW (Health Care)**

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The study emanates from the need to explore and gain insight into the factors that led to the criminal behaviour of persons with mental disorders who are admitted to Lobatse Mental Hospital following a criminal offence. Objectives of the study were to provide a broad theoretical background on criminality amongst persons with mental disorders; to explore factors that contribute to the criminal behaviour of persons with mental disorders; and lastly, to draw conclusions and recommendations regarding reduction of criminal behaviour amongst persons with mental disorders.

The study utilised and answered a research question that read as follows: What are the contributing factors to the criminal behaviour of persons with mental disorders? The study was therefore centred on this question as it was undertaken to find answers to the research question.

The study used qualitative research approach because the researcher heavily relied on subjective data provided by the small sample, which in turn has been used to generate some understanding of the factors contributing to the criminal behaviour of persons with mental disorders. Applied research was used because it addresses the problem of criminal behaviour of persons with mental disorders and draws conclusions and recommendations to the reduction of the criminal behaviour amongst persons with mental disorders. The study also followed a qualitative research approach, in particular a collective case study strategy.

The population for this study comprised of all offenders with mental disorders at Lobatse Mental Hospital. The researcher relied on purposive sampling technique to select the participants. Twelve patients with a mental disorder admitted at Lobatse Mental Hospital were interviewed face-to-face by the researcher and a tape recorder was used to capture the data. In analyzing the data themes that were categorised in line with emerging patterns, particularly with reference to the research question, were identified.

The conclusion from the literature review revealed that there is a causal relationship between mental disorders and criminal behaviour. It however revealed that persons with mental disorders with psychotic symptoms are at increased risk of criminal behaviour. Literature also showed that persons with mental disorders can commit crimes not necessarily due to their mental disorder but to other factors such as greed, lack of conscience and revenge. The factors contributing to the criminal behaviour of persons with mental disorders as revealed by the participants are as follows: mental disorder accompanied by psychotic symptoms; alcohol and substance abuse; male; single; lower educational achievement; unemployed; self defence; mixing traditional and modern medicine; treatment non-adherence; poor interpersonal relationships with significant others; delay in seeking appropriate treatment; lack of education on one mental condition; living alone without anyone to monitor the signs and symptoms of the mental condition; poor conflict resolution skills.

## KEY TERMS

### English

Social work  
Mental disorder  
Criminal behaviour  
Alcohol and substance abuse  
Factor  
Patient  
Offence  
Violence  
Treatment  
Family

### Afrikaans

Maatskaplike werk  
Geestesversteuring  
Kriminele gedrag  
Alkohol en dwelmissbruik  
Faktore  
Pasiënt  
Anstoot  
Geweld  
Behandeling  
Familie

## Chapter 1

### General orientation of the study

#### 1.1 Introduction

The relationship between crime and mental disorders (illness) has been explored over time, but there is no consensus on the interrelationship between the two. These concepts have led to the involvement of several professionals from various fields such as law, sociology, and medicine, to shed light on this particular relationship. Questions have been raised as to whether the mentally ill should be incarcerated for minor offences such as creating disturbances, trespassing, and shoplifting (Pegram, 2007:1).

Junginger, Claypoole, Laygo, and Crisanti (2006:1) argue that the belief that serious mental illness is considered a crime is based on the fact that seriously mentally ill persons are most likely to be arrested and are in prison or jail in large numbers. The same authors state that persons with serious mental illness symptoms are likely to be arrested for merely displaying their symptoms. This should however not be interpreted to mean that persons with serious mental illness symptoms cannot commit crimes. Research has also shown that persons with mental illness have re-offended after being released or discharged (Prince, Akincigil, & Bromet, 2007:1).

Many theorists have, over time, written extensively on the assumptions and interrelatedness of various factors of crime. Siegel (2004) proposes four theories of crime causation as follows: choice theory, trait theories, social structure theories, social process theories, conflict theory and development theories. On the other hand, Winfree and Abadinsky (2003:29) list the following crime theories: deterrence and opportunity theories, biological and biochemical theories, psychological and abnormality theories, psychological learning and

developmental theories, social organisational theories, social process theories, labelling and conflict theory, Marxist and feminist theories. All the above listed theories will be discussed briefly, so as to conceptualise and contextualise the study. This discussion will demonstrate the influences they have on the phenomenon under study.

Choice theory is rooted on the assumption that criminals carefully decide whether to commit criminal acts, and that this is strongly influenced by the fear of the criminal penalties associated with conviction of violations of the law (Siegel, 2004:129). This theory holds that offenders can be deterred from committing criminal offences by being educated on cost-benefit analysis where it is assumed that the risks outweigh the benefits of committing crimes. These theorists further state that penalties should be harsh and severe to deter offenders from committing criminal offences (Winfrey & Abadinsky, 2003:36). Choice theory has not been spared criticism, in that, according to Siegel (2004:130), it tends to overlook "... the intricacies of the criminal justice system, and does not take into account the social and psychological factors that may influence criminality". This study will therefore explore these factors that need to be considered for choice theory to be applicable, or ruled out in the case of persons with mental disorders.

The second theory to consider is the trait theory, which is based on the belief that certain people manifested primitive traits that made them born criminals, especially when it comes to violent crimes (Siegel, 2004:167). A distinction is made between biological and psychological areas of interest, although not much difference exist between the two. Several areas are considered in this theory, and according to Siegel (2004:167), they are: (1) biochemical factors such as diet, hormonal imbalances, allergies and environmental contaminants (such as lead); (2) neuropsychological factors, such as brain disorders, EEG abnormalities, tumours, and head injuries; and (3) genetic factors, such as XYY syndrome and inherited traits.

Another aspect of the trait theory is the psychological perspective, where three important areas are considered, namely: the psychodynamic view, the cognitive view, and the social learning view (Siegel, 2004:167). The psychodynamic view, according to Winfree and Abadinsky (2003:104) links an individual's aggressive behaviour to conflicts experienced in childhood, while the cognitive view is based on the individual's development focusing on amongst other things, ability to process information, and the degree of moral development. Lastly, social learning clearly stipulates that criminal behaviour is learned. The trait theory is relevant to the current study, as it focuses on the bio-psycho-social aspects of an individual's criminality. These factors will be explored in the study from the participant's perspective.

The third theoretical perspective under discussion is social structure theory. It is influenced mostly by sociological orientation, and focuses on the suggestion that people commit crimes as a result of influences of their socio-economic structure (Siegel, 2004:205). The poor people, the author continues, are more likely to commit crimes, because they are not able to achieve monetary or social success through acceptable means. Winfree and Abadinsky (2003:173) acknowledge that the assumption that crime is inexplicably more common in the lower socio-economic classes, where gaps between goals and resources are greatest, can also be used as an excuse for people involved in criminal activities to blame the system. The usefulness of this theory to this study will be subjected to a test, as the factors contributing to criminal behaviour are explored and compared to those advocated under social structure theory.

Siegel (2004:240) states that "Social process theories view criminality as a function of people's interaction with various organisations, institutions, and processes in society". This theory is not far from social learning discussed above under the trait theory. This is so because it assumes that people learn how to commit crimes as much as they learn behaviour that is acceptable to society. Secondly, there is blame on society for failing to control criminal behaviour of its

people. Winfree and Abadinsky (2003:193) reveal that process theorists blame society for producing crime by endorsing or failing to stop the learning process by which criminals are taught. Lastly, negative labels have been associated with criminality. In light of Brockington, Hall, Levings, and Murphy (1993:93)'s observation that there is public rejection and fear of the mentally ill, this theory provides vital insight for consideration with regard to persons with mental disorders and criminal behaviour.

Conflict theory, as the name suggests, is all about conflict between people and follows on the writings of Karl Marx and his predecessors who suggest "...that crime in any society is caused by class conflict" (Siegel, 2004:275). Winfree and Abadinsky (2003:239) view conflict as emanating from two sources, namely cultural roots and group interests. This theory holds that laws are in place to safeguard the interests of the powerful and wealthy at the expense of the poor who are over represented in crime statistics. This theory has been heavily criticised for lack of substantive data to prove its stand, hence its applicability to the study can only be in line of conflict experienced by persons with mental disorders and those with whom they interact with.

The development theory is also under discussion in this study. It comprises two theories, namely the latent trait theory and the life course theory. These are discussed by Siegel (2004:311). The latent theory, according to Siegel, states that underlying conditions at birth such as low IQ and impulsivity remain with the person and explain why they continue to offend. These persons continue to offend, regardless of available options not to commit crimes. As for the life course theory, the author reveals that events that take place over the lifespan of an individual affect the criminality of that individual. The theory holds that crime "... may be a part of a variety of social problems, including health, physical and interpersonal troubles" (Siegel, 2004:311). The researcher finds the development theory useful, as it is not restrictive, and entails that all the factors be considered for the criminal behaviour of persons with mental disorders in order to be holistic.

These factors will follow the life course and events critical to the lives of the participants.

The researcher has been working with offenders with mental disorders since 2002 to date. During this time, he made observations that persons with mental disorders commit various crimes due to several factors. Some of these persons are not first offenders, implying that the factors contributing to their criminal behaviour are either not known, or are not adequately addressed to curb a recurrence of the criminal behaviour. The researcher also made an observation that some of the factors are known as to why persons with mental disorders commit crimes, but a detailed scientific study has not been carried out to explore these factors.

Experts on the field from Lobatse Mental Hospital such as Dr Panova (2007); Mr Lekgaba (2008) and Mr Kebeng (2008) were consulted by the researcher for an opinion on the proposed study. These experts have been working with persons with mental disorders who have committed crimes and believe that the study will offer valuable information on the factors contributing to the criminal behaviour of persons with mental disorders. They went on to say that if the factors are known and well documented, effective and efficient measures can be put in place to prevent or reduce the criminal behaviour of persons with mental disorders.

The study will therefore fill the gap by undertaking a scientific course in search of factors contributing to the criminal behaviour by persons with mental disorders at Lobatse Mental Hospital, Botswana. This study will benefit the patients by identifying the risk factors associated with their criminal behaviour. The family and relatives will also benefit, as they are mostly the carers of these patients when not well. Lastly, service providers in mental health will also benefit, as they will have access to the findings of the study for incorporation into their services.

## 1.2 Problem formulation

Problem formulation forms part of the research effort as it provides the reader with an overview of the topic of enquiry to be developed (Fouché, 2005a: 116). This overview is mostly comprised of three sections, namely the background or rationale for the study, the preliminary literature review, and the statement of the problem that "... should be a clear and unambiguous statement of the object of study (the unit of analysis) and the research objectives" (Mouton, 2001:48). Having gone through the literature, the problem formulation may also entail that the researcher identifies gaps in the existing body of knowledge and then provides justification for the need of the intended study.

Literature reveals a number of persons with mental disorders in jails and prisons (Junginger *et al.*, 2006:1; Lamberti, Weisman & Faden, 2004:1). This is due to several factors, such as the particular condition the person is suffering from, and its symptoms. It is also partly due to other factors not related to the person's mental disorder, such as alcohol and drug abuse (Juginger, 2006:1; Walsh, 1997:125). Clagett (1997:7) states that the processes of psychosocial and subcultural systems result in an independent phenomenon. This phenomenon, the author continues:

in turn, require analysis as an integral system with equivalent emphasis given to each of the subsystems - in order to validly explain how individuals become delinquent, and how individual criminal quotient (CQ) potential affect and are affected through the social organisation of subject actors' reference groups

From the above quote, it is evident that a thorough holistic analysis of all factors should be carried out in trying to understand the criminal behaviour of people including persons with mental disorders. This is also based on the assumption that persons "... possessing certain psychological traits, attitudes, values, and beliefs or other attributes, which facilitate the learning and effective execution of

criminal activities, may have higher criminal potential than other persons operating in the same environmental setting” (Clagett, 1997:7).

Factors leading to the criminal behaviour of persons with mental disorders are not well-documented and addressed in Botswana. As such, these persons commit criminal offences and are jailed, imprisoned, and often hospitalized at the National Referral Psychiatric Hospital (Lobatse Mental Hospital). Based on the above recognition of varying factors for analysis, the study is aimed at filling the gap by providing information on the factors contributing to the criminal behaviour of persons with mental disorders in Botswana.

### **1.3 Goal and objectives of the study**

The word goal has often been used interchangeably with aim and purpose, especially in research vocabulary as Fouché and De Vos (2005:100) state that:

The terms “goal”, “purpose” and “aim” are thus often used interchangeably, i.e. as synonyms for one another. Their meaning implies the broader, more abstract conception of “the end toward which effort or ambition is directed”, while “objective” denotes the more concrete, measurable and more speedily attainable conception of such an “end toward which effort or ambition is directed”.

The study will stick to the use of the term “goal”, and it will not be used interchangeably with other terms such as “aim” or “purpose”. The goal of this study is as follows:

- To explore the factors contributing to the criminal behaviour of persons with mental disorders.

The objectives of this study are as follows:

- To provide a broad theoretical background on criminality amongst persons with mental disorders.
- To explore factors that contribute to criminal behaviour of persons with mental disorders, empirically.

- To draw conclusions and provide recommendations regarding reduction of criminal behaviour amongst persons with mental disorders.

#### 1.4 Research question

A research question forms one of the components of this research study. Trochim and Donnelly (2007:15) reveal that most social research emanates from a general problem or question. The same authors specifically define a research question as "... the central issue being addressed in the study, which is typically phrased in the language of theory" (Trochim & Donnelly, 2007:15). A research question is drawn from the research topic or study and instead of addressing the larger issue of interest to be studied; it only focuses on the narrowed area of concentration.

A hypothesis is a statement about the relationship between two or more variables, and often has to be proved true or false (De Vos, 2005a:34). It is not applicable to this study, as there are no variables to be studied in relation to each other, nor is there any statement made on the relationship between variables that has to be proven as true or false. The study is purely explorative in that it intends to explore the factors contributing to the criminal behaviour of persons with mental disorders.

The area of interest for this particular study is exploring the contributing factors to the criminal behaviour of persons with mental disorders. The research question therefore is as follows: **What are the contributing factors to the criminal behaviour of persons with mental disorders?**

#### 1.5 Research approach

The researcher has observed that there are two widely accepted approaches to research, namely the quantitative and qualitative research approaches. Only the

qualitative approach will be discussed, as it is the one relevant to this study. The researcher will heavily rely on subjective data provided by the small sample, which in turn will be used to generate some understanding of the factors contributing to the criminal behaviour of persons with mental disorders. According to Fouché and Delport (2005:74), a qualitative study relies on subjective exploration of the descriptive data obtained from the participants' perspective. In a qualitative study, the researcher attempts to understand the participants' views and utilises small samples selected for a particular purpose, and there is little or no use of statistical methods of data analysis.

As already mentioned earlier in the preceding text, the goal of this study is to explore the factors contributing to the criminal behaviour of persons with mental disorders. This implies that the researcher will explore the data from the participants' point of view.

## **1.6 Type of research**

A thin line separates applied and basic research. This is mainly due to the overlapping of goals of both applied and basic research. Nonetheless, the researcher used applied research which is concerned with problem situations and the scientific attempt to solve such problem situations (Fouché & De Vos, 2005:105). Kumar (2005:9) concurs in stating that research techniques, procedures, and methods under applied research are implemented in the collection of information on a particular situation, and may be used for policy formulation, administration, and better understanding of phenomena.

The goal of this study is to explore the factors contributing to the criminal behaviour of persons with mental disorders. It implies exploratory research, and answers the question of "what" are the factors that contribute to the criminal behaviour of persons with mental disorders. One of the objectives of this study is to come up with recommendations for the reduction in criminal behaviour of

persons with mental disorders. These recommendations will be useful to patients, family members, and service providers to address the problem situation of persons with mental disorders. In light of all the above, this study forms part of applied research.

## **1.7 Research design and methodology**

The research methodology that was used in this study is discussed here to facilitate understanding of this chapter. The researcher utilised a qualitative approach and heavily relied on subjective data provided by the small sample, which in turn has been used to generate some understanding of the factors contributing to the criminal behaviour of persons with mental disorders. Applied research was used in light of what Kumar (2005:9) states, that research techniques, procedures and methods under applied research are implemented in the collection of information on a particular situation and may be used for policy formulation, administration and better understanding of phenomena. Relevant ethical aspects, as mentioned in paragraph 1.10 (chapter 1) of this report, were taken into consideration when conducting this study.

### **1.7.1 Research design**

Research design is often defined differently by various authors. Babbie and Mouton (2001:74) state that “A research design is a plan or blueprint of how you intend conducting the research”. Terre Blanche and Durrheim (1999:483) perceive research design as “... a strategic framework or plans that guide research activity to ensure that sound conclusions are reached”. Durrheim (1999:29) reveals that “A research design is a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research”. From these concurring definitions, one can conclude that a design is a plan or strategy that a researcher adopts in undertaking a particular study.

This study utilised collective case-study as a research strategy. A case study, according to Creswell (1998:61), is thorough, in-depth explorative data collection involving various objects of study, such as individuals, an activity, an event, or a programme. A collective case study is the examination and comparison of groups of cases and concepts, and also the extension or validation of existing theories (Fouché, 2005b:273). Collective case study was found to be relevant to this study, as it enabled the researcher to collect data from a group of persons with mental disorders at Lobatse Mental Hospital through interviews, to determine the factors that contribute to their criminal behaviour. The information has been used against, or in support of, available theory on the factors contributing to the criminal behaviour of persons with mental disorders.

### **1.7.2 Data collection**

Face-to-face semi-structured interviews were utilized to collect data. Semi-structured interviews allow the researcher to access comprehensive information including participants' beliefs about, and perceptions of a particular topic with flexibility (Greeff, 2005:296). Greeff (2005:296) goes on to state that semi-structured interviews are suitable where the researcher is interested in complexity or process, or where an issue is sensitive, controversial and personal. The researcher believes that this study is controversial, sensitive and personal in nature as it deals with the criminal behaviour of persons with mental disorders and therefore a semi-structured interview is ideal for data collection.

The interview schedule was constructed after a thorough literature review was conducted. Themes from the interview schedule were used to engage extensive constructive conversation with the participants, to get as much information as possible until a saturation point was reached. The interview schedule, according to Greeff (2005:296-297), comprises themes or questions constructed before the interview and used as a guide to the interview session. A tape recorder was

used to capture all the data from the respective interviews, with permission from the participants, and data later converted into verbatim transcripts for analysis.

### **1.7.3 Data analysis**

Data analysis is "... the process of bringing order, structure and meaning to the mass of data collected" (De Vos, 2005b:333). Since the study is qualitative in nature, it relied on the researcher to immediately analyse the data the moment it was collected. As the study relied on the use of themes, these were categorised in line with emerging patterns, particularly with reference to the research question of the study. The bulk of the raw data has been reduced to meaningful themes through the coding system, which, according to De Vos (2005b:338) assists the researcher to have an understanding of the findings, and to determine necessary direction for the study.

## **1.8 Population, sample and sampling method**

The three concepts are defined and discussed individually as follows:

According to Babbie (2005:112-113) and Trochim and Donnelly (2005:34), the population for any particular study is mostly a group of people a researcher wants to draw conclusions on, and from which a study sample will come. The population for this study consisted of all persons with mental disorders who have committed crimes and were hospitalised at Lobatse Mental Hospital, by the time this study was conducted and they were 47 in total.

### **1.8.1 Sample**

Neuman (2006:219) argues that a sample is "... a small collection of units from a much larger collection or population, such that the researcher can study the small

group and produce accurate generalisation about the larger group”. The sample for this study consisted of 12 patients, who were selected by using purposive sampling method.

### **1.8.2 Sampling method**

Purposive sampling is described by Kumar (2005:179) and Punch, K. (2005:293) as a sampling technique which dictates that the researcher uses his discretion and judgement to target those elements that can provide the best information to achieve the objectives of the study. Purposive sampling was found suitable for this study because the researcher was aware of challenges such as the ability of patients to cooperate and to provide reliable information, due to their mental health state. The researcher relied on the professional staff of Lobatse Mental Hospital, such as nurses and doctors, as they are aware of the mental stability of the patients.

The criteria the researcher used for selection were: stable patients; both males and females; ability to speak either Setswana or English; 21years and above; non-specific diagnosis and all offences were included. The first 12 patients with the above characteristics and who were willing to participate in the study were included in the sample.

### **1.9 Pilot study**

A pilot study according to Kumar (2005:10) is “... usually carried out when a researcher wants to explore areas about which s/he has little or no knowledge. A small scale study is undertaken to decide whether it is worth carrying out the detailed study”. The researcher addressed aspects of a pilot study under the following sub-headings.

### **1.9.1 Feasibility of the study**

Factors for consideration as highlighted by Strydom (2005a:208) include practical aspects, such as transport, finance, and time factors. From the above literature, it was evident that this research effort be subjected to a test of feasibility. This was critical in that it had implications for the success of the research effort. The researcher considered all of the above listed points, so as to be clear as to what extent the research was likely to succeed or fail.

The costs of the study were covered by the sponsorship from the employer of the researcher that is The Government of Botswana. The actual research study took approximately a year (from proposal writing, data collection, data analysis, report writing and final submission). The researcher conducted the study at Lobatse Mental Hospital, Botswana where he is working as a social worker and known to the employees.

It is critical to note that permission to undertake the study has been obtained from the authority, that is, the research unit of the Ministry of Health, and management of Lobatse Mental Hospital, Botswana (Appendices 1 & 2). The participants' availability was well anticipated, in that they were always available in the hospital wards. The researcher did not experience difficulties accessing the participants.

### **1.9.2 Pilot testing**

Since the researcher was using a semi-structured interview that was guided by the interview schedule, a pilot test was mandatory to benefit the study, in that it helped refine the schedule following the pilot testing, thereby allowing an accurate and effective schedule to be used for the main study. A total of three participants were used for the pilot test, and they were excluded from the sample of the actual study.

### **1.9.3 Consultation with experts**

Dr E. Panova, a psychiatrist and head of the medical department at Lobatse Mental Hospital was consulted.

Mr O. Lekgaba, head of the psychology department at Lobatse Mental Hospital was also consulted.

Mr M. Kebeng, Social Worker at Lobatse Mental Hospital was consulted.

All the above consulted employees of Lobatse Mental Hospital have been working with persons with mental disorders who have committed crimes. They acknowledge the presence of various factors implicated in the criminal behaviour of persons with mental disorders. In turn, they are optimistic that the study will avail the factors which contribute to the criminal behaviour of persons with mental disorders.

### **1.10 Ethical aspects**

For any research to be valid and up to scientific standard, it should be subjected to an ethics test as a way of proving beyond reasonable doubt that the study has some ethical considerations. Various authors have written extensively on the ethics subject. Babbie (2005:62) quotes *Webster's New World Dictionary's* definition of ethical as "... conforming to the standards of conduct of a given profession or group". Neuman (2006:129) adds to the above definition by stating, "The ethical issues are the concerns, dilemmas, and conflicts that arise over the proper way to conduct research. Ethics define what is or is not legitimate to do or what "moral" research procedure involves". This study was not different, in that it intended to comply with research ethics through a thorough demonstration of

adherence to ethical considerations pertinent to the area of study. The ethical aspects found applicable to this study are discussed in paragraphs below.

One of the critical ethical considerations entail that any research effort avoid doing harm to the participants (Neuman, 2006:132; Babbie, 2005: 63; Punch, K.F., 2005:59; Babbie & Mouton, 2001:522). In anticipation of possible emotional harm of the study to the participants, the researcher intended to utilise the available counselling services at Lobatse Mental Hospital. The institution has professionals offering counselling services such as social workers and psychologists. The researcher has been working with patients since 1999 and specifically offenders with mental disorders since 2002 at Lobatse Mental Hospital. The experience of working with such clients enabled the researcher to guard against doing any harm to the participants. The researcher formally informed the participants, prior to the study, of the possibility of emotional harm, and that they are free to quit the study at any time, should they feel the need to do so.

The researcher carefully considered the principles of anonymity, confidentiality, and privacy of the participants. The participants were guaranteed confidentiality and privacy prior to and after being interviewed. Anonymity, according to Babbie and Mouton (2001:523), entails that "... the researcher cannot identify a given response with a given respondent". Neuman (2006:139) is in agreement with Babbie by defining anonymity as "... the ethical protection that participants remain nameless; their identity is protected from disclosure and remains unknown". Anonymity could not be maintained in that face-to-face interviews were conducted as a way of collecting data. The names of the participants are withheld and not disclosed in the presentation of data or writing of the final report as a way of adhering to the principle of confidentiality.

Neuman (2006:139) defines confidentiality as:

The ethical protection for those who are studied by holding research data in confidence or keeping them secret from the public; not releasing information in a way that permits linking specific individuals to responses. Researchers do this by presenting data only in an aggregate form (e.g., percentages, means, etc.).

