CHALLENGES EXPERIENCED BY HOSPITALISED FORENSIC STATE PATIENTS REGARDING MENTAL HEALTH SERVICES IN NAMIBIA

BY

LOREEN MAPARURA

(14270316)

A MINI DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

MASTERS IN SOCIAL WORK- HEALTHCARE

IN THE DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY

AT THE

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

SUPERVISOR: DR N. BILA

AUGUST 2017

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

DEPARTMENT OF SOCIAL WORK & CRIMINOLOGY

Declaration of originality

Full name: Loreen Maparura

Student Number: 14270316

Title of mini-dissertation: Challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia

---

I declare that this mini dissertation is my own original work. All secondary material used was carefully acknowledged and referenced in accordance with the university's requirements.

I understand what plagiarism is and I am aware of the university's policy and its implications in this regard.

August 2017

_____ _____

Signature Date

Acknowledgements

I would first of all like to thank the Almighty God, for enabling me to carry on with my studies.

Secondly, I would like to thank my supervisor Dr N. Bila, for her patience, immense support and help when I needed it most.

I would like to thank the University of Pretoria for awarding me a Post Graduate Bursary that made it possible for me to meet my financial obligations.

I appreciate my family for being there for me throughout my studies.

I would also like to thank the staff at the Mental Health Care Centre at the Windhoek Central Hospital and everyone who was there to help and guide me in my studies. You took me by the arm and showed me the way. Thank you.

A big thank you goes to all the participants who volunteered to take part in this study, thank you all for your immeasurable support, may you all be blessed!

Title: Challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia

Candidate: Loreen Maparura

Degree: Masters in Social Work - Healthcare

Supervisor: Dr N. Bila

Department: Department of Social Work and Criminology

Abstract

For years, mental health has not been a priority in both developing and developed countries and this is seen in low budgets, if at all, allocated to various mental health sectors worldwide. Recent studies show that one in three countries has a budget dedicated to mental health. This is further compounded by a shortage of infrastructure and mental health staff. Consequently, this has a huge impact on forensic state patients (FSPs) who receive fragmented services from various stakeholders. Namibia has a shortage of mental health staff and only has one fully fledged centre offering mental health services. Whilst FSPs experience a wide array of challenges, there is a dearth of studies that particularly explore these challenges from a Namibian perspective. This user-led research sought to inform mental healthcare workers on these challenges.

The goal of the study was to explore and describe the challenges experienced by hospitalised FSPs regarding mental health services in Namibia. The study utilised a qualitative approach and was applied in nature. It employed a collective case study design and utilised purposive sampling to intentionally select a sample of hospitalised FSPs. A sample of 12 participants was drawn from a population of 75 hospitalised FSPs at the Mental Health Care Centre of the Windhoek Central Hospital.

The study's findings show that participants faced challenges such as lack of access to mental health treatment prior to their admission, stigmatising attitudes, and lengthy stays in both holding institutions and at the forensic unit.

The study proposes the training of all staff on the *Patient Charter* (Ministry of Health and Social Services, 2016) and the utilisation of a patient-centred approach to

treatment of FSPs. It also proposes granting leave of absence to FSPs so as to prepare them for eventual discharge.

Key words

Forensic

Forensic state patients (FSP)

Mental illness

Mental health services

Namibia

Abbreviations and acronyms

EST:	Ecological Systems Theory
PLWMI:	People Living With Mental Illness
FSPs:	Forensic State Patients
FU:	Forensic Unit
MHCC:	Mental Health Care Centre
MoHSS	Ministry of Health and Social Services
WHO:	World Health Organisation
MDT:	Multidisciplinary team

Table of contents

Table of figures

Table of tables

Appendices

Chapter 1
General background to the study

1.1 Introduction

According to Marais and Subramaney (2015:86) forensic state patients (FSPs) are individuals who committed serious crimes while mentally ill and are hospitalised for an indefinite period. Abdalla-Filho and Bertolote (2006:57) argue that legislators worldwide came up with measures allowing those treating patients with mental illness to apply for a court order for the compulsory confinement of FSPs. While in hospital, FSPs receive both treatment and rehabilitation services aimed at treating their symptoms and re-orientating them to reality, thereby reducing the risk of danger to self and society. Within the Namibian context, FSPs are detained by a court order under section 28 of the Mental Health Act 18 of 1973. This order comes about after an initial request by the court to have a person placed under psychiatric evaluation as provided by sections 77, 78 and 79 of the Criminal Procedures Act 51 of 1977. The evaluation is done by a state psychiatrist and is aimed at determining whether the accused is fit to stand trial or has had a mental illness during the time that he or she committed the crime in question. After the evaluation, a report with recommendations is compiled for the court by the state psychiatrist. These findings are then used by the courts to conclude the case (Marais & Subramaney, 2015:86).

The order to have individuals detained at a forensic hospital for treatment partially removes their rights and transfers these rights to other persons designated by the court. Abdalla-Filho and Bertolote (2006:57) therefore caution that evaluation requires accurate clinical evidence due to the seriousness and repercussions of such an interdict. The process of evaluation and admission for treatment of an individual deemed unfit to stand trial and found not accountable for the crime he or she committed due to mental illness, falls under forensic psychiatry, which is an interface between law and psychiatry. The treatment and rehabilitation of individuals with mental illnesses has had some successes and is regarded effective due to reduced rates of criminal recidivism (Abdalla-Filho & Bertolote, 2006:58).

Salize and Dressing (2004:163) state with concern that the scarcity of data relating to the admission of FSPs is due to possibly poorly understood legal, political, economic, social, medical and methodological systems. They therefore call for

increased research in this area which they regard as a very controversial, yet important matter. Tromp (2015) asserts that Namibia has only one forensic unit (FU), which is state run and is located within the Mental Health Care Centre (MHCC) of the Windhoek Central Hospital. This FU is situated in Windhoek, the capital city of Namibia but it provides treatment and rehabilitation services to hospitalised FSPs and serves all the 14 regions of the country. The FU has a bed capacity of 76 beds where FSPs who have been admitted, some for over ten years, are accommodated. The FU also admits, at any given time, up to 16 newly accused persons for psychiatric evaluation. There are 76 hospitalised FSPs at the FU, with only five of these patients being females. Due to space shortages, over 150 patients who were ordered by the courts to receive forensic services were detained in various police holding cells and correctional facilities countrywide until 2015 when they were transferred to Gobabis and Oluno Correctional Facilities whilst awaiting admission at the FU (Tromp, 2015). It should be noted that Namibia uses the out-dated Mental Health Act 18 of 1973 to admit FSPs (Gureje, 2013:4). However, the government is working on a Bill which will eventually replace this out-dated Act in order to capture the changes that have come over time (Tromp, 2015).

This study sought to explore the challenges experienced by FSPs with regards to the delivery of mental health services in Namibia. The study tapped on the personal experiences of FSPs and will contribute to the growing body of knowledge in forensic social work, as no similar studies have been done in Namibia. The study's findings will inform the promotion of social justice, social inclusion and the safeguarding of human rights (Wilson & Daly, 2007:435) in mental health policy planning.

1.2 Definition of key concepts

The following key terms were central to the study; forensic, forensic state patient, hospitalised forensic state patient, mental health services and mental illness.

Forensic: The word forensic means related to or associated with legal issues (Forensic Mental Health, 2016:1). In this study, the word forensic is associated with patients living with mental illness who committed crime as a result of their mental condition.

Forensic state patient (FSP): In relation to the present study, a FSP is a "person detained by order of any court of law or other competent authority at any place

pending the signification of the decision of a judge in chambers" (Mental Health Act 18 of 1973, section. 1). In Namibia, FSPs are known as State President's Decision Patients and this mainly refers to their discharge which is commissioned by the State President (Mental Health Act 18 of 1973, section. 1). However, for the purpose of this study, these State President's Decision Patients are referred to as FSPs.

Hospitalised forensic state patient: This term refers to a FSP who has been admitted at the FU for long-term treatment and rehabilitation, which is usually for an indefinite period of time (Abdalla-Filho & Bertolote, 2006:57; Marais & Subramaney, 2015:86).

Mental health services*:* These are any one or a group of government, professional or lay organisations operating at a community, state, national or international level to aid in the prevention and treatment of mental disorders (*Mosby's Medical Dictionary*, 2009). In this study, the term mental health services refers to any form of services offered by the government of Namibia to FSPs.

Mental illness: Barlow and Durand (2012:539) define mental illness as a legal concept that refers to severe emotional or thought disturbances that have negative implications on a person's health and safety. The study utilises the phrase mental illness to refer to disturbances in one's thought process, perception, behaviour and functioning.

Namibia: Namibia is a vast Southern African country with a population of over 2.5 million people. It is divided into 14 regions and covers a surface area of 824 292km. It stretches for about 1300km from north to the south. It shares borders with South Africa on its south; Angola and Zambia to its north and Botswana eastwards (Office of the Prime Minister, 2017).

1.3 Theoretical framework

The present study was informed by the Ecological Systems Theory (EST) which sees the environment as a set of nested structures represented by circles within each other (Bronfenbrenner, 1994:39). Within these nested structures, individuals constantly engage in transactions with other individuals and systems and these reciprocally influence each other (Hepworth, Rooney, Rooney, Storm-Gottfried & Larsen, 2006:16, 17; Sauber, 2013:57; Stokols, 1996:282). This illustration shows

that human beings, in one way or the other, relate to their environment. This person-in-environment outlook gave a holistic picture of the various facets that enhance or affect the well-being of FSPs. The researcher deemed the EST as the most applicable theoretical framework to the present study, which explored the challenges encountered by FSPs in relation to mental health services. The active interplay between personal and situational factors in health and illness helps in identifying person or group-environment misfits which are essential in developing interventions that enhance the fit between them (Stokols, 1996:284).

Bronfenbrenner (1994:39-40) outlines the five system levels within the EST, namely; the microsystem, mesosystem, exosystem, macrosystem and chronosystems. At the micro level are those people who have direct contact with an individual such as the family and school mates. FSPs have been in direct contact with their families, community members and staff members at various police, judicial, medical and correctional institutions, who contribute to the construction of the environment they experience.

The mesosystem level includes relationships between systems in a person's life. Meaning that, the subjective experiences of patients in one setting can be as a result of their experiences with other microsystems. For instance, if the relationship between FSPs and their family members is supportive, then their behaviour towards healthcare workers will also be positive. Conversely, if their relationship is unsupportive, the patient may be rebellious in society, due to the negative experiences they have had with family members.

The exosystem level deals with interactions and processes between two or more settings which do not contain the individual and yet these can affect the person in an indirect manner (Bronfenbrenner, 1994:39). Of note is Namibia's current mental health legislation, the Mental Health Act 18 of 1973, which has not been updated to accommodate FSPs to go home on leave, thereby negatively affecting them as they are confined to the forensic unit for lengthy periods, without leave of absence. Another critical issue is that, in the current Mental Health Act 18 of 1973, FSPs' rights regarding access to treatment are severely limited (Ileka, 2017:1)

As noted by Bronfenbrenner (1994:39) the macrosystem level involves the culture of an individual which determines their socioeconomic status. For example, if a person

is born into a poor family, they may have difficulty accessing healthcare in some instances. In addition, some beliefs of causes of mental illness may affect the access or adherence of FSPs to medical treatment (Ileka, 2017:1). Lastly, as pointed out by Bronfenbrenner (1994:39), the chronosystem level of the EST deals with life transitions, which may shift a person's course of life. These transitions could be divorce, loss of a loved one or as in the case of FSPs, committing a crime and being hospitalised at a FU for an indefinite period. Another example is lack of social support, which may not necessarily be a result of neglect, but due to loss of their loved ones.

It is therefore important to analyse the experiences of FSPs and the effects of various environmental systems they have encountered (Bronfenbrenner, 1994:39) as this shapes the questions to be asked regarding their challenges and helps in identifying the changes that are needed in identified systems. The use of the EST assisted the researcher in understanding the various systems that impact on FSPs and their behaviours. It furthermore provided a holistic view of the challenges faced by FSPs and how interventions can be implemented to improve their quality of life. The EST furthermore assisted in structuring recommendations directed at the various systems and processes that can potentially contribute to improving the lives of FSPs.

1.4 Rationale and problem statement

Studies that gather the experiences of FSPs in most countries, including Namibia, are not documented from the perspectives of FSPs. FSPs in general receive fragmented services from various stakeholders, from the time of their arrest until their admission for treatment and rehabilitation. Social workers working in mental health settings seek to provide services and programmes that are responsive to the needs of patients diagnosed with mental illnesses. From a social work perspective, research that explores the challenges experienced by FSPs will assist in the formulation of social programmes that promote the well-being of FSPs. The lack of research in this area was identified as a gap that prompted the researcher's curiosity to investigate the challenges encountered by FSPs in the Namibian context. Furthermore, FSPs do not make decisions about their treatment, hence the need for a study which seeks to give detailed descriptions of their experiences. The present study is a user-led research, which according to the National Association of Social

Workers (1996) is in line with the primary mission of social work, which seeks to enhance human well-being, and help meet the basic needs of all people with particular attention to those who are vulnerable. It is the opinion of the researcher that the findings from the present research may contribute to the development of effective policies and social capital aimed at improving the quality of life of FSPs and enhancing their social inclusion (Huxley, Sheppard & Webber, 2010:427).

This research is essential as it is directed at policy makers in charge of formulating mental health policies in Namibia. The findings from the study could inform social work practice with FSPs and prove valuable as Namibia is in the process of formulating the Mental Health Bill, by bringing service users' experiences into light. This is in line with the speech given by the President of the Republic of Namibia, Dr Hage Geingob (Geingob, 2015) during his inauguration, where he stated that his administration's main priority was to address socio-economic gaps that exist in the Namibian society and to improve on overall government service delivery. This study might contribute to better service delivery to FSPs.

The research question that guided the present study was: **"What are the challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia?"**

In order to answer the research question, the following sub-questions were asked:

- What were FSPs experiences of mental health services received before admission at FU?
- What challenges were experienced by FSPs since they got ill?
- What were FSPs experiences of support from systems such as family, community, holding institutions' staff and healthcare workers?
- What challenges were faced by FSPs regarding facilities at the FU?

1.5 Goal and objectives of the study

The goal and objectives of the study were as outlined below:

1.5.1 Research goal

- To explore and describe the challenges experienced by hospitalised FSPs regarding mental health services in Namibia.

1.5.2 Research objectives

The above goal was realised by the achievement of the following **research objectives**:

- To conceptualise and contextualise mental health services provided to FSPs within the framework of the Ecological Systems Theory.
- To ascertain what types of mental health services were accessed by FSPs in Namibia.
- To explore and describe the obstructions and difficulties experienced by FSPs whilst accessing mental health service in Namibia.
- Based on the findings that emerge from the study, identify strategies to improve mental health services for FSPs in Namibia.

1.6 Research methodology

This section of the research report gives an outline of the research methodology that was used in the study. Particularly, the study utilised a qualitative research approach as it explored the experiences, reality and deeper meanings that FSPs ascribe to services which they received (Fouché & Delport, 2011a:65). By means of a qualitative research approach, the researcher was able to develop a holistic view of the challenges experienced by FSPs and was able to draw conclusions based on in-depth inquiry into their experiences with mental health service delivery in Namibia. Thus, the study revealed the social context of processes and outcomes (Rubin & Babbie, 2013:95) of the journey of FSPs from the time of their arrest to the time of their admission at the FU, where they receive long-term treatment and rehabilitation. The study conducted was applied research, as its outcomes can be employed at solving particular problems in practice (Fouché & De Vos, 2011:94-95). The study was also exploratory in nature as no similar studies on the challenges experienced by FSPs in Namibia have been conducted.

The researcher adopted a collective case study design where multiple cases were selected to show different perspectives of an issue in order to provide an in-depth case picture, exploration and understanding of a particular subject (Creswell, 2012:99, 103; Fouché & Schurink, 2011:322) in this case, the service delivery challenges experienced by FSPs. The study population consisted of all FSPs hospitalised at the FU of the Mental Health Care Centre at the Windhoek Central

Hospital. The participants were purposefully selected with the help of senior nursing staff and a psychiatrist at the Mental Health Care Centre, using the purposive sampling method. Purposive sampling falls under non-probability sampling and is a method which allowed the researcher to choose participants that illustrated the phenomenon to be studied. It allowed the researcher to collect rich, diverse data from specific participants who could provide in-depth information on the topic being studied (Strydom & Delport, 2011:391, 392).

A sample of 12 participants, who were asymptomatic and were on medication, was drawn from the 76 FSPs hospitalised at the FU. Data was collected using one-on-one interviews which were guided by an interview schedule that was formulated to be easily understood by participants (Creswell, 2013:164). The interviews were recorded with participants' informed consent. A thematic data analysis process (Creswell, 2013:99) was utilised for analysing collected data. More details on the research methodology and the relevant research ethics which the study adhered to are captured in Chapter 3.

1.7 Division of the research report

The research report is divided as follows into four chapters:

Chapter 1 gives a general introduction of the study and discusses the theoretical framework employed.

Chapter 2 presents the literature review of the challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia and explores these from a global, regional and Namibian perspective.

Chapter 3 provides an in depth discussion of the research methodology and reports on the findings of the study and measures these against existing literature.

Chapter 4 is the last chapter in this research report, which highlights the key findings and conclusions of the study and put forth recommendations on improving mental health service delivery to FSPs.

The next chapter, chapter 2, focuses on literature that relates to the various challenges experienced by FSPs before and during their admission in forensic treatment facilities.

Chapter 2

Literature review on the challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia

2.1 Introduction

As put forward by the ecological systems theory, the engagement of individuals and their environment generally influence each other (Hepworth et al., 2006:16, 17; Sauber, 2013:57; Stokols, 1996:282). It is therefore apparent that the experiences and challenges of FSPs regarding mental health services are largely impacted by the various systems that are linked to them. Within the Namibian context, there is scarcity of studies that explore the personal experiences of FSPs with regards to the challenges they encounter in the provision of mental health services. Resultantly, this lacuna in knowledge prompted the researcher to conduct this study, with the view of informing policy makers and healthcare workers, particularly social workers in practice with FSPs.

This chapter reviews literature pertaining to the global, regional and local challenges experienced by FSPs. Whilst being in conflict with the law gives FSPs a different identity, FSPs are primarily people living with mental illnesses (PLWMI). Based on this, it is therefore important to discuss the various issues that are common amongst PLWMI and then move on to the issues that are particular to FSPs, given that there is not much literature focusing on FSPs in Namibia and across the rest of the world.

The chapter starts with discussing the provision of services to PLWMI followed by a broader outlook on the conditions they face before and after committing crimes. This discussion helps to give an understanding on the challenges faced by FSPs, in addition to the stigma that comes with committing an offence. Additionally, the chapter will discuss the provision of services to PLWMI. It will also discuss the few studies that have been done in Namibia relating to mental health. The chapter will also highlight the human rights issues peculiar to FSPs. It will also discuss the legislative provisions of the Mental Health Act 18 of 1973, which is currently under revision. It will also examine the history of forensic psychiatry, and will give information on the admission rates and characteristics of FSPs. The chapter will also look at issues that are specific to forensic settings such as containment, therapeutic

relationships between staff and FSPs, as well as the role of families in the support and treatment of PLWMI.

In trying to understand other forensic settings across the globe and the perceptions of patients in other countries, the chapter will also examine the experiences of forensic patients in studies conducted in the United Kingdom, New Zealand, Australia and South Africa. In addition, the chapter will discuss the treatment programmes that have been used in correctional facilities to address some elements of criminality which some FSPs may present with; and which are seen to be effective in their treatment and rehabilitation. Lastly, it will discuss the role of social workers in mental healthcare.

2.2 Provision of services to people living with mental illness

The World Health Organisation (WHO) (as cited by Ministry of Health and Social Services (MoHSS), 2005:3) reports that mental health disorders accounted for 12 percent of the global burden of disease in the year 2000. Lien (2016) states that this global disease burden has increased to 15.4 percent, with around 450 million people being affected by mental illness globally. Whilst this represents a large population of people with mental illness, only one in three countries in the world has a budget dedicated to mental health. Abdalla-Filho and Bertolote (2006:58) argue that global changes in mental healthcare originated in the 1970s, when a new model of deinstitutionalisation focusing on five principal priorities namely, decentralisation of authority; shifting from hospital to community care; active participation of family and community members; integration of healthcare by non-specialised health workers and a focus on prevention and health promotion were developed. This model thus focused on deinstitutionalisation and the move towards community mental healthcare, which in itself requires far more resources at community level.

Gaps in service delivery to people living with mental illness are widespread in both developed and developing countries. For instance, changes to mental health services in the State of Nevada, in the United States of America saw a reduction of staff by 364; funding by 80 million dollars and bed capacity from 234 to 190 between 1963 and 2007 (Watson & Marschall, 2013:18). These changes resulted in some state facilities being left without psychiatrists. Consequently, the state faced lawsuits relating to bussing patients to the State of San Francisco and its failure to provide

court-ordered treatment for offenders who were diagnosed with mental illnesses. In addition, there were inadequate community based services and housing for PLWMI. This prompted investigations which identified gaps in staff related issues such as morale, compensation, recruitment and retention of staff serving PLWMI. All these factors impacted negatively on service delivery to PLWMI (Watson & Marschall, 2013:24, 25, 89). To further compound these problems, little funds were invested in community programmes, which meant that they adopted a crisis intervention response to mental health as opposed to early detection, intervention and prevention (Watson & Marschall, 2013:5). Canada had trends similar to those in the State of Nevada, however, as a corrective measure, Canada gave particular attention to the coordination and access to mental health services to ensure good service delivery and a continuum of services and supports (Kirby, 2004:185). This was critical to the development of an effective strategy to address mental health issues aimed at meeting the needs of PLWMI at different stages of illness and recovery, thus ensuring a responsive mental health system.

Developing countries are affected significantly by mental health disorders which present a heavy burden on the healthcare system (MoHSS, 2005:3). An *Assessment Instrument for Mental Health Services* that was piloted in South Africa by WHO (2007:8), revealed that there was inadequate to no budget set aside for the delivery of mental health services in various provinces. Furthermore, only three of the nine provinces in South Africa, were able to report on their mental health budget. Whereas, Northern Cape allocated one percent of its budget to mental health, North West and Mpumalanga provinces assigned five and eight percent respectively. The study also established that there were no nationally agreed indicators on budgets, staff, facilities, as well as the training of staff on mental healthcare (WHO, 2007:9).

A study done in the KwaZulu-Natal province of South Africa by Burns (2010:663) compared budget allocations between seven psychiatric hospitals and seven general hospitals over a period of five years. These budget allocations were analysed in relation to the figures required in order to comply with national norms. It was found that the mean increase in budget for psychiatric hospitals was between eight to 19 percent over five years, whilst in general hospitals it was between 29 to 64 percent. Burns (2010:665) also highlights a lack of funding allowance for the continual professional development for mental health staff and a huge shortage of mental

health professionals, with 0.34 psychiatrists per 100 000 people. Similarly, in the Democratic Republic of Congo, Moloo (2016:6) gives shocking statistics on how less than one percent of the government's budget in that country is allocated to mental health despite the civil unrest, which has implications on people's mental health. Namibia is not spared from these challenges, with low budgets and inadequate staffing impacting negatively on the treatment and rehabilitation of FSPs in Namibia.

2.2.1 An action call by the World Health Organisation

Recognising the issues around mental health, the WHO (2001:10) on its 54th World Health Assembly with health ministers, called for action regarding mental healthcare service delivery and acknowledged that access to quality mental healthcare was a challenge that policy makers were facing. WHO (2001:10) furthermore called for discussions with various member countries from which lessons could be drawn to inform policy and help the development of appropriate mental health programmes. A lack of community based mental health services was cited as a challenge and was attributed to the historical marginalisation of mental health in many countries' welfare services which, in a way, added to discrimination and widespread stigmatisation of PLWMI (WHO, 2001:16). In addition, WHO (2001:18) notes that poor financing, political considerations, community services, stigmatisation and a lack of trained professionals are some of the challenges related to mental health service delivery across the globe. The researcher is of the opinion that these challenges have a huge negative impact on FSPs as compared to other PLWMI, as FSPs may not receive adequate treatment and care due to the offenses they may have committed. The following is a discussion on the background to mental health services in Namibia and some of the few studies done in Namibia regarding mental health services.

2.2.2 A background to mental health services in Namibia

Namibia attained its independence from the South African apartheid regime in 1990, prior to which the country was involved in years of intense liberation struggle which had major psychological stressors with mental health implications on the Namibian nation (MoHSS, 2005:3). Moloo (2016:6) concurs with the view that war has a huge impact on mental health and reports on an increase in army officers in the Democratic Republic of Congo who were treated for war related mental health problems due to civil unrest.

In Namibia, there is only one state run mental health centre, namely the Mental Health Care Centre, which falls as a department under the Windhoek Central Hospital. Additionally, the country has a single ward for PLWMI at Oshakati Intermediate Hospital, located in a town named Oshakati. This ward, which is known as Ward 16, offers mental health services to patients diagnosed with mental illnesses in the northern regions of the country, where ironically, the majority of Namibia's population is concentrated. As reported by Lien (2016), gaps exist in the number of health professionals working in mental health in Namibia, with 0.23 psychiatrists, 5.88 nurses, 1.36 psychologists, 0.09 social workers and 0.36 occupational therapists per 100 000 people. These figures represent the health workers that offer services not only to the FSPs in the present study, but to all those in need of general psychiatric services in the country. Evidently, these healthcare workers are too few to offer quality and comprehensive services to those in need of mental health services in Namibia.

In a rapid assessment of mental health issues in the Hardap, Kavango, Khomas and Oshana regions in Namibia, it was noted that there were no specific mental health programmes in 75 percent of the regions except for Windhoek's MHCC which hosts the only fully fledged mental health treatment facility in the country which conducts home visits to PLWMI as well as outreach and awareness raising activities on mental health. A lack of aftercare for PLWMI is undesirable and may end up in discharged PLWMI committing crimes due to relapse or lack of proper care. This may consequently result in the significant increase in the number of FSPs.

Service delivery gaps for FSPS are yet to be identified in Namibia particularly due to lack of data. One of the few studies on mental health, which were conducted in Namibia include a study by Ashipala (2013:82) that sought to understand the level of implementation of the *National Policy for Mental Health* (MoHSS, 2005) as an integral part of primary healthcare services in the Oshana region of Namibia. In addition, the study by Gureje (2013:25) revealed that mental health was last on the list of 13 priority illnesses that were identified by regional health managers. This lack of priority in mental health, as stated by Tromp (2015), contributes to delays in diagnosis of mental health conditions which lead to poor treatment and rehabilitation outcomes, resulting in disability which creates a burden for families and the government.

Ashipala (2013:67) also found that services such as counselling, follow-ups and after care of discharged patients, including home visits, were not available in 94 percent of the health facilities that were surveyed. The study by Ashipala (2013:92) also revealed that 77 percent of the nurses trained in mental health who were working in primary healthcare service delivery did not have confidence in delivering mental health services. Ashipala (2013:93) relates these findings as similar to findings in studies done in South Africa, Zambia and Uganda and attributed them to a lack of guidelines on the identification and management of mental health disorders. Despite the importance of early identification and intervention at primary healthcare level, a study conducted in South Africa's Enhlanzeni District, by WHO (2008:155) revealed that 27 percent of nurses thought that PLWMI were dangerous. It is however important to note that these nurses had not received training in mental health as was in the case of those who were studied by Ashipala (2013:93).

The above studies thus show an alarming lack of competence in service delivery at primary healthcare level, even by those nurses who received training in mental healthcare, which poses questions on the quality of services that FSPs receive before their arrest. This incompetence in the treatment and rehabilitation of PLWMI is compounded by a lack of mental healthcare guidelines that are specific to this population. The Republic of Namibia (2016) developed a four year plan of action from 2016 to 2020, called Harambee Prosperity Plan. This plan is aimed at ensuring national prosperity and complements already existing long-term plans such as Vision 2030 and the National Development Plans, which are formulated every five years towards the realisation of Vision 2030. The Harambee Prosperity Plan is hinged on the following pillars: effective governance, economic advancement, social progression, infrastructure development and international relations and cooperation (Republic of Namibia, 2016:11). Improved service delivery as conceptualised in this prosperity plan aims at creating an enabling environment for access to health services (Republic of Namibia, 2016:4). In this plan the Republic of Namibia (2016:5) envisions, as part of its key outcomes, "a culture of high performance and citizen-centred service delivery." It is also directed at ensuring a citizens' satisfaction rate of 70 percent with regards to health service delivery (Republic of Namibia, 2016:20). The researcher holds a view that the implementation of the Harambee Prosperity

Plan can see improvements in service delivery that will have a positive impact on the experiences of FSPs.

2.2.4 The impact of late mental healthcare interventions on patient well-being

Yusuf (2010:92) presents a case in which a man dwelling in a rural area in Nigeria presented with psychotic symptoms for over 5 years and was taken to traditional and spiritual healers on several occasions but later committed murder. The man ended up in a forensic psychiatry unit after which he showed remarkable improvement within 8 weeks of admission. Yusuf argues that traditional beliefs are not only the cause of lack of access to allopathic treatment, but the unavailability of mental healthcare facilities and trained personnel to handle treatment at primary healthcare level. Yusuf (2010:92) also cites poverty and lack of education as contributory factors to the late treatment of mental illnesses and argues that traditional and spiritual healers are important role players in the treatment of mental illness. Thus, proper collaboration of traditional, spiritual and allopathic medical treatment should be emphasised, which results in knowledge sharing and facilitation of referrals to science based treatment. This finding is very relevant to the current study since not all FSPs receive medical treatment before admission but rather seek alternative treatments, which may have failed to improve their mental health conditions and consequently landed them in conflict with the law. The belief of family members and caregivers can have long lasting effects on the lives of FSPs as they are the ones who usually make decisions about the mental healthcare of PLWMI either by enabling them to receive appropriate treatment or by becoming a barrier to effective treatment. As such, there is need for awareness raising activities that inform the public about mental health issues so as to reduce the illiteracy that surrounds this important issue.

2.2.5 Mental health literacy

Ganasen, Parker, Hugo, Stein, Emsley and Seedat (2008:23) put forward that mental health illiteracy is not only about possessing little scientific knowledge on the treatment of mental illness but that knowledge and beliefs may originate from misinformed sources, such as cultural beliefs, superstitions or personal beliefs. Mental health illiteracy, according to Ganasen et al. (2008:27), presents a challenge when it comes to the effective treatment of PLWMI. The authors attribute poor policy backing in mental healthcare to policy makers who, in some cases, have no

knowledge of mental health disorders. This lack of knowledge by policy makers means that they in turn lack an appreciation of the health conditions and experiences of FSPs. This then, may result in policy makers not putting in place effective policies that cater for the needs of FSPs. Furthermore, this lack of mental health literacy by some policy makers also has an implication on the staffing needs and resources that are required by FSPs. This leaves the rendering of quality services to PLWMI and at the mercy of those in policy making. This system, from an EST perspective, depending on the knowledge it has, can either present as a barrier to the quality of care rendered to FSPs or can be enabling and thus ensuring the well-being of FSPs.

