

**PREVALENCE AND CHARACTERISTICS OF OFFENDERS WITH  
INTELLECTUAL DISABILITY REFERRED FOR FORENSIC OBSERVATIONS  
AT THABAMOPO HOSPITAL, LIMPOPO**

by

**DR MALESELA SIMON MATLOU**

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**SUPERVISOR: Dr P. J. Mokoena-Molepo**

**CO-SUPERVISOR: Dr M. E. Mafona**

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## DECLARATION

I declare that *PREVALENCE AND CHARACTERISTICS OF OFFENDERS WITH INTELLECTUAL DISABILITY REFERRED FOR FORENSIC OBSERVATIONS AT THABAMOPO HOSPITAL, LIMPOPO*, hereby submitted to the University of Limpopo, for the degree of Master of Medicine (Psychiatry) has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.



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**MALESELA SIMON MATLOU**

**09/06/2024**

**DATE**

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## **ABSTRACT**

The purpose of this study was to determine IDD (Intellectual Developmental Disorder) prevalence and associated characteristics of offenders referred to Thabamopo Hospital for forensic mental observation from January 2016 to December 2018. Thereafter, quantitative, descriptive research was conducted to determine the offenders' profiles, the types of offences they had committed and their forensic outcomes. Data collection was conducted using a structured data collection form.

Offenders with IDD were 88 (23.3%). All were male, mostly aged between 21 and 29 years, single and unemployed. The majority (65, 9%) had Mild IDD. Psychometric tests were used to diagnose IDD in 78% of the offenders. Medical comorbidities were present in 11% of the cases. Offenders with mild IDD (68%) were found to be using one or more substances, with alcohol the commonest. There was no statistical significant relationship between the nature of the offences and the severity of the IDD ( $p > 0.05$ ).

Rape, murder and assault GBH were the commonest alleged offences. Of the rape case, 66% were committed by offenders with mild IDD. Forty-seven per cent of the offenders were found not fit to stand trial and not criminally responsible, with the usual recommendation that they must be admitted to psychiatric hospitals for care, treatment and rehabilitation. This also implied that 53% of the offenders with IDD would follow normal court proceedings, with the possible outcome of being incarcerated in correctional facilities or being acquitted. It is therefore necessary to consider strategies to help reduce offending behaviour amongst individuals with IDD, minimize the undesirable consequences of offending amongst the individuals with IDD and to re-integrate them back to society.

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## **ABBREVIATIONS**

<b>ASSAULT GBH:</b>	Assault with the intent to do grievous bodily harm
<b>BVMGT:</b>	Bender Visual Motor Gestalt Test
<b>CPA:</b>	Criminal Procedure Act Number 51 of 1977, as amended
<b>CPM:</b>	Coloured Progressive Matrices
<b>DSM 5:</b>	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
<b>ID:</b>	Intellectual Disability
<b>IDD:</b>	Intellectual Developmental Disorder
<b>IDO:</b>	Intellectually Disabled offenders
<b>MHCA:</b>	Mental Health Care Act Number 17 of 2002
<b>NSAIS:</b>	New South African Individual Scale
<b>TREC:</b>	Turfloop Research and Ethics Committee
<b>SA:</b>	South Africa
<b>SPSS:</b>	Statistical Package for the Social Sciences
<b>USA:</b>	United States of America

## **DEFINITIONS OF KEY CONCEPTS**

### *Intellectual disability*

Intellectual disability (ID) is a disorder with an onset during the developmental period and includes intellectual and adaptive functioning deficits in conceptual, social, and practical domains (DSM5, 2013). Intellectual Disability and Intellectual Developmental Disorder also defined in the DSM 5 will be used interchangeably in this study.

In this study, an intellectually disabled offender is an offender who was or has been clinically diagnosed as having intellectual disability based on his or her developmental history, scholastic performance, and a psychological and psychometric assessment using one or more of the following tests: New South African Individual Scale (NSAIS), Bender Visual-Motor Gestalt Test (BVMGT), Vineland test, and whether the offender meets the DSM 5 diagnostic criteria. In this study, the terms offender and alleged offenders will be used interchangeably.