For this particular study, as mentioned earlier, confidentiality was also upheld. This was applied as suggested by Neuman above, through the use of aggregates in the analysis of data obtained, diminishing any possible link to an individual participants. Since this study utilized interviews, numbers were used to replace the names of participants, so as to maintain the information as confidential as possible.

Privacy is concerned with the research intrusion into people's privacy, that is, to what extent and in what ways the research intrudes into people's privacy (Punch, 2005:59). The participants were interviewed individually in a closed private room where there was no access to the interview proceedings by anybody else except the researcher and the participants.

Another critical ethical consideration is that of obtaining informed consent from the participants. Durrheim and Wassenaar (1999:66) warn that:

Obtaining consent from participants is not merely the signing of a consent form. Consent should be voluntary and informed. This requires that participants receive a full, non-technical, and clear explanation of the tasks expected of them, so that they can make an informed choice to participate voluntarily in the research.

In order for this study to comply with the above, an informed consent letter was formulated, detailing the research topic, goal and objectives, potential risks and benefits, advantages, disadvantages, research methodology, and all other procedures involved. The consent letter was translated to Setswana for those patients not conversant with the English language. The letter was read to those participants who are illiterate. This ensured that the participants are adequately

informed about this study and its contents, so as to give an informed consent. Thereafter, they were requested to sign the consent form if they were willing to participate.

Deception entails that there should be an element of truth and honesty, as opposed to misleading the participants (Punch, 2005:59). Although several authors advocate considerable and justified deception (Neuman, 2006:135; Babbie, 2005:67; Babbie & Mouton, 2001:525), this study did not have any deception component. The participants were provided with all the information pertaining to the study.

Debriefing, according to Babbie (2005:68), is a process whereby interviewed respondent's experiences are evaluated for participating in the study, for identification of any possible damage emanating from such participation. The participants taking part in this study were provided with a debriefing session at the end of the data collection process, to restore their level of functioning and to assist in restoring their emotions. Referrals for counselling services at Lobatse Mental Hospital were made, depending on individual participant's needs. The necessary arrangements were made to that effect. This ethical consideration was used in line with that of avoiding any harm to the participants, as discussed earlier.

Cooperation of Lobatse Mental Hospital staff was vital to the success of this study, as this helped with making rooms available for interviewing participants, adjusting their schedules to accommodate time and any possible assistance needed by the researcher. Doctors, nurses, and social workers were of great help as they work closely with the participants. These professionals assisted in identifying stable patients to participate in the study. The professionals' assistance was based on a stakeholders' contract that was drawn, stipulating the roles each had to play. The researcher was not under threat of prescription from

the sponsor as the sponsorship has been effected and the researcher was at liberty to conduct the research as he is comfortable.

Strydom (2005b:63) states that researchers are ethically bound to be adequately skilled and competent to undertake research efforts, especially if it is of a sensitive nature. There is no exception with regard to this study; it is more sensitive, as it deals with offenders with mental disorders. The researcher's training and experience of working with persons with mental disorders made him competent to undertake this study without any compromise. The researcher was also equipped with research skills acquired at undergraduate training and current post-graduate training, which were useful for the undertaking of this study.

### **1.11 Definition of key concepts**

#### **Mental disorder**

"The disturbances in thinking, emotion, and behaviour, caused by complex interactions between physical, psychological, social, cultural, and hereditary influences" (Berkow, Beers, Bogin, & Fletcher, 1997:388).

Barker (2005:269) defines mental disorder as "Impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, or social".

The researcher defines mental disorder as the overall disability to function to one's ability due to mental ill health resulting in distorted thought processes.

#### **Criminal behaviour**

"Actions violating the established laws of a country" (Belfrage, 1998:145-146).

On the other hand, Modestin and Ammann (1995:667-669) use criminal behaviour to mean “labelled actions of individuals that are against the laws of a country”.

Criminal behaviour for this study is defined as any act or behaviour that violates the laws of Botswana.

### **Offender**

“A person convicted of a criminal offence while an offence is an act committed or omitted in violation of the law” (De Sola, 1982:106).

*Oxford Advanced Learners Dictionary* (1995:83) defines an offender as “a person who breaks a rule or the law”.

For the purpose of this study, the word offender meant any person who has violated the laws of Botswana.

### **Factor**

“Any of the things that cause or influence something” (*Oxford Advanced Learners Dictionary*, 1995:414).

It is also defined as “... influence that helps produce a result” (*Longman's Handy Learner's Dictionary*, 1999:154).

The researcher has adopted a definition of factor to mean anything that has an impact on the outcome or end result.

## **1.12 Division of the research report**

The research report is divided into chapters as follows:

Chapter 1 contains the contextualisation of the study, focusing on, inter alia, the introduction, problem formulation, goal and objectives, research question, research approach, type of research, research design and procedures, description of the population, sample, and sampling method, ethical aspects, definition of key concepts, problems encountered, and limitations.

Chapter 2 focused on the literature review, noting the various theories on the factors contributing to the criminal behaviour of persons with mental disorders. It also provided information, including the risk factors for criminal behaviour from experts on the field and from other studies carried out on the topic under study.

Chapter 3 outlines the research methodology used in the study as well as the empirical findings.

The final chapter, which is chapter 4, addressed the summary, conclusions, and recommendations.

### **1.13 Problems and limitations of the study**

The limitations and problems encountered are as follows:

- Most of the literature used in this study was from other countries as there was no adequate literature in the country of study, Botswana.
- Literature on social work and persons with mental disorders who commit crimes was also inadequate hence the researcher used information from general psychiatry.
- The responses of the participants may be affected by the face-to-face contact with the researcher.
- The small sample size of 12 cannot be generalised to the entire population.

- There is a strong possibility that some vital information may be missed due to reliance on persons with mental disorders only as a source of information.
- Due to lack of sources on theories the researcher relied on two sources to discuss these theories, as they were found to be needed to explain behaviour.

## Chapter 2

### Mental disorders and crime

#### 2.1 Introduction

The relationship between mental disorders and crime has been identified by a number of authors (Jones & Ploughman, 2005:138; Belfrage, 1998:148; Modestin & Ammann, 1995:667). This relationship has seen more men with mental disorders linked to criminal behaviour than women (Belfrage, 1998:148). Persons with mental disorders are also capable of committing crimes without any association of the crime with their condition (Jones & Ploughman, 2005:138; Gudjohnsson, 1990:15). They may commit crimes independent of their disorder and for the same reasons as those advanced by people without mental disorders.

Most studies reveal that major mental disorders are mostly implicated in the criminal behaviour of persons with mental disorders (Belfrage, 1998:145; Modestin & Ammann, 1995:673). This focus is due to the seriousness of the symptoms of major mental disorders. Symptoms such as hallucinations and delusion increase the chances of a person with a mental disorder to indulge in criminal behaviour (Hucker, [sa] & Prins, 1990;2005). Alcohol and substance abuse is a major contributing factor to criminal behaviour of persons with mental disorders (American Psychiatric Association, 2000:207; Shaw, Amos, Hunt & Flynn, 2004:1). The situation is worse when there is a combination of alcohol and substance abuse with other mental disorders (Fridell, Hesse, & Billstern, 2007:13; White, Goldkamp & Campbell, 2006:1). The presence of two or more disorders coupled with the presence of alcohol and substance abuse increase the chances of criminal behaviour in persons with mental disorders.

Mental disorders and criminal behaviour offer a great challenge to people interested in these fields. These people range from those in professional fields in mental health such as medicine, nursing, social work, occupational therapy, psychology to law enforcers such as police and prosecutors. It also extends to fields of social policy and legislature where acts and policies are devised to guide implementation of services to persons with mental disorders who have committed criminal offences.

Over the years, researchers have attempted to establish the relationship between mental disorders and crime and this is explored in detail below. Also to be addressed in this chapter, are the needs of persons with mental disorders, stakeholder collaboration and an outline of the risk factors to criminal behaviour of persons with mental disorders. Literature review on a way forward to reducing the criminal behaviour of persons with mental disorders will also form part of this chapter.

A detailed discussion on the theoretical perspectives to crime causation is also provided in this chapter. These theories will provide a general overview of why people commit crimes, and where possible these theories will be discussed with reference to persons with mental disorders. Since the study was conducted in Botswana, the researcher brought forth a brief introduction to the national legal system of the country, pertaining to people with mental disorders who commit crimes. Since this is a social work study, the role of the social worker is also highlighted in this chapter.

## **2.2 Theories of crime causation**

The various theories outlined in this chapter will offer valuable information on why people commit crimes. The theories address one of the objectives of the study namely; to provide a broad theoretical background on criminality among persons with mental disorders. The theories of crime causation are an important aspect of

this chapter as they have paved a way for the researcher to adopt a particular theory, namely life course theory to use as the theoretical framework in the study. Life course theory has been used throughout the study by the researcher and in particular, it was instrumental in the analysis of the data. The other theories are briefly discussed as follows:

## **2.2.1 Choice theory**

This theory, as the name suggests is based on the assumption that every individual has a choice to make regarding indulging in criminal activities or refraining from it (Siegel, 2004:107; Winfree & Abadinski, 2003:44). These authors propose various other theories under choice theory and they are briefly discussed below.

### **2.2.1.1 Rational choice theory**

This theory depicts that people make decisions to commit crimes based on the expected utility principle (Winfree & Abadinski, 2003:44). The expected utility principle implies that people obtain information about crime, store it in memory, process it and analyse it before taking any action to commit the crime. The rationality implied in this theory does not necessarily mean that the decision will be perfect, but that the decision and action will be dependent on the information possessed, recalled and acted upon by the individual in a given time (Winfree & Abadinski, 2003:44). The argument posed here is that, people commit crimes as the best decision for them at that time in light of costs and benefits available at that time.

Siegel (2004:107) does not differ with the above authors on the rational choice theory in stating that the offender "... evaluates the risk of apprehension, the seriousness of expected punishment, the potential value of the criminal enterprise, and his/her immediate need for criminal gain". This clearly shows that

individuals process and act on information available to them before committing crimes. Siegel (2004:109-112) goes on to state that there are factors associated with structuring crime, and those for structuring criminality where crime is considered an event while criminality is a personal trait. In structuring crime, decisions are made on choosing the type of crime; choosing the place and time of crime; and choosing the target of crime. Structuring criminality involves perception of economic gain; learning and experience of the offender; and knowledge of criminal techniques.

Cornish and Clarke (2002:285) also agree that offenders intend to benefit from their criminal behaviour; that the process involves the making of decisions and choices, irrespective of how simple they may be; that these processes exhibit a measure of rationality, although the processes may be constrained by time, ability and availability of important information. The authors continue to state that two major stages characterises the choice process.

First, the individual should decide whether they want to indulge in crime to meet their needs. This decision comes about in light of other existing options which may not be against the law. The decision to indulge in crime is influenced by past learning experiences, including exposures to crime, contact with law enforcements, moral attitudes, self-perception, and the ability to plan ahead (Cornish & Clarke 2002:291). The learning experience is influenced by a wide range of factors such as socialisation, psychological, social, and demographic aspects of their lives. These factors are further broken down to examples as follows: socialisation includes upbringing aspects such as broken home, institutional care and parental crime; psychological include temperament, intelligence, and cognitive style; social and demographic include sex, class, education and neighbourhood (Cornish & Clarke 2002:293). All these factors work together to influence an individual's decision to indulge in criminal activities.

Secondly, the individual has to then decide on the crime to commit and this will heavily rely on the situation the individual is in (Cornish & Clarke 2002:291). For example, an individual who is in need of money is likely to rob someone, or break into someone's home to steal money or goods so that he can sell them to meet the monetary needs. The decision to indulge in criminal activity will heavily rely on the situation the individual is in and will differ from time to time as the needs of the individual changes.

Rational choice theory can therefore be subjected to persons with mental disorders who commit crimes by exploring the factors considered prior to committing crimes. Also to be established is whether careful consideration was made for the cost benefit analysis as contended by the theory. The researcher using this theory has to enquire about the thought process and information processing of participants to validate or invalidate the rational choice theory and its applicability to their study. This theory was not used in this study.

### **2.2.1.2 Routine activities theory**

According to Siegel (2004:130) routine activities theory holds that crime and delinquency are a result of motivated offenders, easy access to suitable targets and the absence of capable and willing guardians. On the other hand, Winfree and Abadinski (2003:48) state that routine activities theory is based on the assumption that criminal motivation and the availability of potential offenders are constants. This implies that there is always someone who is ready, willing, and able to engage in criminal activities in which the victim is available. Based on the above argument, one can therefore conclude that routine activities theory assumes that society has motivated offenders who will always find constant supply of victims to offend.

Routine activities theory can be subjected to persons with mental disorders who commit crimes by looking at the factors that motivate them to commit crimes,

establishing the prevailing circumstances at the time of committing the criminal activity and the targets of these criminal activities. This theory is not applicable to this study; hence it was not used.

### **2.2.1.3 Deterrence theory**

Siegel (2004:130) distinguishes between two theories namely general and specific deterrence. General deterrence holds that people make a cost benefit analysis before embarking on criminal activities. Where the benefits outweigh the costs, people are more likely to indulge in criminal activities. When punishments are severe, certain and speedy, people may opt not to indulge in criminal activities. Special deterrence is concerned with known criminals and the severity of punishment, assuming that if punishments are severe, known criminals will not repeat their criminal activity.

Winfree and Abadinski (2003:61) make a distinction between formal deterrence and informal deterrence. They hold that formal deterrence view people as rational beings, able to differentiate between good and bad, pain and pleasure, and ultimately making informed decisions about their actions. Informal deterrence believe that informal social groups can play an important role in reducing crimes, as people care about what their close relatives and friends think about their actions, than do what the court and jury have to say.

The researcher has observed that deterrence theories are concerned with the punishment given to potential criminals for the purpose of deterring them from indulging in criminal activities. They are also concerned with preventing a recurrence of the criminal activities of known criminals by ensuring that punishment is effected with certainty and timely (Siegel, 2004:130). These theories may be applicable to persons with mental disorders from the perspective of influences of close relatives on the patient. Punishment may not necessarily be effective as these people are deemed to be of unsound mind at the time of

committing the crimes. Treatment and rehabilitation can work better than punishment for people with mental disorders who commit crimes. The theory was not considered in this study.

### **2.2.2 Psychological theories**

Of importance to psychological theory is psychoanalysis, which according to Siegel (2003:168), Winfree and Abadinski (2003:103) entail that the development of an individual's unconscious personality early in childhood, greatly influences their behaviour for the rest of their lives. Criminals have since been identified to have damaged personalities and weak egos.

Another aspect to consider under psychological theory has to do with learnt behaviour modelled after others who are rewarded for their acts, as opposed to being punished for their acts (Siegel, 2004:168). Winfree and Abadinski (2004:136) concur when stating that "Behaviourists see all behaviour as resulting from learned responses to distinct stimuli". They also agree that positive and negative reinforcers shape the behaviour of individuals, where punishment is perceived to be negative reinforcement, while reward is positive reinforcement. Persons with mental disorders are not any different from the rest of society as they also learn what is acceptable and what is unacceptable in their respective communities and society in general. This will however be dependent on the level of mental impairment and will differ from one person to the other. Various theories exist under psychological theory and are discussed briefly below.

#### **2.2.2.1 Psychodynamic theories**

This theory originated from the works of Sigmund Freud (1856-1939) who believed that people carry with them residue of the most significant emotional attachments of their childhood which in turn shape their future interpersonal relationships (Siegel, 2003:154). The theory maintains that the human

personality is comprised of a three-part structure, namely the id, the ego and the superego (Siegel, 2004:154). The id is part of an individual's mental makeup at birth, representing the biological drives for sex, food, and other life-satisfying necessities. The id is governed by the pleasure principle which requires immediate gratification without consideration for the rights of others.

The ego, guided by the reality principle, takes account of what is practical and conventional by societal standards (Siegel, 2004:154). It develops early in life, and the child learns that not all demands will be met instantly as they have to be within the confines of society's way of doing things. The last part, the superego, is a result of the incorporation of norms, values, standards and principles into a person's personality (Siegel, 2004:154). The individual learns these through the family, peers, education system and significant others.

Siegel (2004:155) states that psychodynamics perceive a criminal offender as an aggressive, frustrated person dominated by the events that happened early in one's childhood. These persons are said to have damaged or weak egos that make them unable to function well in the conventional society, hence their criminal behaviour. Crime, under psychodynamic theory, is seen as a "...manifestation of feelings of oppression and people's inability to develop the proper psychological defences and to keep these feelings under control" (Siegel, 2004:155). This weakness makes people prone to criminal behaviours as they find themselves violating the laws, rules and regulations of a particular society.

Psychodynamic theory is not very useful to the current study as it focuses mostly on events that happened in one's childhood. In light of the participants as people with mental disorders, they may not recall all the problems experienced during the childhood period. This therefore means that the theory could not be used in this study.

### **2.2.2.2 Behavioural theories**

Unlike the psychodynamics, behavioural theorists are concerned with the actual behaviour that people engage in during the course of their lives (Siegel, 2004:155). The behaviour will greatly depend on the reaction received from other people. Where one is rewarded, there is a chance that the behaviour will be repeated; as opposed to when the behaviour is punished in that the behaviour is less likely to be repeated. As such, behavioural theorists view criminal behaviour, especially violent crimes as learned responses to life situations (Siegel, 2004:155). Criminal behaviour will therefore be repeated where there was a reward for the behaviour and will be extinguished if there was punishment. The behavioural theory has some elements of deterrence theory as discussed previously under the latter. The theory was not applied in this study.

### **2.2.2.3 Social learning theory**

Social learning theory is constructed on the belief that people are not born with the ability to act violently, rather they learn to be aggressive through their life experiences (Siegel, 2004:156). Social learning theory believes that mental or physical traits can predispose a person to violence, although activating that person's violence will rely on factors in the society. Siegel, (2004:154) supports this by stating that "The specific forms that aggressive behaviour takes, the frequency with which it is expressed, the situation in which it is displayed, and the specific targets selected for attack are largely determined by social learning". The learning process, also called behaviour modelling, is dependent on three sources namely: family members; environmental experiences; and mass media. The learning process which operates in the context of social structure, interaction and situation produces both conforming and deviating behaviours (Akers, 2002:136). An individual may therefore learn what conforms to society or what deviates the societal norms from the family, environment and the mass media.

Akers (2002:137) also state that deviant and criminal behaviour is learned and modified, that is, acquired, performed, repeated, maintained and changed through the same process as the conforming behaviour. The difference is said to be confined to the content, direction and outcome of the learned behaviour. Siegel (2004:157) proposes the following four factors that may contribute to aggressive or violent behaviour:

- **An event that heightens arousal:** an example is a frustrating or provoking act such as an assault or verbal abuse.
- **Aggressive skills:** includes aggressive skills learned from observing others or from the mass media.
- **Expected outcomes:** the assumption that the aggression will be rewarded. Examples include, assuming that one will have improved self-esteem, financial gain, reduction in one's tension and praise from others.
- **Consistency of behaviour with values:** the belief obtained from observing other people acting aggressively, that it is appropriate and justified for one to behave aggressively.

The researcher is of the opinion that social learning theory assumes that an individual has the responsibility to exercise some form of choice in what they learn. This is so in that the theory holds that the learning process of both good and bad behaviour is the same, the only difference is the direction of the learning process. Depending on the level of impairment, persons with mental disorders are also capable of learning from their life experiences. Their behaviour may also be strongly influenced by factors in the family, the environment and the mass media. This theory is relevant to the current study as it looks at various factors contributing to the learned criminal behaviour. Nonetheless, it was not used in the study.

#### **2.2.2.4 Cognitive theory**

The focus of cognitive theory is on the mental processes and how people perceive and mentally represent the world around them (Siegel, 2004:157). Two branches of cognitive theory, namely moral development; and information processing branches are identified. The moral development which is based on the works of Jean Piaget and Lawrence Kohlberg is concerned about the way people morally represent and reason about the world (Siegel, 2003:157). People are subjected to a test of where they fall in the stages of moral reasoning and development. Those who indulge in criminal behaviour are said to be falling at the first two stages of moral reasoning and development. Those at the highest stages of moral reasoning and development have a tendency to sympathise with the rights of others and are linked with conventional behaviours, such as generosity, honesty, kindness and non-violence (Siegel, 2004:160).

The information processing branch is concerned with how people use information available to them to understand their environments (Siegel, 2004:160). People will also heavily rely on their mental state and ability to process the information. Ultimately, they reach a decision and act on that decision.

The cognitive theory does not offer much choice in the factors that contribute to the criminal behaviour of persons with mental disorders. For example, the moral development differentiates between lower and upper levels of moral development where people who commit crimes are said to be at the lower levels of moral development. In a way, this theory is judgemental and offers little opportunity for addressing a wide range of factors that could play a particular role in the criminal behaviour of persons with mental disorders. Information processing branch offers valid points that can be applied to persons with mental disorders. This is the case because their mental state affects the way they process information and understand their environment, and this can have an effect on their criminal

behaviour. All the same, none of the psychological theories were used in this study.

### **2.2.3 Biosocial theories**

Biosocial theory is considered from four areas namely the biochemical, neurological, genetics and evolutionary (Siegel, 2004:168). Under the biochemical, crime and violence are perceived to be functions of hormonal imbalances, diet, food allergies and vitamin intake. Neurological factors include brain damage, and attention deficit/hyperactivity disorder which often results in antisocial behaviour of individuals. Genetics assume that criminal traits are inherited, that is, the criminality of parents can be a determining factor for their children's delinquency and future criminality. Lastly, evolutionary perspective state that overtime, as human nature evolved, certain traits have become deeply rooted resulting in people's aggressiveness and tendency to indulge in criminal activities (Siegel, 2004:168).

Biosocial theory offers valuable points to consider in the criminal behaviour of persons with mental disorders although it is not easy for any person to establish exactly which of the four perspectives has contributed to the criminal behaviour and to what extent. The dilemma also lies in the fact that people may not be in a position to know what to do to minimise any possibility of indulging in criminal behaviour as the perspectives advanced are vague and not always determining factors for one's criminality. An example is the issue of food, diet, vitamins which are not specified. Another problem is the fact that persons with mental disorders may not be in a position to comprehend perspectives advanced under the biosocial theories.

## **2.2.4 Development theories**

Development theories hold that the age at which people commit crimes differs and is influenced by various factors, such as family factors for the child offender and marital and job related factors for the adult offender (Siegel, 2004:312). A distinction is made between life course persistent offenders and adolescent limited offenders in that life course persistent offenders are said to begin early, have deep rooted neurological problems and few skills (Winfree & Abadinski, 2003:151). Adolescent limited offenders in contrast begin later, have more social skills and fewer behavioural problems, and are more likely to quit their criminal behaviours. Following is a brief discussion of the two development theories identified in the literature:

### **2.2.4.1 Life course theory**

According to Siegel (2004:283) life course theory holds that people begin relationships and behaviours at a very early age and this will greatly influence their adult life course. They are expected to go through a transition that will see them go to school, get work to sustain themselves, establish relationships, get married and even have children or a family. This transition will not be smooth and will not be achieved by all, as others fail to meet the expected targets or meet them at different times. The disruptions in major life transitions may be destructive and can ultimately promote criminality, especially amongst those people with socioeconomic problems or family dysfunction as they are susceptible to these unusual transitions (Siegel, 2004:284).

As people grow, they experience different factors that influence their behaviours. As such, when children are still young, the family is the most influential; in adolescence, the school and peer relations dominate; while later in adulthood,

the influences of vocational achievement and marital relations are critical (Siegel, 2004:284). This means that children who grow up as delinquent may refrain from the delinquency as they grow up due to a difference in the influential factors that shape their behaviour. Criminality from a life course theory's point of view is multidimensional, that is, it has many roots, including maladaptive personality traits, educational failure and family relations (Siegel, 2004:284). These include a combination of social, physical and environmental factors that influence behaviour through life's transitions.

The social, personal and environmental factors are listed by Siegel, (2004:285) as falling under problem behaviours and best explains why certain people are at increased risk of criminal behaviour. Social factors include: family dysfunction, unemployment, educational underachievement, school misconduct, and victimisation. The personal factors comprises of: substance abuse, suicide attempts, early sexuality and parenthood, sensation seeking, criminal behaviour, accident-proneness, medical problems, mental disease, anxiety, and eating disorders. Environmental factors include: high crime areas, disorganised areas, racism, and exposure to poverty. All the above factors are examples of social, personal and environmental situations that shape an individual's behaviour including criminal behaviour. People who experience a lot of these situations are at greater risks of indulging in criminal behaviour.

The researcher has identified development theories especially the life course theory as the best theory to use in this study. Development theories offer valuable information for consideration by the researcher, as they give several factors in the development of an individual that contribute to their criminal behaviour. The researcher was interested in exploring all factors that have contributed to the criminal behaviour of persons with mental disorders and focused only on adult offenders. The factors listed in this theory (family factors, marital and job related, behavioural problems, social skills) were subjected to a test of whether they played any significant role in the criminal behaviour of

persons with mental disorders. The life course of the participants were explored and all the factors from childhood to date in the life course of each participant were analysed for possible contribution to the criminal behaviour. It is also important to note that since the participants are all adults, there were a number of factors to consider as they have been through the life transition for some time and it was assumed that they have reached a certain level of development.