2.2.6 Mental illness and stigma

WHO (2001:58) defines stigma as socially constructed peculiar attitudes that bear a negative identity such as labelling someone as "…deranged, violent, homicidal, incompetent, incurable, morally flawed, unmotivated or inadequate and depicting them in the media as unpredictable and violent." Stigma is prevalent in social relationships. WHO (2001:58) notes that some cultural beliefs lead to the fear of PLWMI and that stigmatising attitudes are also found in healthcare workers and mental health personnel. Kapungwe, Cooper, Mwanza, Mwape, Sikwese, Kakuma, Lund, Flisher and the Mental Health and Poverty Project (MHaPP) Research Programme Consortium (2010:192) concur with this view and state that PLWMI deal with symptoms and disabilities as well as with stigma and discrimination, which may emanate from societal beliefs of how the mental illness comes about such as possession by evil spirits, punishment for wrongdoing, or the belief that the PLWMI are bewitched or cursed. According to WHO (2005:1) stigmatisation is marked with "stereotyping, fear, embarrassment, anger and rejection or avoidance." WHO adds that, the violation of basic human rights due to stigma is rampant in both communities and mental health institutions. Thus, FSPs are no exception to being stigmatised. In their case, stigma may even be more severe as they are viewed with additional lens of judgement due to the crimes they might have committed. This puts their experiences of stigma and discrimination on a different level compared to ordinary PLWMI.

Kapungwe et al. (2010:198) add that the contribution of stigma to the treatment of PLWMI has a negative impact which removes support for such persons. WHO (2005:3) also points out that discrimination affects access to treatment, employment,

education and shelter provision and this can also exacerbate mental disorders. In addition, PLWMI are subject to physical abuse, deprived of basic healthcare services and are detained against their will. This is relevant to FSPs as they are involuntarily admitted and this may add to the negative experiences of the care they receive, hence the need to explore their experiences.

2.2.8 Stigma and human rights

According to WHO (2005:3) human rights form the basis for mental health legislation, with key rights and principles being "equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, principle of the least restrictive environment and the rights to information and participation." The inability to access treatment violates a patient's right to health (WHO, 2005:3; MoHSS, 2016). WHO (2005:46) points out that involuntary admission may come with the infringement of an individual's right to choose and on their liberty, but conversely, it may be necessary so as to prevent harm to self or others and is vital as it helps some patients in achieving their right to health as they get treatment which they could not have sought due to their mental condition. In keeping with the rights of PLWMI, WHO (2005:46) discusses the *African (Banjul) Charter on Human and Peoples' Rights* (1981) which is legally binding on member countries. Articles 4, 5 and 16 of this charter deal with issues related to an individual's integrity, respect for dignity and the prohibition of all forms of exploitation, degradation and inhumane treatment. These articles also apply to FSPs as they are involuntarily admitted for psychiatric treatment.

The International Covenant on Economic, Social and Cultural Rights (United Nations General Assembly, 1966) protects against inhumane and degrading treatment and this applies to institutions, particularly those offering psychiatric care, with article 7 of this covenant obliging governments to "provide information on detentions in psychiatric hospitals, measures taken to prevent abuses, appeals process available to persons admitted to psychiatric institutions and complaints registered during the reporting period" (WHO, 2005:46).

WHO (2001:1); Kapungwe et al. (2010:96) cite inhumane treatment of patients in psychiatric hospitals as contributing to stigmatisation and discrimination, which also lead to violations of human rights. This concurs with a study by Rao, Mahadevappa,

Pillay, Sessay, Abraham and Luty (2009:282) which found out that FSPs were stigmatised more by nursing staff as compared to patients in general psychiatry. This could be linked to the offences committed by some FSPs which may be serious crimes. In addition, PLWMI are at times seen as violent, untreatable and dangerous persons, which results in rejection by those who are supposed to assist them such as relatives, employers, neighbours and friends resulting in patients feeling rejected, lonely, and demoralised (Kapungwe et al., 2010:96). WHO (2001:1) also states that people's attitudes are instrumental in discrimination such that it becomes socially acceptable to deprive stigmatised individuals of legally granted entitlements. Of note is the inadequate cover of PLWMI in health insurance, labour and housing policies (WHO, 2001:18).

Social attitudes, as suggested by WHO (2001:18-9), also create barriers to the acceptability and the reintegration of PLWMI after their discharge from mental health institutions, which has an impact on social and family relationships, employment, community inclusion and self-esteem. Resultantly, this impacts on access and restrictions to treatment options. WHO (2001:19) views as unfortunate some negative attitudes towards persons with mental illness by mental hospital personnel. As found by Ukpong and Abasiubong (2010:56) these attitudes can be attributed to belief systems of the causes of mental illness. These authors conducted a survey at a university teaching hospital in Nigeria where final year medical students had different views on the causes of mental illness, despite having knowledge on the genetic and psychosocial factors that contribute to mental illness. Fifty two percent of these students believed that witches and 44 percent believed that demons were responsible for mental illnesses, while 4 percent believed that mental illness could be a result of divine punishment. Such beliefs, despite the participants' high levels of education, were attributed by Ukpong and Abasiubong (2010:59) to socio-cultural beliefs amongst most Africans, as these beliefs were not different from those without medical training. These attitudes by healthcare workers may in turn negatively affect FSPs and influence their experiences of the services they receive.

WHO (2001:37) however suggests more mental health advocacy and treatments at community level which could help improve the situation and calls for legislative reforms to protect the rights of PLWMI. This is especially relevant in Namibia which uses mental health legislation that was formulated during the apartheid era. WHO

(2001:37) furthermore encourages research on mental health issues as this is needed to help improve policies and services to PLWMI, especially in developing countries. WHO (2001:19) also advocates for awareness raising initiatives on mental illness that are targeted at health professionals, employers and to the general public that are carried out in collaboration with non-governmental organisations. However, the non-governmental sector in Namibia is mostly absent in mental health initiatives. Such initiatives alongside research can potentially give FSPs a voice which facilitates an awareness of their experiences and possibly bring about meaningful changes in their lives.

Kapungwe et al. (2010:200) in their study concluded that stigma and discrimination was rife in families, communities, mental healthcare providers as well as at government level. According to Marimbe, Cowan, Kajawu, Muchirahondo and Lund (2016:5), some families of PLWMI live in isolation and are believed to have sinned, with one woman in their study being accused of having brought mental illness to her married family. In addition, Kapungwe et al. (2010:96) discovered that some family members perpetuate stigma by ill-treating and abandoning a family member with mental illness. These authors also reveal that in some cases family members with a child living with mental illness do not want to be known as having one. Healthcare workers in the study by Kapungwe et al. (2010:96) revealed their negative way of looking at PLWMI and narrated how in one workshop, they forgot that they were interacting with people with mental illnesses and were surprised by their level of intelligence and their ability to contribute meaningful ideas to that workshop. Similarly, nurses surveyed by Kapungwe et al. (2010:97), perceived PLWMI as being a burden to their families and how ‘being independent’ would make them to be seen as human beings.

Kapungwe et al. (2010:201) add that government level stigma and discrimination is evidenced by out-dated mental health legislation as well as inadequate funding, which puts PLWMI at a disadvantage, constituting a violation of international human rights. Stigmatising attitudes by the various systems such as families, communities, healthcare workers and government are worrisome as these are the systems that are supposed to assist FSPs. These also add to the challenges that FSPs experience. Consequently these various systems may present as barriers or enablers to FSPs, and this issue is explored in the current study.

2.3 Legislation for PLWMI

WHO (2005:1) states that PLWMI are vulnerable to abuse and have their rights violated. WHO (2005:1) also concurs with the view by Kapungwe et al. (2010:201) that in countries where mental health legislation is out-dated, this out-dated legislation actually serves as a means of violation of the rights of PLWMI. WHO (2005:1) alludes this to the predominant focus of such legislation on protecting people rather than promoting the rights of PLWMI. WHO (2005:1) reveals that for those countries worldwide with mental health legislation across the globe, only 51 percent of these were passed after 1990 and that these old laws prevent the modification of mental health policies, thereby perpetuating abuse of PLWMI. The experiences of FSPs regarding the provision of quality mental health services are to a large extent influenced by the out-dated Mental Health Act 18 of 1973, which is still being used in Namibia. Thus, these patients do not enjoy provisions such as leave of absence as do FSPs in other countries where the legislation was updated. The Constitution of the Republic of Namibia, 1990 upholds the humane treatment of all people by pointing in Articles 8 and 10 the following:

Article 8: Respect for Human Dignity

(1) The dignity of all persons shall be inviolable.

(2) (a) In any judicial proceedings or in other proceedings before any organ of the State, and during the enforcement of a penalty, respect for human dignity shall be guaranteed.

(b) No persons shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.

Article 10: Equality and Freedom from Discrimination

(1) All persons shall be equal before the law.

(2) No persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status.

The Constitution makes it clear that all persons, including FSPs are entitled to be treated with dignity in Namibia. This leaves no room for their ill-treatment regardless of the reasons they are detained for. It also means that their rights must be protected

and be treated with respect and dignity, failure of which amounts to violation of their rights and can also influence their experiences negatively. In addition, FSPs should not be tortured or treated in a degrading and inhumane way. While, the *Patient Charter* (MoHSS, 2016) and the Constitution of the Republic of Namibia, 1990 outline and emphasise a care based approach towards patients, it is not supported by the current Mental Health Act 18 of 1973. Countries which reformed their laws like South Africa factored in various human rights issues and focused more on the care of patients as compared to the out-dated law in Namibia. Below is a comparison of the out-dated Namibian Mental Health Act 18 of 1973 and the more progressive South African Mental Health Care Act 17 of 2002, which brings some of these issues to light.

2.3.1 A comparison of the Namibian Mental Health Act 18 of 1973 and the South African Mental Health Care Act 17 of 2002

Namibia is still using the out-dated Mental Health Act 18 of 1973 (RSA GG 3837), which was adopted from the South African apartheid regime prior to its independence in 1990. This legislation however does not give patients much privilege to participate in their treatment. Instead it mentions under section 60 that if a patient is unable to consent to treatment, other persons may consent on their behalf. Conversely, South Africa repealed the same Act and replaced it with Mental Health Care Act 17 of 2002, which offers a comprehensive and rights based approach to the treatment of mental health patients.

South Africa's Mental Health Care Act 17 of 2002 emphasises care as evidenced by the word care in its title. It also stipulates and emphasises more on the rights and duties of patients and this is important as this conscientises healthcare workers on the importance of upholding the rights of patients. In Namibia, patients' rights are stipulated in the newly revised *Patient Charter* (MoHSS, 2016) as well as in the Convention on the Rights of Persons with Disabilities (United Nations, 2006) which both Namibia and South Africa ratified. Of particular importance is the involvement of the patient in their care plan and treatment process as PLWMI should not be excluded from this due to their mental condition (MoHSS, 2016). This involvement of patients with mental illness is not provided for by the Mental Health Act 18 of 1973.

The lack of focus on care for FSPs in this out-dated Mental Health Act 18 of 1973 means that FSPs do not receive services in an environment where their care is enforced by legislation. This in turn does not oblige healthcare workers to always act in the best interests of FSPs. Having discussed the various issues that pertain to PLWMI in general and FSPs in particular, the focus now turns to the literature on the history of forensic psychiatry.

2.4 The history of forensic psychiatry

The history of forensic psychiatry can be traced back to two thousand years ago and has developed into a discipline with strong scientific investigations due to its involvement with the law (Abdalla-Filho & Bertolote, 2006:57; Ogunlesi, Ogunwale, Wet, Roos & Kaliski 2012:3). There are differences in the forensic psychiatry systems in various countries and these are attributed to differences in resources, legislation and priorities (Abdalla-Filho & Bertolote, 2006:57; Ogunlesi et al., 2012:3; Salize & Dressing, 2004:163) with the former adding that cultural practices, as well as a lack of standards affect the services rendered to FSPs. Marais and Subramaney (2015:86); To, Vanheule, De Smet and Vandevelde (2015:1607) state that admission to a forensic unit is usually for an indefinite period pending a court order, with the main reason for admission being treatment and rehabilitation.

The admission of FSPs is done while monitoring and managing the risk they may pose to the community (Marais & Subramaney, 2015:86). According to Marais and Subramaney (2015:86) admission of FSPs at the Sterkforntein Forensic Hospital in South Africa, helped reduce the rate of recidivism of seven forensic state patients who were followed up in a three year period to 90 percent. The patients were admitted for a period of two years, between 1 January 2004 and 31 December 2005. Poor social support and difficult life circumstances were cited as major reasons for forensic state patients' remaining in hospital after a period of three years in admission (Marais & Subramaney, 2015:90). This finding is relevant to FSPs in Namibia as they spend an indefinite period of time admitted in the FU at the Windhoek Central Hospital, with approximately 20 years being the longest admission ever recorded for a single patient. Family support is another determinant factor when mental healthcare staff considers recommending a FSP for discharge, making it difficult for those FSPs whose family support is virtually absent to be recommended

for discharge; with the only option being reclassification and continued support by the government as they are transferred to civil psychiatry.

2.4.1 Admission rates and patient characteristics in forensic psychiatry

Coid, Kahtan, Cook, Gault and Jarman (2001:532) conducted a study in England and Wales using admission information spanning a period of seven years. The study was done in order to help predict admission rates in England and Wales with the view of gathering knowledge of the level of service provision required for the population in these districts. In this study, Coid et al. (2001:532) looked at admission levels in relation to social deprivation and established that England and Wales had roughly 4000 beds for offenders who had mental disorders and were said to be detained against their will due to the various offences of a serious nature they had committed, which ranged from violence, sexual assault and arson. Barnao, Ward and Casey (2015:1028) add a range of other crimes committed by FSPs in their study. These include murder, attempted murder, and assault with intention to do grievous bodily harm. Seventeen out of 20 patients in their study committed at least one of the above mentioned offences, with some of the patients committing more than one offence. Coid et al. (2001:532) reported that patients were detained for lengthy periods and their care required a lot of staff members and the cost per bed in the medium security ward was around 120 000 British pounds per annum.

The study by Coid et al. (2001:536) revealed an inadequate provision of beds to FSPs which led to patients being sent to private hospitals that were far from their homes and family support; and were of a different cultural affiliation. Coid et al. (2001:537) also note that court orders for psychiatric hospital admissions were on the increase. In Namibia, there are few beds to cater for FSPs as the country only has a meagre 76 beds at the Windhoek Central Hospital FU, which caters for patients from all the 14 regions of the country. In addition, a larger number of over 150 FSPs are kept at any one period at Gobabis and Oluno Correctional Facilities, whilst awaiting admission at the FU. Worrisome is the situation where most of the FSPs are unable to get admission to the FU where they can access specialised multidisciplinary team treatment and rehabilitation. FSPs that are detained in correctional facilities only receive pharmacology treatment and miss out on the much needed rehabilitation, which is mainly the reason for committal. Again, since the Windhoek Central Hospital is the only Mental Health Care Centre in Namibia, it is

obvious that most of the FSPs are admitted far from their home areas and this affects the level of support they get from their families.

Priebe, Badesconyi, Fioritti, Hansson, Kilian, Torres-Gonales, Turner and Wiersma (2005:124) conducted a study that analysed data regarding the admissions of FSPs from six European countries which included England, Germany, Italy, the Netherlands, Spain and Sweden, from the period of 1990 to 2002. The study noted that forensic beds had increased in all these countries following reduction in general psychiatric beds. Priebe et al. (2005:125) indicate that in England, beds increased from 1.3 beds in 1990 to 1.8 in 2002 per 100 000 people, which showed a 38 percent increase. During the same period, Germany had an increase of about 70 percent from 4.6 to 7.8. The Netherlands showed a drastic increase of over 143 percent with a rise from 4.7 in 1991 to 11.4 in 2001 per 100 000 population.

Priebe et al. (2005:125) give a possible explanation for the above increases, stating that de-institutionalisation was over compensated for by re-institutionalisation in forensic and supported housing. These authors relate this to the increased frequency of illness, severity of illness as well as the use of illegal drugs and loss of social support, which they attributed to change in traditional gender roles, where women, who were primary caregivers, took professional roles. Priebe et al. (2005:125) point out however, that during the same period there was also a substantial increase in the general prison population, which may not be attributed to healthcare delivery but also to an attitude to contain risk by European society in the 21st century.

In a report on *Mental Health Systems in Egypt* by WHO (2006:11) it was found out that in a forensic in-patient unit with 725 beds, around 14 percent of patients were admitted for less than a year, while 31 percent were admitted for between one and four years. Around 21 percent were admitted for between five and ten years and 26 percent spent more than 10 years in admission. Egypt is the first country in Africa to have a Mental Health Act which was enacted in 1944 following earlier attempts by Nigeria and Ghana to pass ordinances in 1888 and 1916 respectively. Egypt reviewed its law in 2009, making it the only country with the most recent legislation on mental health in Africa (Ogunlesi, Ogunwale, De Wet, Rooi & Kaliski, 2012:11). This may explain why the country discharges forensic patients within a short period of time.

A study by Young, Gudjosson, Needham-Bennett and Chick (2009:291) sought to obtain demographic, offending and admission records of forensic patients at a forensic rehabilitation ward in London. The information collected also included clinical characteristics and information on the discharge of patients over a period of five years at an open forensic ward. In order to evaluate the effectiveness of services to FSPs, Young et al. (2009:299) analysed the following four areas; period of stay, place to which a patient is discharged, reduced risk of reoffending and relapse.

The rehabilitation services were rated to be effective because patients moved from maximum to medium security wards within an average period of 15 months and were subsequently re-integrated into the community. A follow up of patients after their re-integration was said to be important as it evaluates their progress in the community and bring out true successes, following analysis of relapse or further reoffending (Young et al., 2009:296). Seventy six percent of the patients in this study were successfully re-integrated into the community and this was said to be cost effective even though some patients remained in the forensic facility for longer periods. Kasmi (2010:65) attributes long periods of admission to an environment with fewer stimuli. Young et al. (2009:296) remark that other patients also remained in the facility as they had serious mental illnesses and comorbidity problems and were, thus, at greater risk of violent re-offending. Resultantly, delays in discharge were attributed to uncertainty and anxieties related to discharging some patients into less secure environments (Young et al., 2009:296). Poor motivation to engage in therapeutic activities was also cited by Young et al. (2009:296) as a factor that delays the discharge of patients to which they emphasised a need to identify and deal with this poor motivation.

Young et al. (2009:296) recommend a multidisciplinary plan of care in forensic facilities as this improves the quality of care of patients. They also recommend the effective care, treatment and rehabilitation of FSPs so as to help reduce pressure on beds in forensic services, the period of stay, relapse and recidivism. In Namibia, FSPs stay for long periods without hope of reintegration back into the community and this could be attributed to minimal levels of rehabilitation due to staff shortage. In in addition, rejection from family members can also delay the discharge of FSPs as family members are an important part of the discharge process, as it is required that

family members be appointed as custodians before any discharge of a FSP can take place (Tromp, 2015).

With regards to the characteristics of FSPs, Barnao et al. (2015:2028) note that schizophrenia, bipolar disorder, schizoaffective and psychosis were the most common illnesses that participants in their study were diagnosed with. Young et al. (2009:295) add personality disorder as a predominant comorbid condition for FSPs, while Pereira, Sarsam, Bhui and Paton (2005:22) add that FSPs in their study, presented with complex problems including substance misuse. These multiple problems entail secondary diagnoses and thus two or more reasons for admission. Some patients according to Pereira et al. (2005:22) were in need of assistance with substance misuse and were homeless. Ndjaba (2013:23), who studied the prevalence of substance use disorders amongst FSPs at the MHCC in Namibia, found the prevalence of substance use at 82.7 percent. This calls for intensified programmes on substance use for FSPs before discharge. Regarding education level as a characteristic, Barnao et al. (2015:1029) discovered in their study that the level of education of FSPs ranged from a year in high school to university but most patients had no formal qualifications. Pereira et al. (2005:18) note that 96 percent of patients in their study were unemployed prior to their admission. This could be related to levels of education among other factors.

Pereira et al. (2005:18-9), in their study of psychiatric intensive care units in London, discovered that 80 percent of the studied population were males who were of a mean age of 33. Pereira et al. (2005:18-9) also found that 50 percent of the population studied were black and had all been involuntarily detained except for only two patients. The results of the study by Pereira et al. (2005:18-9) also showed that 66 percent of their population were diagnosed as having schizophrenia while 55 percent were admitted due to physical violent behaviour, with 73 percent having comorbid substance misuse problems. Ndjaba (2013:21) also established that 67 percent of the FSPs studied were diagnosed as having schizophrenia. Pereira et al. (2005:20-1) found that 65 percent of patients in their study were said to have had physical aggression as part of their clinical profile. Kasmi, (2010:66) concurs with this finding and adds that patients in forensic wards pose greater threats of violence to self and staff members.

Kasmi (2010:67) found that most of the participants had been diagnosed as having a schizophrenic spectrum of illness and around 75 percent had comorbid substance abuse and that the main reason for their admission was a worsening mental state as well as threats of violence. Due to these threats of violence around 50 percent of their participants were said to be verbally abusive, three participants having been sent into seclusion, while nine were put in a special low stimulus room where staff members were reported to have been assaulted during two of these nine confinements. Kasmi (2010:70) suggests that the report of abusive behaviour and verbal threats in the study could have been a result of proper reporting procedures and zero tolerance policies on violence. In addition, these offences were said to be non-reflective of disturbed mental state but showing some primary criminality traits. It was however noted that more than half of the incidents reported were only from two of the patients. It is noted by Kasmi (2010:69) that some patients in medium secure units were prone to reoffending, which was said to reflect non-compliance to medication, social disorganisation and relapse. Of the patients who participated in a study by Kasmi (2010:66) over two thirds were said to have received psychiatric services previously.

Pereira et al. (2005:22) suggest that patients with complex needs should receive specifically tailored interventions that address their complex needs in order to prevent relapse and subsequent admission. Pereira et al. (2005:23) also recommend a multidisciplinary team approach that helps to address the multifaceted needs of FSPs. The highlighted studies are relevant to the current study in that they provide information on the admissions and characteristics of FSPs. Such information can then be used in devising plans for effective treatment programmes and the staffing and training needs of mental health staff, so as to cater for the needs of FSPs in service delivery.

2.5 Therapeutic relationship between forensic patients and staff

Gilbert (1990) (in Van den Heever, Poggenpoel & Myburgh, 2013:2) describes therapeutic communication as being derived from the person centred approach. It encapsulates important components such as the acceptance of patients, the ability to listen to them, as well as constructive communication techniques that are both verbal and non-verbal. Van den Heever et al. (2013:2) emphasise the need for mental healthcare workers to “show empathy, positive regard and respect to all

patients…" and comment that this was lacking in general due to the medical model of care which results in the non-existence of the expected therapeutic relationship. Their findings (Van den Heever et al., 2013:6) show that healthcare workers lacked awareness of patients' emotional needs and recommend the establishment of a therapeutic relationship between the healthcare worker and patient as this is important in reducing misunderstandings and the distresses experienced by patients.

Van den Heever et al. (2013:6) also call for attention to the need of continual training for healthcare workers in mental health, regardless of previous training backgrounds. They established that the healthcare workers surveyed in their study were ill equipped to adequately work with patients diagnosed with mental illnesses. According to these authors, the staff displayed a lack of concern for patients' feelings and added that supervision was required to monitor this. In addition to competences, staff also needs to improve their self-awareness and self-reflection skills so as to change their insight of PLWMI.

In a related study, Barnao et al. (2015:1038) found that some patients preferred not to interact much with staff. The patients employed tactics such as avoiding eye contact and using electronic music devices such as iPods to distract their attention. Others stated that their relationship with staff was superficial and only engaged staff members when they needed practical help. Other patients in the study by Barnao et al. (2015:1038) reported that regular weekly meetings helped them to air their complaints. However, the general experience was that patients endured their stay in a forensic facility due to the restrictive nature of the environment, whilst some felt that staff did not relate to them as human beings. Hörbergs, Sjögren and Dahlberg (2012:744) studied patients' perspectives on forensic care and found that support from staff has an impact on patients as it enhances the therapeutic relationship positively as well as the patients' motivation to engage in treatment.

Barnao et al. (2015:1039) recommend the adoption of guidelines that engage patients in the treatment by means of a person-centred approach, a focus on patients' strengths, inclusion in decision making, power sharing, self-determination and collaboration. Barnao et al. (2015:1040) additionally cite a lack of guiding principles for healthcare workers that deliver mental health services. These guiding principles are said to be essential in balancing risk and treatment planning which

incorporates views of the patients who use the services. Barnao et al. (2015:1041) also ascertain that most complaints by patients in forensic settings relate to security, containment, compulsory detention as well as the supervision that patients received. Barnao et al. (2015:1040) report that forensic services are predominantly professionally driven and make use of the biomedical model which stresses illness as opposed to the human being behind that illness and has clinician led decisions. They note that prior to their study, no detailed studies had been conducted to explore the lived experiences of the rehabilitation process of FSPs. Their study was comprised of patients who had been acquitted as a result of mental illness or had been deemed unfit to stand trial.

Donnelly, Lynch, Delvin, Naughton, Gibbons, Mohan and Kennedy (2011:21) state that forensic mental health services have an extra degree of stigma as they hinge more on protecting others and not so much the person being treated. Donnelly et al. (2011:21) add that forensic mental health treatment is seen as more coercive than other treatments in mental health due to the nature of it being court ordered and is therefore typified by non-engagement and rejection in service provision. FSPs' experience of this coercion may affect their involvement in rehabilitation programmes, which also impacts negatively on them as they may end up staying longer at the forensic facility, as opposed to a situation where they comply with the treatment modalities in forensic settings.

It is therefore important that a therapeutic alliance be forged if treatment outcomes outlined by Donnelly et al. (2011:21) such as recovery, improvement and fulfilment are to be achieved. The study by Donnelly et al. (2011:27) also sought to identify the working alliance and trust that existed in forensic mental health and made use of the views of both service users and providers. The patients studied were those with schizophrenia and other psychoses. Donnelly et al. (2011:27) found that the best working alliance and interpersonal trust was in pre-discharge units which did not have a lot of limitations while it was lowest in secure wards. One healthcare worker who was interviewed by Donnelly et al. (2011:27) related stronger therapeutic relations with patients doing well on treatment as compared to those who were not. Violence can be an expected negative outcome if the relationship between patients and staff is unhelpful, and at times this violence is linked to psychosis. Meehan, McIntosh and Bergen (2006:19) studied the causes of aggressive behaviour from the

perspectives of FSPs who attributed these to negative staff attitudes and forcible behaviour. This was one of the few studies that sought to get the perspectives of FSPs. The researcher is of the opinion that in order to forge a good working relationship with FSPs, an understanding of their experiences, is key. It is also important to understand how FSPs experience the care that health workers offer them. Knowing their experiences of care can help health workers to understand how they can better serve FSPs in a way that is meaningful at the end of the treatment and rehabilitation programme. Below is a discussion of the perception of care by FSPs in forensic settings.

2.5.1 Perception of care in forensic settings

Hörbergs et al. (2012:743) regard being sent for care in forensic psychiatry as the worst violation or infringement a society can impose on a person. They explored, in their study, the experience of care of patients in a forensic setting in Sweden, where patients were admitted for periods of time ranging from three months to six years. These researchers wanted to understand and experience the notion of care in an involuntary care location where the main goal was to prevent new crimes and minimise violence. The admission of patients to this involuntary care location was mainly aimed at the safety of society as well as improvement of the patients' health, which Hörbergs et al. (2012:743) say creates ambiguity, as the aim of care is coupled with containment.

Hörbergs et al. (2012:743-4) report that nurses who specialised in psychiatric care and licensed assistant mental healthcare nurses took care of patients on a daily basis, with physicians, psychologists, counsellors and occupational therapists having the duty to engage patients in planned therapeutic sessions either as individuals or in groups. The above mentioned team however, does not include social workers. The researcher is of the opinion that social workers play a vital role as an interface between the families and the hospital, while serving the patients.

Positive therapeutic relationships were reported as paramount pre-requisite for patients to engage in treatment (Hörbergs et al., 2012:744). Results from the study by Hörbergs et al. (2012:745) show that being cared for in forensic psychiatric units involved "insecurity, unreliability, and uncertainty...constant desire to escape the care, which is not perceived as caring but as punishment…" In addition, some

patients experienced their treatment by mental healthcare staff as non-caring even though they acknowledge that there were elements of good care which were said to be temporary.

Hȍrbergs et al. (2012:745) report that some patients expressed uncertainty about when they would be discharged and what was required for that to occur, knowing that they had no influence on the situation. This was accompanied by feelings of powerlessness, compulsion, and feeling as if they were chained and thus needed only to survive the situation. Patients also related a sense that life was meaningless as well as the inability to put into perspective what happened to them in the past, what was happening to them presently and what would happen in their future. The need to be discharged put some patients at a place where they felt they had to try hard to do what was expected of them, which Hȍrbergs et al. (2012:745) believed put some patients in a position where they were struggling to exist and almost giving up. The struggle brought about tension which resulted in frustration which Hȍrbergs et al. (2012:745) figuratively supposed was manifested in patients screaming loudly, yet, this seemingly went unnoticed by the healthcare workers. The patients' daily life was furthermore dominated by fear of punishment.

Hȍrbergs et al. (2012:745) noted a sense of loneliness amongst FSPs in their study, even though the patients were surrounded by other people. Another factor they noted was the tensions in relationships between patients and staff with some being seen as superficial. Hȍrbergs et al. (2012:746) point out patients' sense of longing for meaningful relationships, evident in that some sought to have close relationships with other FSPs. Hȍrbergs et al. (2012:746) emphasise the need for authentic carers being available to care for patients as this is seen as addressing the need for humane care, which some patients may have lacked in their lives. The findings yielded by Hȍrbergs et al. (2012:748) showed more of a yearning by patients to leave the forensic psychiatric care than working through the main reasons why they had been admitted. The authors caution healthcare workers to give efficient care and not continuously expose forensic patients to "exertion of authority, power, punishment, offensive behaviour and at the same time a lack of caring care." From the study by Hȍrbergs et al. (2012:743) it was also evident that there was no proper care for patients and this was against the goal of providing adequate healthcare which is the duty of health workers.

Patients in the study by Hörbergs et al. (2012:748) voiced that they also wanted to be respected, heard, and seen as humans, and that carers should show availability, openness, honesty and that feedback should be evident in all healthcare provision. Some patients used sleeping as a strategy to do away with their situation so that they do not continue to think a lot about it (Hörbergs et al., 2012:747). The authors saw that the inability of patients to choose their relationships and the environment creates tension as patients were required to be in a place which contributed to the volatile situation among patients in forensic settings. In addition, it was noted that companionship among patients usually developed where health workers were more offensive or caused humiliation to patients. Hörbergs et al. (2012:748) reiterate the need to provide good care to patients in forensic settings and the need to question and examine health workers' attitudes. This is true for FSPs as they may be frustrated by long stays at the FU. Given the risk of violence in forensic settings, it is important to discuss how staff can deal with such violence.

2.5.2 Risk in forensic setting regarding violence

Warren, Mullen, Thomas, Ogloff and Burgess (2008:599) state that threats to kill in forensic mental hospitals can be towards health workers, other patients, a third party or unspecified people and was said to be so serious such that it required special expediency. Warren et al. (2008:599) caution that threats to kill should be treated with urgency as failure to do so could result in both medico-legal and professional problems. However, they acknowledge the scarcity of literature that guides assessment of these threats to kill.