### *Forensic observations*

These are processes in which the court of law requests an evaluation of a person charged with a crime to determine whether the person has or had a mental illness at the time of the commission of the crime; whether he/she will be able to follow court proceedings, and lastly whether they can be held responsible for the alleged crime (South Africa 1977:51).

In this study, forensic observation refers to the court-prescribed proceedings in which offenders are sent for evaluation by a psychiatrist, in terms of section 77 or 78 of the Criminal Procedure Act.

### *Criminal Procedure Act*

Criminal procedure act refers to the Criminal Procedure Act 51 of 1977 (South Africa 1977:51).

In this study, the Act refers to three sections: section 77(fitness to stand trial); section 78 (criminal responsibility); and section 79, which outlines the psychiatric report.

### *Fitness to stand trial*

This refers to the accused's ability to understand alleged charges against him/her, and to instruct legal counsel and the ability to follow court proceedings (Chadda 2013:120).

In this study, fitness to stand trial refers to the outcome of the psychiatric evaluations in which a psychiatrist would determine whether the accused will be able to stand trial. This includes assessment of whether the accused understands the charges levelled against him/her, knows how he/she will plead, the implication of that plea, and whether he/she knows different court officials and understands their roles.

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### *Criminal responsibility*

A person is endowed with criminal responsibility if he/she has the mental abilities required by the law to be held responsible and liable for his unlawful conduct (Snyman 2017:155).

In this study, criminal responsibility refers to a psychiatric evaluation to retrospectively determine whether the accused appreciated the wrongfulness of the alleged offence and whether he/she could act in accordance with the appreciation during the time of committing the alleged offence.

### *Observation outcomes*

On completion of a psychiatric evaluation by psychiatrists or multidisciplinary mental health teams, an accused can be found either accountable for his/her actions, or not accountable as result of a mental illness or defect (Snyman 2017:164).

In this study, 'observation outcome' refers to the actual verdict from the evaluation of the intellectually disabled offender as either fit or unfit to stand trial or criminally responsible or not responsible. Based on the outcome, an offender found not fit to stand trial and/or not criminally responsible, is referred to a psychiatric hospital for care, treatment and rehabilitation.

### *Offence*

In South Africa, an offence is defined as an act punishable by law (South Africa 1977:51). In the United States of America, an offence is defined as an unlawful act, which is classified as such by law, whose characteristics are defined by law, and for which a penalty is defined by law (Section 7). For any trial awaiting prisoner, as it is applicable to all offenders referred for forensic mental observation, the term alleged offences are used, as it has not yet been proven that they committed the alleged offence. For this study, offences and alleged offences will be used interchangeably with the knowledge that they are still alleged offences.

### *Offender*

This is defined as a person who commits an act or makes an omission which constitutes an offence (South Africa 1977:51)

In this study, the offender refers to a person who was referred for psychiatric evaluation after he/she was accused of committing an illegal act that constituted an offence and who was suspected to be suffering from a mental illness at the time of such commission or omission. Because their involvement in the alleged offence has not yet been proven in a court of law, these offenders are referred to as alleged offenders, but the terms offenders and alleged offenders will be used interchangeably in this study.

### *Prevalence*

Prevalence measures the proportion of individuals who have a particular disease or disorder at a specific point or period (Burns & Roos 2016:25). In this study, prevalence will refer to the proportion of offenders diagnosed with intellectual disability to all offenders referred for observations during the study period

## **CHAPTER 1: INTRODUCTION**

### **1.1 Introduction and Background**

People with intellectual disabilities form a heterogeneous group that shares a history of early developmental delays that affect its functioning in two broad areas (Kaliski 2006:287). First, their level of intellectual functioning places them in the lowest 2.5% of the population; second, they have significant difficulties in social and adaptive functioning when compared to their peers (Kaliski 2006:287).

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5) lists the essential features of intellectual disability or intellectual developmental disorder) as deficits in mental abilities (Criterion A) and impairment in an individual's everyday adaptive functioning, in comparison to the individual's age, gender, and socio-culturally matched peers (DSM 5 2013:51). The DSM 5 further states that Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgement, learning from instruction and experience, and practical understanding (DSM 5 2013: 37). According to Mosotho, Bambo, Mkhombo, and Mgidlana (2020) an "intellectual disability" is described as the incomplete development of the mind and the lack of necessary skills that are typically acquired during the intellectual development of an individual. These skills play an important role in the individual's level of intelligence.