#### **2.2.4.2 Theories of the criminal life course**

Several models are discussed under the theories of the criminal life course, namely, the social development model, Farrington's theory of delinquent development, and interaction theory (Siegel, 2004:281). Social development model holds that, people are susceptible to develop antisocial behaviour as a result of community-level risk factors. An example is a poverty stricken, low income, disoriented community with high rates of criminal activities whereby more members of that community have more opportunities to commit crimes than for social control. People, according to the social development model must maintain attachment with the family and significant others as opposed to being attached to bad company of friends who might influence them negatively.

Farrington's theory of delinquent development is based on the assumption that persistent criminality is a result of the existence of chronic offenders, the continuity of offending and early onset of criminal activity (Siegel, 2004:295). Interactional theory, although not different from delinquent development, is based on the assumption that people identify peers with the same interest so that they can reinforce their behaviour (Siegel, 2004:296-297).

In the current study the researcher was interested in the contributing factors to the criminal behaviour by persons with mental disorders. Social development model offers various factors to consider and these are found at the community level, for example poverty and low income as already shown. The theory further

advises people to have attachment with family members and significant others. The researcher appreciates the stand above but was interested in establishing the potential contribution of the family in the development of antisocial and criminal behaviour of persons with mental disorders.

Farrington's theory is too judgemental and does not provide hope for possible intervention as it assumes that criminality will always be present. It however offers valid points in that early onset of criminal behaviour is likely to lead to continuity of offending. Lastly, the researcher is of the opinion that interactional theory has little room in the understanding of persons with mental disorders. This is so in that the researcher believes that persons with mental disorders do not identify peers with same criminal intentions, rather they are overwhelmed by their illness and a magnitude of other factors that were explored in the this study. These theories did not form part of this study.

### **2.2.5 Social process theories**

Social process theories are strongly based on the learning aspect of offenders in their day to day interactions (Siegel, 2004:241; Winfree & Abadinski, 2003:217). It holds on the assumption that criminal behaviour is not any different from any behaviour in that it too is learned. Social bonding theory under social process theories state that deviant behaviour is curbed by the societal presence of attachment, commitment, involvement and belief, whereas weakness in any is likely to result in deviant behaviour (Winfree & Abadinski, 2003:218). Social process theory attempts to establish why certain people do not commit crimes while others in the same situation do commit crimes. A learning process is attributed to this difference in behaviour. The learning could in part be due to socialisation, association, reinforcement and societal reaction. People learn what is right and what is wrong from an early age. As they grow, they have the choice to associate with others and continue to learn what is acceptable and rewarded in society as opposed to what is not acceptable and is punished by society.

### **2.2.6 Conflict theory**

The central assumption to conflict theory is that conflict is inevitable, as power is considered a scarce and treasured resource, which various groups try to obtain and use to advance and protect their interests (Winfree & Abadinski, 2003:248). This conflict is categorised into two, namely culture conflict and group conflict. Culture conflict occurs where there is a clash between an individual's culture of origin and the dominant culture where they live, while group conflict occurs when the powerless objects to existing laws and violates them. Siegel (2004:275) reveals that crime is a result of class conflict and laws are defined by people who hold social and political power.

Persons with mental disorders, who commit crimes, may be fitted into the conflict theory from the perspective of being a group that is not well understood by the general population. They may be considered a minority in terms of numbers as they are fewer than the so called "normal". Another point worth considering is that of conflict between people with mental disorders, and those they interact with frequently such as family, relatives and close friends. This is supported by Belfrage (1998:149-150) who reveals that the general public is afraid of persons with mental disorders and close relatives have been victims of crimes by persons with mental disorders. This fear can be linked to a lack of understanding and tolerance for persons with mental disorders. As a result, all these impedes on the relationship between persons with mental disorders, their close relatives and the community at large. This theory was also not used in this study.

### **2.2.7 Labelling theory**

Labelling theory according to Winfree and Abadinski (2003:248), is highly subjective and enjoys popular support among practitioners such as social workers and juvenile officers. Nicely put, Winfree and Abadinski (2003:224) state

that the use of symbols is not focused on "... the behaviour of any social actor, but on how others, including society and the criminal justice system, view that behaviour or actor". This is based on the exclusion of certain behaviours as deviant and constituting a criminal act and the differences observed with different societies and cultures. Siegel (2004:233) does not differ with the above in stating that crimes such as murder, rape and arson are only bad because people label them as such and that these are matters of legal definitions, which will differ from one place to the other and from time to time.

Confusion often arises when a person with mental disorders' behaviour is labelled as deviant and against the law, when they are merely displaying the symptoms of their illness. This is further extended to whether these people are in turn labelled as patients or criminals. As patients, they receive treatment and rehabilitation while as prisoners; the result is punishment which at times is accompanied by rehabilitation.

As already shown throughout this subsection, there are a wide range of theoretical perspectives on why certain people commit crimes and others do not. The reasons advanced are many and mostly different from each other. They range from focusing on the individual, to society, genetics and the environment. Also of importance to note is that one's criminality is a complex process that needs careful consideration of a lot of factors to determine the causes, solution and possibility of continued criminality. Most theories as shown attribute a learning aspect to people's criminal behaviour which to some extent shows that the individual and society has a role to play as they are the ones in charge of the learning process and its content. Nonetheless, the researcher has decided to use the life course theory under development theories to help in understanding the phenomenon under study. This theory was instrumental in among others, the analysis of the research findings and conclusion of the study.

### **2.3 Relationship between mental disorders and crime**

It is important to note that not all offenders with mental disorders are prone to violent and dangerous behaviours just as not all dangerous and violent offenders are not mentally disordered (Jones & Ploughman, 2005:138). With regard to the relationship between crime, especially violent ones, Jones and Ploughman (2005:138-139) offer three types of relationships between violence and mental disorders. To start with, violence can occur as a result of the mental disorder, in which case the solution would be to treat the mental disorder and the dangerous and violent behaviour would be ameliorated. Secondly, violent behaviour may occur in the person with a mental disorder but treatment will not reduce or do away with the violent and dangerous behaviour. Lastly, violence can occur in the absence of a mental disorder. Of particular interest to this study are the first two types advanced below as the study intended to establish the contributing factors to criminal behaviour of persons with mental disorders.

The researcher has observed that several studies have been conducted to establish the relationship between mental disorders and crime. Of particular interest are the findings of a ten-year follow-up of discharged patients from mental hospitals in Stockholm in 1986 (Belfrage, 1998). The study followed [1, 056] patients aged between 17-70 years diagnosed with schizophrenia, affective psychosis, and paranoia. These patients were followed-up ten years later to determine if they had committed any offence after discharge from the mental hospital. The police register provided valuable information regarding the criminality of the patients, that is, the crimes committed and the sentences given.

The findings of the study revealed that in 10 years time 163 of the patients had died, 53 of them through suicide. Out of the remaining 893 patients in the study group, it became evident that "... the base-rate of registered criminality in the study group is 28 per cent" (Belfrage, 1998:147). This led the author to conclude that the criminality rate is three times higher in the study group than in the

general population. It was also observed that criminality among those patients younger than 40 years were higher (37%) compared to other age groups.

More men (42%) than women (14%) committed crimes according to Belfrage (1998:148) who also states that more males are likely to commit violent crimes (murder/manslaughter, assault, illegal threat and violence against officers) while women are likely to commit property crimes (theft/robbery, fraud). This is in line with the fact that, most frequently committed crimes by persons with mental disorders are violent crimes. Kebeng (2008) reveals that there are more male offenders with mental disorders in Lobatse Mental Hospital than their female counterparts. These male offenders have in most instances committed violent crimes such as murder, arson, and rape.

A different study by Modestin and Ammann (1995:673) also revealed that men with mental disorders were 1.8 times more likely to have been convicted of an offence, and 4.8 times likely to have been convicted of a violent offence than men without mental disorders. The same study showed that women with mental disorders were 4.1 times likely to have been convicted of an offence compared to women without mental disorders. In terms of violent crimes, there was no difference between women with and without mental disorders. This study is in line with that of Belfrage (1998) mentioned above, in terms of gender differences of persons with mental disorders particularly with reference to violent crimes.

The study by Belfrage (1998) also revealed that, often the victims are parents and relatives of the patients or at times total strangers. The public's rejection and fear of the mentally ill makes any efforts to re-integrate patients back into society difficult or close to impossible. This is supported by Brockington *et al.* (1993:93) who say that society is intolerant to the mentally ill and that the level of tolerance is dependent on factors such as age, education, occupation, and acquaintance with the mentally ill. People with higher education and professional experience on mental illness were found to have less fear of the mentally ill. Those of advanced

age, without education, and of low occupational status were found to be with restrictive attitudes to the mentally ill.

Lekgaba (2008) is in agreement with what is indicated by Belfrage (1998) that persons with mental illness tend to have their immediate family members and close relatives as victims. He attributes this to the fact that family members and close relatives are the ones in close contact with the patients, be they well or unwell. He further stated that the relationship between the patient and the family member(s), who are mostly carers and supervisors of the former (patient), is of paramount importance because it can trigger the criminal behaviour or guard against it.

Gudjohnsson (1990:15) is of the opinion that it is not always that there is a causal relationship between mental disorders and criminal behaviour. This is so because persons with mental disorders are also capable of committing crimes for reasons other than their mental condition. They may commit crimes as a result of any reason that may be advanced or present in a person without a mental condition such as greed, lack of conscience and revenge. The researcher has also observed that most authors (Belfrage, 1998; Modestin & Ammann, 1995) prefer to write about major mental disorders, than about all mental disorders. The above mentioned authors tend to focus on the following conditions: schizophrenia, affective disorders, alcohol and drug use disorders and paranoia. The rest of other mental disorders are grouped under category of other disorders. This implies that the association and risk to criminal behaviour is evident only to major mental disorders in the likes of the above listed disorders.

The researcher is of the opinion that there is an association between mental disorders and crime. The association is elevated when other factors not related to the disorder are present. An example is the gender difference in that most men with mental disorders are prone to criminal behaviour than their female counterparts. The researcher also notes that it will not always be that people with

mental disorders commit crimes as a result of their disorder but because of other factors such as those present in people without mental disorders. An example is provocation which may yield retaliation from both parties, although it will have to be proven beyond reasonable doubt that the individual with a mental disorder acted out of circumstances within his disorder, or the disorder had no role in his retaliation.

Another observation made by the researcher is that not all mental disorders are linked to crime, at least at the same magnitude. Studies undertaken prefer to focus on major mental disorders such as schizophrenia and their relationship with crime. The situation is worsened by the presence of more than one mental disorder especially the combination of alcohol and substance abuse and other mental disorders. This is discussed at a later stage in the chapter.

## **2.4 Risk factors associated with criminal behaviour for persons with mental disorders**

Several factors have been identified as unique and impacting on an individual's criminality. These factors, most authors argue, if present increase the chances of an individual indulging in criminal behaviour. They are listed and briefly discussed below.

### **2.4.1 Psychosis**

Psychosis is defined by Berkow *et al.* (1997:435) as a loss of contact with reality, and a significant loss of functioning. Link, Andrews, and Cullen (1992:275) state that, "Although mental patients have elevated rates of violent/illegal behaviour compared to non-patients, the differences are modest and confined to those experiencing psychotic symptoms". The assumption is that if a patient is not having psychotic episodes, or the mental disorder is not accompanied by psychotic symptoms, then the patient is not at risk of indulging in violent and

illegal behaviour than the average person. Psychotic symptoms such as hallucinations and delusions are discussed below.

### **2.4.2 Acute psychiatric symptoms**

Although other authors state that diagnosis such as schizophrenia, antisocial personality disorder, and epilepsy pose great risk for violence and criminal behaviour. Hucker ([sa]:3-5) prefers to consider the acute psychiatric symptoms presented by persons with mental disorders rather than their diagnosis. These symptoms are considered in relation to violence and criminal behaviour and they are briefly discussed as follows:

- **Mania**

According to Hucker ([sa]:3) persons with mania, a serious mental disorder, show characteristics such as elevated mood or irritability, sense of grandiosity, racing thoughts and speech. These persons, it should also be noted, are capable of threatening and assaultive behaviour although serious intentional violence is not common. Prins (1990:7) concurs when he states that persons with varying degrees of mania or hypomanic disorder are often in contact with the courts because of their outrageous, disruptive and dangerous behaviour. Manic patients pose a great challenge to courts and mental health team, because they are able to provide rationalised justifications and explanation for their actions. Prins (2005:102) reveals that significant others such as family, friends and professionals who attempt to interfere with what the sufferer believes to be his or her rightful activities may lead to serious injuries to themselves.

#### **Case illustration**

The case concerns a salesman in his twenties. He initially impressed his employer as a bright, energetic and very enthusiastic worker. However, it was not long before his ideas and activities took a grandiose and highly unrealistic turn. For example, he sent dramatic and exaggerated letters daily to a wide range of

motor manufacturers. His behaviour began to deteriorate rapidly, he lost weight through not eating (he “never had time”) and he rarely slept. One night, in a fit of rage, directed towards his “unsympathetic” employer, he returned to the car showrooms, smashed the windows and did extensive damage to several very expensive cars. He appeared in court, was remanded for psychiatric reports and was eventually hospitalised.

From the above case illustration, the researcher observes how a person with mania or hypomanic disorder can come to the attention of the courts for their outrageous, lack of insight and potential dangerous behaviour. Also evident from the above case illustration is the impact of the patient’s behaviour on the employer’s business as he was seen to be getting on the way of their rightful activity. Damage was caused to the employer’s business as he was seen as unsympathetic.

- **Depression**

Major depression is characterised by feelings of inappropriate guilt or worthlessness, lack of concentration, loss or gain of weight and appetite, persistent depressed mood, loss of energy and general fatigue, persistent lack of interest and pleasure in activities, and at times thoughts of death and suicide (Gerhart, 1990:87). Hucker ([sa]:3) reveals that violence can be self inflicted, for example, suicide or directed to others especially those close to the individual. An example cited is that of a depressed mother who kills her children or depressed men who kill their families and themselves.

Prins (1990:7) offers another dimension to the depressive disorder. He states that unless there are informants available to reveal that the person was depressed prior to the offence, it is difficult to establish whether the person’s depressive disorder is due to the seriousness of the offence or the action already taken of his offence such as arrest and imprisonment. Nonetheless, both authors agree that a person with a depressive disorder is likely to exhibit violence or

criminal behaviour but the challenge remains in proving whether the depressive disorder took place prior to the offence or after the offence.

According to Prins (2005:101) in very severe cases of depression, a patient may have a higher degree of retardation of function, thereby preventing implementation of any thoughts the patient might have such as suicide. He goes on to warn against premature discharges from the hospital as it increases the chances of the patient implementing the plans they had since they would have regained a certain degree of functioning. Prins (2005:101-102) demonstrates this through a case illustration below:

### **Case illustration**

A male patient, aged 45, had developed many of the signs of serious depression over the past couple of months (abnormally high levels of anxiety, disturbed sleep patterns, loss of appetite resulting in weight loss and consequent preoccupation with bowel functions). He overdosed sleeping tablets (prescribed by his GP for his insomnia), was admitted to a local hospital and later transferred to a psychiatric unit. Having received some treatment for his depression he felt better; his brother convinced him to take his discharge (against medical advice). Several days later, he went out alone for a walk, threw himself under a train which cut his head off.

The above case illustration clearly shows how unpredictable a person with severe depression can be. It also reveals that the patient and close relatives should not be fooled by the improvement of the patient's condition; rather they should work cooperatively with the professionals to avoid any hasty implementation of thoughts such as suicide which is common among these patients.

- **Delusions**

Delusions are illusionary beliefs, which are to a lesser extent related to reality, and almost everybody has them (Gerhart, 1990:77). Prins (2005:108) posits active delusions to be “powerful factors where the patient perceives some threat, where there is a lessening of mechanisms of self control and dominance of the patient’s mind by perceived forces that seem to be beyond his or her control”. They are said to be symptoms of mental disorders when they affect a person’s thinking to the extent that they control his actions. Of importance to note are delusions of being threatened by others, and paranoid delusions where personal control is overridden (Hucker, [sa]:4). These persons are at a higher risk of exhibiting violence to the people they interact with or those implicated in their delusion.

The researcher is in agreement with the facts advanced above and gives an example of a person who is deluded to think that his family is out to kill him. Anything they do will be associated with the plan to kill him. As a result he might for example counter their plan to kill him by harming or even killing them before they kill him. It is important for such a person to get adequate and efficient treatment before they can act in an antisocial behaviour as a result of their delusions.

- **Auditory hallucinations**

According to Gerhart (1990:77) auditory hallucinations are most frequently experienced by persons with mental illness. These persons hear voices talking or singing to them and this may differ in frequency and strength. An example of auditory hallucination is a command hallucination where voices may order a person to kill or harm themselves. Hucker ([sa]:5) contends that about 40% of persons hearing command hallucinations, act on those commands. The chances increase if the voice command is familiar, for example voices of one’s mother. The voices may instruct a person to do illegal acts, hence the criminal behaviour of persons with auditory hallucinations.

The researcher acknowledges the contribution of auditory hallucinations to criminal behaviour of persons with mental disorders. This is so in that the person with mental disorder who is having auditory hallucinations will take them to be real hence they need treatment to alleviate the hallucinations and guard against any possibility of committing a criminal act.

- **Intellectual disability**

According to Prins (2005:134) there are several ways in which mental impairment or intellectual disability may be associated with criminality. Firstly, the impairment can be very severe to the extent that the person may not comprehend that his/her action is legally wrong. Secondly, a mild to moderate mentally impaired offender is more likely to be easily caught in the criminal act. Thirdly, some mentally impaired offenders may be misinterpreted as they have a difficulty in making others understand their harmless intentions. Fourthly, a moderately impaired individual may be provoked into an unusual act of violence. Fifthly, mentally impaired persons may easily be used by others for their personal gain and may find themselves as accomplices. Lastly, if the impairment is associated with some organic disorder, such a person may have elevated levels of impulsive and unpredictable behaviour.

### **Case illustration**

A mildly mentally impaired man in his forties had worked well under friendly, but firm supervision. His work situation changed; with the result that his new employers felt he was being lazy and did not have much compassion for his disabilities. Furthermore, his new co-workers teased and picked on him. One day, one of them taunted him about his lack of success with women. Irritated beyond endurance, the defendant stabbed his tormentor with a pitchfork in his chest, causing fairly serious internal injuries. When the case came to the Crown Court, evidence was given as to his mental condition, his social situation and the

way in which he had been provoked. The court made a hospital order for him to be hospitalised.

- **Anxiety states**

Anxiety is defined by Berkow *et al.* (1997:395) as an unpleasant emotional state that is without a clear source and can be accompanied by physiologic and behavioural changes. The same author goes on to define another related concept, fear, as an emotional, physiologic, and behavioural response to a predictable external threat. Symptoms of anxiety may include palpitations, giddiness, nausea, irregular respiration, feelings of suffocation, excessive sweating, dry mouth and loss of appetite (Prins, 2005:121). Anxiety has been linked to criminal acts as according to Prins (2005:121), "... morbidly anxious individuals may feel so driven by their anxieties that they may commit an impulsive offence". An example could be a person who out of an overwhelming feeling of anxiety attacks a total stranger without any particular provocation.

The conditions listed above, specifically the symptoms and their association with the risk of criminal behaviour are in line with the researcher's observation from working with persons with mental disorders. The researcher supports the stand advanced and adds that a distinction should be made that the relationship is not always automatic as evidenced by some patients not indulging in criminal behaviours but presenting with the same symptoms. The existence of other factors such as gender, socio-economic status, alcohol and substance abuse, to name but a few, increases the risks further of an individual indulging in criminal behaviour. These factors will be addressed at length in other parts of this chapter.

This subsection provided valuable information on the aspects of mental disorders that are associated with criminal behaviour. The focus has been mainly on the symptoms of particular mental disorders that greatly affect and change how people think and behave in a given situation. Examples are disorders that have a

high association with hallucinations, delusions and marked confusion. Often, as has already been established, people who experience the above symptoms are prone to irrational, spontaneous outbursts that have seen them in contact with the law enforcement agents than persons without these symptoms. Alcohol and drug abuse, as alluded to in the preceding subsection, almost always worsens the situation. The researcher therefore, based on his experience of working in a psychiatric institution, is in agreement with the points advanced by the various authors above.

### **2.4.3 Alcohol and substance abuse**

In the context of this study it becomes also important to discuss the relationship between alcohol and substance abuse and crime. Walsh (1997:125) and Juginger (2006:1) agree that alcohol and substance abuse have a role to play in the criminal behaviour of individuals. Although Hester and Eglin (1992:37-38) agree that drugs and alcohol result in certain behaviour effects when they are being used, they also hold strong the perception that the effects will not be automatic. After taking alcohol or drugs, the authors argue that the influence will heavily rely on what is known of the drug, what they expect of it, and what is culturally permitted in the way of behaviour.

Other authors have a different observation than the above, in that they strongly believe that drugs and alcohol have an effect on an individual's criminality, especially with regard to violent crimes regardless of the knowledge the person has or the cultural expectations (Shaw *et al.*, 2004:1; Prins, 1986:202). Hiday (1995:122) reveal that people indulging in alcohol and drug abuse have a higher prevalence of violence. Alcohol is rated at 25%, while drug abuse is rated at 35%, and is in exclusion of the presence of a mental disorder.

According to the American Psychiatric Association (2000:207), "Substance abuse can be associated with violent or aggressive behaviour, which may be

manifested by fights or criminal activity, and can result in injury to the person using the substance or others". It is also revealed that substance abuse is implicated in large numbers in suicide cases, road and transport fatalities. People abusing substances including alcohol pose a greater danger to others and themselves as their behaviour is almost always unpredictable and they are not always in control of their actions.

Modestin and Ammann (1995:674) differentiate between men and women's abuse of alcohol and drugs in relation to criminal behaviour. They reveal that men abusing alcohol and drugs are 5 times likely to be registered as criminals. On the other hand, alcohol and drug abusing women are found to be 14.5 times likely to be registered as criminals. A distinction is also made to the effect that the drug abusers have been observed to have a higher criminality role than alcoholics for all crimes except for violent and sexual crimes (Modestin & Ammann, 1995:674). This implies that women are more influenced by alcohol and drugs to commit crime compared to men.

The researcher agrees that alcohol and substance abuse has an impact on the person with mental disorder's criminal behaviour. A distinction should be made between occasional use and prolonged use of alcohol and other substances to the extent that in the latter, the habit becomes a problem one. The researcher's observation of working with persons with mental disorders who have offended is such that, most of them were under the intoxication of alcohol and other drugs especially dagga, with males being more than females. In fact, alcohol related disorders accounted for the second highest number of patients after schizophrenia with 166 patients while cannabis induced disorders came third with 133 patients for the year 2006 (Lobatse Mental Hospital, 2007:15). Although the statistics is for all patients including those who have committed offences, it shows how widespread the problem of alcohol and substance abuse is for patients receiving treatment at Lobatse Mental Hospital.

#### **2.4.4 Antisocial personality disorder (ASPD)**

According to Berkow *et al.* (1997:427) most persons with antisocial personality disorder are males, have disregard for feelings of others and exploit others for personal gratification or material gain. Persons with antisocial personality disorder are also said to have a low tolerance for frustration, and are sometimes hostile or violent. They are impulsive and irrational when faced with conflict and often do not show any remorse or guilt for their actions.

Rutter (1996:4-6) makes a distinction between several factors regarding antisocial personality disorder and criminal behaviour. Firstly, is the age of onset of the disorder in that a distinction is made between early-onset and adolescent-onset. Early-onset is associated with aggression, poor relationships and a higher likelihood of persistence into adult life (Hucker, [sa]:7). In contrast, adolescent-onset antisocial personality disorder is seen as less pathological, and as a way to get free from adult control. Hodgins and Johnson (2002:190) make a distinction that early-onset is more prevalent among men while late-onset is prevalent among women.

Berkow *et al.* (1997:427) and Rutter (1996:4) are in agreement that more males than females show signs of antisocial personality behaviour and that there is a strong association to one's upbringing and life situations. Persons with antisocial personality disorder have a strong family history of antisocial behaviour, substance abuse, divorce, physical abuse, weak family relationships, and parental criminality (Rutter, 1996:5; Hucker, [sa]:7). The more severe and differently exposed the child is to these conditions the more the chances that the child will engage in violent and criminal behaviours in adulthood.