In their study, Warren et al. (2008:603) discovered that those who uttered threats to kill had mental disorders and a diagnosis of schizophrenia. They warned that most threats to kill were usually not taken seriously with only a few receiving evaluation of risk. Warren et al. (2008:599) also found that patients with schizophrenia who had uttered threats to kill were at a higher danger of carrying out a homicide which should warrant that threats to kill be taken seriously. Evaluation of these threats were said to be important as they had legal consequences for professionals in the event that the patient carries out the act. Warren et al. (2008:604) found that those who threaten to kill were at high risk of engaging in violent behaviour against others and would possibly harm themselves. As there can be many triggers of violence for FSPs, it is therefore important for staff to be trained on how to handle these triggers

without violating the rights of the patients, and at the same time protecting themselves from harm. What follows is a discussion of patients' experiences and perceptions of some of the measures of restraint that are taken by staff in order to curb perceived violence or harm to self or others.

2.5.3 Patients' experiences and perceptions of seclusion, sedation and restraint

Mayers, Keet, Winklerr and Flisher (2010:60) conducted a study aimed at documenting the perceptions and experiences of patients regarding sedation, seclusion and restraint. These authors noted that the communication between patients and staff members was insufficient and that the treatment patients received during some periods of illness violated their rights as human beings. Mayers et al. (2010:60) also note that patients in their study reported that restraint methods were castigatory, instead of being remedial or therapeutic. Furthermore, their participants reported that witnessing the forced containment of other patients was distressing to the rest of the patients.

Mayers et al. (2010:63) add that service users in South Africa came up with an advocacy body which raised concerns about human rights violations, particularly during emergencies in psychiatric facilities and how important it was to treat PLWMI in a humane way. This body made it known that service users, despite being in an emergency situation, had awareness and a recollection of their experiences. The body felt that if service providers were aware of this reality, it would humanise the way in which they handled patients. Mayers et al. (2010:63) argue that there is little attention given by studies to finding out how FSPs preferred to be handled in emergency situations. A summary of the rights of service users as contained in the Constitution of the Republic of South Africa, 1996 and the Mental Health Care Act 17 of 2002, which should form the basis of care standards for FSPs as espoused from Mayers et al. (2010:62) is given below:

Service users have rights:

- To receive such health and social care as is appropriate to their health needs.
- To equality of treatment.
- To be protected from harm, including unjustified medication and abuse.

- To be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate in their health needs.
- To treatment directed towards preserving and enhancing personal autonomy.
- To receive medication only for therapeutic or diagnostic purposes and never administered as a punishment or for the convenience of others.
- To only be subjected to physical restraint or involuntary seclusion if these methods are the only means available to prevent immediate or imminent harm to the service user or others.
- To adequate information about all procedures, to exercise choice, express opinions and make complaints.

Mayers et al. (2010:66) also revealed that seclusion was seen as a way of punishment by 78 percent of patients with females being more negative than males in their responses. Seclusion, in Mayers et al. (2010:66) findings was said to be traumatising whereas sedation was for all respondents said to be the least traumatising of the options. Mayers et al. (2010:67) found that these processes were not well communicated and that no consent was sought, additionally, no choices of options were given to patients. Furthermore, some service users felt they should be reoriented after seclusion as they would have lost a sense of time and place. Mayers et al. (2010:67) found that isolation was also experienced by patients who were being treated far away from their homes or villages as they did not have the support that they needed from family and friends, which they felt could help during the reorientation period. The authors point out that seclusion was seen as the most inhumane treatment as there were no toilet facilities and supervision for the service users. In addition, the fact that patients were undressed and put in a dirty seclusion area that was littered with broken glass was said to be very traumatic for patients.

Mayers et al. (2010:67) established that there was use of force and that even though they were diagnosed with mental illnesses, patients felt that they were not being treated as human beings but as animals. Mental healthcare workers were also said to be provocative towards patients, such that some patients resorted to acting funny towards staff members due to fear of having their medication increased. One patient for instance cited that patients could be asked to sing for the mental healthcare worker and had to compose a song even if they did not have a song, so as to remain in favour of the service provider (Mayers et al., 2010:67).

Mayers et al. (2010:68) report that security officers were said to be inadequately trained to handle psychiatric patients and this was viewed as disrespect for patients' rights. Mayers et al. (2010:69) state that patients in their study felt that sedation was used as a form of punishment and also as a way to keep patients quiet. Other patients however viewed sedation as a means of containment that at least respected their rights compared to restraint which was associated with distress and was a form of human rights abuses.

Patients who participated in the study by Mayers et al. (2010:69) reported feeling that they had been given a voice by the researchers through which they could air their experiences. Mayers et al. (2010:71) recommend clear policy and guidelines including implementation of these when secluding patients. This observation applies to FSPs as they are at times perceived to be violent and may be handled in ways that they do not prefer. This information may assist healthcare workers in understanding that while FSPs are perceived to be a danger, they are still human and should be handled in ways that do not amount to torture.

2.6 Services provided to forensic state patients globally and in Namibia

Various countries offer forensic services in medium to maximum security hospitals, where patients that are deemed dangerous and that may have serious mental illnesses are admitted. According to the Forensic Mental Health Services (2016:1), the United Kingdom has alternative to prison forensic facilities that offer assessment, treatment and care of forensic patients, whilst admitted in secure units where they are not free to leave. In addition, the recovery of each individual patient determines how long they stay. In the British Columbia province in Canada, forensic mental health services are offered in the community by means of a court order where service delivery is based on the general model of care in collaboration with probation officers (Livingstone, Chu & Milne, 2015:79). Services are also offered by community based forensic mental health teams that work with probation officers and visit the patients once a month or twice a month in cases where there are adherence problems (Livingstone et al., 2015:74).

As alluded to by Tromp (2015), services that are offered to FSPs in Namibia, are limited to treatment and rehabilitation. Furthermore, FSPs are treated by a multidisciplinary team that offers a range of services, which include; assessment,

pharmacotherapy, psychotherapy, and other rehabilitation services. This team comprises of psychiatrists, medical officers, nurses, social workers, psychologists, occupational therapists, security officers and prison guards. However, these professions are critically short staffed. The services rendered to FSPs are aimed at protecting the public and the patients themselves from harm. According to Moloo (2016:6) most forensic staff members in developing countries do not have specialist training which poses a question on adequacy of services to FSPs. In Namibia, goal 3.3.7 of the *National Policy for Mental Health* (MoHSS, 2005:10), seeks to develop community based residential facilities for PLWMI such as halfway houses. This, according to Tromp (2015), is not yet in place and presents a challenge for discharge when some relatives are not willing to welcome FSPs back home.

2.6.1 Forensic focused treatment planning standards

Schaufenbil, Kornbluh, Stahl and Warburton (2015:250) state that the number of forensic patients across the globe is rising and that the available treatment standards do not meet the needs of this growing population. These treatment standards thus need re-development, however literature regarding explicit unique treatment plans is lacking. These authors add that treatment plans should focus on violence reduction and inability to stand trial since these are the main causes of admission. Schaufenbil et al. (2015:250) emphasise that evaluation of forensic patients should compare previous violence and check current negative attitudes, together with the existence of positive symptoms and should determine how these can have an influence on patients' behaviours when exposed in future to destabilisers. Schaufenbil et al., (2015:250) stress the importance of focusing more on violence, risk and mitigation instead of mere attainment of recovery since violence alleviation reduces risk to other people around the patient and the chances of re-offending. Schaufenbil et al. (2015:251) stress that treatment should focus on trial competency restoration as it equally focuses on violence reduction and this should be included in consideration of discharge criteria, inferring that treatment should basically target the legal reasons for admission and discharge be based on improvement of these. Schaufenbil et al. (2015:251) advise that treatment should result from an understanding of the patients' psychiatric illness, substance abuse, cognitive impairment and criminogenic thinking. Focusing on the reasons for admission can help ensure lower risks of re-offending,

but also other acceptable ways of doing things in society should be taught to FSPs, in order to generalise the gains on rehabilitation.

2.6.2 Treatment perspectives of forensic patients

To et al. (2015:1605) conducted a study on treatment perspectives in medium and high secure forensic setting in Flanders, Belgium, in which most of the participants in treatment settings reported experiencing a lot of pressure and a lack of control compared to those who were in prison settings. This, according to To et al. (2015:1605) could in some way affect the change over from prison to treatment settings. To et al. (2015:1606) also attributed negative experiences of staff by patients as being associated with self-harming behaviours, while control and restraining was said to be detrimental to relationship building and boundaries between staff and patients. It was also found that there was a need to improve the communication between the staff and service users. To et al. (2015:1608) also cite the impact that staff shortages have on therapeutic activities, as outside activities were limited and needed to be done under the supervision of staff members.

The findings by To et al. (2015:1611) also showed that there often was a feeling of lack of control by patients due to ward rules and daily activities planned by staff members. The authors found that patients' experience of ward rules was that they were too strict, rigid and they felt like children being controlled. Some patients, according to To et al. (2015:1611) experienced the inability to smoke at certain times negatively, while others felt they could not control their sex lives, yet others said they had to ask staff members for everything. For those who had forensic mental health setting experience, To et al. (2015:1612) found that they preferred staying in prison over being in forensic settings, as they had the leeway to decide to participate in prison programmes as compared to the programmes in the forensic setting. Those in forensic settings felt the pressure to perform in fear of the possibility of being sent to prison.

To et al. (2015:1613) realised that mostly patients felt they were being pressured to cooperate with staff and ward rules. To et al. (2015:1616) also discovered that patients at forensic settings encountered more negative experiences than those in prison settings. Forensic patients indicated to To et al. (2015:1613) that the indefinite period of stay in forensic setting was stressful and some felt the need to be trusted

again by staff members as this would enhance their ability to take up more responsibility. To et al. (2015:1614) found that some patients felt that there was no privacy when it came to patients consulting with the psychiatrist as ward staff would be present and this reduced requests to be examined by the psychiatrist. However, patients had a need to discuss more issues with the psychiatrist but feared ill treatment by ward staff afterwards. The authors discovered that patients perceived some staff members as artificial, sarcastic or mocking while others were regarded as professional in their conduct. To et al. (2015:1615) documented the negative experience of living with other patients as some were said to be noisy, stressful and chaotic, which was very difficult for some patients. To et al. (2015:1616) argue that their study's findings would help understand various factors that could either facilitate or hinder the treatment of patients where relationship quality has an impact on the provision of care.

To et al. (2015:1617) found that patients in prison generally reported a degree of freedom compared to those in forensic settings. To et al. (2015:1619) note that self-determination in forensic settings appears to be an unmet need. Hence, treatment which is well-intentioned may be regarded as frustrating rather than supportive, which negatively impacts on the therapeutic relationship between staff and patients. Such findings should help healthcare workers rethink their attitudes when they are working with FSPs. The present study can help inform staff to be more sensitive when working with FSPs and to endeavour to establish a good working relationship that will have positive health outcomes.

2.6.3 Rehabilitation treatment models

Barnao, Ward and Casey (2016:776) state that the Good Life Model (GLM) is an approach to offender rehabilitation which the authors say has been ignored by forensic mental health service providers. This strength based, humanistic approach was administered by Barnao et al. (2016:776) to forensic service users and their perceptions sought afterwards. The GLM seeks to promote individual personal goals while reducing risk of reoffending in future. This is done by equipping patients with resources and enhancing offenders' capacity to reach their goals by engaging in socially acceptable means. This model is said to have a lot to offer for those providing services to patients in forensic mental health facilities (Barnao et al., 2016:767).

Barnao et al. (2016:767) assert that the GLM of rehabilitation could improve communication problems between staff and service users, non-inclusive care plans, concerns about rehabilitation measures in forensic settings that are seen as punitive, institutional control as well as unpreparedness of service users for discharge. Barnao et al. (2016:777) relate that the authoritarian approach to decision making was reported by service users and this does not put the patient at the centre of care. Due to this lack of patient centred approach, some participants initially had a negative attitude towards therapeutic programmes as they felt that these had limited benefits to them especially the ones they perceived as compulsory (Barnao et al., 2016:778).

Barnao et al. (2016:781) state that some participants reported dehumanising treatment based on their forensic history. It was noted in the study that service users perceived service providers' attitudes and stance, when relating to users who may not have insight into their illness as a real challenge. Barnao et al. (2016:783) also note that service users also set personal rehabilitation goals, despite a lack of trust in forensic services, given that they were involuntary recipients of services. Improving the relationship between FSPs and mental healthcare staff is vital and can help to focus on treatment and rehabilitation, which are the main reason for them being in forensic settings.

2.7 Programmes for forensic state patients globally and in Namibia

There is limited information regarding programmes for FSPs compared to those offered for general psychiatric patients. In a study conducted in Australia by Meehan et al. (2006:21) on patients' perception on the causes of aggressive behaviour, FSPs cited boredom due to the minimal involvement of patients in programmes as one such cause. The FU in Namibia employs the biopsychosocial model of treatment; however, most of the staff members at this unit have generalist and not specialist qualifications in rendering forensic mental health services. This FU offers various programmes to admitted patients, which include therapeutic and educational groups that are aimed at assisting patients in adhering to medication, dealing with the negative experiences that got them in conflict with the law and with their troubled past (Tromp, 2015). This unit also offers other programmes such as church services, bible study groups and cultural days, which fulfil patients' spiritual needs and allow them to be in touch with their cultures. With the help of occupational therapists, patients at the unit are also taught useful skills that may assist them in finding

employment after their release. These include skills in woodwork, how to operate a carwash, a coffee shop, and a tuck shop. However, due to space shortage at the FU, some FSPs are held in Namibian correctional facilities, at times for long periods of up to nine years, or more, whilst awaiting admission at the FU. They thus miss out on these programmes which are aimed at rehabilitating them (Tromp, 2015). This brings about the question on the adequacy of services to FSPs in Namibia.

2.7.1 FSPs experiences in a health promotion programme

A study of an evaluation of experiences of forensic state patients in an exercise programme was conducted by Wynaden, Barr, Omari and Fulton (2012:229). This programme sought to document the changes that patients realised after participating in the programme for six months, after which patients completed a self-report questionnaire. Wynaden et al. (2012:229) cite that, this group of patients was a high risk group for developing obesity and other physical comorbidities due to their lifestyle choices ranging from poor diet, smoking, inactivity and substance abuse as well as social isolation. They further state that patients were said to be at high risk of dying early due to physical diseases such as cardiac, obesity, cancer, diabetes as compared to the general population. Wynaden et al. (2012:230) attributed obesity and weight gain amongst participants in their study to antipsychotics and other factors such as the inability of medical doctors to identify and treat physical conditions, patient's inability to report physical conditions to healthcare staff as well as a lack of regular exercises.

Wynaden et al. (2012:230) also noted that a lack of using physical exercises as a treatment modality, especially for psychotic patients contributed to poor health outcomes. The outcome of the evaluation of an exercising programme conducted by Wynaden et al. (2012:232) showed that the programme helped patients improve their physical well-being, mood, fitness and enabled them to cope with stress as well as improving the therapeutic environment for both staff and patients. Such a programme would be helpful for FSPs as it can improve their general well-being.

2.7.2 Programme planning for Forensic Assertive Community Treatment (FACT)

Forensic treatment and rehabilitation services can also be done at community level. Cuddeback and Morrissy (2011:91) describe Forensic Assertive Community

Treatment (FACT) as an adaptation of the Assertive Community Treatment (ACT) model. This adaptation was necessitated by an increase in the number of forensic patients who were mandated to receive treatment as outpatients by the courts. The authors gathered data from various systems in order to compare clinical, demographic and criminal justice attributes of ACT and FACT eligible service users. Cuddeback and Morrissy (2011:90-1) believe the results of the comparisons would then help inform the implementation of FACT, which would be adopted from ACT, a concept that has been applied for over thirty years. Areas that would benefit would be staffing, training and competences of teams required to work in FACT.

Cuddeback and Morrissy (2011:92) put forward that this information is vital in informing staffing as the already existing ACT teams needed retooling in order to assist those with mental illness and justice involvement. Based on their findings, the authors concluded that more males, preferably of colour, should be considered to work with FACT consumers as they strongly matched their set characteristics and constituted huge numbers, while considering the need to be culturally competent. Cuddeback and Morrissy (2011:92) recommend that teams need to be able to identify other general medical conditions so they could also include this in their treatment programmes. Cuddeback and Morrissy (2011:94) add that the issue of substance use among FACT consumers meant that the teams should have competences in dealing with this and were to have specialised knowledge in dealing with antisocial personality disorders as well as schizophrenia as these were challenging to deal with yet prevalent in FACT consumers. This would then be important when they engage them in the treatment programme.

Cuddeback and Morrissy (2011:9) also mention that due to the challenges posed by the comorbid antisocial personality disorders, it was envisioned that the teams would need more time to engage with FACT consumers in comparison to ACT consumers. Over 50 percent of FACT consumers were said to have had violent offences which had implications on training, to needs such as diffusing violent situations, adding that this requires policies and clear guidelines in order to protect both the consumer and staff, highlighting the importance of safety. In addition, FACT teams would require skills and knowledge in community housing and placements of the consumers. Comorbidity of mental illness and medical problems indicated a greater need to screen FACT consumers for medical conditions as well as strengthening this through

combined efforts with primary health care providers (Cuddeback & Morrissy, 2011:93). Furthermore, Cuddeback and Morrissy (2011:94) note the co-occurrence of schizophrenia and substance use disorders which showed the need for FACT teams to have competences in motivational interviewing as well. Such a programme could be useful in Namibia as it can help guide the decisions that can be made to establish mental health community teams which can help with supporting discharged FSPs. This can help curb problems that may be encountered in the reintegration of FSPs in the community as highlighted in the following discussion on granting FSPs leave of absence from the FU.

2.7.3 FSPs experiences of leave of absence

Mathanya, Kgole and Lekhuleni (2015:161) noted how psychiatric state patients in South Africa were now staying in hospitals for shorter periods than before as they were released too soon, hence the need arose to study their families' experiences of living with FSPs released on leave of absence after committing an offence. The authors studied the experiences of FSPs during leave of absence in Lepelle Nkumpi Municipality, Limpopo Province, South Africa. Mathanya et al. (2015:162) and found that state patients on leave of absence were feared by family members and therefore suffered emotionally due to a lack of family support. Some were said to be aggressive towards their families because of tobacco, drugs and alcohol abuse. Mathanya et al. (2015:161) pointed out that families also seemed to have fears as they thought of the crimes their family member had committed. In addition, state patients were said to be refusing to adhere to their treatment while being supervised by their families.

Mathanya et al. (2015:162) found that non adherence to medication resulted in state patients having problems such as anger, irritability and sleep disturbances, which resulted in most of them not spending the whole three to six months of their leave of absence as they were taken back to the hospital. Mathanya et al. (2015:162) state that this showed unsuccessful reintegration and it was also noted that soon after their return, families do not follow up on issues that led to re-admission and also stop visiting their relative unless social workers engaged them. Mathanya et al. (2015:165) report that psychiatric state patients were perceived to be disruptive and difficult to control. Most were using cannabis and alcohol as observed by family members. A lack of proper sleep by family members due to behaviours displayed by

some psychiatric state patients on leave of absence, such as roaming around the house and putting high volumes on radio, led Mathanya et al. (2015:166) to understand that family members feared the return of their relative. Mathanya et al (2015:167) got reports that some psychiatric state patients were better during the early days of their leave of absence but soon changed after some weeks where they would isolate themselves. Families felt insecure and could not trust their relative due to negative past experiences.

Mathanya et al. (2015:162) also found that families reported tension, stress, anxiety, resentment, depression, hopelessness, powerlessness, a sense of entrapment, a disruption in their family life and relationships, financial difficulties, physical ill health, restrictions in social and leisure activities, and an overall decrease in the quality of life as a result of having a seriously mentally ill member. A lack of coping mechanisms were also reported and some wives of FSPs on leave of absence took measures to leave relationships that included filing for divorce and going back to their parents' house, as they felt they were more in peace when the patient was not at home (Mathanya et al., 2015:168). A leave of absence programme would be helpful for FSPs in Namibia as it will act like a pilot programme for the reintegration of each patient, which helps evaluate possible areas that may need more work during the treatment and rehabilitation process and thus prepare patients for eventual discharge. This programme may also give an opportunity to help FSPs as well as their families to pinpoint areas where further work is required.

2.7.4 Research on forensic service users' perceptions

In a study aimed at exploring the perceptions of forensic service users at the New Zealand Forensic Hospital, in New Zealand, Barnao et al. (2015:1026) explored various themes which included; the therapeutic relationships that exist between service users and providers, the forensic environment and problems experienced by FSPs such as a lack of knowledge regarding care plans and feelings of unpreparedness for discharge and restrictions to having therapeutic programmes outside of the forensic setting.

Barnao et al. (2015:1029) highlighted various areas which were important in forensic rehabilitation such as staff treatment, understanding the reasons for offending, risks posed by patients, mental illness experiences and responsiveness to activities.

These were examined in light of the person centred approach to patient care where patients were asked if they felt that they were at the centre of the treatment and were working collaboratively with staff members in their rehabilitation. The results showed that some patients felt there were areas which were non-negotiable and not much of personalised care, such as queuing for medication (Barnao et al., 2015:1031).

Barnao et al. (2015:1033) examined the staff - patient relationship by asking patients whether they felt they were being treated like human beings to which 12 of the 20 participants gave negative responses, while 8 responses were positive. Some negative responses included experiencing barriers with staff, focusing more on the illness, risk and reoffending. Some participants reported staff changes as negative as this brought about inconsistences in service delivery, confusion and feelings of being exposed to new staff (Barnao et al., 2015:1034). These authors also asked patients about the expected outcomes of rehabilitation, and found that most of the participants did not know the main purpose of the programme and that they simply had to pass time. Others however knew of the reasons why they were in rehabilitation after being informed of this by healthcare workers.

According to Barnao et al. (2015:1034-5) some patients felt frustrated and let down as a result of not being discharged even though they had been compliant with taking part in the programmes. They also found that most patients' experiences were that of a lack of control as they were being detained in an institution and felt restricted and lacked freedom, substantiating this by saying that they were unable to decide on the clothing they wore, what time they slept and the food they ate as almost everything was controlled for them.

Barnao et al. (2015:1037) discovered that forensic patients' coping strategies existed in two general categories; one of being passive also regarded as compliance or disengagement and the other of being active which was related to emotion or problem focused coping. There were yet others who cooperated with staff in order to quicken their release by suppressing their frustration about their powerless position (Barnao et al., 2015:1037). FSPs may fall victim to staff members who may want to exert their powers on them. Thus, controls should be put in place in institutions where FSPs can feel free and easily report abuse of power without victimisation.

2.8. Services provided to families of forensic state patients

One can infer from Bronfenbrenner's (1994:38) Ecological Systems Theory that families are an integral system in which a person is nurtured. Therefore continued interaction of families with FSPs brings about positive treatment outcomes due to the support they offer. In a survey conducted in Scotland by Support in Mind (2010:4) to assess the help forensic patients' families received, from both the perspective of staff members and the experiences of the families, 44 percent of families were not happy with the inflexible visiting times. Furthermore, some families felt blocked in their attempt to access information regarding their relative, which was to some extent, attributed to the issue of confidentiality. Fifty percent reported that they did not receive any form of advice or information when their relative was first admitted to the forensic unit. Some reported that they faced difficulties in travelling long distances to visit their relatives. However, some expressed gratitude for the positive exchanges they had had with staff members and for the support and therapy group for families, the existence of which was however not known to all families. This survey highlighted inconsistency in various units and within different units (Support in Mind, 2010:3-4).

Tromp (2015) asserts that preventative measures such as education and support to caregivers of patients diagnosed with mental illnesses, provision of safer environments and programmes that help in coping with mental illness may be regarded as an expensive venture, but in the long run helps to reduce the possibility of PLWMI becoming offenders. This view is supported by Watson and Marschall (2013:8) who reiterate the importance of early intervention in achieving positive outcomes. Barandonga (2015) reports that in Namibia, awareness raising activities on issues relating to mental illness are provided to healthcare workers through specialised outreaches from the MHCC. In an interview with Tromp (2015), the researcher established that in Namibia, family members of patients admitted to the FU receive support and education regarding the condition of their relative. Others are referred to social workers who ensure that their concerns are addressed. For those family members who live far from the FU, and have no transport money to visit their relative, the unit through its social workers, arranges a free hospital bus, food and accommodation for a three day visit to the FU. Relatives also enjoy arranged visits which are authorised by social workers outside normal visiting hours. This provision

is especially made for those relatives who do not live in Windhoek, whilst those living in Windhoek are encouraged to visit over weekends. Tromp (2015) also highlighted the lack of coordination when patients are moved from one facility to the other, which left some families not knowing where their family member is, resulting in lack of support. However, research needs to be done on how these families experience the services they receive at the FU.

2.8.1 Family perceived burden of care

Lippi (2016:7) states that families are an integral part of the support system for patients with schizophrenia, who also form a huge number of patients found in forensic hospitals. Recognising the role played by family members, Lippi (2016:7) notes that families experience high levels of burden when it comes to caring for their mentally ill loved ones, and therefore require support and education regarding mental illnesses. Experiences of family members before the arrest of a FSP can influence their obligation to remain in touch with their ill relative. Marimbe et al. (2016:4); Lippi (2016:2) mention among others, the burden of neglect of other family members, disruption of family life, social isolation, loss of productivity, difficulties going on holiday, worry, tension, feelings of resignation as well as exhaustion, physical harm due to assault, psychological or emotional harm which result in depression and distress, while others reported of having lost weight and having developed high blood pressure as a result of dealing with a family member with chronic mental illness.

Marimbe et al. (2016:4,5) studied families of patients with bipolar affective disorder and schizophrenia in Harare, Zimbabwe, where some families had financial burdens resulting from the need to buy medication due to its unavailability in hospitals, even though treatment was for free, while others left their work in a bid to take care of their loved ones. The negative experiences of the families led some to behave negatively towards their ill family member and at times shouted at them. Marimbe et al. (2016:5) documented the needs of the studied family members who called for financial assistance from donors or government, while others called for support groups which they thought would help them to cope. In addition, others sought more information on the illness and ways to care for their ill family member. Marimbe et al. (2016:5) also reported that some family members expressed gratitude for being asked how they felt, caring for their ill family member. Three percent of participants in the study by

Marimbe et al. (2016:6) had suicidal ideation while 93.5 percent reported of thinking a lot within the week of the study. These findings are similar to findings by Mthoko (2017a:30, 31) on the impact of relatives' mental illness on family members in Namibia, where a participant expressed that it was better to die, as they were not equipped to deal with a member living with a mental illness, which indicated the magnitude of the impact for them.

Marimbe et al. (2016:6) recommend that as part of the care plan, healthcare workers should pay more attention to the needs of patients' families and assist them with counselling and with any information they might need. Marimbe et al. (2016:5) state a serious shortage of mental health professionals in Zimbabwe, which they said could be narrowed by training and supervising lay community workers to help with psycho education, support of patients and caregivers as well as help them identify signs of relapse. The lives of FSPs can be impacted positively if there are caregivers who will assist them when discharged in order to minimise the chances of the patients relapsing. In countries like Namibia where there are no forensic community services, caregivers can assist healthcare workers tremendously in this regard. Being away from home for a long time is a challenge for FSPs therefore more needs to be done to put in place forensic community programmes as this encourages FSPs to work towards discharge and gives them a hope of reintegrating back into society.

2.8.3 Effects of mental illness on patient - family relationships

A study on the effects of mental illness on relationships amongst families, relatives and friends with persons with mental illness was done by Magadla and Magadla (2014:127) who noted that multidisciplinary team members including nurses and social workers made efforts to try and locate relatives of patients with mental illness but this was met with negative responses from relatives. Magadla and Magadla (2014:127) cite living far from mental health institutions as a reason for failure to visit patients. Some family members, however, felt that living with PLWMI was a burden as they felt terror, helplessness, rage and despair (Magadla & Magadla, 2014:128).

Magadla and Magadla (2014:128) found that some family members had feelings of shame and embarrassment while others were confused about the illness. Magadla and Magadla (2014:129) suggest that family members be viewed as secondary patients due to the disturbance caused by the mental illness as it also affects their

functioning. Of the patients in their study, only 67 percent received visitors. Magadla and Magadla (2014:133) found that a lack of visitors was as a result of work commitments by family members but it at times indicated that there were problems in the relationships between a patient and his or her family. Magadla and Magadla (2014:133) also found that of the visitors observed during a period of two months, 24 percent were males and the majority (76 percent) were females, with those who visited being said to have love, empathy and acceptance.

Magadla and Magadla (2014:134) also found that patients who had stayed long in hospital had few people visiting them. Magadla and Magadla (2014:127) inferred that others who may have been visiting might have succumbed to death, a change in their work location, or may have had some life changes that would affect their support. Magadla and Magadla (2014:134) emphasised support for relatives of patients as it was important in helping prevent them from resenting those with mental illness. Such scenarios are also applicable to FSPs in Namibia who spend a long period of time in hospital or correctional facilities, only to be faced with life changes that affect their social support. While the situation of FSPs can be appalling, health workers need to be aware of the challenges their families also go through so that they can be able to help them cope and manage the challenges they are faced with.

2.8.4 The strengths in families supporting mentally ill members

In a research conducted in the North West Province of South Africa, Mokgothu, Du Plessis and Koen (2015:2) highlighted the importance of recognising and acknowledging the strengths that families possess, and even better, to build on those strengths. Mokgothu et al. (2015:1) urge families and caregivers to partner with healthcare workers in providing care for those with mental illness. However, family members lacked training and support to do this work which was said to be emotionally draining. According to Mokgothu et al. (2015:4) police officers were identified as a form of external support when it came to assisting families with taking their ill relative to the hospital. In addition, spirituality played a role in strengthening families, as some family members drew strength from their faith in the form of prayers, whilst others had some teams that would come and pray with them while additional social support also came from neighbours and extended family members. Mokgothu et al. (2015:6) found that traditional healers, churches and police featured much as families' external support systems, in addition to internal strengths such as

faith, prayer, positive reinforcement and keeping the person with mental illness busy and calm.

2.9 The role of social workers in forensic service delivery

As noted by Tromp (2015), social workers play an important role in forensic psychiatry. They assist patients and their families with psychosocial support and assume various roles in helping and counselling those affected by mental illness. Social workers contribute to policy formulation, which helps ensure the quality care of FSPs, by identifying any need for policy change and implementation (Hepworth et al., 2006:31). Social workers also ensure that the needs of families are met by giving them information and helping to arrange for meetings with relevant professionals. They work as case managers who ensure that patients and families receive the required services (Davis, 1993:25).

Toseland and Rivas (2009:23) report that at the meso level, the social worker can form educational groups with the view of assisting patients to gain more knowledge on their illness, the importance of adherence to medication as well as avoidance of substance use. Social workers can also establish therapeutic groups with the view of dealing with patients' emotional pain after the patients realise the impact of the crime they committed, which at times can be murder or rape. These therapeutic groups also provide a platform for group members to support each other through the process.