The levels of severity of intellectual disability are no longer defined by IQ (Intelligence Quotient) scores only as it was previously (Mosotho et al. 2020). Intellectual disability was historically defined as significant intellectual impairment as indicated by an IQ below 70, but this has changed. The different degrees of intellectual disability, such as mild, moderate, severe and profound, are defined on the basis of adaptive

functioning because adaptive functioning determines the level of support required (DSM 5, 2013).

According to Calitz, Van Rensburg, De Jager et al. (2007:148), South Africa is known for its high crime rate, and the crime issue is further complicated when crime is committed by mentally ill or intellectually disabled individuals. Enforcement of human rights of these vulnerable populations is important, as it ensures that they are not violated. In South Africa, at least 11% of all defendants referred to psychiatric institutions for forensic mental observations have an intellectual disability (Kaliski 2006:288). According to Calitz, Van Rensburg, De Jager et al. (2007:148), the fitness to stand trial and the criminal responsibility of such individuals are important facets that should be managed by the judicial and health systems.

South Africa has a population of approximately 58.8 million people and is classified as a low to middle-income country (Statistics South Africa (StatsSA) 2020). Although intellectual disability is the term used in South Africa, a wide variation in understanding and lack of agreement on definitions and terminologies have contributed to inaccurate collection and interpretation of epidemiological data (StatsSA 2014). In 1999, the first National Disability Survey yielded a prevalence of 5.9% for all disabilities and 1.1% for intellectual disability disorders (Adnams 2010:437).

Although a significant number of individuals with Intellectual Disability (ID) are law-abiding citizens, there is always a small percentage with offending behaviour that is considered antisocial, socially unacceptable or even illegal (Jones 2007:723-733). It has long been recognised that treatment of individuals with ID or mental health needs should be differently from that of general population (Jones 2007: 723–733).

Difficulties in prevalence studies influence the identification of specific characteristics among offenders with intellectual disability (Holland, Clare, & Mukhopadhyay



2002:113). The exact number of people with ID who are processed by the justice system is unknown as it is often difficult to identify them, because institutions and researchers use different criteria to decide whether a person is intellectually disabled (Kaliski 2006:288). Only a small number of individuals with moderate to severe ID find themselves within the criminal justice system. This may be due to their high dependency on and supervision by caregivers (Holland 2004:17). Furthermore, this could be due to their perceived lack of criminal intent by mental- health and legal professionals, their diminished fitness or capacity to stand trial, and/or the low likelihood of conviction (Holland 2004:17). Studies also demonstrated that similar characteristics and risk factors within the general population lead people with ID to have increased contact with the justice system. These factors include the young age, the male gender, low socio-economic status, unemployment, and comorbid mental-health issues (Jones 2007:723–733).

The problem of people with disabilities as victims of crime has been well recognised and documented, with the same characteristics of people with intellectual disabilities also making them more vulnerable to becoming perpetrators of crimes (Calitz, et al. 2007:147). The judicial process, from the awareness of a determined behaviour to the intricate legal jargon, is particularly complicated for these people when they are accused of criminal offences (Tort, Duenas, Vicens, Zabala et al. 2016:25–32). Furthermore, the intellectually impaired can sometimes not understand their criminal position (Tort, Duenas, Vicens, Zabala et al. 2016:26–32). Estimates of the number of offenders with ID are complicated by the variations and inconsistencies in the process of the criminal justice system (Jones 2007:724).

Studies report wide-ranging estimates of offenders with ID, from 2% to 40%, depending on the technique and diagnostic approach (Holland 2004; Lindsay, Hastings, Beech et al. 2002). It is, therefore, difficult for one to determine the number of individuals with ID who commit crimes, although it is known that illegal and antisocial behaviour is more common in this population group than is typically

reported to the police (Jones 2007:724). Calitz et al. (2007:148) found that “the majority of the intellectually disabled accused were male (96.3%), unmarried (76.3%), and unemployed (63.8%). The median age of the study group was 27 years. Of the subjects, 49% had received some schooling, and 16% had attended special schools. Of the offenders referred, the majority were referred in terms of Sections 77 and 78. Most of the offences were committed against persons- rather than property. Of the intellectually disabled, 62.5% were diagnosed as having a mild intellectual disability and 16% as having a moderate intellectual disability, and 11.5% met the criteria for a severe form of ID”. Of the accused, 71.25% were found to be unfit to stand trial and not criminally responsible whereas 28.75% were found to be fit and criminally responsible (Calitz et al. 2007:147).