Rutter (1996:6) brings about an important point of environmental influences of antisocial personality behaviours, by stating that people select and respond to

their environments. An example given is of a person who has a stable marriage, and steady employment as having protection against criminal and antisocial behaviour. This is opposed to a person who has alcoholism, which is a risk factor for criminal and antisocial behaviour. This therefore shows that, antisocial personality behaviour is a risk factor for criminal behaviour, and the risk is increased by the presence of other factors such as alcohol and drug abuse.

Fridell *et al.* (2007) did a study titled, Criminal Behaviour in Antisocial Substance Abusers between Five and Fifteen Years Follow-up. A group of 125 repeatedly admitted drug abusers to a psychiatric detoxification and short-term rehabilitation ward between 1988 and 1989 were followed for 5 to 15 years. The results of the study revealed that at five year follow-up, ASPD patients were more likely to be current heavy drug users, to rely on welfare, and to have been incarcerated within five years of enrolling in the study (Fridell *et al.*, 2007:11). Between 6-15 years follow-up, a substantial number had passed away, and the Criminal Justice Registers provided information on the criminality of the patients.

The study reached several conclusions (Fridell *et al.*, 2007:13). Firstly, drug abusers with ASPD were more criminally active as was shown throughout the 15 year follow-up. Secondly, abstinence from drugs may have an effect on criminal behaviour in antisocial substance abusers as the study revealed that antisocial subjects who abstained from drugs had a lower level of criminal behaviour than antisocial subjects who did not abstain from drugs. Also, drug abusers without a diagnosis of ASPD were found to have fewer convictions. Thirdly, a combination of ASPD and drug use results in the persistent of criminal behaviour.

The researcher is in agreement with the association between ASPD and criminal behaviour and especially the co-occurring with substance abuse and the elevated criminal behaviour. ASPD and substance abuse on their own have a minimal impact on the individual's criminal behaviour but combined, they make a

huge contribution to one's criminal behaviour. This difference as shown by the findings of the above mentioned study can be continuous for a very long time.

#### **2.4.5 Co-occurring disorders**

Co-occurring disorders, the presence of mental illness and substance abuse increase the chances of an individual to commit crimes (White *et al.*, 2006:1; Shaw *et al.*, 2004:1; Modestin & Ammann, 1995:674; Prins, 1986:202). Hiday (1995:122) clearly states that, the comorbidity of major mental disorders, alcohol and substance abuse increases the chances of violence by 29%. Of importance to note are mental disorders that affect the individual's level of functioning and reasoning in relation to alcohol and substance abuse. Examples are schizophrenia, antisocial personality disorder and epilepsy.

Schizophrenia is one condition that is common to mental institutions including Lobatse Mental Hospital and accounts for more hospital admissions than any other mental disorder (Lobatse Mental Hospital, 2007:15). It has been noted that the rate of violent offences among persons with schizophrenia is four times higher than that of the general population (Lindqvist & Allebeck, 1990:345). Estroff, Zimmer, Lachicotte and Benoit (1994:1) also state that persons with a diagnosis of schizophrenia are more likely to commit violent acts than other persons with different diagnosis. This is worsened by the presence of psychotic features such as hallucinations and delusions.

When alcohol and drug abuse is also present the risk becomes elevated as Prins (1986:202) states that "Such illnesses, exacerbated by alcohol and/or a mixture of alcohol and medication taken to treat the illness, may lead to an outburst of unprovoked and unpredictable violence". The researcher can therefore conclude that persons with schizophrenia and on medication, accompanied by the presence of psychotic features, alcohol and substance abuse, are more at risk of displaying criminal behaviour.

## 2.4.6 Organic Conditions

Although organic conditions (infections, disease, metabolic and hormonal disturbances and trauma) are rare conditions, their presence may arouse criminality (Prins, 2005:126; 1990:8). They are each discussed separately below:

- **Infections**

Infections listed include meningitis, encephalitis and herpes simplex. These are said to be capable of resulting in severe or minimal brain damage, which is followed by marked behaviour changes. Persons with these infections are at risk of displaying unacceptable behaviour that contravenes society's norms, values and laws. An example is encephalitis in children whereby they may show aggressive and antisocial behaviour; infection of the urinary tract in older and elderly people which may result in confusion and disorientation (Prins, 2005:126).

The researcher appreciates the possible contribution of infections to behaviour changes and is of the opinion that should they be present together with mental disorders, then they pose greater challenges to the sufferer and support systems to guard against any display of criminal behaviour.

- **Huntington's chorea**

Huntington's chorea is an inherited disease affecting people in midlife and starts with occasional jerks or spasm and gradual loss of brain cells, progressing to chorea, athetosis, and mental deterioration (Berkow *et al.*, 1997:313). The heredity rate is 50%, that is, 1 out of 2 children will inherit the condition from their parents. Prins (2005:127; 1990:8) states that in the early stages of this terminal condition, there may be unpredictability of behaviour and frequent antisocial conduct. Thus, the researcher is of the opinion that persons with this condition are likely to indulge in criminal behaviour hence they need counselling and

support for them and their families to appreciate the condition and possible consequences.

- **Endocrine and hormonal disturbances**

Hypoglycaemia may occur to some people who have been without food for a long time, and this may result in impaired judgement and extreme irritability, an example being an untreated diabetic person (Prins, 1990:9). These people's antisocial behaviour predisposes them to frequent contact with the law. The researcher is of the opinion that social factors such as illiteracy, unemployment and poverty can be contributing factors to why people would stay for longer periods without food, leading to impaired judgement, which might be followed by antisocial behaviour.

- **Brain trauma, tumour and the epilepsies**

Regardless of the cause, brain injury has both short term and long term behavioural implications such as prolonged confusion (Prins, 2005:129). As such, Prins (1990:9) advises that professionals collect a thorough history if they are to detect brain injury or trauma. Epileptics are overrepresented in prisons and this has been attributed to among others, overcrowding, parental rejection and lack of proper aftercare, hence continued criminality (Prins, 1990:9). It is worth noting that of all types of epilepsies, temporal lobe epilepsies account for more convictions and have resulted in forensic psychiatric interest (Prins, 2005:130-131). It often manifests itself in sudden, unexpected alterations of mood and behaviour. The researcher advocates for action to address the impact of these conditions on the criminality of the sufferers. For example, if brain injury is avoided or minimised, and epilepsy is well managed, then one can expect less cases of antisocial and criminal behaviour as a result of fewer brain injury cases and properly managed epilepsy.

The researcher appreciates and acknowledges the role that infections, diseases, metabolic and hormonal disturbances, and trauma contribute to people's mental

disturbances and ultimately affects their potential for violent and criminal behaviour. Thorough assessment and investigation must be made to identify these conditions and their possible impact on the affected person's behaviour, in this case, the criminal behaviour. People must be well informed of the presence of the above conditions and alerted for behaviour change possibilities. Also, swift actions should be taken to address these conditions prior to any marked change in the affected person's behaviour.

#### **2.4.7 Demographic characteristics, social networks and social support**

The researcher has made an observation that persons with mental disorders who commit crimes are from different backgrounds, life experiences and social networks. Likewise, Estroff *et al.* (1994:1) established the linkages between a person's risk of criminality and the above listed factors. They found out that persons who live in larger networks, those with networks composed primarily of relatives and those who lived with a person not related to them, had increased chances of threatening violence. Financial dependence on family resulted in more violent threats and acts. Persons who perceived hostility from others had higher chances of displaying violent behaviour and acts. The victims of such violent acts are relatives, mainly mothers living with a person with a mental disorder.

According to Estroff *et al.* (1994:1), "The interpersonal and social contexts of respondents and their perceptions of these contexts are important considerations in assessing the risk for violence by persons with mental illness". In particular, the dependence on the family for financial support is critical in determining the risks of violence. Financial dependence has a serious impact on other important aspects of a person's life. Examples are essential services such as food, clothing, shelter, transport and medication. The situation is worsened by the life-long duration of most serious mental disorders such as schizophrenia.

Hiday (1995:123) extends a different dimension to the relationship between mental illness and violent behaviour. Mental illness alone does not pose much risk to violent behaviour relative to other characteristics of an individual. These characteristics are: young, male, single, lower class, and substance abusing or substance dependent. A young, single, male person of a lower socioeconomic class is more likely to commit violent acts. According to Hiday (1995:125), "... persons in low socioeconomic positions are characterized by powerlessness, exploitation, and threat of victimization". These persons, in turn, resort to violent behaviour in retaliation and to protect themselves from others. The presence of a mental disorder, in particular hallucinations and delusions, increase the chances of the person indulging in criminal acts.

Link *et al.* (1992:290) concur with Hiday above by stating that, "Compared with the risk associated with variables like age, gender, and education, the risk associated with mental patient status is modest". They both agree that a young male of low education is most likely to indulge in violent and illegal behaviour. These factors have a stronger influence on an individual's criminality than the mere presence of a mental disorder.

The researcher is of the opinion that relationships between a person with a mental disorder and significant others is considered vital in the reduction of criminal behaviour of the former. Critical to this reduction in criminal behaviour, the researcher advocates that the interpersonal relationship between the family and the person with a mental disorder be one that can cushion the burden of dependency. This is such that if the relationship is of respect, love, care, tolerance, maybe the financial dependency will not be an issue and its existence will not be noticed. If the relationship is a caring one, persons with mental disorder will be well cared for in a supportive environment that does not encourage relapses and tensions which are the fuelling factors for violent and criminal behaviour. The assumption that being young, single, male and of lower socioeconomic class is not disputed by the researcher, rather society is blamed

for not empowering people to improve their socioeconomic status. Persons with mental disorders are challenged than the ordinary person; hence they have to be assisted to equally compete as opposed to being made dependent on the system through routine handouts except those that are severely challenged such as chronic patients.

#### **2.4.8 Lack of adequate and appropriate treatment**

According to Hodgins and Johnson (2002:108), the implementation of the policy on deinstitutionalisation in the field of mental health has resulted in a situation whereby, persons with major mental disorders receive no treatment or inadequate and/or inappropriate treatment. This in turn results in lack of care which has been associated with illegal activities by persons with mental disorders discharged into communities. The lack of appropriate and adequate treatment often results in persons becoming symptomatic or prone to alcohol and substance abuse and having increased risk of indulging in criminal behaviour.

The researcher is aware of the disparity between urban, semi-urban and rural areas with regard to the availability of adequate and appropriate treatment. This remains a challenge for persons with mental disorders as they have to travel long distances to access health services and receive appropriate treatment. In some cases, health facilities are without psychiatric services as there is a shortage in Botswana. This could lead to the reluctance by the family members to take their ill members to the hospital for treatment and rather use the little amount of money at their disposal to buy food and other basic necessities to benefit all family members. This reluctance may aggravate the occurrence of violent behaviour in the person with mental disorder, as has already been indicated in the preceding discussion.

#### **2.4.9 Poor adherence to medication**

Poor adherence to medication may signal a higher risk of violent behaviour by persons with mental disorders in the community (Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998:1). Lekgaba (2008) concurs with the above based on his experience of working with persons with mental disorders who have committed crimes. He attributes this to several factors, such as poor support systems, lack of education, poverty, alcohol and substance abuse, and side effects of medication.

The researcher is of the opinion that, persons with mental disorders who do not adhere to treatment end up having relapses. They in turn, are prone to symptoms of their mental disorder and have potential to indulge in criminal behaviour, as already shown in preceding text. Some persons with mental disorders need to be on treatment for the rest of their lives and for the maintenance of psychotic symptoms that are implicated in their criminal behaviour.

#### **2.4.10 Recommendations to address the risk factors**

The problems experienced by persons with mental disorders and in particular those related to their criminal behaviour can be minimised if not resolved through the active participation of all stakeholders. Hodgins and Johnson (2002:193) advocate that an array of treatment and services should be readily available in the community, in order for persons with mental disorders to live in the community without causing harm to themselves or to other people. This comes about in light of the fact that most persons with mental disorders require treatment for the rest of their lives.

Treatment and services according to Hodgins and Johnson (2002:193) have several components. They include medication, support services provided by a stable person who is conversant with the patient and builds a relationship with

the patient. The relationship includes supervision of treatment, substance abuse behaviour, and specialised behavioural training programs such as life skills, social skills, coping with stress, anger, and frustrating situations (Hodgins & Johnson 2002:184). All these activities require money and time for them to be readily available, effective and efficient. Commitment from governments, communities, mental health service providers, persons with mental disorders and their families can ensure that the treatment and services rendered are a success.

Hodgins and Johnson (2002:193) also advocate for civil law to provide a possibility of reinstitutionalising persons with mental disorders quickly and efficiently, upon a comprehensive assessment by mental health team, and it is observed that they are at significant risk of committing crime. Effective treatment should then be made mandatory.

The researcher is without doubt that the recommendations above can reduce the number of criminal cases against persons with mental disorders. This situation can only happen if there is commitment from all stakeholders and plans are fully implemented. The researcher has observed that although there is a focus on deinstitutionalisation of psychiatric services, the plan is good on paper only because implementation has not lived to expectations. This observation comes about as more and more patients are still admitted to psychiatric institutions for very long periods of time, something that is against the plan of deinstitutionalisation.

To support the above observation, the researcher refers to the average length of stay of patients in hospital from 2000 to 2006 subsequently as follows: 98, 75, 70, 74, 74, 71, and 57days respectively (Lobatse Mental Hospital, 2007:3). This proves that on average patients spend more time admitted in the hospital. It is in a way a sign that mental health services in the community are failing to keep patients in the community or they do not exist. The researcher is of the opinion that if resources could be made available for the implementation of the principle

of deinstitutionalization, then many patients could be cared for within their families, where they could be provided with love and support, maybe minimizing their risks of engaging in criminal behaviour.

## **2.5 The need for collaboration in addressing the needs of offenders with mental disorders**

There is a general concern that offenders with mental disorders should be cared for and treated, rather than being punished through the criminal justice system (Fitzgibbon & Cameron 2007:1). This still remains a challenge for many governments (Botswana included), to adequately meet the needs of above mentioned persons. Governments are therefore encouraged to put in place policies, measures and mechanism to address the needs of the offenders with mental disorders. Emphasis is put on "... a need for partnership working, and full and timely sharing of information across criminal justice, health agencies and others involved in the care and management of mentally disordered offenders" (Fitzgibbon & Cameron 2007:1). This is seen as a step in the right direction to meet the needs of persons with mental disorders, and a diversion from the usual punitive action taken against such persons. Hodgins and Johnson (2002:193) concur with what has been said by Fitzgibbon and Cameron (2007:1) above, that mental health policy must be based on the real needs of individuals with mental disorders and on empirical evidence about their behaviour (including criminal behaviour).

The researcher has observed that the community of persons with mental disorders comprises of people who are unique and different from each other. These people have different life experiences, challenges that have to be explored if their needs are to be adequately met. According to Fitzgibbon and Cameron (2007:2) the following are factors that are found to be contributing to mental health problems of persons with mental disorders: unemployment; homelessness; lack of support from family; lack of accommodation; poor

educational and employment skills; substance misuse; relationship problems; problems with thinking and attitudes and the risks they pose to the public. These factors can in turn be perceived as areas of need for offenders with mental disorders. A comprehensive tool can therefore be devised to assess these risk factors, and to devise means to address them. The researcher aimed at identifying the contributing factors regarding persons with mental disorders who commit crimes through this study. The needs were also identified, that led to the formulation of conclusions and recommendations regarding the reduction of criminal behaviour of persons with mental disorders.

Home Office (2004) as cited by Fitzgibbon and Cameron (2007:2) states that: "... offenders are not a homogeneous group and that they are differentiated by age, gender, ethnicity, family background and geographic location, and by the nature, circumstances and frequency of the crimes they commit." The above stated document goes on to reveal that offender's problems are complicated and inter-related ranging from frequent long-term disengagement from services to history of poor relationship with their carers.

The researcher supports the need to treat each offender as unique from other offenders and the general population. If each offender's situation is adequately assessed, their intertwined problems and needs can be identified and a plan put in place to address the areas of need. In exploring the factors contributing to the criminal behaviour by persons with mental disorders, each participant was treated as a unique individual with unique life experiences and situations.

## **2.6 Risk assessment**

Jones and Ploughman (2005:141) provide a guide for various disciplines working with offenders with mental disorders. Risk assessment is mostly carried out for the purpose of intervening in that it often focuses on the harmful consequences (Kumar & Simpson, 2005:329). The same authors go on to reveal that prior to

intervening; there should be a thorough risk benefit analysis to ensure that the intervention is not harmful to the clients. Before detailing the proposed guide, it is worth bringing in the involvement of the patient in risk assessment. In fact, Kumar and Simpson (2005:329) state that patients should be involved in their own risk assessment if they are expected to understand and appreciate why interventions are necessary.

The guide provided by Jones and Ploughman (2005) is intended to be included in the broad assessment of these persons to ascertain the possibility of re-offending and of possible violent and dangerous behaviour. The various areas to cover are discussed below:

- **Family background**

Of importance to note is the quality of the relationship with the parents, primary caregivers and the siblings. Also critical to document are areas of conflict and tensions both in the home and in the community; experiences of abuse either as a perpetrator or victim and if possible the impact of this on the patient's development (Jones & Ploughman, 2005:142). The current study explored the family relationships of persons with mental disorders who have committed crimes. This is so in that the researcher believes that the family offers two alternatives, that is, it can make or break the person with a mental disorder.

- **Educational history**

Jones and Ploughman (2005:142) posit that a detailed description of a patient's educational experience and the impact on the patient should be documented. This should be extended to an assessment of the quality of the relationship with peers and teachers. Also to be included is how the patient views the educational process, focusing on areas found to be rewarding or non-rewarding; and how the patient coped with any stressful experience throughout the educational process.

The researcher is of the opinion that a distinction should be made between formal and informal education. The researcher, acknowledging that not all persons with mental disorders are able to enrol into formal education, is of the opinion that this should be also documented and the reasons why the patient was not enrolled outlined. Also to be documented according to the researcher's opinion is the outcome of the lack of enrolment with the education system from the patient's point of view.

- **Occupational history**

The patient's experience with the employment sector should be thoroughly documented (Jones & Ploughman, 2005:142). If the patient has ever been employed, the relationship with the employer, supervisor and colleagues should be documented. It is also vital to document the lengths of employment, the intervals and reasons why there were intervals. The researcher adds that if the patient has never been employed the reasons should be documented. Also, assuming that all adults are engaged in productive and income earning activities, there should be a documentation of what the patient was involved in at a time they are supposedly to engage in work of some form.

- **Relationship history**

The focus of the assessment as advocated by Jones and Ploughman (2005:142) should be on the patient's experience of intimate (romantic) relationship, particularly the ability to establish and maintain close affective bonds. The assessment should be extended to the ways and strategies of resolving any conflict experienced in the relationships. If any relationship was terminated, the reasons should be explored and documented. If there were children involved, it will be worth considering how well the patient provided love, care and support to the children.

Pollock (2006:XVII) advocates for the assessment to examine the nature of the relationship between the offender and the victim. Of importance to consider, is

how the victim is perceived, approached, controlled, treated and left which will reveal the thinking patterns of the offender (Pollock, 2006:XVII). Where there is more than one victim, their relationship with the offender should be explored. The researcher is of the opinion that this exploration can benefit the intervention to be put in place as there will be a clear understanding of the nature of the relationship between the offender and the victim, and of the contributing factors to the criminal behaviour.

On the other hand, Kumar and Simpson (2005:330) state that, the incidence of any unpleasant event including the risk of violence requires the presence of three factors, namely, a perpetrator, a potential victim and an environment or an opportunity for the event to occur. This is in line with what Pollock advocates above except for the inclusion of an environment or opportunity for the event to occur. This extension reveals the importance of the relationship between perpetrator, victim and environment that need not be overlooked.

- **Substance abuse history**

Jones and Ploughman (2005:142) state that the relationship between alcohol and substance abuse should be established for the patient's violent and criminal behaviour. They advocate that the patient's reasons for alcohol and substance use should be established. This will avail the reasons for use or abuse of the substance; the pattern of use or abuse of the substance; the impact of the substance used or abused on the patient's health, and particularly on the violent and criminal behaviour. Jones and Ploughman (2005:142) observe two scenarios involving violence and substance abuse. Firstly, the violence may occur as a way to acquire resources for the continual support of the dependency. Secondly, the violence may come as a result of the distress resulting from the substance abuse.

- **Forensic history**

The patient's past forensic history should be assessed and documented, that is, previous arrests, charges and convictions (Jones & Ploughman, 2005:142). The same authors go on to advise that concentration should be extended to the patient's antisocial behaviour throughout their lifespan. The information should detail the types of offences committed and any possible intervention ensued to ameliorate the offending behaviour. Since the patient may not recall all the information, Jones and Ploughman (2005:143) reveal that witness statements, police interview transcripts, and court-related documents can be used to fill the gaps on the information provided by the patient.

In order to obtain a comprehensive, reliable history on the patient, the clinician should use a variety of information sources (Jones & Ploughman, 2005:143). These sources include but are not limited to: the patient, relatives, friends, colleagues, employers, patient hospital files, and any other important document or significant people in the patient's life. The purpose of having a wide range of people and documents to get information from is for comparison and corroboration. This is in light of the fact that people may provide information based on what they stand to gain or avoid, for example, a patient might hide information that can work against his discharge so as to be discharged early. Another example is that the patient might not recall all the information due to the illness, hence there would be a need for relatives to assist with information the patient does not recall.

Kumar and Simpson (2005:331-332) reveal two important assessment tools mostly used in psychiatry as Violence Risk Assessment Guide (VRAG) and HCR 20 (translated to: past (historical), present (clinical) and future (risk) circumstances). Of these two, the researcher can identify with the HCR 20 although not familiar with it. The HCR 20 is divided into three scales namely the historical, clinical and risk management scales. The items under each scale are listed as follows by Kumar and Simpson (2005:332):

- Historical scale: previous violence; young age at first violent incident; relationship instability; employment problems; substance use problems; major mental illness; psychopathy; early maladjustment; personality disorder; prior supervision failure.
- Clinical scale: lack of insight; negative attitudes; active symptoms of major mental illness; impulsivity; unresponsive to treatment.
- Risk management scale: unrealistic plans; exposure to destabilizers; lack of personal support; non-compliance with remediation attempts; stress.

The above listed items are very useful in assessing the chances of a client's risk of violence in that they look at the client's historical factors, the clinical (current) factors and predict the future possibility of a risk of violence. Several factors are the same as those mentioned by Jones and Ploughman (2005) such as relationship instability, employment problems, substance use problems and previous violence (forensic history). This therefore means that each discipline will devise its assessment tool with contents relevant to their field and together with other disciplines will combine the outcomes to have a comprehensive assessment of the client.

The researcher acknowledges the importance of an extensive thorough assessment of risk of violence as advocated above. He agrees with the authors that if the assessment is undertaken by a multidisciplinary mental health team, it can provide valuable information that in turn can be used to guide decisions on persons with mental disorders who have offended. The researcher is of the opinion that a subheading of leisure, sport and recreation should be included in the history. This will provide areas of interest the patient is involved in and how they contribute to the patient's wellbeing. It will also shed light as to what the patient enjoys and the people in interaction with outside the confines of family,

friends and co-workers. The assessment will include the duration of the relationship and the coping strategies in place when faced with conflict.

## **2.7 The role of the social worker**

Since this study is conducted from the social work frame of reference, it is important that the role of the social worker in dealing with offenders with mental disorders is discussed. In fact, it remains a challenge for the social workers to "... abandon a simplistic and narrow notion of social workers as mere "psychotherapists," or for that matter, case managers" (Bentley & Taylor, 2002:1). Clearly, these authors are challenging social workers to broaden their scope by aggressively adopting and embracing the diverse roles of their day to day practice. The authors see this as a way of comprehensively and effectively meeting the needs and wants of their clients. This is especially the case in dealing with persons with mental disorders who have committed crimes as they are a diverse group with different situations, needs and wants.

Bentley and Taylor (2002:1) state that the ultimate role of the social worker is to be an active resource in the patient's recovery and rehabilitation. They go on to reveal that the social worker also plays other roles not confined to mental health treatment and these include concerns of: employment, health, housing, education, recreation, family issues, transportation, community life and significant relationships. Several roles of the social worker are discussed below:

- **Assessment**

Pritchard (2006:109) provides the "... BASIC IDDS: Behaviour, Affect, Sensory, Imagery, Cognition, Interpersonal relationships, Drugs, Defences, and Social factors" as a tool that can be useful in the field of mental health social work. Several questions are asked in connection to the BASIC IDDS system and will provide the social worker with valuable information on the abbreviated letters.

Pritchard (2006:110) provides the following questions that are asked by the social workers using the above stated system: What is happening to the client (behaviour)? How do they feel about this (affect)? How do they feel physically, do they have any symptoms (sensory)? How did they think about this (cognition)? What ideas do they rehearse in their heads to resolve it or to avoid it (imagery)? How do they get on with people, especially significant others (interpersonal relations)? Have they started treatment, medication, or counselling, as this will account for their behaviours or feelings (reaction to drugs)? Ask how they usually deal with any painful material, while you observe their defensive responses (defences)?