At the macro level, social workers do preventative work in communities by planning and developing programmes aimed at educating community members on mental health and awareness raising (Hepworth et al., 2006:27). This helps to eliminate ignorance, change people's attitudes and equip community members with knowledge (Weyers, 2011:254). Furthermore, social workers can conduct research of which the findings can be used in formulating policies to ensure the well-being of PLWMI. Tromp (2015) adds that research findings can inform practice and enhance knowledge that can be used in service delivery to the society. In line with the primary mission of social work, it is important that social workers continue to work towards helping FSPs as they are a vulnerable group.

2.10 Summary

The chapter started by discussing provision of services to people living with mental illness. It also reviewed literature relevant to FSPs globally and in Namibia. Even though being in conflict with the law gives FSPs a different identity, they are primarily people living with mental illness (PLWMI). The researcher found it necessary to discuss issues regarding living with mental illness in general, since FSPs experience the stigma attached to mental illness. In addition, human rights and the current mental health legislation in Namibia and in selected African countries such as South Africa and Egypt were also discussed. The chapter also examined the history of forensic psychiatry, which included the admission rates and characteristics of FSPs and additionally looked at issues that are usually found in forensic settings such as containment, therapeutic relationships between staff and FSPs, as well as the role of families in the lives of PLWMI.

In trying to understand other forensic settings and perceptions of patients in other contexts, the chapter examined the experiences of forensic patients in studies conducted in other countries. In addition, the chapter discussed some treatment programmes that have been used in correctional facilities to address some elements of criminality which are present in some FSPs. Lastly, the chapter discussed the role of social workers in forensic service delivery. The next chapter, chapter three, discusses the research methodology in detail as well as the study's findings.

Chapter 3
Research methodology and empirical study

3.1 Introduction

This chapter discusses the research methodology that was used in carrying out the study. It covers the research questions, the research approach, the type of research and the research design. The chapter additionally discusses research ethics that guided the researcher's conduct and how the trustworthiness of the study's findings was improved. In addition, the chapter discusses the limitations to this study and thereafter presents the study's findings, starting with participants' demographic data, which is presented in the form of tables and participants' narratives which are clustered according to themes and their associated sub-themes.

The research question that guided the study was: **What are the challenges experienced by hospitalised forensic state patients regarding mental health services in Namibia?**

In order to answer the research question, the following sub-questions were asked:

- What were FSPs experiences of mental health services received before admission at FU?
- What challenges were experienced by FSPs since they got ill?
- What were FSPs experiences of support from systems such as family, community, holding institutions staff and healthcare workers?
- What challenges were faced by FSPs regarding facilities at the FU?

3.2 Research approach

The researcher employed a qualitative research approach as the aim was to explore the experiences, reality and deeper meanings that FSPs ascribed to the challenges they faced in accessing mental health services in Namibia (Fouché & Delport, 2011a:65). By so doing, the researcher was able to develop a holistic view of these challenges and so was able to draw conclusions based on in-depth inquiry into the service delivery experiences of FSPs. Thus, the research revealed the social context and processes of selected cases in their journey from before the time of arrest (Rubin & Babbie, 2013:95).

3.3 Type of research

The type of research that was conducted was applied research as the study aimed at solving a particular problems in practice (Fouché & De Vos, 2011:94), specifically the challenges that are faced by hospitalised FSPs in Namibia, with the view of informing mental health policies in Namibia. The study was also exploratory (Fouché & De Vos, 2011:94-95) in that no similar studies have been conducted in Namibia. The findings emanating from the study could potentially be instrumental in informing policy and refining the formulation of the Mental Health Bill. The findings may also help institutions, which deal with FSPs to become more responsive to the needs of FSPs as they are vulnerable members of society.

3.4 Research design

The researcher made use of a collective case study design where multiple cases were selected to show different perspectives of an issue in order to provide an in-depth case picture, exploration and understanding of a particular subject (Creswell, 2012:99, 103; Fouché & Schurink, 2011:322) in this case, the service delivery challenges that are experienced by FSPs.

3.5 Research methods

In this section, the researcher outlines the study's population as well as the data collection and analysis methods.

3.5.1 Study population and sampling

The study population was comprised of all FSPs hospitalised at the FU at MHCC, which is located at the Windhoek Central Hospital. The FU houses at any given time, three types of forensic patients namely; those coming for psychiatric evaluations, which are also known as observations, trial awaiting prisoners and FSPs ordered to receive long-term treatment and rehabilitation by the courts (Mental Health Act 18 of 1973). At the time of the study there were 76 patients that were admitted at the FU and were receiving long-term treatment and rehabilitation.

3.5.2 Sampling techniques

The researcher used purposive sampling, which is a non-probability sampling method (Creswell, 2012:99) to select a sample of participants who were receiving long-term treatment and rehabilitation at the FU. The use of purposive sampling allowed the researcher to collect rich, diverse data from specific participants who

could provide in-depth information on the study topic (Strydom & Delport, 2011:391). The researcher drew a sample of 12 participants from the 76 FSPs hospitalised at the FU by means of a list which was obtained from a senior nursing staff member who had worked with these patients for long and was therefore in a better position to assist with the selection of research participants that met the following criteria:

- English speaking.
- Hospitalised in the unit for at least 6 months.
- Being asymptomatic and on medication.
- Male or female.
- Being of any ethnic group.
- Older than 18 years of age.

In addition, the researcher took the list of potential participants to a psychiatrist at the centre who certified them as mentally stable and therefore could participate in the study at that time. The English speaking criteria for eligibility in the study was necessitated by the fact that the researcher wanted to conduct the interviews herself but is not fluent in the vernacular languages spoken in Namibia. The researcher also did not want to lose some expressions from participants through the use of a translator, which would also compromise the privacy and confidentiality of patients.

3.5.3 Data collection methods

The researcher utilised one-on-one interviews which were guided by an interview schedule to collect research data. The semi-structured interview schedule outlined a list of issues which the researcher covered during the interviews. The questions and sub-questions in the interview schedule were formulated in a manner that could be easily understood by the participants (Creswell, 2013:164). The researcher also arranged the questions in a sequential manner, starting with less sensitive questions (Greeff, 2011:352). The questions indicated on the schedule were followed up with probing questions. The interview schedule helped the interviewer to be flexible and informal in allowing conversation (Rubin & Babbie, 2013:123).

As the interviews were aimed at exploring and getting rich descriptions of the challenges that FSPs experience, the researcher made use of open ended questions that gave participants an opportunity to express their experiences, thoughts and feelings about the range of services that they received. The researcher also probed

into the deeper meanings of participants' nonverbal language (Rubin & Babbie, 2013:95). The researcher took down field notes on observable interactions in the interview setting (Babbie, 2011:345). These were utilised in understanding participants' non-verbal reactions and served to enrich the study with additional information that enabled the researcher to understand the social reality in which FSPs find themselves (Holliday, 2008:62, 64).

The interviews were recorded by means of a digital voice recorder, which assisted with the full preservation of participants' responses, whilst helping the researcher to focus on facilitating communication and documenting the various cues observed (Rubin & Babbie, 2011:470). The recording was done with participants' full informed consent and was consequently used for transcribing the research data. To avoid making participants anxious, the researcher placed the recorder more towards herself.

3.5.4 Data analysis

Qualitative data analysis is a non-numeric examination and interpretation of observations for the purposes of discovering underlying meanings and patterns of relationships (Babbie, 2013:390). Creswell (2013:180) states that data analysis entails coding then reducing and presenting information in figures, tables or discussions which helps bring meaning and structure to the huge amounts of data gathered. Creswell describes qualitative data analysis as a process of moving in analytical circles, which can be represented in a spiral image where a researcher enters with text in the form of data or images and leaves with a narrative. Creswell (2013:98) states that the key to understanding good case study research is describing the case and themes that emerge during the study and arranging them in chronological order. The researcher analysed the data in and across cases in order to capture differences or similarities among them. The researcher ended the case studies with conclusions from assertions derived from the overall meaning of the data gathered and lessons learnt (Creswell, 2013:99). The study utilised the following qualitative data analysis steps as put forward by Creswell (2013:182):

- **Data collection and preliminary analysis**

The researcher collected research data by means of interviews, observations and field notes taken during interviews (Creswell, 2011:149). Schurink, Fouche, and De

Vos (2011:405) state that collecting data is a two-fold approach where data analysis can commence in the field, during the collection of data while the second analysis can be done off the field in the researcher's office.

- **Organising and managing the data**

The researcher prepared the research data for analysis by saving the audio recordings of the interviews on a computer after every interview, as well as on a memory stick that served as a back up to the data saved on the computer. The researcher thereafter listened to the audio recordings and transcribed each interview by typing it word for word into interview transcripts in order to immerse and feel the cumulative data (Schurink et al., 2011:408). This data was then clearly labelled by assigning it with numbers in place of participants' actual names.

- **Reading and writing memos**

The researcher then read the transcripts entirely several times as this helped make sense of each interview. She identified patterns and wrote down memos or short phrases, concepts and ideas that came to mind during reading (Creswell, 2013:183). These served as reminders of various vital areas of analysis from the beginning of data collection to just before completion of the final research report (Schurink et al., 2011:409).

- **Generating categories and themes**

During this stage, the researcher gave detailed descriptions of data by describing what was seen in the data and developing themes and dimensions in her own view and from the perspectives of literature (Creswell, 2013:184). The researcher identified salient themes that emerged, which were central to creating categories as well as patterns in various cases and coded the data using words (Schurink et al., 2011:411). From these codes the researcher determined their commonness and themes were derived from the participants' descriptions of their experiences.

- **Testing emergent understandings for alternative explanations**

The researcher then made use of within-case analysis, where she gave a detailed description of each case and highlighted the themes that emerged within each case. This was then followed by thematic analysis across the cases and interpretation of cases. The researcher also incorporated emergent themes to the prefigured ones that came from the theoretical framework as well as the literature (Creswell,

2013:185). Similarly, the researcher searched for negative instances of patterns in the data and incorporated them into larger constructs. This process involved challenging the general understanding from the study (Schurink et al., 2011:415).

- **Interpreting and developing typologies**

Creswell (2013:187) points out that interpreting data involves making sense of the data and bringing out the lessons learnt. The interpretation was a result of the researcher's intuition, insights and hunches. The researcher took time to think through what the data was bringing out. The researcher then developed typologies, by grouping research phenomena using characteristics they had in common with others (Schurink et al., 2011:416).

- **Presenting the data**

The analysed data is presented in this chapter in the form of visuals that include tables and figures which are used for comparing the biographical information of patients in this study. They are also presented in the form of themes and sub-themes that are captured in narrative passages (Creswell, 2013:187).

3.6 Trustworthiness of data

The researcher ensured the authenticity of data by ensuring that the data collection and analysis methods reflect accurately participants' feelings, thoughts experiences and meanings (Lietz, Langer & Furman 2006:444). In order to ensure the trustworthiness of the study's findings, the following components namely; credibility, dependability, conformability and transferability were addressed.

Credibility: In line with social work's mission of raising awareness of the needs of underprivileged populations, the researcher used this research to bring out the experiences of FSPs by amplifying their voices in order to give an authentic representation of their experiences. She made use of the strategies outlined by Lietz et al. (2006:444) such as prolonged engagement, where the researcher spent periods of time observing the setting as well as collecting data until the data was saturated. She also made use of member checking which entails getting feedback from participants when analysing data and drawing conclusions (Thyer, 2010:368). Member checking was accomplished by taking parts of the themes and case analyses to participants and hearing from them (Creswell, 2013:252). The researcher also utilised peer debriefing by engaging a former social worker from the

Ministry of Health and Social Services who critically analysed and helped with uncovering some biases, assumptions or perspectives in the research process (Thyer, 2010:367).

Dependability: In order to ensure dependability, the researcher documented the research process and the various decisions made during the research in a notebook, a method known as an audit trail (Thyer, 2010:356).

Confirmability: The researcher ensured confirmability by making use of auditing throughout the research process, which helped substantiate the findings and the interpretations made (Schurink et al., 2011:420). In the research, data collected from participants was compared with that given by a key informant. Confirmability enabled the researcher to check if information gathered substantiates the research being undertaken. After the study, the researcher availed raw data to her supervisor in the form of digital recordings and transcripts.

Transferability: Relates to the extent to which the research findings can be used in other contexts or similar contexts by ensuring that the researcher gave detailed information about the participants' experiences. To ensure the transferability of findings, the researcher made use of the EST theoretical framework and stated parameters of the research, where transferability can then be determined by those working on policy research. However, transferability is not a major focus in qualitative studies (Bryman, Teevan & Bell, 2009:132).

3.7 Pilot study

Strydom and Delport (2011:395) stress the importance of a pilot study which tests the measuring instrument and the planned data collection procedures. The researcher carried out a pilot study with two FSPs meeting the selection criteria, in order to evaluate if the proposed data collection instrument and methods were appropriate to the study. The pilot study helped ensure that the study gathered the intended information and checked that questions used in the interview schedule were well understood by the pilot participants. These interviews helped the researcher to make a few changes on the interview schedule such as re-arranging the order of the questions. The researcher decided to skip asking for participants' demographic information during the main interviews and got this information from their hospital files. The researcher only verified with the participants, information

which was not captured in their files such as their work status prior to their admission. As the data that emerged from the two pilot studies proved useful to the study, the researcher included this information in the main study. The changes that were made during the pilot study were incorporated to improve the quality of the interviews in the main study (Delport & Roestenburg, 2011:195).

3.8 Ethical considerations

The researcher got authorisation to conduct the study from the MoHSS (see appendix 3), and also got approval to interview participants from the head of the MHCC (see appendix 4). Ethical clearance for the study was obtained from the Research Panel of the Department of Social Work and Criminology and the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see appendix 5). Whilst carrying out the study, the researcher was guided by research ethics, which are moral principles that function as a guideline to minimise any form of harm to participants and that guide the quality of work that is expected in a study (Best, 2012:20; Strydom, 2011:114). The researcher was guided by the following ethical considerations:

- **Privacy/ confidentiality/ anonymity**

Strydom (2011:119) states that everyone has a right to privacy. In ensuring privacy, the researcher conducted the interviews herself and kept collected data in a private place. Confidentiality is an extension of privacy where parties agree on the limits for others to access private information (Babbie, 2013:36). Information in the study was given anonymously in order to protect participants from being identified (Strydom, 2011:120). The researcher also employed the use of pseudonyms so that readers of the findings could not link responses to any participant (Babbie, 2013:35).

- **Informed consent**

Participants were accurately informed about the nature of the study by the researcher through an informed consent letter (see appendix 2), which the researcher read together with each participant. This informed consent letter gave a thorough description of the procedures that would be followed in the study such as the audio recording of the interviews (Babbie, 2013:34; Babbie, 2011:480) and the dissemination of the findings (Best, 2012:23). The researcher took time to answer

participants' questions before they signed the consent letter. The letter also indicated that collected data in the form of transcripts will be archived at the University of Pretoria for a period of 15 years. Having clarified all the planned procedures, the researcher then obtained participants' written consent to participate in the study (Babbie, 2013:34).

- **Voluntary participation**

Participants voluntarily agreed to participate in the study (Babbie, 2011:478; Strydom, 2011:116). The researcher informed participants not to feel obliged to take part in the study as their participation would not count for a favourable report in the rehabilitation programme (Babbie in Strydom, 2011:117). Even though the institution had permitted the study, the researcher upheld participants' right to self-determination by not forcing participants who refused to take part into participating (Strydom, 2011:117). In addition, the researcher informed the participants that they could discontinue from participating at any time of the interview, if they so wished, and that this would not affect them negatively in any way.

- **Avoidance of harm**

Strydom (2011:115) stresses the importance of making sure that participants are protected against any form of harm. The researcher informed participants about any possible emotional harm that may result if they were to participate in the research and allowed participants to withdraw their participation during the interviews, if they so desired. Harm in the present study, included reliving various experiences which could affect them emotionally. The researcher also minimised harm to participants by upholding confidentiality so that participants' information was not linked to them for security reasons (Denscombe, 2012:128). The researcher checked throughout the interviews for any form of distress so she could stop the interview, but this was not evident in all the FSPs who participated in the study.

- **Deception**

The researcher made sure that all potential participants were informed about the true nature of the study and no information was withheld from them. Babbie (2013:38) states that researchers must always inform research subjects about the purpose of their research without misrepresenting facts or withholding information in any form. Strydom (2011:114) believes that no form of deception should be imposed on

participants. The researcher ensured that participants were well aware of the goal and objectives of the study. This enabled participants to make an informed decision about their participation.

- **Debriefing research participants**

The researcher conducted debriefing sessions with participants at the end of the interview in order to identify any problems that might have arisen as a result of taking part in the interview. Debriefing gives participants a chance to work through their experience and its aftermath (Strydom, 2011:122). However, none of the participants showed any signs of distress despite giving very distressing information. There were only two participants who indicated that they needed assistance to have family visits and the other wanted help in arranging for an appointment with a doctor and these participants were referred to their social worker. During the debriefing sessions, participants generally seemed happy for being afforded an opportunity for their views to be heard (Strydom, 2011:122).

- **Competence of the researcher**

Strydom (2011:124) stresses the importance of the researcher's competence and skills. The researcher deemed herself competent to undertake this study as she has prior exposure to conducting qualitative research. The researcher participated as a research assistant in two other qualitative studies. Being a qualified social worker, the researcher has gained some skills in conducting interviews that prepared her to undertake the study. Furthermore, in conducting this study, the researcher worked under the guidance of her research supervisor.

- **Publication of findings**

The research findings were published in the form of a mini-dissertation, in partial fulfilment of a master's degree in social work at the University of Pretoria. The researcher presented the findings of the study clearly and accurately in unbiased language and all limitations were clearly mentioned in the research report (Strydom, 2011:126). She also ensured that the themes drawn from the transcripts were a true representation of participants' responses. The researcher will at a later stage negotiate for co-authorship of the findings with her supervisor, in an accredited journal (Creswell, 2014:96).

3.9 Limitations of the study

When interpreting the study's findings, the following limitations should be taken into account. The researcher utilised English as a medium of communication as opposed to participants' vernacular languages as the researcher is not conversant with these languages. However, conducting the interviews in participants' mother tongue would have proved difficult as the participants were from five different ethnic groups. As such, the participants could have expressed themselves better had their vernacular languages been used during the interviews. To overcome this barrier, the researcher selected only those participants who were very conversant with the English language.

In the next section, the researcher presents the empirical findings, starting with participants' demographic information.

3.10 Empirical findings

The various biographical details of the participants are presented below in the form of tables and figures.

3.10.1 Biographical details of participants

Number	Age range	Sex	Marital status at time of arrest	No of children	Language	Residential area	Level of education	Employment status before arrest	Crime	Diagnosis
1	44-49	M	Single	0	Damara	Erongo	S	Full-time employment	Rape	Schizophrenia
2	50-54	F	Married	4	Rukwangali	Zambezi	P	Unemployed	Murder	Schizophrenia
3	32-37	M	Single	0	Oshiwambo	Oshikoto	P	Full time employed	Murder	Schizophrenia
4	44-49	M	Separated	1	Silozi	Zambezi	S	Part-time employment	Murder	Schizophrenia
5	38-43	M	Single	1	Silozi	Zambezi	S	Full-time employment	Murder	Paranoid schizophrenia
6	26-31	M	Single	0	Damara	Erongo	P	Unemployed	Theft, house breaking, escape	Schizophrenia
7	32-37	M	Single	2	Damara	Khomas	S	Full-time employment	Rape	Schizophrenia
8	44-49	F	Cohabiting	3	Silozi	Zambezi	P	Self employed	Assault with Grievous Bodily Harm	Schizophrenia
9	44-49	M	Single	0	Oshiwambo	Kavango	S	Unemployed	Robbery with	Schizophrenia

									aggravating circumstances	
10	38-43	M	Single	0	Oshiwambo	Khomas	S	Unemployed	Robbery with aggravating circumstances	Schizophrenia
11	44-49	M	Single	0	Afrikaans	Khomas	S	Unemployed	Attempted murder, arson	Paranoid schizophrenia
12	44-49	M	Married	4	Oshiwambo	Oshikoto	S	Full-time employment	Murder	Schizophrenia

Table 1: Biographical details of participants

Table 1 above gives a summary of the demographic details of the 12 participants in this study, who were FSPs hospitalised at the FU for treatment and rehabilitation. The years, at which participants were first admitted ranged from late 1990s to the year 2015, indicating that there are FSPs who have stayed for over 15 years at the FU. This information has been deliberately omitted from the table above as so as not to link it with the rest of the participants' demographic data, which may make the participants easily identifiable. The table portrays variables such as participants' age range, sex, marital status, number of children, language, residential area, level of education, employment status before arrest, the crimes committed and participants' diagnosis. The majority of participants were males who constituted 10 out of 12 of the total number of participants, whereas two participants were females.

3.10.2 Distribution of participants by sex

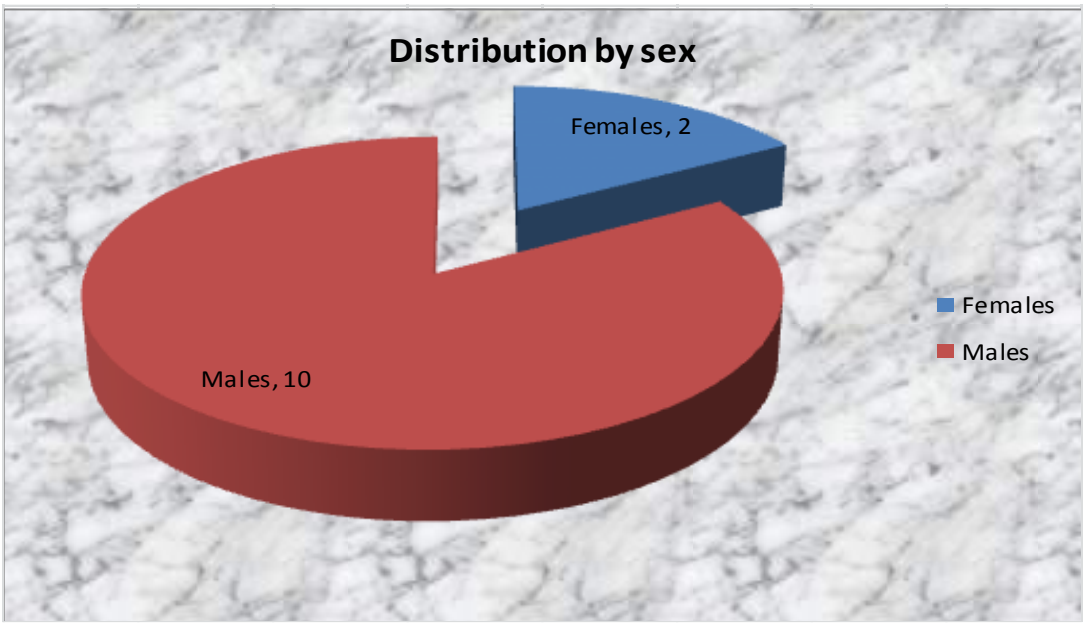

Figure 1: Distribution of participants by sex

Figure 1 above shows the distribution of participants by sex. It shows that only 2 of the 12 participants who took part in this study were female with the majority 10 being male. This difference in numbers is representative of the number of FSPs who were admitted at the FU in Namibia at the time of the study, which had only 5 females while the rest were males. These findings are consistent with a study by Pereira et al. (2005:19) where 80 percent of their study population were male, with Hodgins et al. (2007:215) noting that almost all forensic patients in their studies were males. Similarly, the majority of participants in the study by Marais and Subramaney (2015:87) were male. These findings show that the population in mental institutions is overwhelmingly comprised of males.

3.10.3 Distribution by age

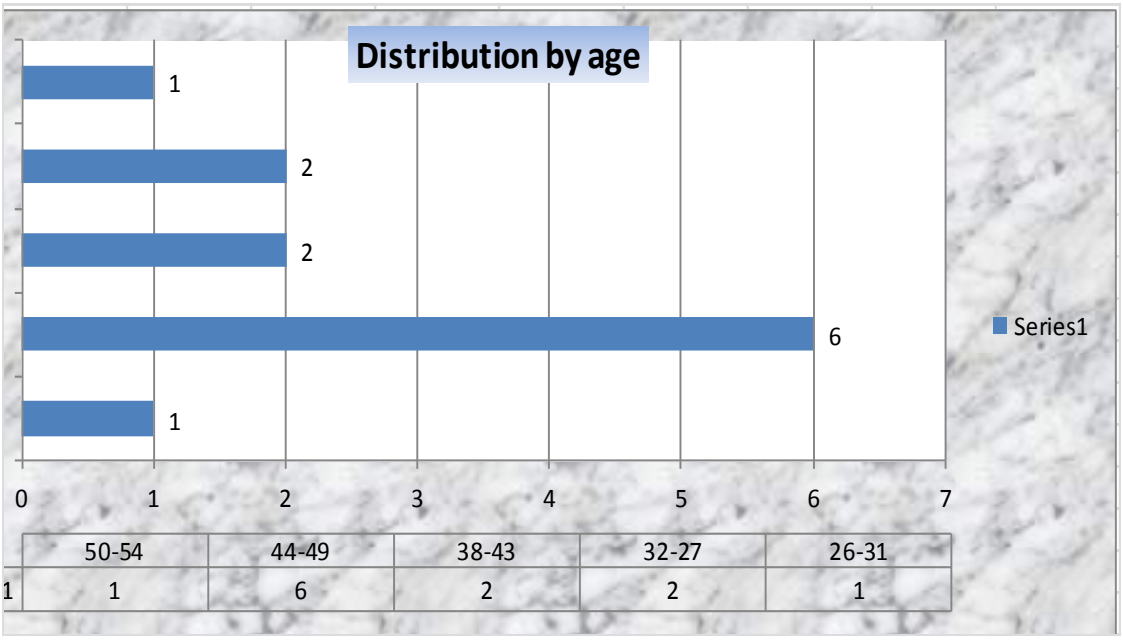

Figure 2: Distribution of participants by age

Figure 2 above shows the distribution of participants by age with the youngest participant being in the 26-31 age range and the oldest being in the 50-54 age range.

3.10.4 Distribution of participants by marital status

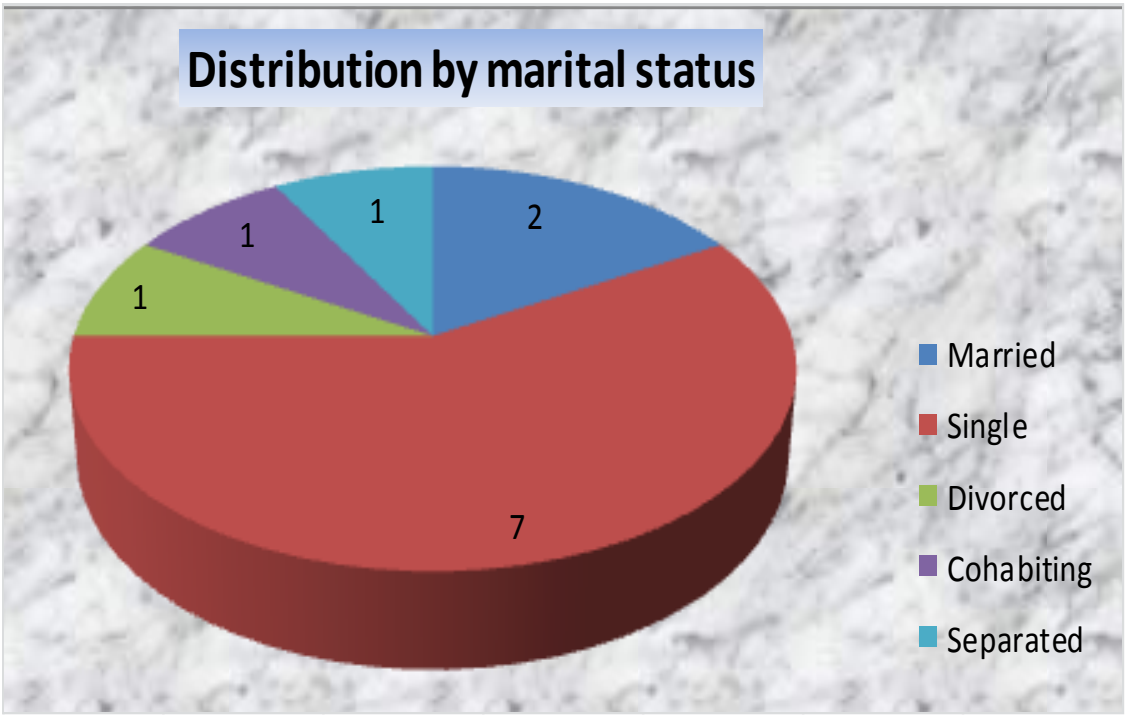

Figure 3: Distribution of participants by marital status

Figure 3 above shows the distribution of the participants by their marital status. Findings show that participants were of different marital statuses when they committed their crimes. Seven participants were single and two were married. One participant was cohabiting and yet another was separated from his or her spouse, with the last one having been divorced. These findings were similar to the study by Pereira et al. (2005:19) where the majority of their participants were single. The EST may offer an explanation for these findings as some of the FSPs may have had difficulties forming relationships due to difficulties they might have faced at intra-personal levels.

3.10.5 Distribution by number of children

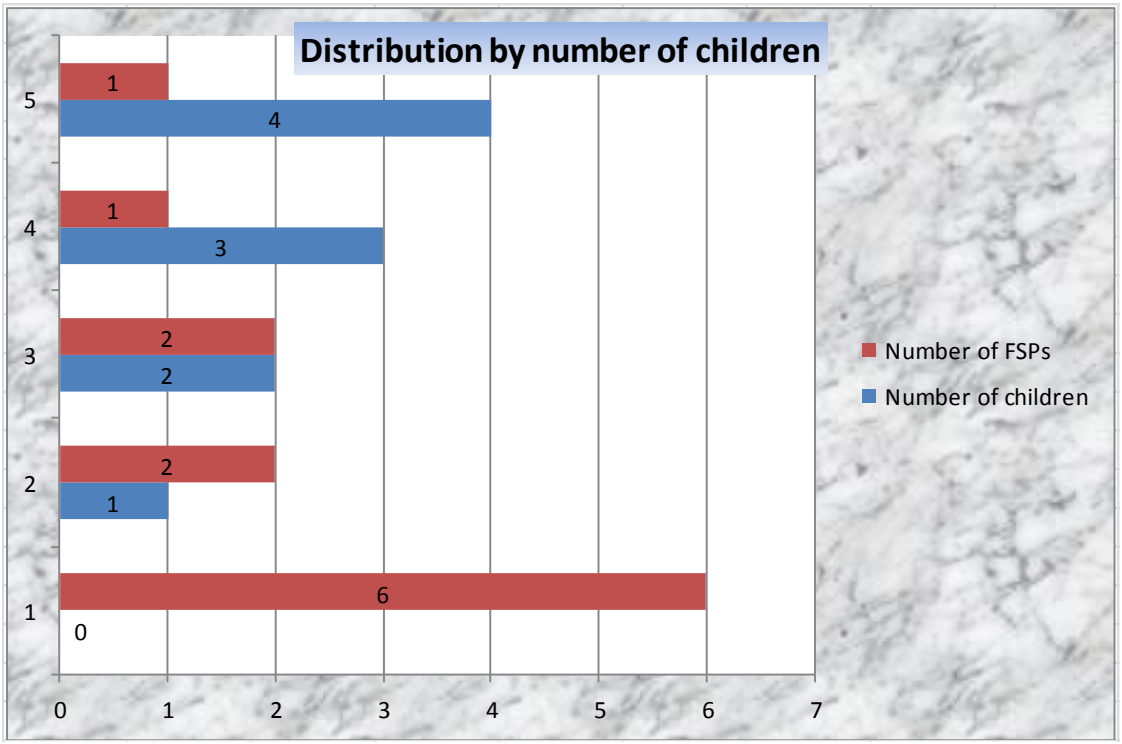

Figure 4: Distribution of participants by number of children

Figure 2 above shows the distribution of participants by the number of their children. It shows that half (6) of the participants had no children. Two of the participants had a child each, and the other two had two children each. The participant who was divorced by the time of arrest had 3 children while the one who was married had 4 children. The other six participants who did not have children were single during the time of arrest, which may show the difficulties some of the patients have when it comes to establishing intimate relationships given some of the symptoms they may be presenting with, which do not promote social interactions. These symptoms include social withdrawal and poverty of thought or speech prevalent in negative symptoms of schizophrenia as described by Barlow and Durand (2009:472).