Concerns about the plight of the mentally and intellectually disabled individuals within the justice, social and health sectors have been raised by different authors. Concerns about ethical, legal, clinical and social issues have been linked to the *judicialisation* of these individuals (Paradis-Gagné & Jacobs 2020; Van Hout & Wessels 2021). Based on the concerns raised about the management of intellectually disabled offenders, the Royal College of Psychiatrists (2021) has recommended care pathways for adults with intellectual disability who are involved with the criminal justice system.

Despite the conducting of forensic mental observations for more than two decades, the Limpopo Province has no record of any study conducted to assess the prevalence of offenders with intellectual disability among the offenders referred to mental health facilities for observations, as well as the characteristics of offenders with the intellectual disability. Such a study will assist policy makers in understanding factors associated with the offending tendencies in intellectually disabled individuals, as well as interventions that may be put in place to address those factors and thus

reduce the offending behaviour. Such a study will also assist the health care providers in addressing the issues raised through the study.

This study reviewed the prevalence of offenders with intellectual disability among the offenders referred to Thabamooopo Hospital by the courts upon suspicion of mental illness. Furthermore, this study explored demographic profiles and other characteristics of intellectually disabled offenders.

## **1.2 Research Problem**

Intellectual disability is the most prevalent disability in the world (Holland 2004; Lindsay, et al., 2002). People with intellectual disability frequently suffer extreme violations of numerous human rights. They may have limitations in advocating for themselves and ensuring that their best interests are prioritised.

The challenges experienced by individuals with intellectual disabilities in the criminal justice system necessitate the involvement of forensic psychiatrists in helping with their criminal proceedings. Broad issues facing defendants with ID entailed difficulties at every stage of the process, from initial detention to eventual release or incarceration.

Thabamooopo Hospital has seen a significant increase in the number of offenders with intellectual developmental disorder referred by the courts for assessment and determination their fitness to stand trial. However, characteristics of these offenders that make them deal to with the justice system are not known.

Despite the conduct of forensic mental observations for more than two decades, the Limpopo Province has no record of any study conducted to assess the prevalence of offenders with intellectual disability among the offenders referred for forensic observation, as well as the associated characteristics of offenders with intellectual disability. Such a study will assist policy makers in understanding the factors

associated with the offending behaviour of the intellectually disabled offenders, as well as interventions that may be put in place to address those factors and thus reduce the offending behaviour.

This study reviewed the prevalence of offenders with intellectual disability among the offenders referred to Thabamopo Hospital by the justice system on suspicion of underlying mental illness or intellectual disability. Furthermore, this study explored demographic profiles and other associated characteristics of intellectually disabled offenders.

It is imperative that the information gap in epidemiology and the burden of disability be recognized in order to plan for and meet the needs of those with intellectual disabilities across the lifespan (Adnams 2010:436).

Understanding some of these factors will assist in designing strategies necessary for early detection, assessment and management of offenders with intellectual disability, thus avoiding unnecessary delays in the criminal justice system and ensuring fair and speedy trials.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

According to De Vos, Strydom, Fouche, and Delport (2005:123–124), a review of literature is aimed at contributing towards a clearer understanding of the nature and meaning of the problem that has been identified. According to these researchers, a literature review is an excellent source for selecting or focusing on a topic, as it reduces the chance of selecting an irrelevant or outdated topic, by focusing on what has already been done on a particular problem area. The literature review in this study focused on the prevalence of intellectual disability among criminal offenders and the associated demographic and clinical factors.

#### ***Search strategy***

Specific search strategies were used to identify studies from a range of sources. Electronic databases searched included Medline, PsycINFO, Embase, and PUBMED. Search terms included a combination of key words such as intellectual disability, crime, forensic and offenders.