On the other hand, Hervey (2006:185) does not differ with Pritchard above in stating that a good social work assessment should allow the patient to explore: their perception of the situation; the nature of their relationship with their relative; what caring tasks they undertake and their impact; what kind of help they would like; lastly the emotional and physical impact of the caring role. Both these authors are concerned with getting as much input from the patient as possible focusing on among others how they feel, think and view their condition in general.

From the researcher's experience of working with persons with mental disorders who have offended, social work assessment is very important because it informs the decisions and interventions to be effected. The assessment entails a thorough assessment of the patient, his family and community. It is important to note that social workers are requested to make a home visit to the patient's home to meet the family and significant others who all play a particular role in the life of the patient. The assessment includes the family and community resources; relationships; substance use and abuse; reintegration and discharge plans; community services to name but a few. These assessments will give the social worker a clear picture of how the patient will be living in the community and the potential for continued criminal behaviour.

- **Social worker as an educator**

Based on various theories, such as social learning theory and cognitive behavioural theory, education involves the dissemination and exchange of information between the social worker and the client, and ongoing professional development and self education for the social worker (Lukens & Prchal, 2002:124-125).

The information above is interpreted to mean that social workers are knowledgeable on their field of practice, in this case on mental health aspects. This comes about as a result of their training, skills and experiences of being in the field. As a result, social workers educate their clients (patients, families and significant others) about mental disorders, symptoms, prevention measures, the psychosocial impact, treatment, and coping strategies.

With particular reference to persons with mental disorders who have offended, the researcher has observed that social workers educate the clients about the medico-legal aspects of their behaviours. Based on their assessment of the situation, the social worker educates the clients on the legal aspects of the patient's criminal behaviour. This includes the procedures with the court, their rights and entitlements, the court's ruling and the implications. An example is the discharge process that is unique in that the patients are discharged by the president following recommendations by the mental health team including the social worker.

- **Social worker as the skills trainer**

Gioia-Hasick and Brekke (2002:144) make a distinction between two critical skills, namely social interactive skills and self-regulatory skills. Interactive skills are said to be concerned with social behaviour such as communication, assertiveness and problem solving. Self-regulatory skills on the other hand are

concerned with non-interactive techniques such as relaxation, self-talk and cognitive restructuring.

The researcher is of the opinion that communication is an important aspect of people's every day life including persons with mental disorders. It shapes the interaction between people. It comprises of conversations (amount of speech, rate of speech, voice volume, intelligibility of speech) and nonverbal communication such as eye contact, body language, and use of personal space (Gioia-Hasick & Brekke, 2002:145). Social workers observe the communication pattern and style of the patient and significant others.

Communication, if well executed by the patient, the family and significant others, the researcher has observed, can help bring about understanding of one another. This is crucial to persons with mental disorders since if there is a general understanding between patient and people in interaction with, certain behaviours such as the criminal behaviour and antisocial behaviour may be curbed. Social workers must identify the problems in communication and address them as they will also improve how concerned people will interact with each other.

From the researcher's observation, persons with mental disorders are at a greater chance of getting in conflict with other people including their families, especially when they are not well. This therefore implies that those in conflict call upon their problem-solving, mediation and conflict resolution skills. Social workers are therefore challenged to assess the patient's skills and to equip the patient and their families with skills such as problem-solving, anger management, assertiveness training, relaxation training and stress management (Gioia-Hasick & Brekke, 2002:147-153).

- **Empowerment**

Empowerment practice is a process in which social workers assist clients to: be self-determining; be active participants in their own life changes; develop an

awareness of their situation and power; develop a sense of mastery of their environment; and lastly, influence decision makers (Bentley & Taylor, 2002:11). This approach has not been spared criticism as Cowger, Anderson and Snively (2006:98) state that “To assume that a social worker can empower someone else is naive and condescending and has little basis in reality”. Social workers, the latter authors argue that act as resource persons who uncover the client’s strengths and resources for effective use by the clients and not necessarily imparting power to the clients.

The researcher nonetheless is of the opinion that social workers are active service providers in the empowerment of people with mental disorders who commit crimes. They assist these people to take necessary steps to address their criminal behaviour by linking them with resources, creating awareness of the criminal behaviour, and developing a sense of mastery of the environment.

The above listed skills do not come overnight and are not simple to achieve as they rely on the expertise, experience and skills of the social worker. They are also demanding and require a lot of time as the patient and concerned people practice and evaluate the effectiveness of acquired skills. They are also about behaviour change which the researcher acknowledges not to be easy to achieve.

- **Advocacy**

Based on the assumption that the environment is rich with resources such as people, institutions, associations, and families, the social worker plays the role of identifying available resources, establishing their accessibility, adequacy and acceptance to the client (Saleebey, 2006:89). Silverman (2002:283) adds that the social worker should be knowledgeable on policies, statutes and laws that have an impact on the clients. Based on the wide knowledge possessed by the social worker, one can therefore expect that the rights of persons with mental disorders will be upheld as the social worker advocates on behalf of the clients.

The researcher has observed that social workers advocate for among others, reconciliation between victims and persons with mental disorders. They also advocate for the reintegration back into the family and society of persons with mental disorders who have offended. These persons are also linked to resources in the community to boost their coping abilities and to prevent relapses and re-offending.

- **Case managers**

Another role played by the social worker is that of a case manager. According to Ambrosino, Heffernan, Shuttlesworth and Ambrosino (2001:268), social workers do not necessarily provide all services to clients directly but manage the case and coordinate other professionals providing the service. Sullivan and Rapp (2002:190) state that the primary focus of case managers is on the psychosocial challenges presented by serious and persistent mental illness. These challenges are said to be comprising of thoughts, feelings and emotions at the personal level and stigma at community level.

The social worker makes follow-ups of the client and gets in contact with significant others such as the family, employer and other appropriate people to ensure that the client is functioning well (Ambrosino *et al.*, 2001:268). In the case of persons with mental disorders with a history of criminal behaviour, the focus will be extended to substance abuse, treatment adherence, and contact with the criminal justice system. The researcher views the above factors as important in determining if the person is functioning well in society.

- **Social workers as policymakers**

As administrators and policymakers, social workers "... develop and advocate for legislation, develop policies and procedures to ensure that the needs of individuals with mental health problems and disabilities are met, and oversee governing bodies that monitor progress to ensure that services are provided" (Ambrosino *et al.*, 2001:269). Social workers are in a better position to influence

policies, legislations and procedures as they are familiar with the needs and situation of persons with mental disorders. They help bring about these changes that in turn can help create a conducive environment for effective functioning of persons with mental disorders. The researcher has observed that social workers in Botswana need to up their role of policymaker so as to ensure that the needs of persons with mental disorders are adequately met. This is so in that the researcher believes that a lot is still to be done to advocate for the needs and rights of persons with mental disorders especially those that have criminal and antisocial behaviour.

Not all social work roles are listed and explained above. Nonetheless, social workers play a very important role in addressing the problems encountered by persons with mental disorders including their criminal behaviour. They have to put in place and implement preventative efforts such as equipping these persons with problem solving skills to avoid violence and aggressive behaviour. Social workers educate and empower those that have committed criminal offences to curb a recurrence of the criminal behaviour. Lastly, they work with the patient and family through follow-ups and ongoing support services to ensure that the patient does not resort to criminal behaviour while in the community. They also make referrals for continuity of service.

## **2.8 Legal framework regarding mental health in Botswana**

There are two important legal documents in Botswana that are in frequent use or reference with regard to persons with mental disorders who commit crimes, namely *Mental Disorders Act*, (Chapter 63:02 of 1971) and *(Criminal Procedures and Evidence Act of Botswana*, (Chapter 08:02 of 2002)).

Section 160 subsection (1) of *Criminal Procedures and Evidence Act* of Botswana (Chapter 08:02 of 2002) stipulates that where it is established that a person brought before the court was not responsible for his actions at the time of

the offence or omission, a special finding to the effect that the accused was guilty of the offence or omission but was insane at the time is made. Subsection (2) goes on to state that the accused shall be kept in custody as a criminal lunatic while a report is sent to the President. Subsection (3) gives the President the powers to order such a person to be confined during his pleasure in a place of safe custody (*Criminal Procedures and Evidence Act of Botswana*, Chapter 08:02 of 2002).

Section 40 (3) of *Mental Disorders Act* (Chapter 63:02 of 1971), stipulates that The Mental Health Board may, on the direction of the President of Botswana inquire into the person detained under Part XI of the *Criminal Procedures and Evidence Act of Botswana* (Chapter 08:02 of 2002) and report back to the President. Usually, the board compiles reports to the President with recommendations on the continued detention or for Presidential release. The board reviews reports of mental health team working with offenders with mental disorders, reviews the offenders and their families before any report can be forwarded to the president.

The researcher is of the opinion that some light be shed as to which legal documents govern the process and procedures to be followed when a person with a mental disorder commits a crime. This is very important in that it has implications for addressing the criminal behaviour of persons with mental disorders. An order is made to put them in an institution where they will get help in addressing their problems including the criminal behaviour. Not all people who commit crimes go through the same system. This is so in that some cases are never prosecuted, others are not reported but those that go through the criminal justice system are governed by the above stated legal documents.

The researcher has also observed that these documents, particularly *Mental Disorders Act*, Chapter 63:02 of 1971 has provisions for addressing the needs of persons with mental disorders even prior to indulging in criminal behaviours. An

example is the provision for mandatory admission to a mental institution where it is observed that the person with a mental disorder is at risk of harming the self or others. Such a provision can curb the criminal behaviour of persons with mental disorders if fully implemented. The challenge according to the researcher is that, not every member of the public or people living with a person with a mental disorder are aware of such a provision hence the need to intensify information dissemination to the public by the mental health team.

## **2.9 Summary**

The researcher has covered a wide range of theories on crime causation. The applicability of each theory was explored. Although some theories were also suitable to the study, the researcher adopted the life course theory as the best to use in the current study. The chapter also established that there is a relationship between mental disorders and crime. An example is the presence of particular psychiatric symptoms, especially hallucinations and delusions. Other factors impacting positively on this relationship are being male, single and young.

Alcohol and substance abuse have been identified to be a major contributing factor to criminality in general and to criminality of persons with mental disorders. Since most persons with major mental disorders are dependent on lifelong treatment, this poses a great challenge as they have to adhere to treatment to avoid having relapses and symptoms linked to a higher likelihood of criminal behaviour. This challenge affects the patient, the family, significant others and the mental health team.

The need to have appropriate and adequate treatment for the patients with mental disorders has also been discussed in the chapter. Having this type of treatment could assist in ensuring that the patients' and their families' needs are addressed adequately.

The social worker is a critical member in the fight against criminal behaviour of persons with mental disorders. As already alluded to, social workers play various roles such as educator, skills trainers, therapists, case managers, administrators, policymakers, and advocates in their day to day contact with persons with mental disorders. They work with other professions in the mental health team, the patient and their families to address all problems related to mental disorders including the criminal and antisocial behaviour.

## **Chapter 3**

### **Empirical findings**

#### **3.1 Introduction**

This chapter comprises of a description of the research methodology, and the research findings on the contributing factors to the criminal behaviour of persons with mental disorders. The findings are presented in accordance with the themes extracted from the participants' experiences and verified with literature.

#### **3.2 Research design and methodology**

The research methodology that was used in this study is discussed here to facilitate understanding of this chapter. The researcher utilised a qualitative approach and heavily relied on subjective data provided by the small sample, which in turn has been used to generate some understanding of the factors contributing to the criminal behaviour of persons with mental disorders. Applied research was used in light of what Kumar (2005:9) states, that research techniques, procedures and methods under applied research are implemented in the collection of information on a particular situation and may be used for policy formulation, administration and better understanding of phenomena. Relevant ethical aspects, as mentioned in chapter 1 of this report, were taken into consideration when conducting this study.

##### **3.2.1 Research design**

Research design is often defined differently by various authors. Babbie and Mouton (2001:74) state that "A research design is a plan or blueprint of how you

intend conducting the research.” Terre Blanche and Durrheim (1999:483) perceive research design as “... a strategic framework or plans that guide research activity to ensure that sound conclusions are reached”. Durrheim (1999:29) reveals that “A research design is a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research”. From these concurring definitions, one can conclude that a design is a plan or strategy that a researcher adopts in undertaking a particular study.

This study utilised collective case-study as a research strategy. A case study, according to Creswell (1998:61), is thorough, in-depth explorative data collection involving various objects of study, such as individuals, an activity, an event, or a programme. A collective case study is the examination and comparison of groups of cases and concepts, and also the extension or validation of existing theories (Fouché, 2005b:273). Collective case study was found to be relevant to this study, as it enabled the researcher to collect data from a group of persons with mental disorders at Lobatse Mental Hospital through interviews, to determine the factors that contribute to their criminal behaviour. The information has been used against, or in support of, available theory on the factors contributing to the criminal behaviour of persons with mental disorders.

### **3.2.2 Data collection**

Face-to-face semi-structured interviews were utilized to collect data. Semi-structured interviews allow the researcher to access comprehensive information including participants’ beliefs about, and perceptions of a particular topic with flexibility (Greeff, 2005:296). Greeff (2005:296) goes on to state that semi-structured interviews are suitable where the researcher is interested in complexity or process, or where an issue is sensitive, controversial and personal. The researcher believes that this study is controversial, sensitive and personal in

nature as it deals with the criminal behaviour of persons with mental disorders and therefore a semi-structured interview is ideal for data collection.

The interview schedule was constructed after a thorough literature review was conducted. Themes from the interview schedule were used to engage extensive constructive conversation with the participants, to get as much information as possible until a saturation point was reached. The interview schedule, according to Greeff (2005:296-297), comprises themes or questions constructed before the interview and used as a guide to the interview session. A tape recorder was used to capture all the data from the respective interviews, with permission from the participants, and data later converted into verbatim transcripts for analysis.

### **3.2.3 Data analysis**

Data analysis is "... the process of bringing order, structure and meaning to the mass of data collected" (De Vos, 2005b:333). Since the study is qualitative in nature, it relied on the researcher to immediately analyse the data the moment it was collected. As the study relied on the use of themes, these were categorised in line with emerging patterns, particularly with reference to the research question of the study. The bulk of the raw data has been reduced to meaningful themes through the coding system, which, according to De Vos (2005b:338) assists the researcher to have an understanding of the findings, and to determine necessary direction for the study.

### **3.3 Research findings**

As it has already been indicated, the data was collected through using semi-structured interviews with a schedule comprising of themes. This enabled the researcher to collect as much information as possible, as the participants were free to share information without any restrictions. The researcher relied on his social work interviewing skills and experience of working with persons with

mental disorders to engage the participants in a fruitful discussion that yielded the necessary qualitative data.

Each participant had to be briefed on the study before they could give consent for their participation. Topics such as purpose of the study, procedures, possible risks and discomforts, benefits, participant's rights, and confidentiality were addressed to ensure informed consent from the participants. This briefing was done in the presence of the hospital social worker to ascertain that the participants were given all the necessary information prior to giving consent to participate in the study. The interviews were then carried out privately in the allocated social work office, after the researcher was satisfied that the participants were informed to make a decision regarding their participation.

Due to the qualitative nature of the study, the findings are presented in themes that were extracted from the massive data that was collected during the semi-structured interviews. Some of the responses given by the participants are provided verbatim, to emphasize their opinions. For the ones that were given in Setswana the English meanings are provided to facilitate understanding of the findings.

### **3.3.1 Central themes**

The participants' information and experiences have been analysed in line with the themes used in the interview schedule. The themes are discussed as follows:

#### **3.3.1.1 Participants' upbringing**

The researcher intended to establish from the participants their overall impression of how they were brought up. The focus was on establishing whether their upbringing had an influence on their behaviour later in life or not. Both the negative and positive aspects of the participants' upbringing were considered.

**TABLE 1: PARTICIPANTS' UPBRINGING**

Question	Would you kindly share your upbringing with me?
Central themes identified	<ul style="list-style-type: none"> <li>• Well-raised [8 participants]</li> <li>• Necessary life principles instilled to deal with life challenges [8 participants]</li> <li>• Mothers at the forefront of their upbringing [12 participants]</li> <li>• Unpleasant upbringing characterised by abuse [4 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>“I have never experienced any problem as I was growing up.... My mother and father were responsible for my upbringing”.</i></li> <li>• <i>“The strictness of my father did not amount to abuse or ill-treatment. It was a way of preparing us for the world outside the family. None of the siblings is well educated, but all of us are able to look after ourselves and we are all self-reliant”.</i></li> <li>• <i>“I grew up well without any problem..... My mother was responsible for my upbringing. My father had a part to play, although at a minimal level”.</i></li> <li>• <i>“Our father was stubborn (tlhogo e thata) and he ill-treated us (o ne a re tshwenya, a sa re tshware sentle)”.</i></li> </ul>
Correlation with literature	<p>According to Siegel (2004:283) life course theory holds that people begin relationships and behaviours at a very early age and this will greatly influence their adult life course. They are expected to go through a transition that will see them go to school, get work to</p>

	<p>sustain themselves, establish relationships, get married and even have children or a family. This transition will not be smooth and will not be achieved by all, as others fail to meet the expected targets or meet them at different times. The disruptions in major life transitions may be destructive and can ultimately promote criminality, especially amongst those people with socioeconomic problems or family dysfunction as they are susceptible to these unusual transitions (Siegel, 2004:284).</p>
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Table 1 above shows that most participants (8 out of 12) revealed that they were raised well and instilled with necessary principles to assist them deal with life's challenges. All the participants revealed that their mothers were at the forefront of their upbringing assisted by the father (when present) and close relatives.

On the other hand, a few participants (4) shared their upbringing as unpleasant and characterised by ill-treatment and beatings. One participant revealed that he grew up in a family characterised by conflict between parents, and among the siblings. In his own words, he said: *"the situation also hurt me as I was growing, especially that I did not have a say in the matter"*.

A participant who stayed with close family members so that he can attend school as there was no school where his family stayed revealed that the relatives *"told me that my father used to ill-treat them. They beat me until I had wounds.... I could have finished school, but due to this treatment I decided to quit"*.

The findings revealed that only a minority of the participants had a negative upbringing while the majority enjoyed a good upbringing.

Based on the above, the researcher is of the opinion that maybe the ill-treatment, beatings and perpetual conflict the four (4) participants were subjected to had an impact on their future functioning criminal behaviour. This is supported by Siegel (2004:284) who state that the disruptions in major life transitions may be destructive and can ultimately promote criminality, especially amongst those people with socioeconomic problems or family dysfunction as they are susceptible to these unusual transitions. The findings suggest that the criminal behaviour of the majority of the participants was not influenced by their upbringing, as they had a pleasant one. The majority of participants, that is, eight (8) did not experience any disruption in their upbringing.

### 3.3.1.2 The living arrangements of the participants' families.

The researcher focused on among other things, the family composition and family's source of income or means of livelihood. The participants also shared their living arrangements from birth until the offence that led to their current admission to Lobatse Mental Hospital.

**TABLE 2: PARTICIPANTS' LIVING ARRANGEMENTS**

Question	How would you describe your living arrangements?
Central themes identified	<ul style="list-style-type: none"> <li>• Participant's families relied on agriculture [10 participants]</li> <li>• Father figure absent due to work commitments [6 participants]</li> <li>• Educational underachievement [9 participants]</li> <li>• Never had formal employment [6 participants]</li> <li>• Lived with family/partners at the time of the offence [10 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>"My family has always been engaged in ploughing. The situation was the same as I was growing up. The family also had livestock</i></li> </ul>

	<p><i>such as cattle, donkeys and goats”.</i></p> <ul style="list-style-type: none"> <li>• <i>“My father used to go to work for the whole year, only to come back at the end of the year”.</i></li> <li>• <i>“I was enrolled in school but I was not an intelligent pupil, ultimately my parents gave up on the school issue as they realised that I was not interested in school”.</i></li> <li>• <i>“I was never employed. I enjoyed decorating the home environment, listening to the radio and attending to the family tuck shop”.</i></li> <li>• <i>“I went to my mother’s place upon discharge from this hospital. I did not go to stay with my uncle. I stayed for some years after which I then committed an offence”.</i></li> </ul>
Correlation with literature	<ul style="list-style-type: none"> <li>➤ Estroff <i>et al.</i> (1994:1) established the link between a person’s criminality and background, social networks and life experiences. They found out that persons who live in larger networks, those with networks composed primarily of relatives and those who lived with a person not related to them, had increased chances of threatening violence. Financial dependence on family resulted in more violent threats and acts.</li> <li>➤ Life course theory acknowledges life as a transition that involves different stages such as school, work and marriage (Siegel, 2004:283). Any instability to any of the above institutions has the potential to affect an individual’s behaviour negatively.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Hiday (1995:123) and Link <i>et al.</i> (1992:290) reveal that lower educational achievement is a factor in the violent and illegal behaviour of people irrespective of their mental status.</li> <li>➤ Fitzgibbon and Cameron (2007:2) acknowledges that several factors such as unemployment, poor educational and employment skills contribute to the mental problems of persons with mental disorders.</li> </ul>
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The researcher discovered that ten (10) of the participants' families relied on agriculture, that is, they ploughed, reared livestock or did both. Half of the participants (6 participants) stated that one of the parents was involved in formal employment as they were growing up. Only the participants' fathers were employed and mostly worked in South African mines and companies. This made them unavailable for the upbringing of their children, hence they were brought up mostly by their mothers. The absence of the father figure might have contributed to their development of criminal behaviour.

Two (2) of the participants revealed that they grew up without the father figure. One participant stated that, *"It is only that my father separated with my mother when I was still young. He went and remarried in Mahalapye and died there. I did not know him"*. Another one stated that, *"My mother raised me as a single mother. She was not married"*. These responses further illustrate the missing father figure in the participants' lives, which might have influenced their behaviour, specifically their involvement in criminal activities.

Estroff *et al.* (1994:1) established the link between a person's criminality and background, social networks and life experiences. They found out that persons who live in larger networks, those with networks composed primarily of relatives and those who lived with a person not related to them, had increased chances of

threatening violence. Financial dependence on family resulted in more violent threats and acts. Persons who perceived hostility from others had higher chances of displaying violent behaviour and acts. This might confirm the findings in the sense that some of the participants grew up without their parents' active involvement in their lives, hence their affected mental health status, accompanied by criminal activities.

It was also revealed in this study that not all the participants stayed with their original family at all times. This is in light of the fact that some of the participants went to school and later on were employed and had different living arrangements. Some participants started their own families with their partners and moved out of their parents' homes to establish their new homes. Life course theory acknowledges life as a transition that involves different stages as ones mentioned above such as school, work and marriage (Siegel, 2004:283). Any instability to any of the above institutions has the potential to affect an individual's behaviour negatively.

The study further revealed that the majority of the participants, nine (9) attended school up to primary school level or had no formal education at all due to interpersonal and intrapersonal factors. They did not proceed due to reasons such as pregnancy, ill-treatment and mostly low IQ as most of them either failed or dropped out of school because they felt they were not benefiting as they were not progressing well.

The findings of this study on lower educational achievement of the participants is in line with what is indicated by Hiday (1995:123) and Link *et al.* (1992:290) that lower educational achievement is a factor in the violent and illegal behaviour of people irrespective of their mental status. Life course theory also reveals that a disruption in the major life transition of an individual can lead to their criminality (Siegel, 2004:283). The participants have not been able to achieve the expected

target of completing their education as demonstrated by their behaviour of dropping out.

- **Employment**

The researcher saw it necessary to enquire about the participants' employment activities as an important transition in life. The sub-theme also impacted on the living arrangements of the participants' families as employment meant urban migration as there are fewer employment opportunities in the rural areas.

Half of the participants (6) revealed that they were once involved in formal employment. Based on the fact that most participants did not have a good education, it is not surprising that none of them was able to be in a formal employment for a long period. They mostly held temporary employment in construction companies as they did not have any skills to secure a permanent or long term job. These temporary job opportunities saw a move to urban centres by the participants where the living arrangements were different as the participants either stayed on their own, with co-workers or close relatives. Between the temporary jobs, the participants repatriated to the home villages where they assisted the family with agricultural duties and household chores.

Fitzgibbon and Cameron (2007:2) acknowledge that several factors such as unemployment, poor educational and employment skills contribute to the mental problems of persons with mental disorders. The findings above reveal that participants had poor educational skills rendering them unemployable, hence increasing their risk of experiencing mental problems such as violent and illegal behaviour.

The theme of living arrangement and its sub-themes is verified by Link *et al.* (1992:290) who state that, "Compared with the risk associated with variables like age, gender, and education, the risk associated with mental patient's status is

modest”. A young, single, male person of a lower socioeconomic class is more likely to commit violent acts (Hiday, 1995:123). They both agree that a young male of low education is most likely to indulge in violent and illegal behaviour. These factors have a stronger influence on an individual’s criminality than the mere presence of a mental disorder.