3.10.6 Distribution of FSPs by their home language

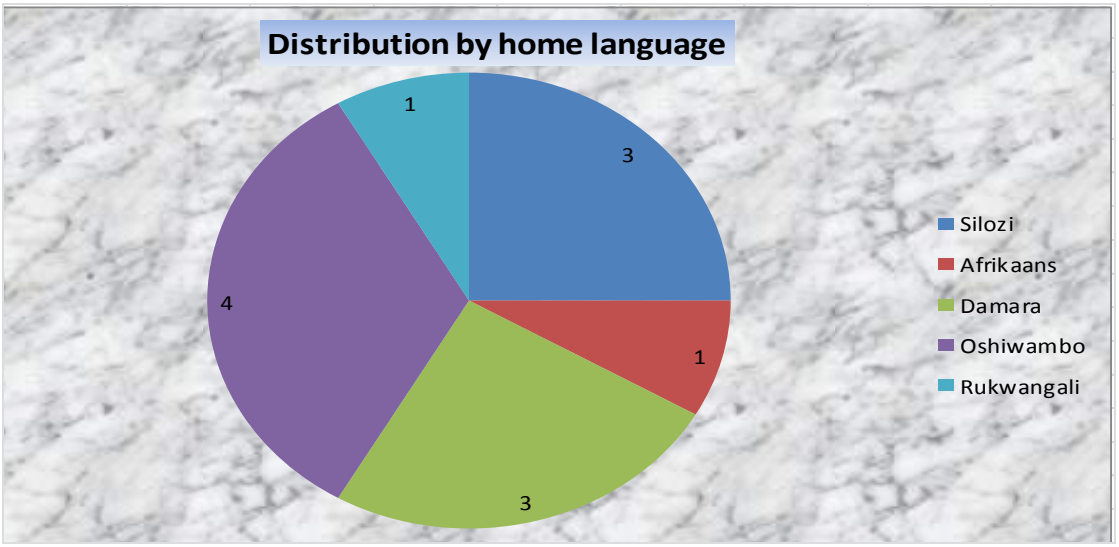

Figure 5: Distribution of participants by home language

Figure 5 above shows the distribution of participants by their home language. The findings show that participants were from five different ethnic groups. It shows that four of the participants, were Oshiwambo speaking, followed by three Damara speaking and three Silozi speaking, one Afrikaans speaking and one Rukwangali speaking participant.

3.10.7 Distribution by area of residence

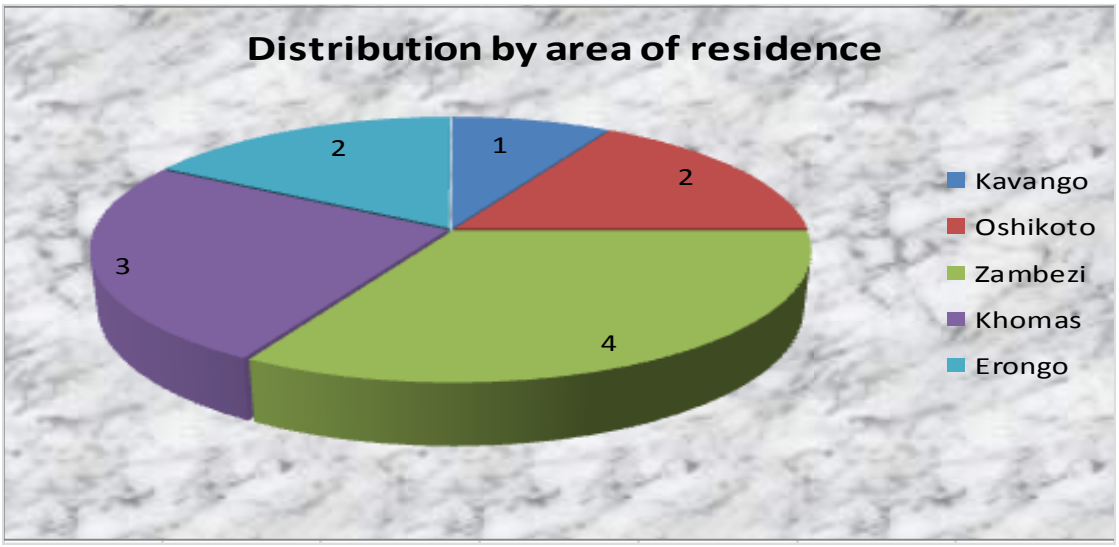

Figure 6: Distribution of participants by area of residence

Figure 6 above depicts the various regions of residence of participants. Zambezi Region with four participants had the highest number of participants in the study,

followed by Khomas Region which had three participants. Erongo and Oshikoto Regions both had two participants each and lastly Kavango Region had one participant. Thus, five regions were represented in the study. This shows that the FU admits patients from various regions across the country, as it is the only forensic unit in the country. This however comes with some challenges as relatives of FSPs find it difficult to visit them regularly due to the fact that they are admitted far from their home areas. This results in lack of social support, which is one vital aspect when it comes to rehabilitation.

3.10.8 Distribution by level of education

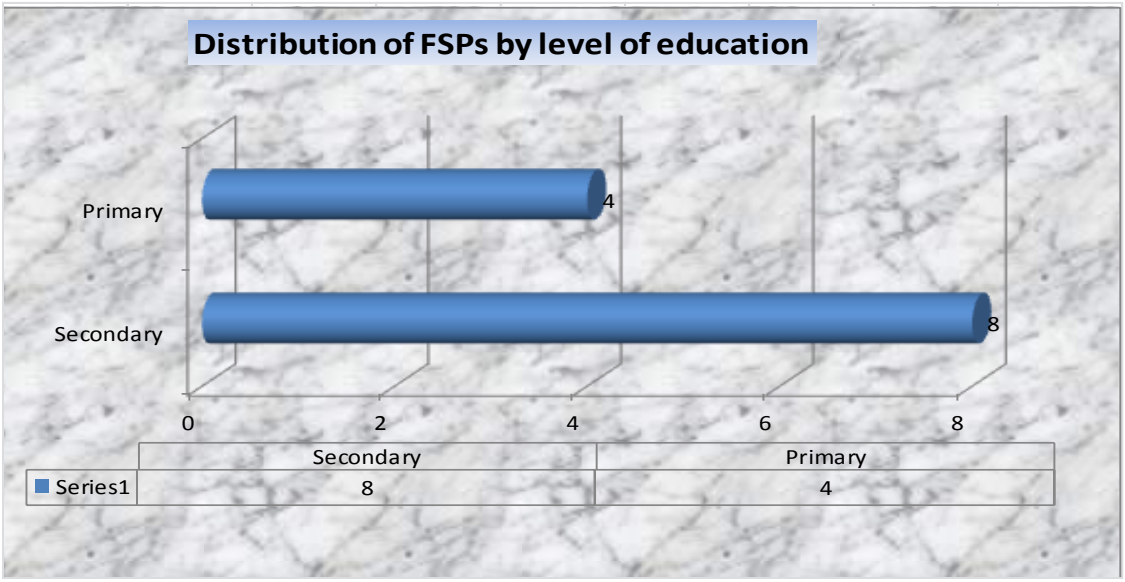

Figure 7: Distribution of participants by levels of education

Figure 7 above shows the distribution of participants by their levels of education. Eight participants reached secondary level, whilst four participants reached primary school level, but none of the participants had tertiary education. This finding corresponds with findings by Barnao et al. (2015:1029) where none of their participants had tertiary qualifications. The findings could be indicative of the challenges that are faced by FSPs as illness interferes with their functioning, thereby affecting different tasks they need to accomplish at various stages of their lives.

3.10.9 Distribution by employment status

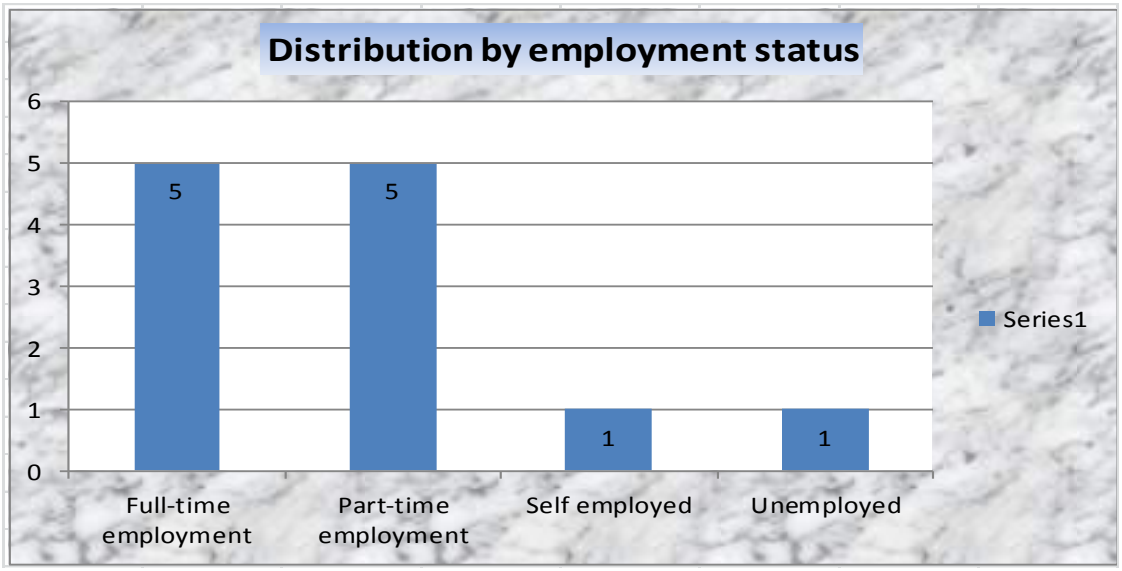

Figure 8: Distribution of participants by employment status

Figure 8 above indicates the distribution of participants by their employment status before they were arrested. Five of the participants were in full time employment, while the other five were employed part-time. One participant had a small business and one was unemployed.

3.10.10 Distribution by type of crimes committed

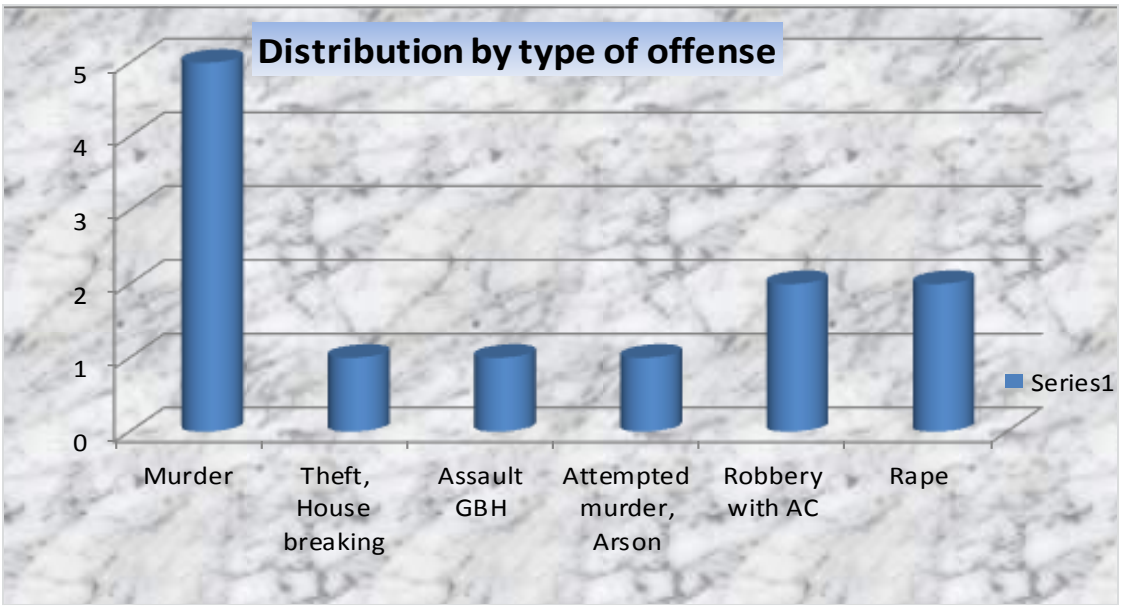

Figure 9: Distribution of participants by types of crimes committed

Figure 9 above shows distribution of participants by the types of offences they committed. The highest number of participants, which were five participants,

committed murder, whilst two committed rape. The other crimes that were committed by the other participants included assault with intent to do grievous bodily harm, attempted murder and arson. Two of the participants committed robbery with aggravating circumstances. The findings are similar to findings by Coid et al. (2001:532) who attributed the detention of FSPs to offences of a serious nature, with Barnao et al. (2015:1028) also reporting on the serious crimes that were committed by participants in their study and these included murder, attempted murder, arson, assault with intention to do grievous bodily harm. Thus, the crimes committed by the participants in this study called for the long term rehabilitation of FSPs.

3.10.12 Distribution of participants by diagnosis

Figure 10 below shows the distribution of participants by the type of illness they were diagnosed with. Most of the participants were diagnosed as having schizophrenia, with only two participants having been diagnosed with paranoid schizophrenia. These findings are in line with findings by Barnao et al. (2015:1028) who pointed that schizophrenia was among the common types of illnesses found in FSPs; however in this study all participants had schizophrenia with differential diagnoses of paranoia.

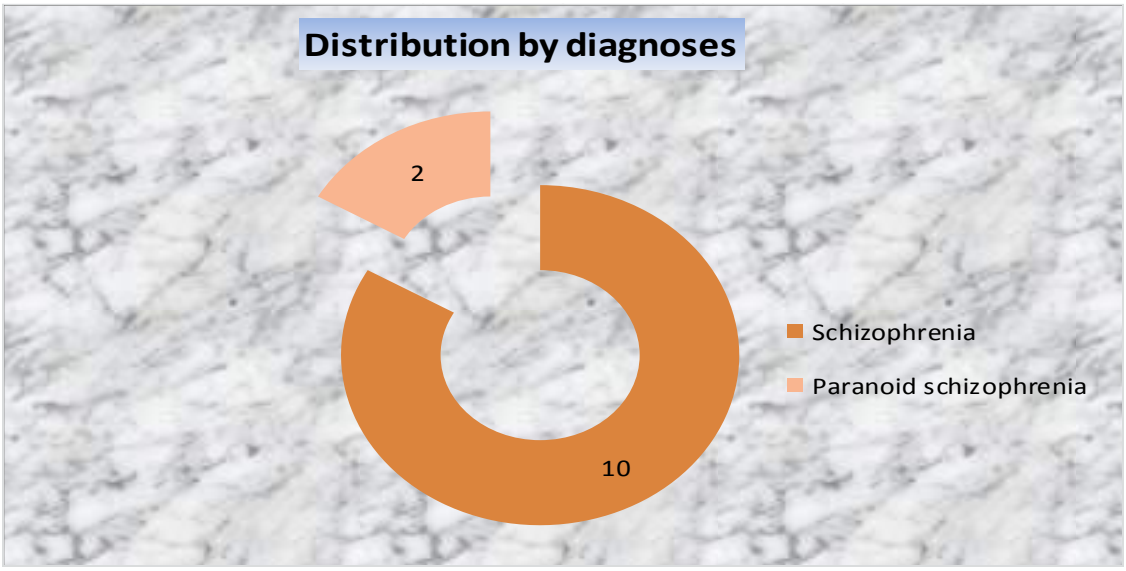

Figure 10: Distribution of participants by diagnosis

3.10.13 Distribution by year of admission at FU

Figure 11 below indicates the distribution of participants by year of admission at the FU. The bar also shows the length of stay of participants from the time they were admitted to date. This shows that there are many FSPs who have been taken out of the society for a very long time. The longest staying participant has been

hospitalised at the FU for 21 years compared to the participant who has stayed for the shortest period of two years. Six of the participants in this study spent 10 years or more in the FU. This is a long period considering that FSPs also spend some time either in custody or correctional facilities.

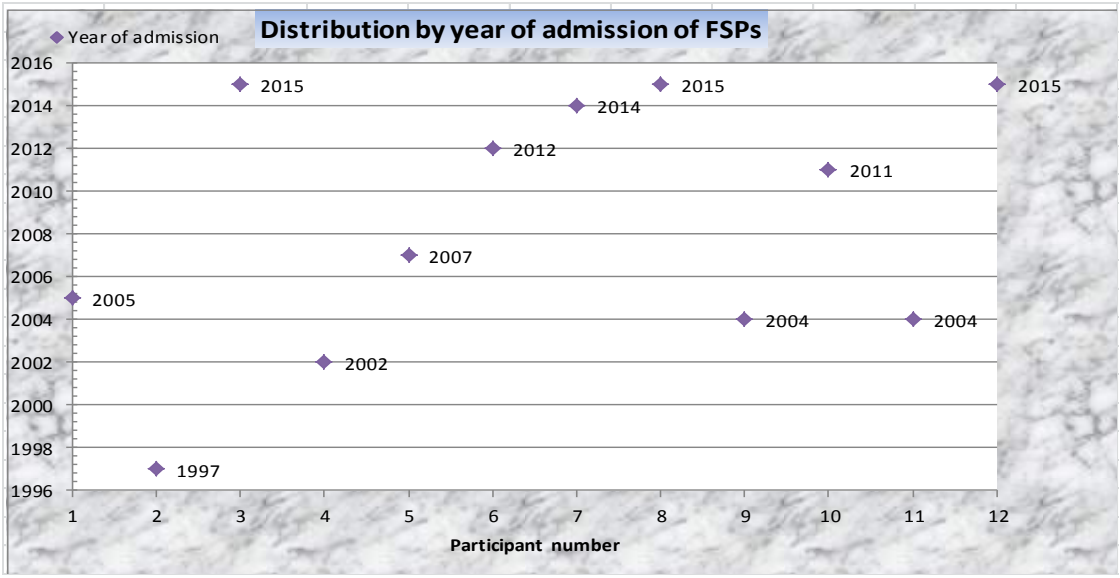

Figure 11: Distribution of participants by year of arrest and admission

3.10.14 Distribution by length of stay in various facilities since arrest

Number	Year of arrest	Admission to FU	Period spent in custody/correctional facility	Period being held at FU	Total years being held
1	2003	2005	2	12	14
2	1996	1997 [2011] 2012	1	20	21
3	2005	2015	10	2	12
4	1999	2002	3	15	18
5	2004	2007	3	10	13
6	2010	2012	2	5	7
7	2006	2014	8	3	11
8	2012	2015	3	2	5
9	2002	2004 [2011] 2012	2	13	15
10	2008	2012	4	5	9
11	2002	2004	2	13	15
12	2006	2015	9	2	11

Table 2: Distribution by length of stay in various facilities since arrest

Table 2 above presents the number of years that participants have spent in either police custody or in correctional facilities or both as well as their year of admission at the FU and the total period spent at these facilities. Furthermore, the table gives the number of years that were spent by 11 of the participants except for one who narrated that he was released on bail after he contracted tuberculosis but was later re-admitted at the FU. The years in brackets indicate the two participants who were once discharged in 2011 but were readmitted in just six months for alleged violation of discharge conditions which was non-adherence to medication and resultant aggression. As indicated in the table above, some participants were held for long periods of time in correctional facilities or in police custody. This arrangement can be attributed to the lack of space for FSPs at the FU. This then puts these FSPs at a disadvantage as they miss out on rehabilitation during that time when they are held at correctional facilities. At the same time, the admission of FSPs for indefinite periods at the FU compounds this situation, as space is not easily available for new admissions. This finding is supported by Marais and Subramaney (2015:86) and To et al. (2015:1607) who state that admission at forensic units is usually for an indefinite period pending a court order of discharge.

Having presented the above biographical data, the next part of the report presents the main themes and sub-themes that emanated from the study. The themes were analysed in and across the cases and compared to the available literature on these issues. Direct quotations from the interviews with participants are used to substantiate the themes.

3.11 Thematic analysis

Table 3 below presents the themes and sub-themes that emerged from the study Research findings are complemented by participants' verbatim quotations and with literature.

Themes	Sub-themes
Theme 1: Challenges regarding FSPs experiences of their mental health	1.1 Challenges regarding mental illness before admission 1.2 Challenges regarding stigma 1.3 Challenges regarding mental health services after

	arrest 1.3.1 Positive experiences of mental health services while in custody and in correctional facilities 1.4 Challenges regarding facilities at the FU 1.5 Challenges regarding living with other FSPs 1.6 Experiences of mistreatment by staff members 1.7 Participants' experiences of seclusion rooms 1.8 Challenges regarding length of stay at the FU 1.9 Participants' experiences of the death of family members
Theme 2: Alternative mental health services received by FSPs in the community before admission at the forensic unit	2.1 Participants' experiences of treatment by traditional healers 2.2 Participants' experiences of allopathic treatment 2.3 Participants' experience of spiritual treatment
Theme 3: Support received by FSPs regarding mental health services after arrest	3.1 Participants' experiences of support by family and community members
Theme 4: Participants' experiences of medical treatment at FU	4.1 Participants' experiences of illness after admission at forensic unit 4.2 Participants' experiences with side effects of medication
Theme 5: Participants' experiences of the multidisciplinary	5.1 Participants' experiences of treatment by multidisciplinary team members at the FU 5.2 Challenges experienced by FSPs regarding communication patterns

approach to treatment	
Theme 6: Coping mechanisms	
Theme 7: Strategies that can improve the services rendered to FSPS	7.1 Communication with patients 7.2 Appropriate treatment of FSPs 7.3 Staff - patient relations 7.4 Discharge Planning

Table 3: Thematic analysis

Theme 1: Challenges regarding FSPs' experiences of their mental health

This theme documents the various challenges that were experienced by FSPs regarding their mental health. It captures their journey from the time they became ill to the present time. Some of their challenges included the problems they faced regarding mental health treatment while in police custody and/or correctional facilities, which participants referred to as prison. It further discusses the challenges encountered by participants in general during their treatment and rehabilitation at the FU which includes problems with poorly maintained facilities; challenges faced while staying with other FSPs; mistreatment by some staff members; stigma; challenges experienced regarding seclusion; problems regarding length of stay; and problems regarding the death of family members in their absence.

Sub-theme 1.1: Challenges experienced by FSPs regarding mental illness before admission

The findings revealed that most participants experienced symptoms of mental illness for long periods without access to medical treatment. Their descriptions indicated that participants had no control over these symptoms; moreover their expressions showed some level of distress as they experienced the symptoms then. These were characterised by obvious signs of psychosis which include hallucinations and delusions and some negative symptoms of social withdrawal.

> *"…then I am falling down then, I'm listen* (hearing voices) *… I am listen my mother talking there, I am not see… but that time I'm listening my mother, my mother for the drip …for the sick* (was in hospital and not home). *… I want to*

run away to support my mother… so they say the river is full. I want to go in the river of nothing (without) *the canoe …*

"When I was at the primary education…I (started to) *experience that* (mental) *illness I used to become angry and sometimes I wanted to stay alone. I don't want to stay with somebody to get my time free… I was hearing voices… but the … problem that voices which I was hearing, it didn't reduce, I kept on hearing voices whatsoever until I did the killing, the murder."*

"I get that problem, but I remember something when I start, I'm just start to begin to fear and not to eat, … not to talk to the people as a family, only just to go to work and come back and … and but I were try to work but it was a problem … when I start I feel only I just fear the people maybe when I walk in town… when I walk in the town, I just have fear (of) *the people. Maybe I think the people want to kill me or what … I just need help to* (of) *someone to take me in the house or where. I don't remember now my house …It was very difficult."*

The findings show that participants experienced longstanding symptoms that were stressful for them and impaired their normal functioning. These symptoms are similar to the ones described by Barlow and Durand (2009:470, 473) which are related to schizophrenia. Most of the FSPs expressed some form of fear during the times of active symptoms. Some went on to express how mental illness affected their lives including committing the offence. The lack of access to medical treatment contributed to some of the participants experiencing mental illness for a long time and eventually resulted in them being arrested for issues that could have been avoided had they been assisted to get medical treatment. These findings concur with Yusuf (2010:92) who reported of a man who had psychotic symptoms for over five years and had been taken to traditional and spiritual healers on several occasions. Later, the man committed murder and ended up in forensic psychiatry after which treatment within 8 weeks of admission showed his remarkable improvement. The environments in which the participants found themselves had an impact on their access to medical treatment. These environments include the family systems, which, if unaware of the nature of the illness, may not adequately assist a person with symptoms of mental illness for long and he or she may end up committing crime. If

institutions offering medical treatment are not easily accessible, the well-being of patients is affected. Stokols (1992:6) emphasises the importance of promoting health programmes targeted at families and making efforts to improve their health practices.

Sub-theme 1.2: Challenges regarding stigma

Most participants revealed that they experienced stigmatising attitudes from various systems such as their family members, community members and staff members. This resulted in participants not receiving support such as visits from these various systems even though the family and community members were well aware that the patient was arrested. Some participants also expressed ill-treatment at the hands of their families. The following narrations capture these views:

> *…why cannot one of my families not come* (visit) *me? You see, and there is also the youngers* (young ones) *and big people but no one (visits) me."*

> *"My brother was (last here) two years ago…I tell him why doesn't he come* (to visit) *… he tell me no after, 4, 3 years I will come. ...like my case when I was working I was having a lot of people. I helped them, now I am working not, I am here, the only one*(s) *who comes is my mother and my father and the others they don't come, but I sacrificed my school because of them so that they must get something. But now today they are employed and they are having, they say why that guy was like this and now he is like this…"*

> *"…my sister who come back of me* (younger) *is here* (in Windhoek)*, she says she don't have money to come* (visit me) *here… the first born for us is also here* (in Windhoek) *but say he don't know this place but he was one which maybe 1995 or 96 he was here, he was working here* (at FU)*… At this place now… he don't know this place… uhh he tell my mother…That one is also, there at [OM village], [and] there at* (correctional facility)*, he didn't used to come, maybe he afraid or what?"*

> *"…now I see a lot of people. I know now that people that time the police officer put handcuffs now he take me out now, I see a lot of people this time outside "…you must go and to another country you must not stay with us". It's the community. …but now also I remember I see lot of people that day … say* (saying) *the people* (police) *he must sell for me in another country…"*

Some of the participants revealed that it was difficult for them to act normally around their family members by expressing emotions such as getting angry or using a loud voice as this was viewed negatively and families would react to this by calling the police to apprehend the participants as expressed below:

> *"Our family members, they are also mistreating us because of our mental health problems, because if, even if you are loud at your voice you cannot loud your voice, even a kid* (child) *you cannot say, ehh go, don't do that …It's* (be)*cause they always just think that you are angry and you want to beat the kid. In my case I was mentally sick but I was not so mentally sick, I just hearing voices that I could not see but from there I can remember what happened. What happened with me… This things of these people ehh how must I say? Accuse you, but not actually accuse but the way that they treat you it's not so well when you have mental sickness.* (Be)*cause if you have mental sickness, it doesn't mean that you cannot talk* (louder) *or you cannot, also lot of things that some things is* (you) *get angry and win. There is also soccer if you play you can get angry and you can win…it does not mean that if you are angry you can just take it out on someone… in that case … what the family can do is, the family must support …then you know you are supported, then you can even share your story with someone and they will know how you are feeling, yaa during that time, now you are not talking with this person you are just there and* (they are) *just accusing, oh now he is angry, oh now he is what like what … and they call the police…"*

> *"…lot of time I grow up with my grandmother. If I maybe come that time, now maybe some people he take my things nè, now if I angry nè, I'm angry but my heart is not fight of I speak only loud, now the people also its mos first time they see me now, my grandmother* (s)*he phone the police officers, he take me to the hospital and I go to get injection of (or) if I can maybe give only that injection he* (it) *make for you sleep."*

The above findings are confirmed by WHO (2001:18) which attributed this treatment of patients by their family members to the stigmatisation of PLWMI. The family system may then present as an obstacle to better quality of life for the FSPs. As stated by Hepworth et al. (2006:231) social workers can target these systems in their

work in order to effect change that can be enabling and ensuring the well-being of FSPs. Two participants in the present study were initially discharged from the FU but did not get support from family members that could have helped them to reintegrate and were consequently re-admitted. This is resultant if systems are not tapped into to support FSPs. The following quotations capture these views:

> *"…most of my family members accept it just as fate that I'm a criminal… they labelled me now just to say that I'm a criminal."*

> *"…then I am go there the police … then you write* (they wrote a statement) *I am talk … he must call my son and my sister, that one who beat me and my father … they* (were) *locked, then he* (they) *give statement, tell the police 'don't listen this woman, she is not normal'. Then the police release them".*

One of the participants related an experience which showed that he was being stigmatised against by a staff member as summarised in the narration below:

> *"The other day when she was still busy with cleaning, I come there I come in I come take a sugar 'yaa who is that person who open you guys to come in and what and what. If somebody being raped here what …' and I just look at her and I say, I tell her even if you know me, you don't know me my inside who am I… my case is rape but it's not all of us who can come and can catch someone and start raping..."*

The finding that participants were viewed as being harmful was confirmed by WHO (2001:58) which notes that some cultural beliefs lead to fear of PLWMI, creating negative attitudes held by some people who end up painting all PLWMI as deranged, violent, homicidal, incompetent, incurable, morally flawed, unmotivated or inadequate and depicting them in the media as unpredictable. Hodgins et al. (2007:212) state that when a person living with a mental illness is involved in criminal activity, it increases the stigma against them and gets people to think that they are dangerous which in turn adds to rejection by community and family members. Similarly, WHO (2001:58) states that stigmatising attitudes are also found in healthcare workers and mental health personnel. Nurses, who were surveyed by Kapungwe et al. (2010:97), perceived PLWMI as being a burden to their family and how being independent would make them to be seen as human beings. This implies

that they are not viewed as human beings by some healthcare workers. As suggested by the EST, stigmatising attitudes of PLWMI by various systems such as families, communities, healthcare workers, non-treating staff and governments are worrisome as they have an impact in the way they experience their lives.