### **2.2 Prevalence of Offending Behaviour in People with Intellectual Disability**

The available research suggests an association between ID and criminal offending, which has served to propel public fear and reinforce perceptions of the need for social distance (Jones, 2007:724). The prevalence of offending behaviour in people with intellectual disability has typically been estimated using either the rates of offending in a known population of people with an intellectual disability or the rates of ID present in a known offending population (Nixon, Stuart, Thomas et al.,

2017:617–626). However, the evidence from which these conclusions have been drawn remains far from definitive, with significant methodological limitations marring what are arguably tentative conclusions' (Holland, et al. , 2002:46). Comparison of available research on the prevalence of ID in the criminal justice system is extremely difficult because research samples are not always representative of "true" ID offenders, and the method by which studies obtain the data varies substantially among studies (Holland et al., 2002; Lindsay et al. 2007).

The estimated prevalence of offending in people with intellectual disability ranges from 2% to 10% and varies depending on the population and methods utilised (Fogden, Thomas, Daffern et al. 2016:170). There is much variation within prison populations, with estimates ranging from less than 2 % to 30% (Fogden, et al., 2016:170). A recent systematic review, pooling results from ten studies and including a total of 11 969 prisoners concluded that typically 0.5% to 1.5% of prisoners are diagnosed with intellectual disabilities (Riches, Parmenter, Wiese et al. 2006:29). Estimation of offending prevalence with prison populations is problematic as many individuals with ID have been diverted into the community or forensic services rather than prison. Hence, there may be an under-estimation of the true prevalence when this method is used (Fogden, Thomas, Daffern et al. 2016:170).

Marais and Subramaney (2015), on their study on the three year follow-up of state patients at Sterkfontein Hospital, found that 16% of patients had intellectual disability, second highest after psychotic disorders (69%) and greater than mood disorders which came in third at 4%.

In their study on the criminal recidivism in offenders with and without intellectual disability referred to forensic care in Sweden, Edberg, Andine, Larsson, and Hirvikoski (2008) found that 7.7% of the individuals referred during their study period had intellectual disability.

### **2.3. Gender Differences among Offenders with Intellectual Disability**

In their study, Fogden et al. (2016:170) found gender differences in offending within the total ID sample, with males more likely to have a record of criminal offences compared to females. This result was also reflected in the community population with offence convictions. In this study, males and females in the total ID group had significantly higher rates of criminality compared to males and females in the community group. The most pronounced difference was for females, with females with ID violently offending at a rate 11 times higher than that of females in the community.

Locally, similar percentages were reported by Douglas et al. (91.0%), Wang et al. (87.7%) and Strydom et al. (95.8%) wherein males dominated the percentage of the offenders. In his literature review, Sirotich noted that some studies considered male gender an important predictor of violent or criminal behaviour among persons with IDD.

### **2.4 Crimes Committed by Intellectually Disabled Offenders**

Studies have also examined the risk of individuals with ID to commit particular offences (Jones 2007:725). However, there has been much debate amongst researchers and clinicians on the misinterpretation of research findings and official statistics. Although now refuted, it was previously believed that sexual and arson offences were more common for offenders with ID (Holland et al. 2002:46). “This theory was based on biased samples of individuals already diverted to hospital or prisons for serious crimes, and therefore, the findings cannot be generalised to the larger population of offenders with ID.” (Holland 2004:2334) In their study in Australia, Nixon, Stuart, Thomas et al. (2017:617–626) found that males with ID were at higher risk of being charged with any offence, as well as with a nonviolent offence, compared to males in the community comparison sample. Males with ID had a nearly 13 times higher risk of committing any sexual offence and over three times the risk

for a violent offence compared to males in the community comparison group. For females with ID, the risk of having a charge recorded for a nonviolent offence, was over two and a half times higher, and the risk of having a charge for a violent offence was five times higher than that for females in the general population. On the contrary, Jones (2007:725) concluded that in the absence of population studies, it is safe to say that the types of offences committed by individuals with ID seem to be similar to those by individuals without ID.

In a local study, Calitz et al. (2007: 150) reported that most offences against persons or victims were rape, murder and indecent assault. Of the offences against persons, 78% were sexual, and the number of perpetrators who committed this type of offence constituted 53.8% of the total study population. The remainder of the offences against persons were of another violent nature rather than sexual. The majority of offences involving property were housebreaking and theft.