- **The living arrangements of the participants at the time of the offence.**

The researcher also finds it necessary to outline the living arrangements of the participants around the time they committed the offence. This is motivated by the fact that the participants’ living arrangements changed as they grew up and might have had an influence on their behaviour. At the time of committing the offence (criminal behaviour), seven (7) participants were staying at parents’ place, three stayed with their partners and the remaining two stayed on their own. The responses below demonstrate the different living arrangements:

The findings from the study confirm the risks of violent and illegal behaviour associated with variables such as gender, education, marital status and socio economic class. Majority of the participants were males, single, and of lower educational level. The researcher was however not able to ascertain the variables of age as the participants were not asked how old they are or were at the time they committed the offences. Judging from the participants’ outlook and the general discussion, the researcher can rightfully conclude that they were of a middle or lower socioeconomic class. The participants relied on subsistence agriculture and temporary jobs.

### **3.3.1.3 Family relationships**

The researcher is of the opinion that relationships within the family are critical as they influence the behaviour of the family members including the display of criminal behaviour by persons with mental disorders. Participants were therefore

asked to share the family relationships with the researcher focusing among others on relationships, conflict resolution and roles of family members.

**TABLE 3: FAMILY RELATIONSHIPS**

Question	Kindly describe your family relationship according to your perception
Central themes identified	<ul style="list-style-type: none"> <li>• Good relationships [9 participants]</li> <li>• Poor relationships with fathers [3 participants]</li> <li>• Conflicts not always resolved effectively in the family [4 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>“There was a good relationship between us in the family and between our family and members of the extended family”.</i></li> <li>• <i>“The only person who was troublesome was my father ... he would say that I be denied food at home”.</i></li> <li>• <i>“There was poor interpersonal relationship between me and my husband. There were fights, neglect, misunderstandings and favouritism. I sought help from parents but the situation continued”.</i></li> </ul>
Correlation with literature	<ul style="list-style-type: none"> <li>➤ According to Estroff <i>et al.</i> (1994:1), “The interpersonal and social contexts of participants and their perceptions of these contexts are important considerations in assessing the risk for violence by persons with mental illness”.</li> <li>➤ Jones and Ploughman (2005:142) reveal that it is critical to document areas of conflict and tensions both in the home and in the</li> </ul>

	community; experiences of abuse either as a perpetrator or victim and if possible the impact of this on the patient's development.
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Generally, nine (9) participants enjoyed good relationships in their families and extended family members. Only a few (three) had a mixture of good and bad relationships in their families. Of the bad relationships, most were with the participants' fathers. The bad relationships emanated from the ill-treatment and strictness of the father figure. Another possible explanation could be that the fathers were mostly absent from the participants' lives due to work commitments as shown under participants' living arrangements. It is also interesting to note that two of the participants offended members of their families they have had problems with. This clearly shows how important good interpersonal relationships are and the researcher believes that they can lower the potential of criminal behaviour amongst persons with mental disorders.

According to Estroff *et al.* (1994:1), "The interpersonal and social contexts of participants and their perceptions of these contexts are important considerations in assessing the risk for violence by persons with mental illness". In particular, the dependence on the family for financial support is critical in determining the risks of violence. Financial dependence has a serious impact on other important aspects of a person's life. The participants stayed mostly at their parents' places and were out of work hence the dependence on the family.

Another important area of interest to the researcher was to establish how the family resolved conflicts at home. The findings showed that four (4) participants' families did not always resolve conflicts effectively. This led to a continued conflict between family members as the conflict was not resolved. It is also possible that this situation contributed to the future criminal behaviour as participants carried unresolved conflicts with them. To support the above, one participant stated that:

*“There was poor interpersonal relationship between me and my husband. There were fights, neglect, misunderstandings and favouritism. I sought help from parents but the situation continued”*. The participant approached the family for intervention on the marital problems she was experiencing and failure to that, she stated that, *“There came a time when I lost patience in my marriage due to the interpersonal problems we were going through. I started developing negative thoughts until I ended up committing an offence that led to my admission to this hospital”*.

The above scenario clearly shows that the family was not effective in addressing the couple’s interpersonal relationship problems and this impacted negatively on the participant as it led her to commit an offence. The researcher concludes that either most participants’ families experienced little or no conflict or for those that experienced conflict, there was just no organised way of addressing it within the family, which made life unbearable for the family members.

Also critical to document are areas of conflict and tensions both in the home and in the community; experiences of abuse either as a perpetrator or victim and if possible the impact of this on the patient’s development (Jones & Ploughman, 2005:142). The findings from this study revealed that conflicts were not always addressed effectively. In fact, the participants could not outline the conflict resolution patterns of the family but just the individuals vested with the powers of resolving conflicts in their families.

#### **3.3.1.4 Self introspection**

This proved to be a difficult task to get the participants to talk about themselves and the qualities they possessed. Instead, the participants preferred to talk about other people. Nonetheless, the researcher carefully probed to get them to open

up and give an account of their self introspection. The interview focused on among others, likes, dislike, strengths, weaknesses, and conflict resolution.

**TABLE 4: SELF INTROSPECTION**

Question	Please share your personal analysis/introspection with me?
Central themes identified	<ul style="list-style-type: none"> <li>• Poor coping strategies to stressful situations [5 participants]</li> <li>• Good approaches to conflict resolution [3 participants]</li> <li>• Good interpersonal relations [12 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>“I am very sensitive, especially when someone talks to me in a degrading, angry or vulgar way. I am short tempered, and lose my temper fast. I would then decide that if it warrants a fight then let it be. But I have realised that this is not good. I have been assisted by the psychologist who also gave me pamphlets and handouts to help me work on my temper”.</i></li> <li>• <i>“I am a peace loving person... I confided in my parents whenever I had problems because I was in constant contact with them. They always assisted me to their ability. I am a trustworthy person and my parents can bear testimony to this”.</i></li> <li>• <i>“I am a sociable person (ke rata batho). I like to be among happy people, who share good things and enjoy themselves. I also like to discuss life issues. I am not discriminating when it comes to interacting with others”.</i></li> </ul>

Correlation with literature	<ul style="list-style-type: none"> <li>➤ Cornish and Clark, (2002:291) state that the decision to indulge in crime is influenced by past learning experiences, including exposures to crime, contact with law enforcements, moral attitudes, self-perception, and the ability to plan ahead.</li> </ul>
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All the participants revealed that they are good people. They were however not all convincing when it came to the justification for being good in that some would then talk about things that were not related to being good such as work. For those that were able to disclose their qualities, the qualities varied and depended on the situation. The findings revealed that the participants possessed more good qualities than bad ones. The good qualities extracted from the participants' responses includes, peace loving, being trustworthy, reliable, forgiving, hard working, patient, being good listeners, progressive, non discriminative, and sociable. The bad qualities the participants revealed were, being short tempered, sulking, very sensitive, having low self esteem and fond of isolation.

The participants shared how they coped with stressful situations and resolved conflict. The bad qualities were eminent in five (5) participants who revealed poor coping strategies to stressful situations. It was necessary to explore this as it greatly influences the display of the criminal behaviour of the participants. The other participants mostly responded that they seek help of a third party when confronted with a stressful situation. An example is a participant who revealed that, *"When provoked or not happy, I call somebody to share my experience with. By so doing, immediately I am getting consoled and I will be done with the issues. When under a lot of stress, I pray and then take a rest"*.

The participants have different ways of reacting to stressful situations and conflicts. They acknowledged awareness of their strengths and weaknesses when confronted with conflict, as one participant stated that it is not good to fight

when provoked. The participants also revealed that they consult someone to share their experiences with and seek advice to address the problem situation. None of the participants attributed their criminal behaviour to their personal qualities. The researcher is of the opinion that the bad qualities possessed by the participants may be triggered when confronted by a spontaneous stressful situation and may result in the criminal behaviour. Cornish and Clark, (2002:291) state that the decision to indulge in crime is influenced by past learning experiences, including exposures to crime, contact with law enforcements, moral attitudes, self-perception, and the ability to plan ahead.

### 3.3.1.5 Alcohol and substance abuse

The use of substances was explored to establish its influence on the criminal behaviour displayed by the participants. This was found relevant as indicated in the literature review done in chapter 2 of this report.

**TABLE 5: ALCOHOL AND SUBSTANCE ABUSE**

Question	How would you describe the extent to which you use alcohol and other substances as well as all the other information pertaining to the use of these substances?
Central themes identified	<ul style="list-style-type: none"> <li>• Only men used/abused substances [6 participants]</li> <li>• Alcohol was the most used substance [5 participants]</li> <li>• Alcohol and dagga most combined substances [3 participants]</li> <li>• Substance use/abuse associated with criminal behaviour [4 participants]</li> <li>• Peer pressure behind use/abuse of substances [5 participants]</li> </ul>

	<ul style="list-style-type: none"> <li>• Family against use of substances [5 participants]</li> <li>• Awareness of effects of alcohol and substance abuse [12 participants]</li> <li>• Benefited from alcohol and substance use [3 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>“I committed an offence as a result of alcohol and substance abuse. That is the offence that led to my current admission to this hospital”.</i></li> <li>• <i>“At the time of the offence both of us had taken alcohol but to a lesser extent”.</i></li> <li>• <i>“I was doing form three when I started sniffing glue. It started in class after one of us sniffed it and he got hilarious. We also sniffed it to get a feel of what he was going through. The habit continued as we went on to sniff glue after school”.</i></li> <li>• <i>“During school holidays I did not take alcohol or dagga because I was scared of my parents. My parents did not tolerate alcohol or drugs. No one was taking alcohol or drugs at home”.</i></li> <li>• <i>“My family ended up knowing that I was using alcohol and dagga. They talked with me at length to talk me out of these habits, and to get me back to a life of going to church. My parents never stopped talking to me about the alcohol and dagga”.</i></li> <li>• <i>“The impact of alcohol and dagga on me was a negative one. They are the things that put me in trouble. The consequences are not</i></li> </ul>

	<p><i>good”.</i></p> <ul style="list-style-type: none"> <li>• <i>“Honestly, I had to quit glue because it was affecting me and I did not notice it as I had no pain until one day when I coughed a chunk of blood. That was a wake-up call for me”.</i></li> <li>• <i>“I am not a talkative person. After drinking, all this changes because when I get home, I mix with everyone easily and keep them entertained. Without alcohol, I am quiet and cannot entertain them like when I have had alcohol”.</i></li> </ul>
Correlation with literature	<ul style="list-style-type: none"> <li>➤ As people grow, they are faced with different factors that influence their behaviours. As such, when children are still young, the family is the most influential; in adolescence, the school and peer relations dominate; while later in adulthood, the influences of vocational achievement and marital relations are critical (Siegel, 2004:284).</li> <li>➤ People abusing substances including alcohol pose a greater danger to others and themselves as their behaviour is almost unpredictable and they are not always in control of their actions (American Psychiatric Association, 2000:207).</li> <li>➤ Hiday (1995:122) reveals that people indulging in alcohol and drug abuse have a higher prevalence of violence, that is, alcohol is rated at 25%, while drug abuse is rated at 35%, and is in exclusion of the presence of a mental disorder.</li> </ul>

	<p>➤ The findings above are in line with a strong believe that drugs and alcohol have an effect on an individual's criminality, especially with regard to violent crimes regardless of the knowledge the person has or the cultural expectations (Shaw <i>et al.</i>, 2004:1; Prins, 1986:202).</p>
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It is interesting to note that there is a balance between the participants who have used alcohol and drugs and those who never indulged. All the female participants never used or abused substances. All the participants who used alcohol and substances were male. Four (4) participants used alcohol and other drugs. Alcohol and dagga were the most combined substances as three (3) participants used both. Alcohol was the most used substance as five (5) participants used it. Dagga came second with four (4) participants and lastly glue was used by only one (1) participant.

There is a strong link between substance use/abuse and the participants' criminal behaviour in that four (4) of the participants associated and attributed the use of substances to their offences. Most participants (5) started using alcohol, dagga and glue due to peer pressure as one participant responded that, *"To tell the truth it is because I had a lot of friends. I was involved in temporary employment opportunities as I was growing up. I made friends with my co-workers who happened to drink alcohol and smoke dagga. They ended up leading me to join in these habits"*. It is also worth noting that these habits started outside the family, for example, at boarding school and work.

As people grow, they are faced with different factors that influence their behaviours. As such, when children are still young, the family is the most influential; in adolescence, the school and peer relations dominate; while later in adulthood, the influences of vocational achievement and marital relations are

critical (Siegel, 2004:284). The participants earlier on revealed that they were raised well by their parents. This in turn shows that other forces played a role in their behaviours especially that of engaging in alcohol and substance use, such as peers at school, work and the community.

Most (5) participants' families were against the participants' habits of drinking alcohol and using other substances. Only one participant revealed that his family was not aware that he was using substances. The participants who had other influences from other systems in their communities such as church were also talked against these habits. In support of this, one participant stated that, "*My church mates asked me why I was drinking and no longer coming to church*".

The participants' experience of using alcohol and other substances is further addressed by looking at the impact the habit has had on them. It is critical to note that the impact has been perceived to be both positive and negative by the participants.

The responses above according to the participants demonstrate the other side to alcohol and substance use that is thought to be positive whereas it is not. Participants revealed that they were able to entertain people, to propose to a girl, to celebrate and have a good time. The participants felt good. They justified their use of substances and this could possibly mean that they would continue to indulge in these substances as they are in denial of the consequences of alcohol and substance abuse. This is contrary to literature that states that people abusing substances including alcohol pose a greater danger to others and themselves as their behaviour is almost unpredictable and they are not always in control of their actions (American Psychiatric Association, 2000:207).

These participants are convinced that they benefited from the use of alcohol and other drugs. The researcher however, is of the opinion that the benefits of using alcohol and other substances are outweighed by the costs and the damage. The

participants' experiences support the researcher's opinion and this is confirmed by their following responses:

*"After taking dagga, I felt sick. I was also acting strange and confused. In the morning I would be told of the things I did the previous night which were not good, such as harassing other men's women. I was once given corporal punishment by the village chief for this behaviour... "*

*"I committed an offence as a result of alcohol and substance abuse".*

*"The impact of alcohol and dagga on me was a negative one. They are the things that put me in trouble. The consequences are not good".*

*"Honestly, I had to quit glue because it was affecting me and I did not notice it as I had no pain until one day when I coughed a chunk of blood. That was a wake-up call for me".*

*"As for alcohol, the problem has always been money. I have never worked in my life. I have been to various levels of the education system, and went for national service where we had a monthly allowance. Others would use this money to buy clothes and nice things but for me it all went into alcohol. I ended up finding it difficult to make ends meet as I squandered money on alcohol".*

From the above, it is clear that the participants felt that alcohol and drug use has had a negative impact on their lives. Their experiences reveal that the impact was on the financial, health and legal aspects. This does not mean that the impact of alcohol and drug use is limited to only these areas as showed by the participants. To illustrate this, the researcher gathered information from all the participants about the impact of alcohol and substance abuse, not necessarily restricting them to their experiences but also from observation and other means

of acquiring information such as through the media and health education. The researcher gathered the following information from the participants:

- ❖ *It is illegal to smoke dagga*
- ❖ *People do not understand themselves, they get confused*
- ❖ *People waste money and are not able to buy basic things such as food*
- ❖ *People are at risk of getting infections such as HIV*
- ❖ *Alcohol and substance abuse leads to conflicts and misunderstandings*
- ❖ *People lose their minds and do not think straight when intoxicated*
- ❖ *Alcohol negatively affects household duties and activities*
- ❖ *Alcohol and substance abuse impacts on other members of the family such as children, for example, they are deprived of love from the abusing parent*
- ❖ *People under the influence of alcohol and substances are prone to accidents*
- ❖ *Alcohol and dagga damages the brain*
- ❖ *Alcohol and substance abuse spoils interpersonal relations*
- ❖ *Alcohol encourages bad behaviour such as disrespecting others and foul language*
- ❖ *Alcohol and substance abuse can reverse your achievement and land you in jail*
- ❖ *People can take advantage of you when intoxicated*

The findings above are in line with a strong believe that drugs and alcohol have an effect on an individual's criminality, especially with regard to violent crimes regardless of the knowledge the person has or the cultural expectations (Shaw *et al.*, 2004:1; Prins, 1986:202). Hiday (1995:122) reveals that people indulging in alcohol and drug abuse have a higher prevalence of violence, that is, alcohol is rated at 25%, while drug abuse is rated at 35%, and is in exclusion of the presence of a mental disorder. Literature above verifies the findings that there is an association between alcohol and substance abuse and the criminal behaviour

of the participants. For example, one participant stated that he was given corporal punishment by the chief for his behaviour after taking dagga. Another one said that he committed an offence because of alcohol and drug abuse.

From the above, it is evident that the participants are aware of the dangers of alcohol and other drugs. The participants revealed that they observed a lot of what is listed above from their communities including families, relatives and friends. It is interesting to note that regardless of this knowledge, some participants still continued with the habit. The researcher also notes that at the time of interviews, the participants did not have access to alcohol and drugs that they used to engage in because it is forbidden by the hospital. All of the participants who ever indulged in alcohol and drug use revealed that they have stopped the habit.

### 3.3.1.6 Aspects pertaining to the illness

The participants' illness formed part of the study as all the participants are persons with mental disorders who have committed offences prior to their admission to Lobatse Mental Hospital. The researcher saw it fit to discuss the participants' illness and related factors so as to explore any link to the participants' criminal behaviour. The illness was discussed with the participants focusing on among others, symptoms, services received, treatment, impact, and health education.

**TABLE 6: ASPECTS PERTAINING TO THE ILLNESS**

Question	Would you kindly explain to me your current illness and all the information pertaining to your condition?
Central themes identified	<ul style="list-style-type: none"> <li>• Treated at psychiatric hospital prior to the offence [8 participants]</li> <li>• Psychotic before committing the offence [4 participants]</li> </ul>

	<ul style="list-style-type: none"> <li>• Delayed seeking medical attention [4 participants]</li> <li>• Patients educated on their condition and related information [8 participants]</li> </ul>
Examples of responses	<ul style="list-style-type: none"> <li>• <i>“I heard voices calling me in the bush the day before I committed the offence”.</i></li> <li>• <i>“I started hearing quotations from the scriptures, what they call auditory hallucinations”.</i></li> <li>• <i>“I confided in friends at a farewell party about what I was going through. I then alerted my parents back at home that I was not well, who then asked me to come home so that they can assist me. I delayed and before I knew it, it was too late as I committed an offence”.</i></li> <li>• <i>“I was educated and informed about my condition. I was told that I can live with the condition in a stabilised way provided I do not use drugs as they can trigger a relapse”.</i></li> <li>• <i>“I was told to take treatment everyday without interruption as this disorder is only stabilised and not cured”.</i></li> </ul>
Correlation with literature	<ul style="list-style-type: none"> <li>➤ Psychosis is defined by Berkow <i>et al.</i> (1997:435) as a loss of contact with reality, and a significant loss of functioning.</li> <li>➤ Hucker ([sa]:5) asserts that 40% of people that hear command hallucinations act on the commands, and this confirms the fact that participants committed offences under the influence of their mental health status.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Link <i>et al.</i> (1992:275) state that, “Although mental patients have elevated rates of violent/illegal behaviour compared to non-patients, the differences are modest and confined to those experiencing psychotic symptoms”.</li> <li>➤ According to Hodgins and Johnson (2002:108), the implementation of the policy on deinstitutionisation in the field of mental health has resulted in a situation whereby, persons with major mental disorders receive no treatment or inadequate and/or inappropriate treatment.</li> </ul>
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- **Symptoms**

Eight (8) participants were treated at a psychiatric hospital prior to committing an offence. Out of these, only four (4) participants revealed that they had psychotic symptoms before committing the offences. The participants revealed the following psychotic symptoms: heard voices calling me in the bush; seeing bizarre things, e.g. I touched a pen and it grew big, and my fingers were too big than the normal size; possessed excessive powers to do great things such as destroying buildings; felt creatures crawling inside my body; someone was scraping my brain with thorn tree; hearing quotations from the scriptures.

The above symptoms from the participants reveal that they were not well at the time and needed attention to address their ill-health. Since the participants were not well and not thinking straight, they were therefore at elevated risk of harming themselves and others. For example, if a participant felt that he possessed destructive powers, the action to follow might be to actually destroy something to prove this power. The temptation to do something to address the voices heard

also leads to an increased chance of criminal behaviour. In fact, Hucker ([sa]:5) asserts that 40% of people that hear command hallucinations act on the commands, and this confirms the fact that participants committed offences under the influence of their mental health status.

Psychosis is defined by Berkow *et al.* (1997:435) as a loss of contact with reality, and a significant loss of functioning. Link *et al.* (1992:275) state that, “Although mental patients have elevated rates of violent/illegal behaviour compared to non-patients, the differences are modest and confined to those experiencing psychotic symptoms”. The assumption is that if a patient is not having psychotic episodes, or the mental disorder is not accompanied by psychotic symptoms, then the patient is not at risk of indulging in violent and illegal behaviour than the average person. It is evident from the above information that persons with mental disorders engage in criminal behaviour due to the disturbed mental state.

- **Services and treatment**

Based on the above listed symptoms from the participants, the researcher made a follow up on the steps that were taken either by the participants or their family members or concerned parties, to address the symptoms that were displayed. These are the various experiences and responses to the symptoms of the mental disorder:

*“I did not share with anyone about the voices I was hearing prior to the offence. I did not receive any help as no one knew what I was going through”.*

*“When this condition started, I am not sure if it was around 1991, I was taken to church by my father, uncle and younger sibling”.*

*“When it started, I was a first year student at a tertiary institution and affiliated to Good News. They prayed for me as I had told them of what I was going through. The Dean of Student Affairs told my parents to take me to a mental hospital to*

*get other services and to be able to produce a medical certificate whenever I had to come back to school. That is how I came here in 1996, but that was before I committed an offence”.*

*“I confided in friends at a farewell party about what I was going through. I then alerted my parents back at home that I was not well, who then asked me to come home so that they can assist me. I delayed and before I knew it, it was too late as I committed an offence”.*

*“My co-workers observed that my general behaviour was strange and I was taken to hospital. I noticed change after getting treatment from Lobatse Mental Hospital”.*

*“I was admitted to Sefhare Primary Hospital, where they referred me to Nyangabwe Referral Hospital upon discharge. My parents took me to the traditional healer for treatment, where I vomited some black stuff”.*

Four (4) participants were only diagnosed and treated for their disorder after they had committed the offence. Some of these people had signs and symptoms of a mental disorder but did not seek appropriate services in time. To illustrate this, one participant stated that, *“I delayed and before I knew it, it was too late as I committed an offence”*. The researcher posits that people seek various services when faced with a problem situation such as a mental disorder. The action to be taken will also depend on the understanding and interpretation of the presenting symptom. If for example, the family believes that the symptom is a result of witchcraft, they will definitely take the patient to a traditional healer. The belief system of the patient and family is also crucial here in that some patients are taken to church and prayed for with the hope that they get better.

According to Hodgins and Johnson (2002:108), the implementation of the policy on deinstitutionalization in the field of mental health has resulted in a situation

whereby, persons with major mental disorders receive no treatment or inadequate and/or inappropriate treatment. The findings above reveal that much as there is already a challenge to have adequate and appropriate services, the family does not always use the appropriate services if available. This affects the person with a mental disorder as their symptoms may worsen and they may end up displaying criminal behaviours.

Another important aspect the researcher acknowledges is the family's knowledge of mental disorders and available services. The families can also use all or some of the above listed services to address the patient's condition, for example the patient may be taken to a traditional healer, to church and hospital in no particular sequence. This delay the time the patient could be helped and may lead to criminal behaviour than would be the case if they immediately received appropriate medical attention to address their disorders and presenting symptoms.

- **Health education**

The health education sub-theme emerged from the interviews and was coined with the participants' illness so as to establish if the participants were fully informed of their conditions prior to the offence. The rationale for the sub-theme was such that if the participants and their significant others were fully informed of the participant's condition, then they would know how to relate well with each other and will better accommodate the participant and his/her condition. The researcher established whether the participants were aware of their conditions and other related information regarding their illness.

Eight (8) participants admitted to have received education about their illnesses and related information. Nonetheless, the participants did not always adhere to the information provided as one participant stated that,

*“I was educated and informed about my condition. I was told that I can live with the condition in a stabilised way provided I do not use drugs as they can trigger a relapse. I was prescribed treatment and told that I will get back to school the coming year. I stayed at home and ended up drinking alcohol again. I stopped taking treatment as I was operating in a normal way. I told myself that the first attack was not permanent and that I was completely cured and could operate well without treatment”.*

The above case demonstrates that the participant was informed of his condition, given treatment and told that the condition will be stabilised. Nonetheless, he felt he was doing well and stopped treatment on his own. The researcher is of the opinion that what is lacking is follow-ups of patients on treatment to ensure that they adhere to treatment and support to supervisors of medication for the patient.