Sub-theme 1.3: Challenges regarding mental health services after arrest

Most participants indicated that they did not get proper mental health treatment after their arrest. The findings continued to show that there was no alternative support in police custody or correctional facilities, where participants were kept before their admission at the FU. Some participants reported of being moved from one institution to the other. Thus, the participants continued to experience mental illness symptoms as evidenced by the narrations below. This could have been due to a lack of medical staff in these institutions to supervise the treatment and adherence by FSPs.

> *"… then I am…(*hearing voices) *in the custody… then am say I want the pastor to pray for me… then the police say…they cannot come here…The prison ward 'but here the pastor not coming, you must go back to the hospital'"*

> *"*(At prison) *I was having problems to come take my injection or my tablets…there is no car to go* (to the hospital) *there is no person who can take you there… I used to come* (to MHCC only) *if they get transport. Maybe* (after) *4 or 5 days… it affected my mental* (well-being) *because if I don't take injection or tablets, I started hearing the voices."*

> *"I remained* (in custody) *for almost 3 years*, *the only challenge is the police officers were not able to take people to hospitals… they were just saying there is no car, you will be taken, just hold on."*

> *"…there was medication they* (which the doctors prescribed for) *me*… (When I took it) *I looked like I have smoked marijuana, so the police did not want to give me again the pills… at the police cells"*

> *"Nobody even took responsibility for us to take the medication every month, I even* (went for) *3 or 4 months* (without) *injection or treatment….."*

> *"…I was in prison for almost 2 months. There I didn't receive any medication. …I only talked to them once, I told* (the correctional officers) *to bring me to the hospital but they didn't, they said they will do it but I waited until I was just brought here* (for admission)…*I felt bad.*
>
> *"As a prisoner I was having a lot of challenges because the nurses there if the injection day come they say no I will inject you later, if you come this one say go to who and… but the injection is there but they are still keeping the injection, and the tablets are strong* (but) *that food we are eating is not so well."*

Some of the challenges faced in the narrations above by the participants could be a result of shortage of mental health personnel serving in police and correctional facilities. There are very few mental health specialists in Namibia to be able to treat every FSP. FSPs were initially scattered in various police detention and correctional facilities throughout the country. However, since 2015, FSPs were all put in two correctional facilities namely Gobabis and Oluno (Tromp, 2015). The staff shortage is similar to a report by Lien (2016) where he states that in the Namibian context, gaps exist in the number of health professionals working in mental health with 0.23 psychiatrists, 5.88 nurses, 1.36 psychologists, 0.09 social workers; and 0.36 occupational therapists per 100 000 people. These figures represent the health workers that offer services not only to the FSPs in this study but also to those in need of general psychiatric services. Evidently, the numbers of mental healthcare staff in Namibia are quite low to offer quality and comprehensive services to those in need of mental health services. This is comparable to findings by Burns (2010:665) who highlighted a huge shortage of mental health professionals with 0.34 psychiatrists per 100 000 people in South Africa.

Apart from not being able to get proper mental health services while in prison, some participants had negative experiences during their stay in custody and correctional facilities, awaiting admission at FU. Particularly, some participants were mixed together with offenders who were not having mental illness and were consequently ill-treated by some of these offenders, in addition to the poor living conditions there. This was a challenge to most of the FSPs who stayed in custody and correctional

facilities for long periods of time due to lack of accommodation at the FU. The following narratives capture these experiences:

> *"When we get visits, then the patients, it's not the patients, the prisoners,* (would) *wait* (for) *you in the corridors and tell you that they want some of your things. I gave them cigarettes, sometimes they just take* (your stuff) *without asking. It was difficult."*

> *"You see…I'm very, very afraid of the prisons mama …if you make a mistake or what, he can stab you* (and you) *die because the people* (offenders) *is very aggressive…"*

> *"It was difficult…you will hear the shouting of saying, yaa bring him here, bring him here, you are going to shower today, those lot of things… beaten up by the prisoners."*

> *"…most of the…police members, some of them they are also very, very bad… they know that the person are going through…such a circumstance, but they don't involve themselves. They just leave you to be treated by the other* (offenders) *the way they are treating you"*

The conditions in these holding facilities were similar to those in South Africa as presented in a *Final Report to the Minister of Corrections Services* - Mapisa–Nqakula (2011:73), where it was noted that there was limited mental health professionals assisting people living with mental illness in correctional facilities. In addition, some patients were not being taken to hospital for treatment. The holding facilities, which are systems interacting with FSPs as put forth by the EST, do not make it easy for FSPs to get the much needed treatment. This lack of access to services has a negative impact on their day-to-day lives as they continue to get symptoms that are distressful to them.

Sub-theme 1.3.1 Positive experiences of mental health services while in custody and in correctional facilities

Despite the challenges that were faced by the participants, there were some positive experiences that were reported regarding their mental health treatment while in custody or at a correctional facility.

"They gave my medication… There is a hospital there at the…Prison. Once in a month the doctors were coming there then they take us to the hospital. Then they ask of course how the pills work …and then they talk to us, the doctors they come from here (MHCC)*."*

"…if (the correctional officer) *see*(s) *your medication is finished, that …morning he will take for you to hospital …"*

"There at prison.… (the correctional officers) *helped me to take my medication. If they finish, I tell them this medication is finished… then they give … a report there at the nurse."*

Such provision of services despite staff shortages is commended and should be the ideal and standard throughout the country. If access to services by FSPs is positive, it ensures that they do not default on treatment. Hepworth et al. (2006:231) note that this improves the patients' quality of life. Stokols (1992:8) adds that positive transactions with the environment have health promoting capacity that influences human well-being.

Sub-theme 1.4: Challenges regarding facilities at the FU

Most participants indicated that they were having problems with the shortage of functional showers, toilets and lights at the FU. Although these facilities were available, they were broken and not repaired and so it put pressure on the daily activities of some participants in terms of meeting their daily tasks.

"…and the shower also its only you will find that more than 27 …in the ward …they are only having 2 showers or 3 showers…the other showers are not working…so it's very difficult to get a bath so the time when you are going to take shower its other time, the food is already there, it's the time to eat or they are calling you again, the sister to go and drink your medication…like now we are having the problems of …bathing cold water. (That side) *its only two* (toilets which) *are flushing and this side … its one, the others are not… all of them they are just broken."*

"(I) *don't have lights, no water in my toilet… I fetch the water in the kitchen to pour in the toilet pot…"*

The lack of functioning toilet and shower facilities may be a result of lack of priority for mental health related issues or may be due to the lack of adequate budgets to repair mental health facilities (WHO, 2007:9).

Sub-theme 1.5: Challenges regarding living with other FSPs

FSPs come from various upbringings, ethnic, cultural and religious backgrounds and home areas. Most participants showed, in their experiences, that they faced challenges relating to sharing the same space with other FSPs. Moreover, FSPs have different diagnoses and may behave differently from the participants who were predominantly diagnosed with schizophrenia. From the voices of the FSPs in the study, it is clear that some of the participants expressed fear of other FSPs as indicated below:

> *"These people* (other FSPs) *can also kill you…most of these people …here come aggressive. Its only maybe the tablets which is making (them) him to become cool but after few minutes or five minutes when you are speaking someone can come and grab you like that* (grabbing own hand in an aggressive manner while demonstrating the act)"

> *"Yaa, sometimes they make me, bullying me, but I just keep quiet. …Sometimes they are bullying me. … there at prison I was fighting, then here they say you cannot fight, assault and what else … I just say don't say like that then I go to stay another place."*

> *"Uhh those things its difficult man, the problem nè to sleep with someone, to sharing with someone, you find that sometimes there is the patients who are understanding the person… (*Others) *they will not understand … you start quarrelling, you are angry, he is angry also, it's those problems."*

> *"…I was injected I come sleep in my room, he* (another FSP) *come and he shout at people outside, outside my room, then the people who is working there he shout and I say no I want to sleep, please go out. 'Yaa this is not your house, its government house.' … and later it come to a fighting …"*

Two of the participants expressed that they had problems with some FSPs stealing their toiletries. As FSPs are not provided with toiletries during their hospitalisation,

this finding to some extent shows that vulnerable patients may lack these basic necessities and resort to stealing from others.

> *"… I think the problem which they are giving me is just… stealing... just stealing…your properties… sometimes they steal the toiletries of others…"*

> *"…we share the room with someone and there is a locker and my locker was not having a key for the soap. But one day I see there was somebody in my locker but I don't know…. I just close my locker and I leave it,* (so that) *nobody can come again."*

Barlow and Durand (2009:468) discuss schizophrenic symptoms that show that at times patients may be not in touch with reality. These may then affect other FSPs and can be interpreted wrongly. Another contributing factor may be the many challenges that FSPs face, which makes some FSPs more likely to be unfriendly towards the others. Some FSPs form a microsystem of support within the lives of other FSPs in the FU setting and how they relate to each other will have a huge impact on their recovery. The result of these interactions can become an enabling factor or a barrier to proper mental health experience. Bronfenbrenner (1994:39-40) describes the microsystem as those people who have direct contact with an individual such as the family and schoolmates. FSPs are in direct contact with other forensic patients they live with in the institution and interaction with these other patients is important as they contribute to the construction of the environment they experience.

Sub-theme 1.6: Experiences of mistreatment by staff members

Most of the participants pointed out that they experienced abuse at the hands of some staff members. Below is a summary of some forms of abuses that the participants experienced. What follows are narrations of participants that express their experiences. Of note is that some participants mentioned that the situation seems to have changed and is better now, meaning that it was no longer as common as it was in the past.

Type of abuse	Description (how it was experienced)
Physical	Beating with hands Forceful handling

	Grabbing Aggression Pushing Pouring water on FSPs body, wetting their clothes
Psychological/emotional	Being harassed Being laughed at Pouring water on FSPs clothes
Physical and emotional	Forced to drink a 2 litre container of water at one go, and rolling in the soccer ground, and ending up vomiting

Table 4: Summary of types of abuse experienced by participants

"That beating peoples, forcing peoples with injections. You see how the people grab you like this and from there (demonstrating)… *give injection, forcing people, like, like this or beat you or it was it was very aggressive things here. Or he kick you and…It was like a fighting maybe by the place… how can I say by the… kind of place maybe the soldiers its working here. It was like that mos. It was not the kind of place … you cannot say it's the* (staff) *this one which is working with us here. It was not like that. …it was different."*

"'You sick', Uh uh you say, I am not sick I say I am angry why push for me the (staff) *push for me in the office. Me I want to talk something with you … why push for me, that's things which makes for me angry".*

"(patient) *he start to beat for m*(e)*, …* (another staff says) *the say come "nadengwe omunhu nadengwe,"* (meaning lets beat, assisting the other patient) *… 'ah ah don't beat her',* (another staff tells them not to beat) *'ah ah kom ons beat her …" then that time he say kom ons beat her, you start bhu bhu bhu …*

"… (the staff) *he tell them the* (other staff) *then he laughing,…"*

WHO (2005:3) agrees with the above participants' experiences by specifying that some PLWMI are subject to physical abuse, deprived of basic healthcare and are detained against their will. This also is against the *Patient Charter* (MoHSS, 2016) which promises treating patients with respect and dignity. FSPs gave reports of abuse at the hands of some staff members, who were mostly nonclinical staff and who were supposed to safeguard them from any form of harm. The main reason for their admission is to ensure that they do not harm themselves and others in the community. Marais and Subramaney (2015:86); To et al. (2015:1607) state that the main reason for admission in forensic is treatment and rehabilitation, which also helps to curb the danger FSPs pose to the community. However findings in this study were contrary to the main reason of admission where some staff members became the source of harm to the FSPs. This again is not in agreement with the Harambee Prosperity Plan (Republic of Namibia, 2016:5), which emphasises, as part of its key outcomes, a culture of high performance and citizen-centred service delivery and also aims to ensure a citizens' satisfaction rate of 70 percent with regards to service delivery. The above findings also show a violation of the Constitution, and other laws as discussed in chapter 2.

The narrations below also talk about physical abuse but differentiate treatment in the hands of police and correctional officers, at custody and correctional facilities, where participants say they were not beaten at all. This treatment was different from the treatment at the FU where beating was used as a form of punishment. The participants further describe the reasons for ill-treatment and how the ill-treatment was done.

> *"The challenge that the police officers… were not beat*(ing) *us if you are doing wrong things like the, like as I told you in the beginning that they were like separating us from the other prisoners … that I am a patient I have to come this side. So here they were beating us like if you are in the morning after bathing maybe you forget to drink your medication, that* (staff) *will not just tell you he will just come and start beating you and later on he say you know what you didn't do. Later on, you remind yourself that I didn't drink my tablets then you go and run and drink your tablets.… It's very difficult … if you are a smoker to stay the whole day without smoking so you steal the tobacco* (take more at smoking time and keep for use later) *or someone your friends then he*

smoke that time then he give you a little bit then you smoke then later on you will be caught. One day they come and start giving us these two litres of water and drinking and start vomiting the food we were eating. Those things… was the punishment. You drink that time …three cups of water then from there you make that zol (cigarette), *then you smoke it after you finish to smoke it, then you have to roll like this to this goal* (post) *…up to* (the other) *goal* (post) *of the soccer field, so when you reach that side of the soccer field, you have to drink that water again and smoke again and you come. Yaa, you roll on the ground then from there the stomach is full of water, then you start* (vomiting) *them out, those things. During the day is the punishment which we were given here. It was very difficult when I came in this place."*

"…they were using yes the hands…, kicking us… If you are late you didn't go to make exercise, they will just come and beat you and lock you up in the single room."

"… the challenge which I was facing …is when, a patient was insulted by…assaulted, by staff members… I was also given to exercise also …and, and then, to be thrown with water, to be made, made ehh wet with water. Also drinking also water, while being punished with exercise, and then given water to drink, a lot of, in, in a lot of quantity. …just for the punishment."

"I saw some of the patients…saying that you, telling the staff members that no, you do not treat these peoples like that. ...he was also made to be harassed. Yaa, he was also harassed …when he spoke out about such things happening. … Just on behalf of those which are being, being punished … because the problem also is that, here, when you are in forensic, we have got several doctors, social workers, securities ,doc- eh, eh, … nurses, kitchen members, cleaners. …And that's, that's how now, most of the time, you see everyone have got his own experiences, or perhaps he treat patients in his own experiences … his own way just. … It's also just like that. Some of them, they don't understand their own rights.

The narration below confirms the beatings, and aggressive behaviour. It further indicates the demand for respect by some staff members, whereas they did not show the same respect for patients. One participant expressed anger, and mentioned that

he initially felt like killing the concerned staff, but commented that the presence of other new staff and prison officers seemed to minimise the incidences of inhumane treatment.

> *"…they* (the staff members) *put you down, they are above. You must say sir to them and for you they just* (call you by) *your name but for them you must say sir, sir, sir and so on… I feel very bad.…I want to kill them, I feel like … I can do nothing…because all of them are together with that stories, they have changed now. They are afraid now because the new staff that come and the prison officers."*

These findings are confirmed by WHO (2001:1) which cites that the inhumane treatment of patients in psychiatric hospitals is resulting from stigmatisation and discrimination, which constitutes violation of human rights. It also appears that participants became used to beatings as a form of corrective measure and that they felt that the beatings were somehow justified, as some would have misbehaved. Such type of treatment affects FSPs and as indicated by the EST, may create barriers that make it difficult for good working relationships between FSPs and staff members. Such types of conflicts were pointed out by Stokols (1992:11) who says that these are likely to impair physical and emotional well-being of people in an environment, in this case, the FSPs.

Sub-theme 1.7: Participants' experiences of seclusion rooms

Most participants expressed dissatisfaction with being put in seclusion rooms, which they referred to as single rooms. In their descriptions participants expressed how unpleasant it was for them to be in such a secluded environment. They expressed negative experiences that ranged from the setup of the room to how they were made to stay in those rooms without clothing and at times for long periods of time.

> *"… it is not good. That single room, the window is also high, you see and there is no fresh air … If you want the fresh air you stand there by the window and get little bit of fresh air* (lifting the head)*."*

> *"… nothing of the heater om te make it hot there in the floor, nothing, also I am thinking someone cold …"*

In the narration below, a female participant was on her menstrual period, without adequate sanitary protection and the blood was dripping on the floor and this was evidently a very traumatic experience for her.

> *"… then the* (sanitary pad) *got full in the evening also the blood was going on the floor."*

Solitary confinement to single rooms, without clothing as a form of punishment is a cause of concern to all FSPs and female FSPs in particular, especially during menstrual periods. Being unable to maintain hygiene during these periods can be dehumanising. A study by Mayers et al. (2010:66) revealed that seclusion was seen as a way of punishment by 78 percent of service users with females being more negative than males in their responses. Seclusion, in the same study by Mayers et al. (2010:67) was also seen as inhumane treatment and was said to be traumatic for the service users whereas sedation was for all respondents said to be the least traumatising of the options.

Mayers et al. (2010:67) point out that seclusion was seen as inhumane treatment where there were no toilet facilities and inadequate supervision for the service users and in situations where the seclusion area was said to be dirty. This is similar to the view by many participants in this study regarding being in single rooms with no assistance with toileting, and also having to be further punished for messing up the room. The narration below shows that seclusion was used regularly as the rooms would get full. This seemed as a way of dealing with indiscipline at the FU.

> *"…they were full sometimes the single room*(s) (are) *is full there is no chance they just lock you in the room, in your room. Each and every one of those guys they were getting punishment here... It's not good because when they lock you inside there, they are not even giving… taking you out if you want to go to visit the toilet. They just keep you there until lunch time, until supper time, until tomorrow morning. …so they only open you that time when they bring the food or the tablets, it's the time when they come and open* (for) *you to get a little bit of that release, then you come inside, but for that time its finished you will not again go unless they bring the supper again."*

Clearly the participant's narration of the aforementioned ordeal expresses that such treatment was not good. Mayers et al. (2010:60) reports that witnessing forced

containment of others was also distressing to others. Staff members, can serve as a system that can be a barrier to the full recovery of patients. This can result in negative experiences by patients which may affect the rehabilitation process due to the trauma they would have encountered. This finding is similar to findings by Mayers et al. (2010:68) who reported that security officers were inadequately trained to handle psychiatric patients and they viewed this as disrespect for the patients.

> *"There is* (no toilet), *it's only to make there* (defecating and urinating) *where you are sleeping. You just sleep like that with the smell. …It's very difficult. … unless sometimes you find someone who is good. He can give you the bottle where you can use* (for relieving yourself) *…it was not good to me, it just make me afraid ..."*

The following narrations discuss FSPs knowledge of when seclusion should be used. There is a sense that it should only be used when a person is a danger to self or others and not for the purposes of punishment and participants seemed to know this better than some staff. The narrations clearly show that some confinements were not called for, such as in cases after reporting conflict with a roommate. The narrations also show that other patients in seclusion were also beaten.

> *"I think isolation will help … if maybe someone is angry, he wants to fight someone and you advise him and he don't want to listen."*

> *… patient*(s) *always are being punished, to single room. Yaa, we used to be thrown in a single room, if you come now to report even a certain case to the, to (staff), or sometime if you've got a problem with someone in the room…"*

> *"…I was, sent twice in a single room….but, even so…at my side, in my own experience of that. … I wasn't mistreated or maltreated, no. But I would see other patients being also beaten there in the single room. Maybe they were not coping... Because may be the staff, they are not coping also too…."*

The following narrations, talk about the various situations where seclusion was used. However, it was clearly not because a patient had posed a danger to self or others but for situations like being late to go for eating or smoking tobacco during times that were not allowed. As indicated in the narration, one could be in seclusion from two days to two weeks or up to three months for trivial issues that could have been

addressed using other means which were not punitive. It was also mentioned to participants that after being put in the seclusion, they would not do the same thing again. Therefore seclusion was in a way used as a form of disciplining participants. This type of rehabilitation of patients is uncalled for as found in a study by Mayers et al. (2010:60) that the patients reported that restraint methods were castigatory instead of remedial or therapeutic.

> *"They call you and they tell … you are not allowed to keep the matches, you are not allowed to keep the tobacco, you have to be punctual, to go and drink your medication or to come at the dining room to eat, you are wasting time for others. Those things 'so today we are going to lock you for two days or for three days or for two weeks for this punishment, then after that you will come out, you will not repeat it again.'"*

> *"That time I come here we were smoking, if you smoke, there was a time you smoke… maybe I make three months in and I make that three months, I come out* (of seclusion) *I come smoke again, the people he catch he put me again* (for another) *three months …"*

According to Mayers et al. (2010:63) a service user's advocacy body established in South Africa's City of Cape Town, cautioned that health care staff should know that despite being in an emergency situation, patients had awareness and a recollection of their experiences, therefore this should inform them so that they can handle the patients in a more humane manner. This is in agreement with the descriptions that are given by the FSPs in their narration of their experiences of seclusion. Mayers et al. (2010:63) suggest that more research be done to find out how patients preferred to be controlled in emergency situations. Such can also be done at the FU where notes on preferred form of containment, if needed, can be indicated on the file of every patient which staff can refer to when the need arises.

Mayers et al. (2010:69) report that service users who participated in their study felt that they had been given a voice through which they could air their experiences on various forms of restraint. This shows that it is important to engage FSPs in the discussion regarding seclusion in order to establish their previous experiences as well as views on how to manage difficult issues in a better and acceptable manner.

In this case, as held by the EST, actions by some staff members may present a challenge to FSPs which can contribute to negative experiences of their lives.

Sub-theme 1.8 Challenges regarding length of stay at the FU

Most participants complained about the long period of time they have spent after arrest without going back home. Some expressed no hope regarding their release back to the community. The following participants' narratives document their frustration with their prolonged stay at the FU and possible misunderstandings as they alleged misinformation by the courts regarding their length of stay.

> *"There are people who stay* (here) *11 years, 12 years, 13 years, 15 years, but this is a hospital… what kind of a hospital is this? Even the court knows that they sent for us to the prison, this one is a prison….it's not a hospital. …but the court doesn't want to talk the truth that I send you to jail"*

> *"It is difficult, when I came here my mind were* (was) *just thinking outside. …the court told me we are sending you at the hospital… to psychiatry so you will not stay long time. My mind was just there. When am I going back? I want to go home now, now. …it was the only thing which was in my mind. I, even now it's still giving me problems. Although sometimes I used to think of it but I think now I am just here, what can I do? Unless to wait there is nothing I can do… I have got no such power, unless to wait until maybe everything is ok."*

> *"Me I want to go home only… I am missing my family, my daughter and son my granddaughters and my grandson and I am having a cattle and my things there. I'm left my things that the people I don't know where [they are] now."*

> *"…the problem which I see is not good, is to be rehabilitated for so long, a period, for a long time…. even though a person is healed already … or a person is in a … a good track. They are just being forced to remain here and to take medication while also the medication is supposed to be regulated, or to* (be) *minimised…"*

In addition, some participants' experiences of seeing others patients who had more serious cases, being discharged from the FU after having stayed for less time seems to indicate inconsistencies in the FU system for those FSPs who would have been admitted for very long periods.

> *"I want to go home but …they don't tell me which year but they have released somebody who came together with me and who has got a bigger case of murder but he is released going home early, I don't know now what's the problem with me because I had a little case…"*

> *"I only just wait to go home… I don't feel* (good) *because if I was at jail I was long time ago at home. There for attempted murder, attempted murder and arson they will not keep you so long, so many years I have been here from 2002…"*

These findings agree with a study by Barnao et al. (2015:1034-5) who state that some patients felt frustrated and let down as a result of not being discharged even though they had been compliant with taking part in the programmes. The researcher is of the opinion that lengthy stay can be a result of FSPs receiving fragmented services, as their discharge is not solely the responsibility of the MoHSS. Continuous periodic reports have to be sent to the Ministry of Justice by the MoHSS documenting the FSPs progress in rehabilitation and which is further sent to the Office of the State President to determine the release of some FSPs.

One participant expressed a yearning for human needs such as an identity, feeling needed, valued by others, companionship and a sense of belonging and wanting to be with own family members (Hepworth et al., 2006:7). Continued thoughts of these human needs may also be negative for the recovery of patients as they get affected by the period they have spent in the FU despite having stabilised. FSPs are affected at the exosystem level which deals with interactions and processes between two or more settings which do not contain the individual and yet these can affect the person in an indirect manner. This can be related to the current mental health legislation in Namibia which is out-dated and does not allow for FSPs to go home on leave, thereby affecting them as they are confined to the forensic unit for lengthy periods without leave of absence.

Sub-theme 1.9: Participants' experiences of the death of family members

Most of the participants who lost relatives during detention expressed sadness. Some of the participants lamented on the loss of their family members, which had a negative impact on them as some of the deceased were the ones who used to visit them while in holding institutions and at the FU. In addition, these were the family

members who were most likely to accept them and become their custodians in the discharge planning.

> *"Oh it's bad by me sister, it's bad by me because I have my families I love my mother's child*(ren)…*child you see that one who was coming here* (name). *He was very sick but he was coming and look me from the hospital he come and give me something to eat or some money …and he died and I didn't go and put any things there by the grave, and even my brother …he was also having a cancer and he also died you see? How can I feel in my heart? I want so that the peoples can help me … because if I stay here maybe 3 years or 4 years, then my sister* (would have) *died now. I don't know who will come and take me and…. sign for* (my release)"
>
> *"My uncle…passed away,* (while I was in prison). *… and my brother and my sister while I was in prison. I was felt pain and sadness…* (I heard) *After they were buried… the one day I was go and call they said your grandmother, your brother and your sister, they died but I hear that brother he hung himself. I don't know… He was used to come there at custody …to visit me."*
>
> *"When you hear that* (a family member) *passed away* (and) *you are* (not) *there so it's not good."*
>
> *"…that one was very bad, not good for me that was when my grandmother passed away, they didn't allow me to go and see her* (my grandmother was like) *my mom, I didn't grow up with my mom, I grew up with my grandmother."*
>
> *"my father he used to come* (visit), *my mother used to come, my sister used to come but now my brother has died , only my mother there now… Yaa he passed when I was in prison … It made me* (feel) *bad, because my father and the two sisters also passed away while I were in prison. I was feeling bad, very bad, nobody took me to the funeral."*

The findings reveal the effects of the loss of a loved one as put forward by Bronfenbrenner (1994:39-40) at the chronosystem level, which deals with the life transitions, that may shift a persons' course of life such as divorce, or loss of a loved one. An example is lack of social support for some FSPs, which may not necessarily be a result of neglect, but may be due to loss of their loved ones who used to care

for them. Family members who have direct contact with FSPs at various levels and also in terms of support are an important part of the lives of FSPs. Family members are an important system that not only contribute to the FSPs' construction of their environmental experience but are viewed as a system that also gives hope to the forensic patients regarding their discharge apart from boosting their self-esteem as they give them a sense of belonging.

Theme 2: Alternative mental health services received by FSPs in the community before admission at the FU

This theme discusses the various mental health services that were accessed by FSPs while having mental illness before they were arrested. The three main types of treatment received were traditional healing, medical treatment also known as allopathic treatment and spiritual treatment in the form of prayers. These various types of treatment are discussed as sub-themes.

Sub-theme 2.1: Participants' experiences of treatment by traditional healers

Most participants indicated that after they got ill, they initially sought the assistance from traditional healers. Most of the participants were comfortable with receiving treatment from traditional healers, whom some participants referred to as witchdoctors. From their narrations, it was also clear that these were readily available to the participants. These views are shown below:

> *"Our neighbour was a traditional healer… the one who helped me, giving me medicines so that I must drink.* (different) *types of roots … in hot water then they boil and then they give me to drink. …it helped because I managed to continue with my education."*

> *"Then* (the traditional doctor) *checked the things … they give some medication then you take that things you put it the medication that you stamp then put it* (in) *the fire then you take the blanket you put for me* (and cover me to inhale) *…finish* (they) *take you take the roots then you put the cup then you put the water… that time you mix, you mix ahh my neck is ok I am talking nice. I'm not move* (neck) *again I am not listen* (hearing voices)."

> *"It came a long time …* (illness) *before I was arrested. …I was just being treated by traditional healer. …unfortunately, this traditional doctor, he passed away …now it was* (when) *the problem now comes."*

As indicated in the narrations below, two participants did not see the effectiveness of their treatment by traditional healers. Moreover, a family's beliefs system seems to play a major role in determining the type of treatment that a PLWMI gets.

> *"…you know these sangomas, they just cut, cut, cut…and put those…powders and those kind and let you drink a lot of water or maybe drinking another kind of traditional brew…just my mother which was forcing me to say that I must be helped, I must be treated by sangomas, … But me myself I was telling my mother to say, mum, this disease is not of black people. It's a disease of white people… saying that* (that's what) *the medication of tablets is for* (and) *is the one which is proper or correct to be given to me."*

> *"…at the beginning when I start with mental illness…I was going to the traditional healer, and I come back but I was not getting well…I was not getting well…. Yes I continued with symptoms, only the injection* (from the hospital) *helped me."*

The findings confirm what Pera and Van Tonder (2011:201, 204) discuss regarding the way traditional medicine is administered where they make use of roots and powders which they smear on cuttings on the patient's body. Patients are also given some roots which are mixed with water for them to drink, which usually induces vomiting. The macrosystem level involves the culture of an individual which determines their socioeconomic status, for example, if a person is born into a poor family, they may have difficulty accessing healthcare services in some instances. In addition, some beliefs of causes of mental illness may affect access or adherence of FSPs to medical treatment (Ileka, 2017:1). These beliefs may also shape the actions that are taken by families or FSPs when it comes to seeking treatment.

Sub-theme 2:2: FSPs experiences of allopathic treatment

A few participants made use of medical treatment before their arrest. The participants who utilised medical treatment were satisfied by the outcomes as they

indicated that they did not have any problems. It appears that they did not face any challenges with access to treatment centres as they lived in towns. The narrations below capture these views:

> *"I was there* (at the) *civil … psychiatry… anytime, I went to take* (my medication) *also by the hospital, I got* (free) *tablets and injection."*

> *"From mental health…, I was receiving … mental tablets … I got sick when I was in the north and I come back from the north, they admit me here* … (at civil psychiatry) *…for a week."*

> *"I was getting* (medication) *here in Windhoek… ….then others I was getting them from* [D town]*…."*

> *"… I'm just got my health treatment… No problem because … the manager* (at work) *used to take me to the hospital at the end of the month."*

One of the participants who was also receiving treatment says he was taken to the clinic and his experience was that the treatment did not change his condition at all.

> *"Yes I went to … the clinic where I got my treatment, and although it didn't help."*

This participant's experience could be related to the fact that he may not have taken the treatment long enough to realise the impact or that he may have been treated by people who were not competent to treat him. This can be substantiated by findings from a research done in Namibia by Ashipala (2013:67) whose study revealed that 77 percent of the mental health trained nurses involved in primary healthcare did not have confidence in delivering mental health services to patients. The other participants who got medical treatment expressed that it was helping them as they did not complain about it. This could be a result of this treatment method which is described as conventional or modern medicine that focuses on treatment of disease using various techniques. Van Rensburg (2012:594) states that allopathic medicine is based on knowledge, beliefs and attitudes that are verified empirically and continues to search for better ways to eradicate disease through research. The availability of treatment facilities in town made it easy for some participants to get treatment. Thus, institutions can either be a source of the services that are required

by the patients but a lack of these can be a disadvantage to those who will end up not having services they could otherwise have accessed if the services were located near them (Hepworth et al., 2006:231).