## **2.5 Observation Outcome**

Competence to stand trial is generally based on an individual's ability to follow the legal proceedings, to consult with and instruct his/her lawyer, and to understand the outcomes of the process against himself/herself (South Africa 1977). Additionally, competence, criminal responsibility or culpability are also assessed, according to a court order, which refers to whether an individual knew right from wrong at the time the alleged offence was committed. For offenders with ID, the evaluation of competence and culpability is extremely important yet difficult given offenders' cognitive deficits and limited problem-solving abilities (Jones 2007:727).

Calitz et al. (2007:150) found that the majority of offenders (71.25%) were not fit to stand trial and unaccountable, whereas 28.75% were found to be fit to stand trial. The majority of the subjects (85%), were referred according to sections 77 and 78 of the CPA and the remainder were referred in terms of either section 77 or section 78.



These findings support the view that offenders with mild ID can sometimes be fit to stand trial and/or be accountable.

## **2.6 Reoffending/Recidivism**

Data from the New South Wales Department of corrective services for the period 1990–1998 indicate that in percentage terms the ratio of reoffending in those with ID to that in the total inmate population was 68% to 38% (Riches et al. 2006:29). In their study of recidivism among individuals referred for forensic psychiatric care in Sweden, Edberg et al. (2022) found that a diagnosis of ID was associated with a lower risk of criminal recidivism among male offenders referred to forensic psychiatric care, although this finding was not associated with statistical significance.

In their study in South African, Marais and Subramaney (2015:91) noted a 4% rate of recidivism and attributed it to the short follow-up period of their study. These researchers also highlighted the difficulty with obtaining the history of previous conviction or past offences from the police and the patients themselves.

## **2.7 Measurements of Intellectual Disability**

South Africa is a country of multifaceted diversity with differences in socio-economic status, race, gender, religion, and language (Hemson 2007:120). The diverse nature of the population poses a challenge to the education system and the practice of psychological assessment. As a result, issues such as culture, fairness, and test bias of psychological instruments, are points of concern (Visser & Viviers 2010:36).

The field of psychological test use, development and adaptation in South Africa faces many challenges at present. Among the challenges is the fact that culturally appropriate tests, which meet stringent psychometric standards, are required for all age groups in our multicultural society if psychological assessment practitioners are to succeed in employing fair testing practices (Foxcroft, Paterson, Le Roux et al.

2004:140). Linked to this is the challenge of having tests in various language so that test-takers in the multilingual South African society can be assessed in a language in which they are most proficient (Foxcroft & Roodt 2009:78). As a result, progress has been made in creating tests that are cross-culturally applicable. A series of intellectual measures including the Individual Scale for Xhosa-, Tswana- and Southern and Northern Sotho-speaking learners have been normed (Foxcroft, Paterson, Le Roux et al. 2004:140).

## **2.8 Pathways of Care for Intellectually Disabled Offenders**

By virtue of their intellectual functioning, cognitive deficits and other maladaptive issues, intellectually disabled people may commit crimes, and end up in correctional facilities or psychiatric hospitals. Those found unfit to stand trial or not criminally responsible are declared involuntary mental healthcare users (MHCU) or state patients (South Africa 1977:51). Those found fit to stand trial and criminally responsible, may end up in correctional facilities or back in the community. Those in the community, due to lack of community rehabilitation facilities and suggestibility, may be exploited by other individuals to commit criminal offence. It is thus important that these individuals are well managed wherever they are. According to Van Hout and Wessels (2021), the criminalization and incarceration of the mentally ill or mentally incapacitated often occurs where lack of suitable facilities exist in the communities or are still detained in prisons despite acquittal on the basis of their mental state at the time the alleged offence was committed.

The Royal College of Psychiatrist (2014) has recommended that good links between the police and the local mental health, intellectual disability and hospitals must exist in order to ensure good continuity of care.. The RCPsych (2014) also recommends the proper training of Psychiatry Registrars in the management of intellectual disability and criminal behaviour and management.

## CHAPTER 3: METHODOLOGY

### 3.1 Study Design

This was a retrospective, descriptive quantitative study that involved the application of statistical analysis to the data, and the development of statistical approaches for measuring and explaining human behaviour (Swartz, De la Rey, Townsend et al. 2016:37). This study retrospectively reviewed clinical records of the alleged intellectually disabled offenders referred by the courts for forensic observation at Thabamopo Hospital to gain descriptive information about the prevalence and characteristics of those offenders.