*“I have been informed about my condition and given relevant information. They say I have schizophrenia whereby you can lose your mind. They also told me that you can get better with treatment. I was told that it can be caused by alcohol and substance abuse, hence my decision to stop taking these”.*

The participants revealed that they have had the opportunity to be informed and educated about their conditions. Although most of them do not know the exact names of their condition, they do know that they have a mental disorder. The participants revealed that they have to take treatment for the rest of their lives and that alcohol and drugs can reverse the achievement made by treatment. The researcher points out that the participants were better informed of their condition during their current admission as they have been in the hospital for a long time. One participant diagnosed after committing an offence revealed that, *“After gathering all the data, the doctors told me that I have temporal lobe epilepsy”.*

Poor adherence to medication may signal a higher risk of violent behaviour by persons with mental disorders in the community (Swartz *et al.*, 1998:1). Lekgaba

(2008) concurs with the above based on his experience of working with persons with mental disorders who have committed crimes. He attributes this to several factors, such as poor support systems, lack of education, poverty, alcohol and substance abuse, and side effects of medication. The participants did not adhere to treatment as they thought they were doing fine without medication. Nonetheless, they have now been informed of the need to adhere to treatment to avoid the risk of violent and criminal behaviour.

The researcher points out that more needs to be done to educate and inform the patients about their conditions. The education, like one participant said, should be extended to the families as they are the ones who will be taking care of them once discharged from the hospital. The education should be continuous and multidisciplinary if patients are to be expected to live positively with their conditions.

### 3.3.1.7 Factors contributing to the criminal behaviour

The rationale for this theme was to directly answer the research question of the study that reads thus: to explore the factors contributing to the criminal behaviour of persons with mental disorders. The theme was focused on all factors that the participants felt had an input on their criminal behaviour.

**TABLE 7: FACTORS CONTRIBUTING TO THE CRIMINAL BEHAVIOUR**

Question	Would you kindly share with me the reasons that led to your involvement in a criminal behaviour?
Central themes identified	<ul style="list-style-type: none"> <li>• Alcohol and substance abuse [6 participants]</li> <li>• Poor relationship with the victim [3 participants]</li> <li>• Self defence [3 participants]</li> <li>• Defaulted treatment [5 participants]</li> <li>• Delays in accessing appropriate services [3 participants]</li> </ul>

	<p>participants]</p> <ul style="list-style-type: none"> <li>• Lack of supervision [6 participants]</li> </ul>
<p>Examples of responses</p>	<ul style="list-style-type: none"> <li>• <i>“Alcohol and dagga are the only things that made me commit an offence”.</i></li> <li>• <i>“My father came home from drinking alcohol. He locked me in the house and started beating me for no reason. I was surprised and asked myself what was he up to? He continued to beat me and broke my front teeth. I took a spade and hit him on the head”.</i></li> <li>• <i>“My husband was abusing alcohol and substances. There was poor interpersonal relationship between my husband and me. There were fights, neglect, and misunderstandings”.</i></li> <li>• <i>“Another reason is lack of attention by my boyfriend to act immediately so that I can be helped as he was aware that I was not well.</i></li> <li>• <i>“No I was not on treatment. I was supposed to be on treatment. I did not go for my medications after they got finished”.</i></li> <li>• <i>“I was on my own as my girlfriend had gone to attend a funeral and the neighbours did not know that I had a history of a mental disorder”.</i></li> </ul>
<p>Correlation with literature</p>	<p>➤ These findings are confirmed by literature when it is stated that alcohol and substance abuse is a major contributing factor to criminal behaviour of persons with mental disorders (Shaw <i>et al.</i>, 2004; American Psychiatric Association, 2000).</p>

	<ul style="list-style-type: none"> <li>➤ Gudjohnsson (1990:15) is of the opinion that it is not always that there is a causal relationship between mental disorders and criminal behaviour. This is so because persons with mental disorders are also capable of committing crimes for reasons other than their mental condition.</li> <li>➤ According to life course theory, later in adulthood, the influences of marital relations are critical (Siegel, 2004:284). Social factors such as family dysfunction contribute to people's criminal behaviour.</li> </ul>
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Alcohol and substance abuse is a factor identified by six (6) participants to have contributed to their criminal behaviour. This is the case in that the participants admitted to have been under the influence of alcohol and other drugs especially dagga at the time they committed the offence. The assumption is that if the participants were not under the influence of alcohol and dagga, they could have acted differently. These findings are confirmed by literature when it is stated that alcohol and substance abuse is a major contributing factor to criminal behaviour of persons with mental disorders (Shaw *et al.*, 2004; American Psychiatric Association, 2000).

It is interesting to note that some participants revealed that their victims were under the influence of alcohol at the time the offence was committed. One participant justified the above as follows:

*“My father came home from drinking alcohol. He locked me in the house and started beating me for no reason. I was surprised and asked myself what was he up to? He continued to beat me and broke my front teeth. I took a spade and hit him on the head”.*

The researcher traces the bad relationship between the participant and his father above to the participants' childhood as the two never saw eye to eye. They have never related well with each other and were not supportive of each other. The participant reveals that he was acting in self defence.

Another participant also acting in self defence revealed that he too was followed around and beaten by his uncle and retaliated thereby committing an offence. Just like the first case, they too did not relate well for some time. The participant alleges to have sought help from the family but they did not help.

Gudjohnsson (1990:15) is of the opinion that it is not always that there is a causal relationship between mental disorders and criminal behaviour. This is so because persons with mental disorders are also capable of committing crimes for reasons other than their mental condition. They may commit crimes as a result of any reason that may be advanced or present in a person without a mental condition such as greed, lack of conscience and revenge. In the above two scenarios, the participants were acting in self defence as they were attacked.

The above cases bring about the aspect of conflict resolution at the individual and family level. The researcher is justified to conclude that both the individual and the family lack conflict resolution skills because they did not take action to address the relationship problem. Three (3) participants revealed poor relationships with the victims. An example is a participant who stated that, *"My husband was abusing alcohol and substances. There was poor interpersonal relationship between my husband and me. There were fights, neglect, and misunderstandings"*.

She also attributed the poor interpersonal relationship to alcohol and felt that alcohol and substance abuse was a contributing factor to her criminal behaviour. According to life course theory, later in adulthood, the influences of marital relations are critical (Siegel, 2004:284). Social factors such as family dysfunction

contribute to people's criminal behaviour. The case above is a clear indication of the above in that the participant experienced a disruption in the important transition of marriage leading to a family dysfunction and criminal behaviour.

Five (5) participants admitted to have stopped treatment on their own because they felt were functioning well, treatment were finished and did not go for monthly refills. In their own words, they had this to say:

*"I was taking treatment well. I had skipped treatment that month. I did not go to take my monthly supply".*

*"Another reason is failure to adhere with doctor's advice. When I was discharged, Dr X told me that I should never stop taking treatment. I met him by chance in African mall and he continued to emphasise that I take my treatment. I stopped taking treatment as I thought I was operating well".*

*"After the disorder stabilised, I stopped taking the treatment. I blame myself because of that. No one recalled that I had a mental condition. I stayed for a very long time without any symptom of the disorder and not on any treatment. My family had also forgotten that I was ever on any treatment for a mental disorder until I committed an offence".*

Poor adherence to medication may signal a higher risk of violent behaviour by persons with mental disorders in the community (Swartz *et al.*, 1998:1). The participants clearly attribute poor adherence to treatment as a contributing factor to their criminal behaviour. The researcher shares the same opinion as the participants in that poor adherence triggers a relapse in as far as mental disorder is concerned. The researcher adds that the hospital multidisciplinary team including the social worker should actively explore adherence factors and assist the patients appropriately, to prevent relapse.

A participant stated to have committed an offence after taking traditional medicine. This participant was seen at a psychiatric unit and put on medication. At home, the family also sought help from a traditional healer who prescribed traditional medication. The participant took the medicine and later on committed an offence.

The researcher notes that it is advisable for patients and their families to stick to one type of medication and not mix different types at the same time because the outcome of the mixture is not known. The hospital educates the patient and family on this aspect as one participant confirmed it, *“In the hospital I am encouraged to take my medication and not to take traditional medication. They also said that if I am to take traditional medicine, I should discontinue hospital medication and inform them of my decision”*.

Another contributing factor as identified by the participants is delaying accessing appropriate services such as medical attention as identified by three (3) participants. This is supported by the following responses:

*“If I had been given this treatment the moment I was struck by lightening when it was observed that the condition was going towards a mental disorder, I would not have committed the offence”*.

*“I then alerted my parents back at home that I was not well, and they asked me to come home so that they can assist me. I delayed and before I knew it, it was too late as I committed an offence”*.

*“I did not share with anyone about the voices I was hearing prior to the offence. I did not receive help as no one knew what I was going through”*.

*“The mental disorder contributed to the offence. No one noticed this yet I had the signs and symptoms, for example, I had a tendency of waking up and praying”*.

*early in the morning. Parents thought that the Holy Spirit was in me when in fact I was not well as this was unlike me”.*

*“Another reason is lack of attention by my boyfriend to act immediately so that I can be helped as he was aware that I was not well. Now he blames me for the death of our children. He has since parted ways with me”.*

The responses above show the importance of seeking appropriate services especially medical attention immediately when the symptoms are observed, so as to alleviate the presenting symptoms and restore the patient’s normal functioning while reducing a display of criminal behaviour by the patient. The participants and their significant others delayed getting appropriate services and the participants ultimately committed offences.

The researcher has observed that there is stigma surrounding mental disorders. This stigma in turn affects persons with mental disorders in a way as they are torn between their disorder and society’s reaction to the disorder. This in most cases manifests itself in defence mechanisms such as denial of the disorder and missing out on appropriate services in the process. The responses above clearly demonstrate the researcher’s argument. The participants and their families delayed in seeking medical attention and as one participant put it, *“before they knew it, it was too late as I committed an offence”*. This is supported by Brockington *et al.* (1993:93) who say that society is intolerant to the mentally ill and that the level of tolerance is dependent on factors such as age, education, occupation, and acquaintance with the mentally ill. Fear of this intolerance by society makes it difficult for people to admit that they have a mental disorder.

This calls for the de-stigmatization of mental disorders and it can only be achieved by extensive education of the public by mental health professionals such as social workers.

Lack of supervision was identified in six (6) participants as a contributing factor to their criminal behaviour. Staying alone is also considered a factor that contributed to the criminal behaviour of persons with mental disorders. One participant stated that there was no one to monitor the signs and symptoms of a relapse as was the case prior to committing an offence. The same participant added that the neighbours were not aware of his history of a mental disorder and as such were of no help. In his own words, he said, *“I was on my own as my girlfriend had gone to attend a funeral and the neighbours did not know that I had a history of a mental disorder”*.

### **3.3.1.8 Other information**

To conclude the interviews, each participant was given an opportunity to share with the researcher any other information they had. Not surprising, almost all the participants reverberated that they admit to have wronged as they committed offences. They went on to plead to be considered for discharge as they are remorseful of their criminal behaviour, and have been admitted for too long in the hospital (some as long as 12 years) and their intellectual ability is deteriorating because of being restricted to one place for a very long time. Some said that their relatives are dying and ultimately they will not have anyone to be discharged under their care. The following are some of their responses:

*“I am always sad as I do not know what the future holds for me. I wish to get discharged so that I can be with my children. I think doctors should write a letter to the President for him to sign so that I can get discharged to home”*.

*“An offence such as the one I committed is a serious one (ke molato o o tsitsibanyang mmele). I often put myself in the shoes of the children to the deceased, and wonder if I would forgive someone who murdered my father. When you have killed someone, it is once and forever. The deceased will never get a second chance to life. Other people who have committed the same offence*

*have been hanged. I was told not to discontinue treatment but because of my stubbornness (botlhogo e thata kampo go tatalala), I stopped taking it. My request is therefore that we be assessed and considered for release into the society”.*

*“I have no hope of ever being discharged from this hospital. I have been admitted for too many years (12 years). In fact, no one seems to get discharged of all the people I am admitted with under President’s pleasure”.*

## **Recommendations**

The participants requested for the following improvements:

- ❖ *Modification of western interventions to suit the local context so as to better address the patient’s presenting problems in light of their belief systems*
- ❖ *A forum for patients to vent out, instead of a situation whereby staff dictates to patient and there is no forum for open communication.*
- ❖ *Society should be educated on the dangers of alcohol and substance abuse.*
- ❖ *Patients should not be hospitalised for long periods as this affects their level of functioning once discharged.*
- ❖ *Patients and their families have to be educated on mental health.*
- ❖ *Parents should treat their children well. Il-treated children are at increased risk of alcohol and substance abuse as they try to deal with their problems.*

The participants felt that more needs to be done to educate the public on the dangers of alcohol and substance abuse. They also feel that they could benefit from a forum where they are given the opportunities to vent out as opposed to being always told what to do. The participants also recommend that both the patient and the family should be educated on the mental disorder so that they

can live positively with the condition. Parents are requested to treat their children well to avoid a situation whereby the children will be susceptible to alcohol and substance abuse as a way of coping with the ill-treatment by the parents. The ill-treatment can also contribute to future criminal behaviour of the ill-treated child. Lastly, although western interventions are effective in addressing the symptoms of mental disorders, they should be modified and utilised where they are effective. One respondent stated that:

*“The root cause of the condition dictates the intervention suitable, for example if someone is possessed, there is need for another power to assist this person as westerners fail to help in such situations. Western medicine helps a lot but people differ with their presenting problems”.*

Treatment and services according to Hodgins and Johnson (2002:193) have several components. They include medication, support services provided by a stable person who is conversant with the patient and builds a relationship with the patient. The relationship includes supervision of treatment, substance abuse behaviour, and specialised behavioural training programs such as life skills, social skills, coping with stress, anger, and frustrating situations (Hodgins & Johnson 2002:184). This role is mostly played by family members and close friends who are exposed to the patient’s criminal behaviour and often become victims. This has been confirmed by the participants and verified by Belfrage (1998) and Hucker ([sa]:4) who state that most of the victims are people the patients come in contact with, mostly family members.

### **3.4 Summary**

The chapter addressed the findings of the empirical study that was guided by the semi-structured interview schedule. The findings were used against the literature review and life-course theory used to analyse the data. The study revealed that

most participants were male, single, unemployed and had low educational achievement.

Alcohol and substance abuse is one factor that has a great influence in the criminal behaviour of persons with mental disorders. This was revealed by participants irrespective of whether they used alcohol and substances or not. Alcohol and substance abuse affects the thinking process of individuals and cloud their judgement hence hasty decisions and actions. It also disrupts the coping strategies of a person with mental disorders such as treatment adherence.

Another factor identified is that of poor interpersonal relationship between a person with a mental disorder and people in his/her immediate environment. Fights, misunderstandings and conflicts are forms of interpersonal relationship problems which may become unbearable and trigger anti social and criminal behaviour if not addressed well. A poor conflict resolution strategy by the patient and the family is another factor. Failure by the family to address the root cause of the conflict prompts the patient to try to resolve the conflict himself/herself as a party to the conflict and with limited conflict resolution skills.

Patients that do not adhere to treatment are at increased chances of engaging in criminal behaviour. In most cases the adherence is weakened by among others, alcohol and substance abuse, lack of education on the diagnosed mental condition, and poor supervision to name but a few. This lack of adherence may trigger a relapse of the mental disorder and ultimately the criminal behaviour of persons with mental disorders.

Self defence is another factor that was revealed by this study as contributing to the criminal behaviour of persons with mental disorders. When under attack and concerned about their safety, persons with mental disorders may unleash violence and engage in criminal behaviour as a way of defending themselves.

The time one takes to seek medical attention for the signs and symptoms of a mental disorder is critical. Delaying seeking medical attention may worsen the symptoms and lead to a deterioration of one's health thereby exposing the patient to increased risk of criminal behaviour. The assumption is that if treated early, the unpredictable behaviour will be erased as the symptoms are addressed.

Lack of supervision and support as in a patient staying alone is a factor that can lead to a display of criminal behaviour as there will be no one to monitor the signs and symptoms. If on treatment, there will be no one to supervise the patient's adherence to treatment, substance abuse behaviour, and specialised behavioural training programs such as life skills, social skills, coping with stress, anger, and frustrating situations.

## Chapter 4

### Summary, conclusions and recommendations

#### 4.1 Introduction

In this chapter, a summary of the whole research report is presented. Conclusions drawn from the literature review and empirical findings are outlined in the chapter. Lastly, recommendations from the empirical study, for the improvement of social work service delivery regarding patients with mental disorders who have committed crimes, are outlined.

#### 4.2 Chapter 1

##### 4.2.1 Summary

Chapter 1 consists of the following aspects: introduction, problem formulation, goal and objectives of the study, research question, research approach, type of research, ethical aspects, definition of key concepts, and contents of the research report.

In chapter 1 the following goal and objectives were formulated:

**Goal of the study: To explore the factors contributing to the criminal behaviour of persons with mental disorders**

The goal of the study has been achieved, in that the factors contributing to the criminal behaviour of persons with mental disorders were established and discussed in detail in chapter 3 of this research report. The participants shared their experiences of having a mental disorder and the information pertaining to the offences they committed.

**Objective 1: To provide a broad theoretical background on criminality amongst persons with mental disorders.**

The objective of providing a broad theoretical background on criminality amongst persons with mental disorders is addressed in depth in chapter 2 of this research report. The various theories are discussed and only one chosen to be part of the study namely, life-course theory. It has been chosen because it views criminality as multidimensional, that is, it has many roots, including maladaptive personality traits, educational failure and family relations. These include a combination of social, physical and environmental factors that influence behaviour through life's transitions.

**Objective 2: To explore factors contributing to the criminal behaviour of persons with mental disorders, empirically.**

Chapter 3 of the research report addresses and demonstrates how this objective has been achieved. It provided insight into the participants' perceptions and experiences of being mentally ill and having committed a criminal offence. The factors contributing to the criminal behaviour are discussed in details in the chapter and verbatim responses from participants are provided, to emphasize their opinions.

**Objective 3: To draw conclusions and provide recommendations regarding reduction of criminal behaviour amongst persons with mental disorders.**

The objective of drawing conclusions and recommendations for addressing the criminal behaviour of persons with mental disorders was achieved and addressed in chapters 3 and 4 of the research report. The study reached conclusions on the factors contributing to the criminal behaviour of persons with

mental disorders and came up with recommendations for the possible reduction of criminal behaviour of persons with mental disorders.

### **4.3 Chapter 2**

Chapter 2 forms the theoretical framework of the study drawn from the literature review and it addresses the following aspects: theories of crime causation, relationship between mental disorders and crime, risk factors associated with criminal behaviour of persons with mental disorders, the need for collaboration in addressing the needs of offenders with mental disorders, risk assessment, the role of the social worker, and legal framework regarding mental health in Botswana.

### **4.4 Chapter 3**

This chapter comprises of a description of the research methodology, and the research findings on the contributing factors to the criminal behaviour of persons with mental disorders. The findings are presented in accordance with the themes extracted from the participants' experiences and verified with literature.

### **4.5 Research Findings**

The empirical findings are presented in a text form as this was a qualitative study.

- **Participants' upbringing**

The section concentrated on how the participants were raised and their overall impression of their upbringing.

- **The living arrangements**

The focus of this section was on the living arrangements of the participants when growing up and at the time they committed the offence.

- **Family relationships**

The section covered the relationship amongst members of the family and the reasons behind the relationship. Attention was given to all forms of the relationship whether positive or negative and the impact of such relationships.

- **Self introspection**

The focus of this section was to get the participants to provide information about themselves such as qualities possessed, strengths, weaknesses, likes, dislikes, coping strategies to stressful situations.

- **Alcohol and substance abuse**

This section concentrated on all information pertaining to the participants' experience of engaging in alcohol and substance use. Attention was also given to the types of substances used, the pattern of use, the impact, and knowledge of the consequences of alcohol and substance abuse.

- **The illness**

The section covers the experiences of being diagnosed with a mental disorder. It also covers among others symptoms, treatment, impact of the illness, and health education.

- **Factors contributing to the criminal behaviour**

This section identified all the factors contributing to criminal behaviour of persons with mental disorders from the participants' point of view. It addresses and answers the research question of the study.

#### **4.6 Conclusions**

The following conclusions are drawn from the empirical study and literature review:

- Mental disorders are serious conditions that affect all people without any discrimination.
- The impact of mental disorders is far reaching as it not only affects those with the condition but their families, friends, and society in general.
- There is a causal relationship between mental disorders and criminal behaviour.
- The presence of psychotic symptoms in persons with mental disorders increases the rates of violent/illegal behaviour.
- Most persons with mental disorders who commit offences are male, single, unemployed and of lower educational achievement.
- Alcohol and substance abuse is a strong factor in the criminal behaviour of persons with mental disorders.
- The presence of mental illness and substance abuse increases the chances of a patient committing offences.
- The participants showed to be aware of the consequences of alcohol and substance abuse.
- The substance mostly used by the participants is alcohol, followed by dagga and lastly glue.

- Poor interpersonal relationships increase the chances of a person with a mental disorder to commit criminal offences.
- Poor conflict resolution abilities by the family and patient contribute to the criminal behaviour of persons with mental disorders.
- Lack of social support from family is a contributory factor to the criminal behaviour of persons with mental disorders.
- A person with a mental disorder staying alone is at an increased risk of committing criminal offences due to lack of supervision.
- Poor adherence to treatment seems to be a contributing factor to the criminal behaviour.
- Patients experiencing psychotic symptoms have elevated rates of violent and criminal behaviour than those without these symptoms.
- Persons with mental disorders may commit crimes due to reasons that could not be linked to their mental conditions.
- Delaying seeking appropriate services to the signs and symptoms of mental disorders contributes to the criminal behaviour of persons with mental disorders.
- The belief system of the patient and family dictates the services they will seek in order to address the symptoms observed in the patient. For example, a family that believes that their relatives' presenting signs and symptoms are a result of witchcraft will seek services of a traditional healer.
- Patients and their families are not well informed about mental disorders.
- Most victims of the offences by persons with mental disorders are their relatives.
- Lack of adequate and appropriate treatment in rural and underdeveloped areas coupled with the reluctance to use appropriate treatment because of the influence of the traditional healer results in

persons being symptomatic or prone to alcohol and substance abuse thereby increasing the risk of indulging in criminal behaviour.

- It is necessary to thoroughly assess patients prior to discharge for a possibility of not adhering to treatment and appropriate action taken to address the identified areas of need so as to reduce the criminal behaviour amongst patients with mental disorders.

## **4.7 Recommendations**

The following recommendations are based on both the literature and empirical findings.

### **4.7.1 Recommendations from the empirical study**

- Patients are kept in the hospital for long periods waiting for the release by The President and this has an impact on their ability to function well in society once discharged. As a way forward, there is a need to implement the deinstitutionalisation policy so that patients are not kept for a very long period in hospital before they are discharged into the community. This will reduce the number of patients admitted to the hospital. It will also mean patients are closer to their families and can continue with their lives in the community. This will be dependent on the family's readiness to accommodate the patient after discharge. With this recommendation there has to be a thorough assessment regarding the availability of resources in the community, so as to prevent relapses.
- Adequate and appropriate services should be readily available in the community to effectively implement the deinstitutionalisation policy. This will foresee that the patient receives appropriate services and will reduce the relapses and possible violent and illegal behaviour.

- There is a need for effective collaboration of the multidisciplinary team in addressing the needs of persons with mental disorders who have committed offences. This holistic approach will ensure that the patients receive a comprehensive service, which is empowering them to be able to lead independent lives once discharged from the hospital. In a way the patients will be able to distinguish between what is wrong and what is right, hence the reduction of violent and illegal behaviours. The system approach should also be incorporated taking into consideration the interplay of the disease process and its resultant impact on the individual's functioning. This will ultimately ensure that patients receive comprehensive services that address and meet their needs.
- Patients, when not well, seek various services including those of traditional healers, spiritual healers and modern medicine. As a result, assessment of the patient's belief system should always be carried out and incorporated in the assistance given. In conducting this assessment, the social worker can play an important role in informing the multidisciplinary team to ensure that the patient is wholly understood, as this will enhance cooperation amongst all involved.
- The study revealed that not all patients and their families were well informed of the patient's condition and all the implications thereof. This in turn resulted in the patient displaying violent and illegal behaviour due to not making informed decisions about the illness. An example is a patient who stopped taking treatment because he felt he was well only to relapse and commit a crime. The patient and family should therefore be continuously educated on the patient's condition and all the implications, so as to adjust and accommodate it in their lives and prevent violent and illegal behaviour.
- Community members need to be educated on mental illness so as to equip them to accommodate persons with mental illness and understand their behaviour. This could be done through community education programmes within the primary health care approach, to

ensure that persons with mental disorders are supported. This could go a long way in reducing the stigma associated with mental disorders, hence motivate the patients to establish healthy relationships with people in their neighbourhood.