Sub-theme 2.3: Participants' experiences of spiritual treatment

Two participants mentioned that they got assistance with their mental health treatment from spiritual healers. Spiritual healing includes prayers, which according to the participants seemed to help them a lot in dealing with their conditions. One of the two participants narrated how confessing to the pastor helped with cessation of hallucinations and this saw some changes in the participant's daily life as the participant could sleep and eat well.

> *"One day, my father is brought the people from the church so they must pray for me, and give me the sacrament."*
>
> *…then pastor coming here then you tell them all* (confess) *then you stop. I am start I am eat, I'm sleeping."*
>
> *"In* (name of town) *where I was staying, there was a church. Every Sunday I was going to the church and after church we stayed there and we was* (were) *praying … I stay only with Jesus prayers."*

These findings confirm what Taryor in Pera and Van Tonder (2011:198) mention, that confession is important in prayer healing. These findings are similar to those in a study by Mokgothu et al. (2015:6) who found that churches and spirituality played a role in assisting as some families drew strength from their faith in the form of prayers; and others had some teams that would come and pray with them. FSPs should be given an opportunity to practice their spirituality as this helps to manage some of the spiritual issues they face regarding their mental health and in coming to terms with the crimes they may have committed.

Theme 3: Support received by FSPs regarding mental health services

Bronfenbrenner (1994:39-40) states that the mesosystem level includes relationships between systems in a person's life. Consequently, experiences of patients in one setting can be a result of their experiences with another microsystem. If the relationship of FSPs with family members is supportive, then their behaviour towards health workers will be positive, whereas if their relationship is unsupportive, the

patient may be rebellious due to the negative experiences they have with family members. Where there is no support, some patients may feel isolated as found out in a study by Mayers et al. (2010:67) that a form of isolation was experienced by patients who were being treated far away from their homes or villages as they did not have the support they needed from family and friends, which they felt could help during the reorientation period.

Sub-theme 3.1 Participants' experiences of support by family and community members

Most of the participants reported that they received support from various systems that proved vital in the lives of the participants including their families, work colleagues as well as other community members as indicated below:

> *"My father is the one who was supporting me. My father is the one who was calling that person …* (traditional) *doctor.*
>
> *I was with my girlfriend, she used to help me a lot cause every time we were having those topics and we talk and we share and now even if I hear that voice and I say nè the voice is talking, are you hearing these things that I am hearing? She says no ahh I'm not hearing anyone who is calling you or what what, then I know ok oh this one is a voice."*
>
> *"…* (my family) *was assisting me, I remember because when they started they call the people they was coming and doing this for that* (traditional) *doctor* (clapping signs) *… singing some music for that doctor."*
>
> *"There was one woman who is my colleague; she used to help me to talk. If I, she see I want to forget my tablet and injection, she used to* (remind) *me … where I was working."*

These findings agree with Mokgothu et al. (2015:1) who saw families as a source of support for FSPs and urged families and caregivers to partner with healthcare workers to provide care for those with mental illnesses. Such positive experiences are good as they enable the FSPs to flourish and be able to live without any stress Stokols (1992:10).

Theme 4: Participants' experiences of medical treatment at the FU

The FU employs the biopsychosocial model in treating patients with schizophrenia. The biopsychosocial model utilises a multidisciplinary (MDT) team approach that combines biological interventions as well as psychosocial treatments. Biological interventions are offered by the medical doctors with the help of consultants who are specialist psychiatrists, whilst psychosocial treatments are offered by allied healthcare workers such as social workers, psychologists and occupational therapists. According to Barlow and Durand (2009:489) psychosocial interventions help to address skills deficits, minimise chances of a relapse and increase adherence to treatment and other interventions aimed at rehabilitation. A number of participants in the study related how they felt some improvements in their mental condition ever since they were admitted at the FU. This theme covers the positive experiences of treatment and the side effects that some of the participants experienced during treatment.

Sub-theme 4.1: Participants' experiences of illness after admission at the forensic unit

Most of the participants seemed to have experienced some relief when they started getting biological interventions. Some participants even indicated that if they did not take their medication they would feel pain, while others said they would not sleep at all. The following narrations support these views:

> *"…* (The doctors) *say we must drink these tablets forever. … sometime*(s) *I feel bad, sometime*(s) *I feel normal… There when I didn't drink I start to feel pain because if I don't have, if I didn't drink then I didn't sleep. …sometimes when I drink, I sleep too much. …that is a problem also."*
>
> *"Yes. Progress is there … It's happening … Because people are being treated in a good way …They are given, being given proper medication…. for their ailments … people are progressing very well... Even myself also."*
>
> *"...what I notice is, it's just that I am more comfortable than usual. It's the way I think about my future and the way I used* (to) *think before. It's not the same."*
>
> *"For now I feel very well. It's better now. Also when I was there I was not ok but when I get my medication, I see I am better now. Always I say I am healed but maybe* (its) *only the … medication."*

The above findings confirm what Barlow and Durand (2009:489) mention regarding medical treatment. These authors state that schizophrenia is treated by antipsychotic medications known as neuroleptics which take hold of the nerves thereby allowing those affected to think more clearly and reduce hallucinations and delusions. These can be conventional antipsychotics such as haloperidol or chlorpromazine usually with a higher degree of side effects or second generation agents such as clozapine with lower degree of side effects. From the above narrations it can be seen that participants had some relief from their symptoms and could report that they felt much better. The FU offers medical treatment prescribed by medical officers and psychiatrists, which according to the EST presents as a service that is required by FSPs and helps them experience better quality of life (Hepworth et al., 2006:231).

Sub-theme 4.2: Participants' experiences with side effects of medication

Most participants expressed some experiences with side effects of antipsychotic medication. They explained how they did not feel good about the side effects. They also discussed some unpleasant effects such as eyes looking up, biting one's tongue, trembling, shaking, stiff neck and shortness of breath.

> *"I am not feeling good as I drink the tablets …I drink in the morning and evening but I am not feeling good. Of he give you that akineton … not help. One day my eyes looking up."*

> *"I see also that side effects might be there …even I used to see other patients…trembling… because of the medication."*

> *"Me my thing is only these heart pains … When I was just facing heart pains, in fact that from the medication I would, I was taking first …I was taking haloperidol and then changed to chlorpromazine. But when it moved to chlorpromazine, it ceased, the pain ceased."*

> *"… if I take tablets which they are giving me, sometimes I start biting my tongue and in my heart, I feel as if I am dying…it only started happening since … I started taking medication. …they added some tablets but now it's no more."*

> *"Yaa or them you tell them yaa this injection you must tell them the doctor of tablet make so … the tablet make so of my stiff* (neck) *of give me that tablet of*

(or) *maybe the tablet is strong of* (or) *the injection. All them that nurse he tell them, every year all them the years I am staying here as I am drink my neck also, my eyes also … I am tell them the nurse."*

For some participants, the side effects affected their activities during the day, which consequently affects their ability to maintain the skills they would have learnt through occupational therapy.

"… that time the eyes stay it's that time I told him … any injection he don't fit nice to me. The eyes he rolling up and he look there. Now I … the (OT staff) *he come and collect for me. I go but that time I was there … the eyes he start to up now, now I don't want to sit there its pain* (painful) *I want to net go to sleep now I tell him now my eyes he rolling up now and if I know the doctor, he shall not take now this tablets … So it's my challenge that one. The only challenge I have its only me nè until now I pain also now also."*

"Yes so the first time when they start they give me injection then they give me 4 tablets, like that then I drink. I was been drunk the whole day I was just sleeping. When I wake up I stand up I just I'm drunk, so it takes me time later on they changed my tablets."

"No this, the medication which I get nè, he make me slow and most of the time I feel that I become sick [with the medication] if I am drinking the medication. You see most of the time I feel the heart is pumping too much. Most of the time I feel weak most of the time, I feel so drunk … of maybe if I am sit like this and stand up quickly then I feel that I feel dizzy then I can sit back again."

These findings concur with Barlow and Durand (2009:490) who state that drugs may be effective with some patients but not with others. They go on to say that doctors would need to try different antipsychotic drugs until they get one which can work with a patient and that there are some patients who may not find one which works well with them at all. Barlow and Durand (2009:490) add that there are more people who now respond better to newer treatments which are called atypical and second generation medication and they are said to be working better, even on people who were not responding to antipsychotics. Access to medication which may have less side effects for state patients may not be by choice as this is determined by the types

of medications being used in state. Such decisions, according to the ecological systems theory can have an impact at the meso level where decisions between the government and institutions affect FSPs (Bronfenbrenner, 1994:39-40).

Theme 5: Participants' experiences of the multidisciplinary approach to treatment

This theme discusses the positive experiences that participants encountered with the MDT members who were employed at the FU. It also discusses negative experiences of FSPs with some of the staff.

Sub-theme 5.1: Participants' experiences of treatment by multidisciplinary team members

Most of the participants indicated that they were assisted by the MDT members while admitted at the FU. Participants expressed positive experiences which helped their lives. Their contact and work with the members of the multidisciplinary team changed their lives for the better. The following are some quotations that capture these views:

> *"I was having a problem at first but now I understand… the head of the department of this hospital* (psychiatrist), *used to* (give) *me* (education on my illness) *every time."*
>
> *"…starting* (with) *the psychologists they used* (to do) *tests on me, it helps because they told me that if you are doing this way it's wrong. You have to control your temper you … the same with the OTs also they used to do the same things."*
>
> *"No this which they are doing it's enough. Yaa … they are correct now because they used to tell us that no there is a garden there, the OT they are giving those things* (seeds)*, you cannot just stay like that that we can, we are having also the problems at home like where, where. So you work those things* (gardening) *at least you pack those things* (vegetables and sell) *at least you get Vaseline and soap."*
>
> *"…maybe if I want them to come and visit I will talk to the social worker, okay my family wants to come, wants to visit me but I used to talk to them …"*

> *"Yah, me I see that, because, one example is just that when a certain person has infirmity… then you tell the sister* (nurse), *instantly the sister calls the doctor and then the doctor can come. …Very fast. Yah, physical illness yes. Yah, and then, or even medication, or even the medication also too. …When the medication are giving a problem... then I see they used to summon the, the doctor, so fastly. And then the doctor come and to attend to you properly… there is no delay, but in time…. I feel that everything is alright."*

The findings confirm the writings by Ross and Deverell (2010:4, 5, 6) with regards to dealing with illness, which they say is an interplay of interrelated issues not necessarily being caused by one aspect as in the mono causal model of disease, which has since been replaced by a multi causal approach which relates health, disease and disability to various factors such as social, psychological and physique. The findings above show that the participants were not only assisted with medical interventions but also got help from other MDT members. The findings to some extent confirm the findings by Hörbergs et al. (2012:743-4) of MDT members in their study in a forensic setting, except that they had some staff which were not found at the FU such as the nurses specialised in psychiatric care, counsellors and licensed assistant mental health nurses who took care of patients on a daily basis.

Sub-theme 5.2: Challenges experienced by participants regarding communication patterns

Most of the participants described their communication with some staff members as a challenge. This even went to the extent that some would keep to themselves and try to avoid mixing with some staff whose way of talking was experienced as aggressive. It was also noted that some staff members did not respect FSPs and answered participants in a rude manner. This left some participants wondering what wrong they had done. There were however some staff members who were said to be good when communicating with participants. The following quotations show these views:

> *"… most of them do understand but most of them no … they don't. … by that tablets if you talk about tablets and maybe you say to the staff members that I want to go out from here so that I can go and work there. Most of them say 'eh don't tell me* (what) *you are going to do* (or) *how you want to go and take'*

the other stuff or what, you see, to talk with aggressive. Now if there is someone talk(ing) *with you aggressive*(ly) *nè uh you also talk aggressive with someone. … you see, if there is someone talk in the respect and you talk also in the respect you see? It's like that yaa, it's like that. …you see how he talk with us, most of them nè most of them you can say he have respect. Most of them it's come with no respect. … maybe insult you maybe if you talk 'yaa man fuck off man…' you see, like that then you feel that why was I talk with this man. I know that this man he doesn't have a respect of what, what, what… you see? … There is no respect."*

"It's like for those punishments, I cannot feel well, yaa … no, no it's to take me like, what can I say? It's just to take me like a dog, like you said you go this side, or you chase the dog or you call the dog to eat the food when it's finished you chase him. You (it) *want*(s) *to sleep somewhere where you don't want it to sleep, so you chase that dog that no go, go that side. The dog can mos it's not understand what … you are chase him it's the same. …they* (that) *used to happen …and anytime it can happen."*

The views of the following two participants show that they felt there was no help coming when they asked for help with other physical illnesses that were not related to their mental conditions, such as headaches. The patients were usually only assisted when a doctor comes in, and this in some cases could be on the next day.

"(I) *finish to shower then I am start my head pain so I am going to the office* (to get) *the tablets then I am tell them the staff… can you give me, put the tablets the panado. I am feeling pain in my head. 'Haai I will not give you tablets doctor not writing'. Me I am not feeling good. That time I was talking I was talking then he calling* (security), *calling all them the security staying there. Me I want the tablet the panado, I am not given …for me I am talking you don't help for me then now nothing now, I am killing myself."*

"Some of them are nice they … they see there is something wrong they help, then some, other staff don't worry, they just be there and go home. … some of them, I get a headache maybe at night say maybe at night, then then you ask pills they say no the doctor must prescribe the panado, then they will give, now you must lay all the whole night with that pain till the next morning,

till the doctor is coming and all that thing. It's, it's not good that now they say they are afraid of maybe we are allergic to panado then we will die and they are in trouble, but now they can just check the papers before, I had also panado that the doctor prescribed panado, that I am not allergic to panado because panado is there at the cabinet there but some of them don't want to give, but some staff are nice some sisters and nurses is nice they understand, if you have a headache then they give you the pill, 2 panados".

Participants also indicated that they had difficulties accessing doctors when they needed the doctor's assistance and suspected that staff members did not inform the doctors about the request as indicated in the following participants' narrations.

"… (the staff member) *say I am telling the doctor but I don't know* (if) *he tell* (told) *the doctor or lie."*

"… I want to see the doctor you take the, my card you put there, I don't know why (what) *you do with the doctor. Then doctor writing the injection not calling the doctor to see me, hee now I want the doctor. Those other people* (other patients) *as they want the doctor you call the doctor, the doctor come in the office and the patient sit with the doctor and then he talking, talking, …* (some staff say) *'tell me then I am tell the doctor what you want to ask the doctor…' Somebody* (I) *not to see the doctor, now somebody* (other patients) *he see the doctor. …I am not feeling good."*

"Me sometimes, I go to tell another staff (other ward staff), *that staff they say we can talk there with our staff, but there is no help that why I see the doctors* (name) *he write for me that tablets… I don't know the challenge that man* (ward staff) *he give. If he talk something I listen for him and if he say don't make this and this, I listen for him, but if I tell him he start accuse me and he say I must go out he don't want to listen."*

"…communication is also … some of the staff members you just see them that he is just there. You just see him like that… some of the staff members, some of them even if you greet him he just check you like this up (rolling eyes up and down, as if saying) *, this one just ….* (they don't respond) *that's make me feel also very bad and this … I used to say ohh this one is here. This*

people, I don't know what they think, they come here to work, to work with us. If you don't want to be involved in people that is mad (PLWMI)*, why you are coming here to work here, why? Why, if you know that I don't want to be, I don't want to clean this people's ward, why you must come within this* (unit) *why? Then you must start there mos* (when you are appointed), *saying no I will not come there… This now there is another, today, you know these people* (patients)*, if they finish eating they will come and walk here. You clean here what do you expect from us? Haa? If you are sitting here and you are cleaning here you start to work here where will we go out if there is like that? Then you are screaming, 'hey don't go there you see that the floor is wet.' Now where will they* (which way will they use?)…"

"Yaa, but now you 'hey you come, pour your toilet pot, you didn't pour the toilet pot what, what, what. You put rubbish there in the toilet pot.' It's not because you are here because we see you that we throw the paper on the ground, these people here they are mentally, they are sick there in the head… It's like this guy he doesn't want to work here but is working here. …its same story like he doesn't, he don't want to be working here but you are working here, (be)*cause you can see that this person doesn't even like to be here but he is here. …it's only just because of the payment that they get that they are here for… there is no commitment…"*

The findings of the present study agree with findings by Donnelly et al. (2011:21) who assert that forensic mental health treatment is seen as more coercive than other treatments in mental health due to the nature of it being court ordered and is therefore typified by non-engagement or rejection in service provision. The FSPs' experiences of this may affect their involvement in rehabilitation programmes which is also counterproductive for them as they may end up staying longer than if they were complying with the treatment modalities in forensic settings, thereby increasing their frustration towards staff members. The findings also confirm what Meehan et al. (2006:19) found to be the causes of aggressive behaviour from the perspective of FSPs. The authors found that it was a result of negative staff attitudes and forcible behaviour. However, the researcher is of the opinion that in order to forge a good working relationship, understanding the needs of FSPs is key.

While working with FSPs it is also important to understand how they experience the care that health workers offer them. Findings in the present study which indicate that there are some staff members who are relating well with patients agree with a study by Hörbergs et al. (2012:745) which showed that patients also acknowledged that there were 'pockets of good care' which were however said to be temporary. The availability of staff that communicates well and is positive helps the FSPs receive the help they need from this system as put forth by the EST (Hepworth et al., 2006:231).

Theme 6: Coping mechanisms

This theme deals with the various mechanisms employed by participants in dealing with their challenges. The coping mechanisms used by some participants included making sure that they keep to themselves as they were afraid of some staff members, fearing punishment or that they would retaliate and cause injuries. Others put their trust in their faith which was predominantly Christian.

> *"…By me ne 'I'm really afraid to talk with most of the staff members also because it can also cause a problem against he and me you see? … If he aggressive me also talk aggressive. Maybe later maybe he stand up to come by me, you see? Maybe the fighting can be there of* (or)… *I pray by Jesus Christ so that He can help me so that I can go back from this place."*

> *"Then, because me I, I knew God from since that time, and I have been with God. And this is why that, that eh, this situation was not affecting me too much. …No, yaa, me myself because I know I was being healed nè, and, and the medication was also positive to my conditions. That's why I just stood with hope also too, that no, everything one day will be alright. … Though then I was being kept here, of unknown of uncertainty, but I knew that one day things are going to be, to work out, or to be alright."*

> *"Eh, the co(ping), the* (laugh), *it's just, it's just ah, prayer, prayer …Yes, it's prayer. Because I know very well that if you pray, God are taking care of your prayer, also accepting your prayers, … And then any things which are difficult, just God is solving all these problems. … Just the spiritual, spiritual life. … Yaa, it's how I saw that, eh, even the challenges which are, are, are very difficult to handle.…But if you hand it up to God, God will resolve it …He will come, come eh, and rectify, he rectify the, the thing, the situation."*

"Yaa, I am coping, very hard …it's very hard, …to cope with. …Yaa"

"No I walk with the Lord. The Lord help(s) *me to get accustomed to take it just as it is. If there is problems then I pray then I wait on the Lord… even they get to know there was nothing to be done. It was bad but I pray by the Lord."*

Hepworth et al. (2006:201-2) discuss various reactions to dealing with problems. Some of the reactions include worry, resentment, feeling overwhelmed or helpless. The findings in this study show that one of the participants found it difficult to cope at all with an indefinite admission. The findings confirm with literature by Hepworth et al. (2006:202) which states that some use avoidance patterns which may include withdrawal while others may become aggressive. Incorporating spirituality in services rendered at the FU is very important as it ensures continued support for FSPs as this is a huge source of strength for most of them. It is a system which, as put forth by the EST, can be tapped into to assist with emotional healing of FSPs (Hepworth et al., 2006:231).

Theme 7: Strategies that can improve services rendered to FSPs

From the findings it is clear that FSPs have faced challenges that impacted negatively on their lives. As a result the FU needs to come up with some ways to assist FSPs in order to help them recover in a more accepting and enabling environment. The following are strategies that can be employed in order to help them realise this important goal which ensures health for all. The strategies can also help achieve the Namibian government's plan of action namely the Harambee Prosperity Plan (Republic of Namibia, 2016), particularly that of good governance. The following are some areas that can be developed in order to have targeted solutions to the needs of FSPs.

- Communication with patients
- Appropriate treatment of patients
- Staff-patient relations
- Discharge planning

Most of the participants made it clear that they wanted to be treated like human beings and in a humane manner. They experienced a lack of respect and dignity. Participants also indicated that they experienced some challenges with the manner

in which they were being talked to by some staff members, which in a way was said to be aggressive. Some also indicated that they experienced stigma from some staff members which resulted in them being excluded and discriminated against. There was an overwhelming concern on the use of seclusion for punitive purposes, where participants explained that the single rooms should be used only where one is violent and poses a danger to self or others.

Below are brief descriptions of the proposed strategies, followed by actions, outcomes and staff members who can be assigned to carry out the plans.

Sub-theme 7.1: Communication with FSPs

Training of all staff on patient centred care, derived from the person centred approach which is aimed at enhancing the therapeutic relationship between healthcare workers, other staff and patients can see patients contracting more for services. This should be followed up with quarterly refresher courses.

Strategy: 7.1	**Training all staff on patient centred care**
Action steps	-Establish a Mental health training committee represented by heads of departments. -Involve staff by identifying their needs and deficiencies. -Plan for training, with emphasis on the *Patient Charter* (MoHSS, 2016). -Train staff on a quarterly basis. -Do patient satisfaction surveys, quarterly. -Review on a quarterly basis.
Output	-Existence of the training programme. -Positive patient satisfaction reports.
Who?	-Quality assurance department. -Mental health training committee.

Table 5: Training of staff on patient centred care

Sub-theme 7.2: Appropriate treatment of FSPs

The FU must develop and adopt a zero tolerance policy on any ill-treatment of FSPs, which will seek to cover FSPs as they are vulnerable. The *Patient Charter* (MoHSS, 2016) is clear on important issues regarding treating patients with dignity and respect; the provision of safe and effective services and accountability on the part of both the staff and the patients.

- The FU must ensure that the guidelines on dealing with aggressive patients be followed, failure of which hearings on inappropriate handling of patients will be held.
- Appropriate treatment of FSPs can be enhanced through screening of new staff at the FU and ensuring that staff members are aware of what is expected of them in their conduct with the patients.

Strategy: 7.2	**Appropriate treatment of FSPs**
Action steps	-Develop a zero tolerance policy on safeguarding of FSPs. -Develop guidelines to back the policy for staff on how to handle patients they think are presenting as problematic. -Train staff members on the policy and guidelines. -Include conventions and legislation that protect patients. -Train all staff on how to handle aggressive FSPs in more humane ways. -Educate and encourage FSPs to report any form of ill-treatment to supervising staff. -Review yearly.
Output	-Established training programme. -Positive patient satisfaction reports.
Who	-Quality assurance department. -Mental health training committee.

Table 6: Appropriate treatment of FSPs

Sub-theme 7.3: Staff-patient relations

The FU must carry out trainings on how staff should relate to FSPs in a professional manner which ensures objectivity in their dealing with patients. It should also ensure the involvement of patients in the care planning, which makes them active participants in their own care and helps motivate them to take responsibility of their health. This is also included in the *Patient Charter* (MoHSS, 2016) which highlights the MoHSS' commitment to communication by pledging that staff will listen to patients. It also states the involvement of patients in the treatment plan through active participation and makes a promise to take patients' preferences and values.

Strategy: 7.3	**Patient staff relations**
Action steps	-Train staff on the *Patient Charter* (MoHSS, 2016). -Ensure monitoring and supervision by line managers of their departments' operations. -Revive climate meetings in the wards to address issues which should be attended by staff and their departmental managers. -Regular patient audit through files and interviews with FSPs. -Report on the state of audit and patient staff relations. -Review the training needs and implement training quarterly.
Output	-Existence of the training programme. -Positive patient satisfaction reports.
Who	-Quality assurance department. -Mental Health Training committee.

Table 7: Staff - patient relations

Sub-theme 7.4: Discharge planning

The FU must set up a committee to review cases of stable FSPs who have been admitted for a long period of time, which can engage the Ministry of Justice and find out the reasons why their discharge is not being acted upon. The MoHSS should appoint Chief Social Workers in the regions as custodians of the patients who can be accountable for their reintegration and ensure smooth integration with families and the community at large, in order to reduce recidivism and alleviate stress that comes

with adjustment from an institution to the society. These Chief Social Workers should also coordinate services needed by discharged patients and ensure progress reports are submitted to MHCC every six months as patients go for review. In addition, they should also ensure that patients are going on their follow up dates for review and treatment.

Strategy: 7.4	**Discharge planning**
Action steps	a) Appoint a team at the MHCC that reviews longstanding cases of FSPs recommended for discharge -Engage the Ministry of Justice on the reasons for delay of discharge b) Appoint Chief Social workers in regions as official custodians to work with the family system. -Train the Chief Social Workers on reintegration and the services needed to support both the family custodian and the discharged FSP. -Ensure open communication of the Chief Social Workers with social workers at FU and allow information exchange and assistance, enabling follow ups on 6 monthly reports required by the courts that should be submitted to the head of MHCC. -Request monthly reports of FSP on reintegration and progress from the Chief Social Workers in the regions. -Review complex cases on a case by case basis.
Output	-Discharge of stable FSPs with families willing to care for them -Smooth transition of FSPs to the community. -Reduced to non-readmission.
Who?	-Head of MHCC. -Control Social workers.

Table 8: Discharge planning

3.12 Summary

This chapter has given an overview of the research methodology that was utilised in the study, followed by the ethical principles that the researcher took into consideration. Participants' demographic information was presented in the form of tables and graphs and analysed in light of literature. The chapter also gave detailed accounts of the experiences of the participants regarding the challenges they have experienced from the time before their arrest to the present time. Their narrations were used as evidence of these experiences and were analysed in light of literature. The chapter ended with proposing strategies that could be used to address some of the challenges faced by FSPs. The following chapter, chapter four will present the key findings and conclude on these and give recommendations for addressing the challenges faced by FSPs in Namibia.

Chapter 4

Key findings, conclusions and recommendations

4.1 Introduction

This chapter gives an overview of the study's empirical findings. It also examines the research goal and objectives that the study set out to achieve and discusses the extent to which these were accomplished. Most importantly, the chapter presents the findings on the challenges that were experienced by hospitalised FSPs regarding mental health services in Namibia. The chapter ends by providing conclusions and recommendations for future studies.

4.2 Goal and objectives

The goal and objectives of this study were as follows:

Research Goal

- To explore and describe the challenges experienced by hospitalised FSPs regarding mental health services in Namibia.

Research objectives

The above goal was realised by the achievement of the following **research objectives**:

- To conceptualise and contextualise mental health services provided to FSPs within the framework of the Ecological Systems Theory.
- To ascertain what types of mental health services were accessed by FSPs in Namibia.
- To explore and describe the obstructions and difficulties experienced by FSPs whilst accessing mental health services in Namibia.
- Based on the findings that emerge from the study, identify strategies to improve mental health services for FSPs in Namibia.

Below is a discussion on how these objectives were met:

Objective 1

- To conceptualise and contextualise mental health services provided to FSPs within the framework of the Ecological Systems Theory.

This objective was realised in chapter 1, where the situation regarding the facilities available at the only FU in the country, situated at the Windhoek Central Hospital were discussed. The chapter also discussed the huge numbers of other court ordered FSPs who were previously held in police custody and other correctional facilities awaiting admission at the FU, which has a small bed capacity of 76 beds. Sections 2.2.2 and 2.2.3 also discussed how Namibia attained independence from the South African apartheid regime in 1990, prior to which the country was involved in years of intense liberation struggle, which had major psychological stressors with mental health implications on the Namibian nation (MoHSS, 2005:3). The chapter also discussed the out-dated Mental Health Act 18 of 1973, which Namibia adopted from South Africa, and is still using despite South Africa having updated its legislation with the Mental Health Care Act 17 of 2002. The out-dated legislation puts limits on the formulation of policies that could better serve FSPs particularly where care of patients is concerned. The scarcity of mental health care professionals as well as the lack of confidence of staff with mental health training, to render mental health services was discussed, including the paucity of research in mental health in Namibia. Various systems which deal with FSPs were discussed in Chapter 1 and 2 and their impact on this population, which is primarily of PLWMI.

Objective 2

- To ascertain what types of mental health services were accessed by FSPs in Namibia.

The objective to ascertain the types of mental health services that were accessed by FSPs in Namibia was achieved in chapter 3, where sub-themes 2.1; 2.2 and 2.3 gave accounts of treatment modalities that were used by FSPs. These were discussed in light of literature which covered traditional healing, allopathic treatment and spiritual treatment as well as how the participants experienced these types of treatments in terms of recovering from their symptoms.

Objective 3

- To explore and describe the obstructions and difficulties experienced by FSPs whilst accessing mental health services in Namibia.

This objective was realised by literature that was discussed in chapter 2 section 2.2.6 which discussed stigma and its effects as well as its relation to human rights as

discussed in section 2.2.7. Chapter 2 looked at issues regarding legislation, relationships of staff and patients in other forensic settings, perspectives of patients in forensic units regarding seclusion and their view of care. Participants' own narrations captured their experiences of these issues in detail in Chapter 3, and through analysis, a number of areas were identified as impediments and barriers that were experienced by hospitalised FSPs in Namibia. These were discussed in theme 1, sub-themes 1.1 to sub-theme 1.9 which revealed challenges with the illness itself, stigma, services after arrest, living with other FSPs, ill-treatment of FSPs by some staff, use of seclusion, lengthy stay at FU as well as loss of family members by FSPs. In addition, 3.10.13 and sub-theme 1.8 also revealed challenges on the availability of facilities at the FU as well as the lengthy stay of FSPs in other holding facilities such as custody or correctional facilities, where one participant spent a total of 10 years before admission at the FU as shown in 3.10.14, table 2.

Objective 4

- Based on the findings that emerge from the study, identify strategies to improve mental health services for FSPs in Namibia.

This objective was realised by the strategies that were gleaned from literature and findings of this study, which revealed areas of need and showed the importance of continual staff training in mental health service delivery. These areas are discussed in sub-themes 7.1 to 7.4 and the strategies are:

- Communication with patients
- Appropriate treatment of patients
- Staff-patient relations
- Discharge planning

4.2 Key findings and conclusions

This section discusses the appropriateness of the research methodology used, the key findings and conclusions on the literature review and the key findings regarding the empirical study. Based on these findings, conclusions and recommendations are drawn.

4.2.1 Appropriateness of the research methodology

The study was qualitative research in nature which made use of collective case study. One-on-one semi-structured interviews facilitated participants to describe in detail their experiences. The interviews were flexible and informal and allowed conversation to flow (Rubin & Babbie, 2013:123). In addition, the researcher assigned numbers in place of participants' actual names. This enabled an exploration of participants' experiences openly, and gave participants a chance to be heard without fear of being identified. The research enabled FSPs who were initially arrested from various parts of the country to share their experiences which gave an overview of the type and quality of mental health services they received in multiple settings. The sample was representative of most ethnical groups in Namibia and had both male and female representatives. It can be concluded that the purposive sampling used in the present study produced the desired representation. As pointed out by Mthoko (2017b:2) hearing from patients regarding their satisfaction with services is important as it helps improve service delivery. It is recommended that future research with vulnerable populations employs this research methodology in order to gain insight into their experiences.

4.2.2 Key findings and conclusions on the literature review

From the present study, it is clear that the empirical findings of this present study were closely related to the literature on the challenges experienced by FSPs in other contexts, without much difference. An example is the fact that FSPs experience stigma from family, healthcare workers and its impact on the FSPs is universal. The literature review indicates that FSPs in other settings in Africa and elsewhere in the world experienced maltreatment and these findings were confirmed in the present study. The need to appropriately train mental health staff kept coming up in all literature that had to do with staff - patient relationships, and was also suggested by participants in the present study. Given the above findings, it can be concluded that FSPs, apart from experiencing difficulties faced by PLWMI, are further stigmatised because of the offenses they committed.

4.3 Key findings regarding the empirical study

This section discusses themes that emerged from the data as indicated in Chapter 3. The key findings, conclusion and recommendations will be discussed for all the identified themes.

4.3.1 Theme **1: Challenges regarding FSPs experiences of their mental health**

This theme related to the participants' experiences of the challenges they faced due to their ill health.

4.3.1.1 Key findings

The findings show that participants faced various challenges in their journey from the time they got mentally ill leading up to the time they committed crime due to their illness. It can therefore be inferred that participants' experiences were very difficult for them. They experienced symptoms that caused them emotional pain, fear and distress. This affected and altered their courses of life. When mentally ill, one would need support from the family, friends and the community around them, but instead most participants experienced this negatively as some of their family members had stigmatising attitudes towards them, resulting in the lack of support. It was found that stigma also came from institutions where the FSPs were supposed to find help. In relation to the EST, this finding entails that the systems that stigmatise FSPs become a barrier to them, which in turn affects their recovery as they may not readily access the mental health services they need. Stigma also results in discrimination and exclusion from social participation. Findings also revealed that participants had challenges accessing mental health services after arrest, either in police custody or correctional facilities or both. Some participants had difficulties accessing treatment due to a lack of resident mental health professionals and most could not be taken to hospital for follow up and this exacerbated participants' symptoms. Despite some negative experiences with mental health services after arrest, it was also found that there were some institutions which assisted participants with mental health treatment and ensured that they got their medication. This further highlights the difficulty of receiving fragmented services from various stakeholders.

Living with other FSPs was another challenge to some participants. This was because some experienced aggression, fear of being harmed and having their belongings stolen. A lack of adequate facilities was one key finding which revealed that most toilets and showers in some wards at the FU were not operating, with one participant giving an example of only two of these functioning in a ward of over 25 FSPs. This finding revealed a lack of maintenance repairs which can be attributed to lack of priority for mental health issues. Another key finding was the mistreatment of FSPs by staff, who were supposed to keep them safe, given the main reason for

admission which seeks to safeguard FSPs from harm. It was clear that mistreatment was experienced more at the FU compared to holding facilities. This was further highlighted by participants' experiences of single rooms, which served to seclude FSPs and were viewed as a form of punishment as opposed to being used for the purpose of containing aggressive patients or those who pose a danger to self or others. However, some participants indicated a decrease in maltreatment compared to the past.

From the demographic data, a key finding was that most of the participants had stayed for long periods either in custody or at a correctional facility with the longest having spent 10 years before admission to the FU. Of note is the difference on the length of stay where others only stayed for as little as two years, giving rise to the question of how the decisions on admission to FU were made. The participant who had stayed the longest at the FU was admitted there for 21 years, thus one may question the adequacy of mental health rehabilitation programmes in the country. In addition, there were two participants who were readmitted due to challenges they experienced with their families during the reintegration process and both spent only around 6 months after discharge. They were then brought back by their families. This also makes one question rehabilitation programmes or the after care services in the community regarding support of discharged FSPs.

Most participants expressed dissatisfaction and disappointment regarding their long stay at the FU, while others showed hopelessness without any optimism of reintegration back into the society. Mthoko (2017b:47) places importance on dissatisfaction as an important form of feedback which indicates gaps in service delivery. Another key finding was that of the pain and sadness expressed by participants at the loss of their family members but they could not participate in the burial, with some losing significant people in their lives who used to support them through visits. Some participants would only know about the death of their loved ones after a long period of time, which in some way raised questions as to whether this was due to a need to protect the participants from pain or whether they were not significant to the remaining family members to warrant being informed.

It can be concluded that there were a lot of challenges that were faced by FSPs from the time they started to experience mental illness, the time they were arrested up to

date. These challenges included stigma, an unexpected change in their course of life due to offenses committed while ill, unavailability of treatment in some holding institutions and maltreatment.

4.3.2 Theme 2: Alternative mental health services received by FSPs in the community before admission at the FU

This theme discusses the various types of mental health treatments that were accessed by the participants before admission at the FU.

4.3.2.1 Key findings

The findings show that the main services that were received by FSPs were treatment by traditional healers, medical treatment, with a few receiving spiritual treatment in the form of prayers. It was found that the most common type of treatment method used by participants prior to their arrest and admission to the FU was the alternative treatment offered by traditional healers. Most participants used this type of treatment as it was easily accessible. Some indicated that they got well while others said they did not benefit at all from this treatment modality. The second most common treatment accessed by participants before their arrest was allopathic treatment, which was mostly accessed by those who resided in urban settings compared to those in rural areas. Spiritual treatment in the form of prayers was also used by a few participants and was said to be effective. However, only access to allopathic treatment was supported by police holding and correctional service facilities where patients were detained prior to their admission to the FU. Of note are the experiences of some participants who had previously been on alternative treatment but confirmed getting better after medical treatment.

4.3.2.1 Conclusions

It can be concluded that traditional beliefs on the cause of illness as well as access to treatment services determined the method of treatment modality that was used by FSPs. It is therefore recommended that the collaboration of the various service providers be encouraged as PLWMI can benefit from all of these methods. This also shows various dynamics in view of the EST where at micro level decisions of methods of treatment can be determined by close family members.

4.3.3 Theme 3: Support received by FSPs regarding mental health services after arrest

This theme explored the experiences of mental health support by participants after arrest, while in custody or correctional facilities as well as by family and community members.

4.3.3.1 Key findings

Some of the participants received support from their families and community members. This was received positively by the participants. However, it was also clear that some participants failed to receive visits due to the long distance between the FU and their home areas. This can be attributed to the fact that the FU is the only such institution in Namibia, where rehabilitation and treatment of FSPs is done. This finding should also be considered in relation to the fact that Namibia is a very vast country, comprised of 14 administrative regions.

4.3.3.2 Conclusion

It can be concluded that participants valued the support they got from both their families and communities. Some however seemed to understand that distance affected their support from families.

4.3.4 Theme 4: Participants' experiences of medical treatment after admission

This theme explored participants' experiences of illness after admission at the FU, as well as side effects of medication.

4.3.4.1 Key findings

The majority of participants expressed that they felt better mentally, after they were admitted and had become consistent with their medication compared to the period before. They acknowledged positive changes especially regarding symptoms of illness. However, some of the participants lamented that some medications they received had negative side effects which included tremors, eyes rolling upwards, tongue biting, shortness of breath and weakness. The weakness also affected some participants to an extent that they could not participate in daily programmes such as occupational therapy.

4.3.4.2 Conclusion

It can be concluded from the above findings that participants experienced some relief from the symptoms that had caused them some distress even though some were having difficulties with side effects and needed adjustment to their medication.

4.3.5 Theme 5: Participants' experiences of the MDT approach to treatment at the FU

This theme looked into the MDT approach to treatment at the FU. It also covered the challenges experienced by FSPs regarding their communication patterns with the MDT.

4.3.5.1 Key findings

Most participants received services from the MDT members at the FU which employs the biopsychosocial model of treatment. This enables FSPs to be assisted with both the biological and the psychosocial aspects of their lives in a bid to offer comprehensive health services. However, it was found that some participants had difficulties communicating well with some staff members at the FU. This resulted in some participants feeling that they were not regarded as equal human beings. Some felt that force and aggression was used towards them at times. This brought about some feelings of inadequacy which had a negative implication on the therapeutic relationship that should exist between mental health staff and patients.

4.3.5.2 Conclusions

It can be concluded that despite some positive experiences of some participants regarding services by staff members, some of the communication patterns employed by some staff members, including the ways in which they dealt with FSPs were regarded by the participants as counterproductive. This painted some staff in the eyes of some FSPs as being negative and unprofessional in their conduct. It can also be concluded that some staff members lack thorough orientation and training on their duties regarding safeguarding the lives of FSPs.

4.3.6 Theme 6: Coping mechanisms

This theme explored the coping mechanisms that were employed by participants whilst admitted at the FU.

4.3.6.1 Key findings

It was found that some participants avoided some staff members as their interactions with these particular staff members would bring negative responses. The majority of participants indicated that they drew their strength from their spiritual beliefs which were predominantly Christianity. They attributed their strength to withstand the negative experiences to their religious beliefs. One however acknowledged that it was just difficult to cope at all with their situation.

4.3.6.2 Conclusion

It can be concluded that spirituality is an important aspect in the lives of FSPs and that more should be done to enhance the opportunities for FSPs to access and maintain this part of their lives intact as it yielded positive results for them.

4.3.7 Theme 7: Strategies that can improve services rendered to FSPs

This theme explored, the strategies that could be used to enhance the lives of FSPs in view of the challenges they experience.

4.3.7.1 Key findings

It was found that the major areas that required attention, in a proposal to improve the lives of FSPs included; training of all staff members on communication patterns with a patient centred approach to care for FSPs, appropriate treatment of FSPs, enhancing staff - patient relationships as well as discharge planning. These strategies and the action plans were given in theme 7 and sub-themes 7.1 to 7.4.

4.3.7.2 Conclusion

It can be concluded that the training of staff on the *Patient Charter* (MoHSS, 2016), from time to time, could help eliminate most of the negative experiences that FSPs experience.

4.4 Recommendations

Based on the above findings, conclusions and participants' suggestions, the following recommendations can be made:

Awareness raising campaigns

- Massive awareness raising campaigns on mental health should be done in all parts of the country. These campaigns could focus on the education of

families and communities that aim at helping them to identify symptoms of mental illness and seek medical treatment on time.

- The awareness must also inform communities including staff dealing with FSPs of the conditions under which the FPSs committed crimes and should also aim at reducing the stigma associated with mental illness.

Collaboration of the different mental health service providers

- Strong collaboration efforts should be established in Namibia to ensure referrals between the providers of mental illness treatment such as traditional healers and those offering medical treatment so that symptoms can be stopped by treatment before people commit serious crimes.
- The Namibia Correctional Service employs social workers who can assist FSPs admitted to their facilities
- The Namibia Correctional Service should task social workers to ensure continuity of support by family members including informing family members of the admission and movement of FSPs to FU and encourage contact.

Provision of mental health services while in custody and correctional facilities

- It is recommended that the Ministry of Health and Social Services expands the capacity of the FU or better still introduce community forensic mental health services for some cases as was done in Canada, in order to move away from institutionalisation as the only option.
- It is recommended that the Ministry of Safety and Security employs mental health teams that can render comprehensive treatment and rehabilitation services to FSPs being held in correctional facilities awaiting admission at FU.

Repairs and maintenance of the FU

- That repairs and maintenance be done at the facility at an on-going basis.

Providing patient centred care to FSPs

- It is recommended that rigorous training of all staff regardless of their professional training be done initially, followed by quarterly refresher courses.
- That an educational programme be introduced in order to enhance education levels of FSPs who wish to continue with their secondary and tertiary education.
- Assessment of occupational needs of FSPs relevant to their places of origin be done to ensure gainful application of skills by generating income after discharge.

Eliminating ill-treatment of FSPs

- It is recommended that mental health staff receive training on the laws that uphold the rights of FSPs, including availing documents such as the *Patients' Charter* (MoHSS, 2016) among other international conventions that were endorsed by Namibia.
- It is also recommended that staff treat FSPs with dignity and respect.
- It is recommended that line managers monitor operational staff in order to pick up incidents of undignified and disrespectful treatment of FSPs.
- Patients should be encouraged to report any inhumane treatment as provided for by the *Patients' Charter* (MoHSS, 2016). However, it is also important that the patients are familiarised with their rights as outlined in this charter.

Communication with FSPs

- Despite the staff shortage, patients requested that they have contact with doctors at least once in two or three months.
- It is recommended that staff responds promptly to conflicts between patients in order to prevent violence.
- Patients also requested that healthcare workers investigate the relationship between patients and their family members before readmission as some reports by family members were not fully factual due to stigmatising attitudes when they were brought back.

Professional conduct

- Mental health staff should be objective and professional when dealing with FSPs.
- Ward staff should be truthful when reporting matters to the medical doctors.
- Staff must be aware that FSPs are PLWMI and should consider this in the way they treat or handle these patients.
- Treatment should be done directly with patients without interference of non-treating staff.
- Staff should not treat FSPs differently from any other people.
- Staff should listen to FSPs and assist them in a non-judgemental attitude.
- Staff stops abusing patients and recognise that they have rights as human beings.
- That staff follow policies and laws when dealing with FSPs.

- That family members be trained so that they can relate and handle FSPs in a humane way.
- That mental healthcare staff treat FSPs as patients and not as prisoners.

Expediting the discharge of stable FSPs who have stayed for long periods of time

- It is recommended that a special case approach be taken where meetings with the courts are held to find out issues that delay the discharge of FSPs who were recommended years back and have relatives who are willing to act as their custodians upon their discharge.
- Special discharge rules be formulated for stable FSPs who have been admitted for long.
- That government expedites adoption of the proposed mental health bill and enactment into law.
- That a strong support system for FSPs be established for each FSP before discharge to help with adjustment from the effects of protracted institutionalisation.
- That staff members assist with the prompt processing of discharge or at least give leave of absence to FSPs when the bill is enacted into law.

Recommendations for future research

- Following this study, the researcher recommends that future research should focus on the perspectives of healthcare workers regarding the challenges they face in rendering services to FSPs.
- Research should also be conducted with FSPs who are discharged to evaluate the effectiveness of the rehabilitation programmes.
- It is also recommended that more research be done to inform mental healthcare workers on the various issues that hamper successful treatment and rehabilitation of FSPs.

References

Abdalla-Filho, E. & Bertolote, J.M. 2006. Forensic psychiatric systems of the world. Rev Bras Psiquiatr, 28(II):56-61.

Ashipala, D.O. 2013. *Mental health policy implementation as an integral part of primary health care services in Oshana region, Namibia*. Windhoek: University of Namibia. (MA Dissertation).

Babbie, E. 2013. *The practice of social Research.* 13th ed. Canada: Cengage learning.

Babbie, E. 2011. *Introduction to social research*. 5th ed. USA: Cengage learning.

Barandonga, A. 2015. Personal interview with Ms Albertina Barandonga, Senior Health Program Administrator for Mental Health. 6 May. Windhoek, Namibia.

Barlow, D.H. & Durand, V.M. 2012. *Abnormal psychology: An integrative approach.* 8thed. Wadsworth: Cengage Learning.

Barnao, M., Ward, T. & Casey, S. 2015. Looking beyond the illness: Forensic service user's perceptions of rehabilitation. *Journal of Interpersonal Violence,* 30(6):1025-1045.

Barnao, M., Ward, T. & Casey, S. 2016.Taking the good life to the Institution: Forensic Service Users Perceptions of the Good Life Model. *International journal of Offender Therapy and Comparative Criminology*, 60(7):766-786.

Best, S. 2012. *Understanding and doing successful research: Data collection and analysis for the social sciences*. London: Pearson Education Ltd.

Bronfenbrenner, U. 1994. Ecological models of human development. *International Encyclopaedia of Education*, 3(2):37-41.

Bryman, A., Teevan, J.J. & Bell, E. 2009. *Social research methods*. 2nd ed. Don Milld, ON: Oxford University Press.

Burns, J.K. 2010. Mental health services funding and development in KwaZulu-Natal: A tale of inquiry and neglect. *South African Medical Journal,* 100(10):662-666.

Coid, J., Kahtan, N., Cook, A., Gault, S. & Jarman B. 2001. Predicting admission rates to secure forensic psychiatry services. *Psychological Medicine*, 31:531-539.

Constitution of the Republic of Namibia, 1990. (Published in the Government Gazette, (2) Windhoek: Government Printer).

Creswell, J.W. 2013. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches.* 3rd ed. Thousand Oaks, CA: Sage Publications.

Creswell, J.W. 2014. *Research design: Qualitative, quantitative and mixed methods approaches.* 4th ed. London: Sage Publications.

Criminal Procedures Act 51 of 1977 (Published in the Government Gazette, (5654) Pretoria: Government Printer).

Cuddeback, G.S. & Morrissy, J.P. 2011. Program planning and Staff Competences for Forensic Assertive Community Treatment: ACT – Eligible Versus FACT – Eligible Consumers. *Journal of the American Psychiatric Nurses Association*,17(1):90-97.

Davis, H. 1993. *Counselling parents of children with chronic illness or disability: Communication and counselling in health care series.* Leicester: British Psychological Society.

Delport, C.S.L. & Roestenberg, W.J.H. 2011. Quantitative data collection methods. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Denscombe, M. 2012 *Research proposals: A practical guide*. Berkshire: Maryn Denscombe.

Department of Correctional Services. 2011. *Audit on certain categories of inmates within the department of correctional services facilities*. *Final Report to the Minister of Correctional Services – Nosiviwe Mapisa-Nqakula.* February 2011.

Donnelly, V., Lynch, A., Delvin, C., Naughten, L., Gibbons, O., Mohan, D. & Kennedy, H. G. 2011. Therapeutic alliance in forensic mental health: Coercion, consent and recovery. *Irish Journal of Psychological Medicine,* 28:21-28.

Forensic mental health services. 2015. Mental Health Care. Available: www.mentalhealthcare.org.uk/forensic_mental_health_services (Accessed 2016/02/05).

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Delport, C.S.L. 2011a. Introduction to the research process. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Delport, C.S.L. 2011b. Writing the research proposal. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Ganasen, K. A., Parker, S., Hugo, C. J. Stein D. J Emsley, R. A. & Seedat, S. 2008. Mental health literacy: Focus on developing countries. *African Journal of Psychiatry*, 11:23-28.

Geingob, H.G. 2015. Speech delivered at the 25th Independence Day celebrations and swearing in of the 3rd President of the Republic of Namibia, Windhoek, 21 March.

Greef, M. 2011. Information collection: interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Gureje, O. 2013. *Mission to Namibia: Rapid assessment on mental health issues. Report prepared for the Ministry of Health and Social Services*. Windhoek: MoHSS.

Hepworth, D.H., Rooney, R.H., Rooney, G.D., Storm-Gottfried, K. & Larsen, J.A. 2006. *Direct social work practice: Theory and skills.* 7th ed. Toronto: Thompson Brooks/Cole.

Hodgins, S, Tengstrom, A., Eriksson, A., Osterman, R., Kronstrand, R., Eaves, D., Hart, S., Webster, C., Ross, D., Levin, A., Levander, S., Tuninger, E., Muller-Isberner, R., Freese, R., Tiihonen, J., Kotilainen, I., Repo-Tiihonen, E., Vaananen, K., Eronen, M., Vokkolainen, A. & Vartianen, H. (2007). A multisite study of community treatment programs for mentally ill offenders with major mood disorders: Design, measures, and the forensic sample. *Criminal Justice and Behaviour,* 34(2):211-228.

Holliday, A. 2008. *Doing and writing qualitative research*. 2nd ed. London: Sage Publications.

Huxley, P., Sheppard, M. & Webber, M. 2010. Mental Health. In Shaw, I. K., Briar-Lawson, K., Orme J. & Ruckdeschel, R. (Eds). T*he Sage handbook of social work research.* London: Sage Publications.

Hörbergs, U., Sjögren, R. & Dahlberg, K. 2012. To be strategically struggling against resignation: The lived experience of being cared for in forensic psychiatric care. *Issues in Mental Health Nursing,* 33:743-751.

Ileka, S. 2017. Ministry working on new Mental Health Bill. *New Era*, 29 May:1

Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R. & Lund, C., Flisher, A.J. & The Mental Health and Poverty Project (MHaPP) Research Programme Consortium. 2010. Mental illness – Stigma and discrimination in Zambia. *African Journal of Psychiatry*, 13:192-203.

Kasmi Y. 2010. Profiling medium secure psychiatric intensive care unit patients. *Journal of Psychiatric Intensive Care*, 6(2):65-71.

Kirby, M. 2004. *Parliament of Canada, Mental Health, Mental illness and Addiction: Overview of policies and programs in Canada. Report (1) Part 3. Service delivery and Addiction Treatment in Canada: An Historic Perspective*. Available: http://www.parl.gc.ca/content/sen/committee/381/soci/rep/report1/repintnov04vol1table-e.html (Accessed 2015/04/04).

Kline, S.F. 2011. Proposal writing. In Sirakaya-Turk. E. (Ed.). *Research methods for leisure, recreation and tourism*. Cambridge: CAB International.

Lien, L. 2016. Community Mental Health, Report presented at the Mental Health Care Centre, Windhoek Central Hospital. Windhoek, Namibia.

Lietz, C.A., Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work: Implications from a study regarding spirituality. *Qualitative Social Work, 5*(4):441-458.

Lippi, G. 2016. Schizophrenia in a member of the family: Burden, expressed emotion and addressing the needs of the whole family. *South African Journal of Psychiatry*, (1):22.

Livingstone, J.D., Chu, K., Milne, T. & Brink, J. 2015. Probationer mandated to receive forensic mental health services in Canada: Risks/needs, service delivery, and intermediate outcomes. *American Psychological Association,* 21(1):72-84.

Magadla, M.W. & Magadla, N.I. 2014. Effects of mental illness on relationships amongst families, relatives and friends with mentally ill persons. *African Journal for Physical Health Education, Recreation and Dance*, 3:126-135.

Marais, B. & Subramaney, U. 2015. Forensic state patients at Sterkfontein Hospital: A 3-year follow-up study. *South African Journal of Psychiatry, 21*(3):86-92.

Marimbe, B.D., Cowan, F., Kajawu, L., Muchirahondo, F. & Lund, C. 2016. Perceived burden of care and reported coping strategies and need for family caregivers of people with mental disorders in Zimbabwe. *African Journal of Disability*, 5(1):1-9.

Mathanya, M.E., Kgole, J.C. & Lekhuleni, M.E. 2015. Experiences of psychiatric state patients during leave of absence in Lepelle Nkumpi Municipality, Limpopo Province, South Africa. *African Journal of Physical Health Education, Recreation and Dance*, 1(1):161-172.

Mayers, P., Keet, N., Winklerr, G. & Flisher, A.J. 2010. Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *International Journal of Social Psychiatry*, 56(1):60-73.

Meehan, T., McIntosh, W. & Bergen, H. 2006. Aggressive behaviour in the high-secure forensic setting: The perceptions of patients. *Journal of Psychiatric and Mental Health Nursing,* 23:19-25.

Mental Health Act 18 of 1973 (Published in the Government Gazette, (3837) Cape Town: Post Office Newspaper).

Mental Health Care Act of 2002 (Published in the Government Gazette, (24024) Pretoria: Government Printer).

Ministry of Health and Social Services. 2016. *Patient charter*. Available: http://www.mhss.gov.na/files/downloads/70f_MOHSS%20PATIENT%20CHARTER%20(1).pdf (Accessed 2017/08/30).

Ministry of Health and Social Services. 2005. *National policy for mental health.* Windhoek: Ministry of Health and Social Services.

Mokgothu, M.C., Du Plessis, E. & Koen, M.P. 2015. The strengths of families in supporting mentally-ill family members. *Curationis,* 38(1):1-8.

Moloo, Z. 2016. Grappling with mental health challenges in DRC. *The Namibian,* 12 January: 12.

Mosby's Medical Dictionary. 2009. 8th ed. USA: M. Stewart.

Mthoko, N.F.N. 2017a. *The perceived impact of a relative's mental illness on the family members and their reported coping responses: A Namibian study*. Windhoek.

Mthoko, N.F.N. 2017b.*Service satisfaction among patients attending the psychiatric outpatient clinic of the Mental Health Care Centre, Windhoek Central Hospital*. Lisboa: Universidade Nova De Lisboa. (MA Dissertation).

National Association of Social Workers. 1996. *Code of Ethics of the National Association of Social Workers*. Available: https://www.socialworkers.org/pubs/code/code.asp (Accessed 2017/08/30).

Ndjaba H.I.M. 2013. *Prevalence of substance use disorders among forensic psychiatry inpatients at Windhoek Central Hospital Forensic Unit, Namibia*. Available: http://erepository.uonbi.ac.ke/handle/11295/57929 (Accessed 2016/08/05).

Office of the Prime Minister. 2017. About Namibia. Available: www.gov.na/about-Namibia (Accessed 2017/08/30).

Ogunlesi, O.A., Ogunwale, A., De Wet, P., Rooi, L. & Kaliski, S. 2012. Forensic psychiatry in Africa: Prospects and challenges. *African Journal of Psychiatry,* 15:3-7.

Pera, S. & Van Tonder, S. 2011. *Ethics in healthcare.* 3rd ed. Cape Town: Juta & Co Ltd.

Pereira, S. M., Sarsam, M., Bhui, K. & Paton, C. The London survey of psychiatric intensive care units: Psychiatric intensive care; patient characteristics and pathways from admission and discharge. *Journal of Psychiatric Intensive Care*, 1:17-24.

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F. Turner, T. & Wiersma, D. 2005. Reinstitutionalization in mental health: Comparison of data on service provision from six European countries. *British Medical Journal,* 15(330): 123-6.

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. 2009. A study of stigmatized attitudes towards people with mental health problems among psychiatry and mental health nursing. *Journal of Psychiatry and Mental Health Nursing*, 16:279-284.

Republic of Namibia. 2016. *Harambee Prosperity Plan: Namibian Government's Action Plan Towards Prosperity for All*. Windhoek: Office of the President.

Ross, E. & Deverell, A. 2010. *Health, illness and disability: Psychosocial approaches*. 2nd ed. Pretoria: Van Schaik Publishers.

Rubin, A. & Babbie, E. 2011. *Research methods for social work.* 7th ed. Belmont: Brooks/Cole Cengage Learning.

Rubin, A. & Babbie, E. 2013. *Essential Research methods for social work.* 3rd ed. Belmont: Brooks/Cole Cengage Learning.

Salize, H.J. & Dressing H. 2004. Epidemiology of involuntary placement of mentally ill people across the European Union. *The British Journal of Psychiatry,* 184(2):163-168.

Sauber, S.R. 2013. *The human services delivery system: Mental health, criminal justice, social welfare education, health services*. New York: Columbia University Press.

Schaufenbil, R.J., Kornbluh, R., Stahl, S.M. & Warburton, K.D. 2015. Forensic focused treatment planning: A new standard for forensic Mental Health systems. CNS Spectrums, 20(3):250-3.

Schurink, W., Fouche, C.B, & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Stokols, D. 1992. Program in Social Ecology, University of California, Irvine. *American Psychological Association*, 47(1):6-22.

Stokols, D. 1996. Culture change: Translating social ecological systems theory into guidelines for community health promotion. *American Journal of Health Promotion, 282-298.*

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grassroots for the social sciences and the human services professions.* 4th ed. Pretoria: Van Schaik.

Support in Mind. 2016. *Exploring family carer involvement in forensic mental health services, Discussion and summary.* Available: https://www.supportinmindscotland.org.uk/Handlers/Download.ashx?IDMF=6570a7bb-4286-4104-9cd4-d67af9bfcc30 (Accessed 2016/04/12).

Thyer, B. 2010. *The handbook of social work research methods*. 2nd ed. Thousand Oaks, CA: Sage Publications.

To, W.T., Vanheule, S., De Smet, S. & Vandevelde, S. 2015. The treatment perspectives of mentally ill offenders in medium- and high - secure forensic settings in Flanders. *International Journal of Offender Therapy and Comparative Criminology*, 59(14):1605-1622.

Toseland, R.W. & Rivas, R.F. 2009. *An introduction to group work practice*. 6th ed. New York: Pearson Education.

Tromp, J. 2015. Personal interview with Mrs Joey Tromp, Chief Social Worker of Windhoek Central Hospital. 3 April. Windhoek.

Ukpong, D. I & Abasiubong, F. 2010. Stigmatizing attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital. *South African Journal of Psychiatry*, 16 (2):56-60.

United Nations General Assembly. 2007. Convention on the Rights of Persons with disabilities. Available: www.refworld.org/docid/45f973632.html (Accessed 2017/08/30).

United Nations General Assembly. 1966. International Covenant on Economic, Social and Cultural Rights. Available: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (Accessed 2017/08/30).

Van den Heever, A. E., Poggenpoel, M. & Myburgh, C.P.H. 2013. Nurses and care worker's perceptions of their nurse-patient therapeutic relationship in private general hospitals, Gauteng, South Africa. *Health SA Gesondheid,* 18(1):727-733.

Van Rensburg, H.C.J. 2012. Health and healthcare in South Africa. 2nd ed. Pretoria: Van Schaik Publishers.

Warren, L.J., Mullen, P.E., Thomas, S.D.M., Ogloff, J.R.P. & Burgess, P.M. 2008. Threats to kill: a follow-up study. *Psychological Medicine*, 38:599-605.

Watson, L. & Marschall, K. 2013. Comprehensive Gaps Analysis of Behavioural Health Services. Available: http://dpbh.nv.gov/uploadedFiles/04%202013-10-11_BehavioralHealthGapsAnalysisReport.pdf (Accessed 2017/08/30).

Weyers, M.L. 2011. *The theory and practice of community work: A Southern African perspective.* 2nd ed. Potchefstroom: Keurkopie.

Wilson, G. & Daly, M. 2007. Shaping the future of mental health policy and legislation in Northern Ireland: The impact of service user and professional social work discourses. *British Journal of Social Work,* 37:423-439.

Woods, D. 2007. Continuing education and training of nurses. In Kibel, M. Saloojee, H. & Westwood, T. (Eds). *Child health for all*. 4th ed. Cape Town: Oxford University Press.

World Health Organisation (WHO). 2008. *Integrating mental health into primary care: A global perspective*. Geneva: World Health Organisation and World Organisation of Family Doctors [Wonca].

World Health Organization (WHO). 2007. *Report on mental health systems in South Africa*. Cape Town: University of Cape Town.

World Health Organization (WHO). 2006. *Assessment Instrument for Mental Health Systems Report on mental health systems in Egypt*. Cairo: WHO & Ministry of Health, Egypt.

World Health Organisation (WHO). 2005. *Resource book on mental health, human rights and legislation: Stop exclusion, dare to care.* Geneva: World Health Organization.

World Health Organization (WHO). 2001. *Mental Health: A Call for action by world health ministers. Ministerial round tables.* 54th World Health Assembly. Geneva: WHO.

Wynaden, D., Barr, L., Omari, O. & Fulton, A. 2012. Evaluation of service user's experience of participating in an exercise program at the Western Australian State Forensic Mental Health Services. *International Journal of Mental Health Nursing,* 21: 229-235.

Young. S., Gudjonsson, G. H., Needham-Bennett. & Chick, K. 2009. Service audit of a forensic rehabilitation ward. *Medical Science Law*, 49(4):291-297.

Yusuf, A.J. 2010. Consequences of untreated severe psychiatric disorders in Northern Nigeria. *African journal of Psychiatry*, 13:92-94.