- Follow-ups of discharged patients need to be effectively carried out to assist patients to adjust and re-integrate into society and prevent any possible violent and illegal behaviour. The follow-ups will assist patients, families and society to relate better with one another and improve patients' functioning upon discharge.
- The referral system also needs to be improved so that patients are not lost to the system once discharged.
- Patients are challenged to adhere to the discharge plans and to make informed decisions. They are prone to not adhering to treatment, to abusing substances including alcohol. Based on this, it is recommended that there be a strong social support for the discharged patients so that they are able to reintegrate and function well in society. Strong social support, especially from the family can help reduce the risks of violent and illegal behaviour as the family could be able to identify and address the contributing factors to the criminal behaviour of persons with mental disorders, before they could get involved in any criminal activity.

#### **4.7.2 Recommendations for the social work profession**

- Social workers are challenged to abandon the simplistic and narrow notion of operating as mere psychotherapists or case managers. Rather they should broaden their scope by embracing the diverse roles of their day to day practice. Social workers should be thorough in their roles to ensure that they holistically address and meet the needs of their clients. They should not limit themselves to counselling of clients and managing their presenting problems. They should for example be

proactive and follow their cases to the end and work on the environment to effectively meet the patient's needs. Lastly, social workers should ensure that they play all their roles and not be restricted to psychotherapy and case management.

- Social workers need to lobby for the resources and services at the community level, to ensure that the patients are provided with appropriate services after they have been discharged from hospital.
- It is further recommended that social workers be assertive enough to share the necessary information gathered from the patients during the assessment phase, for the other multidisciplinary team members to have a better understanding of the patient's world view. This will facilitate mutual understanding and cooperation from the patients and their families.
- Social workers should strengthen their role as skill trainers. In particular, as showed in the study, the patients and their families can benefit from skills such as problem-solving, anger management, assertiveness training, relaxation training, and stress management.
- Social workers should advocate for the reintegration of patients back into society and for effective social support to be available to ensure that patients function well in society.

#### **4.7.3 Recommendations for further research**

- Mental health professionals, families of the patient and the patient's file are important sources of information to consider in gathering more information on the factors contributing to the criminal behaviour of persons with mental disorders. It is therefore recommended that these sources be explored to compare with the findings from the patients as entailed in the report.

- The impact of long term admission to a psychiatric hospital on the patient and the family needs to be explored.
- The burden of caring for a person with mental disorder needs to be explored so as to guide efforts to advocate for effective social support systems in the community.
- The effectiveness of mental health services in curbing violent and illegal behaviours of persons with mental disorders needs to be explored so as to come up with recommendations to improve the services.
- The needs of persons with mental disorders who have committed crimes need to be explored so as to come up with appropriate services that are responsive to the identified needs.

## References

Akers, R.L. 2002. A Social Learning Theory of Crime. In Cote, S. (Ed). *Criminological Theories: Bridging the Past to the Future*. London: Sage Publication (pages 135-143).

Ambrosino, R., Heffernan, J., Shuttlesworth, G. and Ambrosino, R. 2001. *Social work and Social Welfare: an introduction*. 4<sup>th</sup> ed. London: Thomson Learning.

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual*. 4<sup>th</sup> ed. Washington, DC: American Psychiatric Association.

Babbie, E. 2005. *The Basics of Social Research*. 3<sup>rd</sup> ed. Belmont: Wadsworth/Thomson Learning.

Babbie, E. & Mouton, J. 2001. *The Practice of Social Research*. Cape Town: Oxford University Press.

Barker, R.L. 2005. *The Social Work Dictionary*. 5<sup>th</sup> ed. Washington, D.C.: National Association of Social Workers Press.

Belfrage, H. 1998. A ten-year follow-up of criminality in Stockholm mental patients: new evidence for a relation between mental disorder and crime. *The British Journal of Criminology*, 38(1): 145-155.

Bentley, K.J. & Taylor, M.F. 2002. A Context and Vision for Excellence in Social Work Practice in Contemporary Mental Health Settings. In Bentley, K.J. (Editor). *Social Work Practice in Mental Health: Contemporary Roles, Tasks, and Techniques*. Belmont, Ca: Thomson Learning (pages 1-17).

Berkow, R., Beers, M.H., Bogin, R.M. & Fletcher, A.J. (Eds). 1997. *The Merck Manual of Medical Information*. New Jersey: Merck and Co., Inc.

Brockington, I.F., Hall, P., Levings, J. & Murphy, C. 1993. The Community's Tolerance of the Mentally Ill. *The British Journal of Psychiatry*, 162: 93-99.

Clagett, A.F. 1997. Relative Involvement in Delinquency and Criminal Causality: A Theoretical Model Emphasizing Reciprocal Relations. *Journal of Offender Rehabilitation*, 26(1/2): 1-17

Cornish, D.B. & Clarke, R.V. 2002. Crime as a Rational Choice. In Cote, S. (Ed). *Criminological Theories: bridging the past to the future*. London: Sage Publications (pages 291-296).

Cowger, C.D., Anderson, K.M. & Snively, C.A. 2006. Assessing Strengths: The Political Context of Individual, Family, and Community Empowerment. In Saleebey, D. (Ed). *The Strengths Perspective in Social Work Practice*. 4<sup>th</sup> ed. Boston: Pearson Education, Inc. (pages 93-115).

Creswell, J.W. 1998. *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. London: Sage.

Criminal Procedures and Evidence Act. 2002. *Botswana Laws*, Vol. III, (1 January). Gaborone: Government Printer.

De Sola, R. 1982. *Crime Dictionary*. New York: Facts on file.

De Vos, A.S. 2005a. Scientific Theory and Professional Research. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 27-43).

De Vos, A.S. 2005b. Qualitative Data Analysis and Interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 333-349).

Durrheim, K. 1999. Research Design. In Terre Blanche, M.T. & Durrheim, K. (Eds.). *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press (pages 29-53).

Durrheim, K. & Wassenaar, D. 1999. Putting Design into Practice: Writing and Evaluating Research Proposals. In Terre Blanche, M.T. & Durrheim, K. (Eds.). *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press (pages 54-71).

Estroff, S.E., Zimmer, C., Lachicotte, W.S. & Benoit, J. 1994. The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness. *Hospital Community Psychiatry*. 45(7) [O]. Available:

<http://0-www.ncbi.nlm.nih.gov.innopac.up.ac.za/pubmed/7927291?ordinalpos=9&ito...>

Accessed on 2008/05/23

Fitzgibbon, D.W & Cameron, A. 2007. Working with mentally disordered offenders: government policy, NOMS and inaction.

[O]. Available:

<http://0-proquest.umi.com.innopac.up.ac.ac.za/pqdweb?index=1&did=1262856221&Src...>

Accessed on 2008/02/26

Fridell, M., Hesse, M., & Billstern, J. 2007. Criminal Behaviour in Antisocial Substance Abusers between Five and Fifteen Years Follow-up. *American Journal of Addictions* (10) [O]. Available:

<http://dx.doi.org/10.1080/1055049060107773>

Accessed on 2008/07/10

Fouché, C.B. 2005a. Writing the research proposal. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 111-122).

Fouché, C.B. 2005b. Qualitative Research Designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 267-273).

Fouché, C.B. & De Vos, A.S. 2005. Problem Formulation. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 100-110).

Fouché, C.B. & Delpont, C.S.L. 2005. Introduction to the Research Process. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 71-88).

Gerhart, U.C. 1990. *Caring for the Chronic Mentally ill*. Illinois: F.E Peacock Publishers, Inc.

Gioia-Hasick, D & Brekke, J.S. 2002. Social Workers as Skills Trainers. In Bentley, K.J. (Editor). *Social Work Practice in Mental Health: Contemporary*

*Roles, Tasks, and Techniques*. Belmont, Ca: Thomson Learning (pages 143-179).

Greeff, M. 2005. Information Collection: Interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 286-313).

Gudjohnsson, G.H. 1990. Psychological Treatment for the mentally ill Offender. In Howells, K. & Hollin. C. (Eds). *Clinical Approaches to Working with Mentally Disordered and Sexual Offenders*. Leicester: The British Psychological society (pages 15-21).

Hervey, N. 2006. Social work Provision. In Ramsay, R., Gerada, C., Mars, S. & Szmukler, G. (Editors). *Mental Illness: a handbook for carers*. London: Jessica Kinsley Publishers.

Hester, S. & Eglin, P. 1992. *A Sociology of Crime*. London: Routledge.

Hiday, V.A. 1995. The Social Context of Mental Illness and Violence. *Journal of Health and Social Behaviour* (36) [O]. Available:

<http://www.jstor.org/stable/2137220>

Accessed on 2008/05/23

Hodgins, S. & Johnson, C.J. 2002. *Criminality and Violence among the Mentally Disordered: The Stockholm Metropolitan Project*. Cambridge: University Press.

Hucker, S.J. [sa]. Psychiatric Aspects of Risk Assessment. *Forensic Psychiatry* [O]. Available:

<mhtml:file://E:\Psychiatric%20Aspects%20of%20Risk%20Assessment.mht>

Accessed on 2008/03/04

Jones, J. & Ploughman, C. 2005. Risk Assessment: a multidisciplinary approach to estimating harmful behaviour in mentally disordered offenders. In Wix, S. and Humphreys, M. (Eds). *Multidisciplinary Working in Forensic Mental Health Care*. London: Elsevier.

Juginger, J. 2006. Malignant Criminalization: From Hypothesis to Theory. *Psychiatric Services* (57) [O]. Available:

<http://0-psychservices.psychiatronline.org.innopac.up.ac.za/cgi/content/abstract/57/10/15...>

Accessed 2007/09/20

Junginger, J., Claypoole, K., Laygo, R. & Crisanti, A. 2006. Effects of Serious Mental Illness and Substance Abuse on Criminal Offences. *Psychiatric Services* (57) [O]. Available:

<http://0-psychservices.psychiatronline.org.innopac.up.ac.za/cgi/content/abstract/57/6...>

Accessed 2007/09/20

Kebeng, M. 2008. Interview with Mr Michael Kebeng, Social Worker 1 at Lobatse Mental Hospital, Botswana. [Transcript]. Lobatse.

Kumar. R. 2005. *Research Methodology: A Step-By-Step Guide for Beginners*. London: Sage.

Kumar, S. & Simpson, A.I.F. 2005. Application of Risk Assessment for Violence Methods to General Adult Psychiatry: a selective literature review. *Australian and New Zealand Journal of Psychiatry*. [O]. Available:

<http://dx.doi.org/10.1111/j.1440-1614.2005.01579.x>

Lambeti, J.S., Weisman, R., & Faden, D.I. 2004. Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness. *Psychiatric Services* (55) [O]. Available:

<http://0-psychservices.psychiatronline.org.innopac.up.ac.za/cgi/content/abstract/55/1...>

Accessed 2007/09/20

Lekgaba, O. 2008. Interview with Mr Otsile Lekgaba, Psychologist at Lobatse Mental Hospital, Botswana. [Transcript]. 25 February. Lobatse.

Lindqvist, P. & Allebeck, P. 1990. Schizophrenia and Crime: A Longitudinal Follow-up of 644 Schizophrenics in Scotland. *British Journal of Psychiatry*, 157, 345-350

Link, B.G., Andrews, H. & Cullen, F.T. 1992. The Violent and Illegal Behaviour of Mental Patients Reconsidered. *American Sociological Review*, 57(3):275-296.

Lobatse Mental Hospital. 2007. *Annual Report 2006*. Lobatse.

*Longman's Handy Learner's Dictionary*. 1999. Essex: Pearson Longman.

Lukens, E.P. & Prchal, K. 2002. Social Workers as Educators. In Bentley, K.J. (Editor). *Social Work Practice in Mental Health: Contemporary Roles, Tasks, and Techniques*. Belmont, Ca: Thomson Learning.

Mental Disorders Act, 1971 (Act 5 of 1971). *Botswana Laws*. Vol. X, (23 April). Gaborone: Government Printer.

Modestin, J. & Ammann, R. 1995. Mental Disorders and Criminal Behaviour. *British Journal of Psychiatry*, 166: 667-675.

Mouton, J. 2001. *How to succeed in your master's and doctoral studies: a South African guide and resource book*. Pretoria: Van Schaik

Neuman, W.L. 2006. *Social Research Methods: Qualitative and Quantitative Approaches*. 6<sup>th</sup> ed. Boston: Pearson Education.

*Oxford Advanced Learners Dictionary*. 1995. 5<sup>th</sup> ed. Oxford: Oxford University Press.

Panova, E. 2007. Interview with Dr Elenka Panova, Psychiatrist at Lobatse Mental Hospital, Botswana. [Transcript]. 25 September. Lobatse.

Pegram, C.T. 2007. 'Should the mentally ill be incarcerated?' *The News in Advance, Lynchburg*. [O]. Available:

<http://0-web.ebscohost.com.innopac.up.ac.za/ehost/delivery?vid=11&hid=105&sid=2...>

Accessed 2007/09/20

Pollock, P.H. 2006. Preface. In Pollock, P.H., Stowell-Smith, M. & Gopfer, M. *Cognitive Analytic Therapy for Offenders: a new approach to Forensic Psychotherapy*. London: Routledge.

Prince, J.D., Akincigil, A., & Bromet, E. 2007. Incarceration Rates of Persons with First Admission Psychosis. *Psychiatric Services* (57) [O]. Available:

<http://0-psychservices.psychiatronline.org.innopac.up.ac.za/cgi/content/abstract/58/9/11173...>

Accessed 2007/09/20

Prins, H. 1986. *Dangerous Behaviour, the Law, and Mental Disorder*. London: Tavistock Publications.

Prins, H. 1990. Mental Disorder and Crime- a selective overview. In Howells, K. & Hollin. C. (Eds). *Clinical Approaches to Working with Mentally Disordered and Sexual Offenders*. Leicester: The British Psychological society (pages 4-14).

Prins, H. 2005. *Offenders, Deviants or Patients?* 3<sup>rd</sup> ed. Sussex: Routledge.

Pritchard, C. 2006. *Mental health Social Work: evidence based practice*. London: Routledge.

Punch, K.F. 2005a. *Developing Effective Research Proposals*. London: Sage.

Punch, K. 2005b. *Introduction to Social Research: Quantitative and Qualitative Approaches*. 2<sup>nd</sup> ed. London: Sage.

Rutter, M. 1996. Introduction: concepts of antisocial behaviour, of cause, and of genetic influences. In Bock, G.R. and Goode, J.A. (Eds). *Genetics of Criminal and Antisocial Behaviour*. New York: John Willey & Sons Ltd (pages 1-20).

Saleebey, D. 2006. The Strength Approach to Practice. In Saleebey, D. (Ed). *The Strengths Perspective in Social Work Practice*. 4<sup>th</sup> ed. Boston: Pearson Education, Inc (pages 77-92).

Shaw, J., Amos, T., Hunt, M. & Flynn, S. 2004. Mental Illness in People who kill Strangers: Longitudinal study and national clinical survey. *British Medical Journal*, 328 [O]. Available:

<http://0-proquest.umi.com.innopac.up.ac.za/pqdweb?index=15&sid=5&srchmode=1&...>

Accessed 2008/02/25

Siegel, L.J. 2003. *Criminology*. 8<sup>th</sup> ed. Belmont, CA: Thomson Learning Inc

Siegel, L.J. 2004. *Criminology: theories, patterns, and typologies*. 8<sup>th</sup> ed. Belmont, CA: Thomson Learning Inc

Silverman, S. 2002. Social Workers as Advocates and Community Organizers. In Bentley, K.J. (Editor). *Social Work Practice in Mental Health: Contemporary Roles, Tasks, and Techniques*. Belmont, Ca: Thomson Learning.

Sullivan, W.P. & Rapp, C.A. 2002. Social Workers as Case Managers. In Bentley, K.J. (Ed). *Social Work Practice in Mental Health: Contemporary Roles, Tasks, and Techniques*. Belmont, Ca: Thomson Learning (pages 180-210).

Strydom, H. 2005a. The Pilot Study. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 205-216).

Strydom, H. 2005b. Ethical Aspects of research in the Social Sciences and Human Service Professions. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at Grass Roots: For the Social Sciences and Human service Professions*. 3<sup>rd</sup> ed. Pretoria: Van Schaik (pages 56-88).

Swartz, M.S., Swanson, J.W., Hiday, V.A., Borum, R., Wagner, H.R. & Burns, B.J. 1998. Violence and Severe Mental illness: the effects of substance abuse and nonadherence to medication.1 *Am J Psychiatry* (2) [O]. Available: <http://0-www.ncbi.nlm.nih.gov.innopac.up.ac.za/pubmed/9464202?ordinalpos=1&ito...>

Accessed on 2008/05/23

Terre Blanche, M.T. & Durrheim, K. (Eds.). 1999. *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press.

Trochim, W.M.K. & Donnelly, J.P. 2007. *The Research Methods Knowledge Base*. 3<sup>rd</sup> ed. Mason, OH: Thomson Custom Publishing.

Walsh, T.C. 1997. Psychopathic and Non-psychopathic Alcoholic Offenders. *Journal of Offender Rehabilitation*, 26(1/2): 125-140

White, M.D., Goldkamp, J.S., & Campbell, S.P. 2006. Co-Occurring Mental Illness and Substance Abuse in the Criminal Justice System: Some Implications for Local Jurisdictions. *The Prison Journal* 86 [O]. Available:  
mhtml:file://E:/Document%View.mht  
Accessed 2008/03/04

Winfrey, T.L & Abadinski, H. 2003. *Understanding Crime: theory and practice*. 2<sup>nd</sup> ed. Belmont, CA: Wadsworth.

## **Appendixes**

- 1. Permission letter from Ministry of Health, Botswana**
- 2. Permission letter from Lobatse Mental Hospital**
- 3. Faculty of Humanities ethical clearance**
- 4. Letter of consent**
- 5. Interview schedule**

TELEPHONE: 3632000  
FAX:3914467  
TELEGRAMS:RABONGAKA  
TELEX: 2818 CARE BD



MINISTRY OF HEALTH  
PRIVATE BAG 0038  
GABORONE  
BOTSWANA

REPUBLIC OF BOTSWANA

REFERENCE No: PPME-13/18/1 PS Vol III (17) May 16, 2008

Allen Tebogo Mbakile  
P.O. Box 25789  
Gaborone

**Permit : FACTORS CONTRIBUTING TO THE CRIMINAL  
BEHAVIOUR OF PERSONS WITH MENTAL DISORDERS**

Your application for a research permit for the above stated research protocol refers. We note that you have satisfactorily revised the protocol as per our suggestions.

**Permission is therefore granted to conduct the above mentioned study.** This approval is valid for a period of 1 year effective May 16, 2008.

This permit does not however give you authority to collect data from the selected hospital without prior approval from the management of these. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal will need to be resubmitted to the Health Research Unit in the Ministry of Health.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research Unit, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfilment only.

Thank you,

Handwritten signature of S. El-Halabi.

S. El-Halabi  
For/Permanent Secretary Ministry of Health





REPUBLIC OF BOTSWANA

TELEPHONE: 267-5330267/343/773  
TELEFAX: 267-5332174  
MOBILE: 267-71303416

LOBATSE MENTAL HOSPITAL  
P.O. BOX 126 LOBATSE  
[psidandi@gov.bw](mailto:psidandi@gov.bw)

15<sup>th</sup> August 2008

Mr. Allen Mbakile  
2-46 Jakaranda House  
478 Festival Street  
Hatfield 0083 RSA

Fax 00-27-12 362 7001

**Re: Request for Permission to Conduct Research Project**

Thank you for your letter dated 15<sup>th</sup> August 2008. Permission is hereby granted for you to conduct research on the topic: **Factors Contributing to the Criminal Behaviour of Persons with Mental Disorders.**

I should be grateful if you could e-mail the research protocol to the address given below.

On arrival please contact the Medical Department for advise on how best to go about the project.

You will be required to lodge one copy of the results with the Hospital Library and one electronic copy which can be e-mailed to [paul.sidandi@it.bw](mailto:paul.sidandi@it.bw).

Yours sincerely,

**Dr. Paul Sidandi**  
Senior Consultant Psychiatrist

cc.

The Consultant Psychiatrist,  
Lobatse Mental Hospital



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Faculty of Humanities  
Research Proposal and Ethics Committee

1 October 2008

Dear Dr Sekudu,

**Project:** Factors contributing to the criminal behaviour of persons with mental disorders  
**Researcher:** AT Mbakile  
**Supervisor:** Dr. J Sekudu  
**Department:** Social Work and Criminology  
**Reference number:**

Thank you for the application you resubmitted to the Research Proposal and Ethics Committee, Faculty of Humanities.

I have pleasure in informing you that the Research Proposal and Ethics Committee formally **approved** the above study on 25 September 2008. The approval is subject to the candidate abiding by the principles and parameters set out in his application and research proposal in the actual execution of the research.

The Committee requests you to convey this approval to Mr Mbakile.

We wish you success with the project.

Sincerely

**Prof. Brenda Louw**  
Chair: Research Proposal and Ethics Committee  
Faculty of Humanities  
UNIVERSITY OF PRETORIA  
e-mail: [brenda.louw@up.ac.za](mailto:brenda.louw@up.ac.za)

## **LETTER OF CONSENT**

**Researcher's name:** Allen Tebogo Mbakile  
P O Box 126  
Lobatse  
Botswana

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**Title of the study:** Factors contributing to the criminal behaviour of persons with mental disorders.

**Purpose of the study:** The purpose of the study is to explore the contributing factors to the criminal behaviour of persons with mental disorders.

**Procedures:** Personal interviews will be conducted by the researcher on a one-to-one basis using a semi-structured schedule. The interviews will be taped, with the permission of the participants. The interview session will take approximately 60 minutes.

**Risks and discomforts:** I am aware that talking about my behaviour can evoke some discomfort and I have been given the assurance that I will be provided with emotional support. Should I need further therapy due to my participation in this study, I have been assured that the services will be provided by the hospital social worker at Lobatse Mental Hospital. I have also been informed that there are no known risks that may be linked with the study.

**Benefits:** I am aware that participating in this study does not have financial gain. The findings of this study will benefit other persons in the same situation as I am (offenders), by ensuring that professionals are informed about the real factors that contribute to the behaviour. This will ensure that the service that we are receiving is responsive to our needs.

**Participant's rights:** I have been informed about my right as a participant to withdraw from the study at any time should I find it unbearable to continue. This will not jeopardise the quality of service that I am already receiving from this hospital. My participation is voluntary.

**Confidentiality:** I am aware of the fact that the information that I will provide will be treated as confidential and the researcher will not reveal my identity without

me giving consent. I have been informed that only the researcher and his supervisor will have access to the data obtained from this study. Anonymity can not be guaranteed due to face-to-face interviews as a means of data collection and I am comfortable with that situation. Should I decide to withdraw from the study; the data already collected will be destroyed. I have been informed that the data obtained will be stored for at least 10 years. The findings of this study will be submitted to the University of Pretoria as part of the researcher's requirement for the Masters Degree. The findings may also be published as an article in a professional journal or presented at professional conferences.

**Access to the researcher**

If I have any questions or concerns, I can access the researcher at the following telephone numbers:

(00267) 71678892 (Botswana)

(0027) 079 411 8092 (South Africa)

**Declaration**

I hereby acknowledge that I have been informed by the investigator, Allen Tebogo Mbakile about the purpose, duration, methods, procedures, risks, benefits, and rights (including that of withdrawing from the study) entailed in the study. I have received, read and understood the above provided information. I had adequate opportunity to ask questions which the researcher clarified to my satisfaction. I am aware that confidentiality will be upheld and there will be no deception by the investigator.

I,.....understand my rights and voluntarily consent to participate in this study. I understand what the study is about, how and why it is being done.

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Respondent's signature:	Place:	Date:
Researcher's signature:	Place:	Date:
Supervisor's signature:	Place:	Date:

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## **MEASURING INSTRUMENT**

### **SEMI-STRUCTURED INTERVIEW SCHEDULE**

#### **Factors contributing to the criminal behaviour of persons with mental disorders**

- 1. Would you kindly share your upbringing with me?**
- 2. How would you describe your living arrangements?**
- 3. Kindly describe your family relationships according to your perception.**
- 4. Please share your personal analysis/introspection with me.**
- 5. How would you describe the extent to which you use alcohol or any other substance as well as all the information pertaining to your use of these substances?**
- 6. Explain to me about your current illness, all the information pertaining to your condition.**
- 7. Would you kindly share with me the reasons that led to your involvement in a criminal behaviour.**
- 8. Is there any other information that you would like to share with me?**