### 3.2 Study Setting

The study was conducted at Thabamopo Hospital, which is the specialised forensic psychiatry hospital located 51 km south of Polokwane.



[https://www.google.co.za/maps/place/Limpopo Districts/@-24.3025521,29.546](https://www.google.co.za/maps/place/Limpopo+Districts/@-24.3025521,29.546)

Figure 3.1: Demographic locations of Thabamopo Hospital catchment districts in the Limpopo Province.

The Hospital is situated within the Lepelle-Nkumpi Local Municipality, in the Capricorn District of the Limpopo Province, South Africa. Thabamooopo Hospital is one of the two specialised psychiatry facilities in the province, together with Hayani Hospital in the Vhembe District, at which forensic mental observations are also conducted. The staff complement of the hospital includes specialist psychiatrists, psychiatric registrars, clinical psychologists, occupational therapists, social workers, psychiatric nurses and general nurses, as well as physiotherapists, dieticians, oral hygienists and a dental therapist. This hospital renders general psychiatry services, as well as forensic psychiatric services for the Capricorn District and the surrounding Sekhukhune, Waterberg, and Mopani districts. The hospital also gets some referrals from the Vhembe District. On average, the forensic section assesses approximately 20 forensic cases referred by the courts per month, which include new and follow-up cases, making the estimated total of 240 alleged offenders per year.

### **3.3 Study Population**

A population is the entire set of cases in which a study is interested and is a full set of individuals or objects with some common characteristics (Swartz, De la Rey, Townsend et al.2016:37). In this study, the population comprised offenders with suspected mental illness who were referred for forensic mental observation at Thabamooopo Hospital from 2016 to 2018, in terms of the Criminal Procedure Act.

### **3.4 Sampling Method**

Sampling is defined as a process of selection of part of the population to represent the entire population by giving the information about the population characteristics based on findings of that representative sample (Kulshreshtha 2013).

The convenience sampling method was used in this study. Convenience sampling is referred to as accidental or availability sampling, and it involves the choice of

readily available subjects for the study. (Brink, Van der Walt, Van Rensburg et al., 2009).

The sample in this study referred to the proportion of offenders diagnosed with intellectual disability out of the total number of offenders referred who were for observations during the period of the study and met the inclusion criteria. Based on the admission records and estimates from similar studies (such as Calitz et al. 2007:148), it was estimated that there would be approximately 155 participants in the study. The sampling method was, therefore, convenience sampling.

### **3.5 Inclusion and Exclusion Criteria**

#### **3.5.1 Inclusion criteria**

The clinical files of all the offenders observed during the period between January 2016 and December 2018 were included in the study.

All confirmed diagnoses of intellectual disability through clinical assessment or psychometric tests were included.

All case files in which the diagnosis was made by clinical psychologists with a clear indication of severity of the ID assessment were considered.

#### **3.5.2 Exclusion criteria**

Clinical files of all the offenders who started their observation outside the period of the study were excluded.

All offenders with diagnoses of IDD whose severity was not indicated were excluded.

All offenders with IDD diagnoses made using non-validated instrument were also excluded.

## **3.6 Data Collection**

### **3.6.1 The data collection tool**

A data collection sheet was specially designed for this study. Data were then entered on Excel spread sheets, imported and analysed using IBM SPSS version 28. Clinical data were retrieved from forensic observation reports, clinical notes, and clinical psychology reports. The severity of intellectual disability was captured, i.e. mild, moderate, severe, or profound.

A special request was made to access full psychological assessment reports that are normally not kept in the offenders' files.

Measurement tools with proven validity included those scales standardised for South African use and approved for use with educationally disadvantaged individuals. The tools included the following:

#### **1) New South African Individual Scale**

The New South African Individual Scale (NSAIS) is used to assess both the cognitive and adaptive functioning of an individual (Foxcroft & Roodt 2009:78–82). It consists of verbal and non-verbal scales. The test measures memory, productive concentration, attention, perceptual organisation, problem solving and abstract reasoning. The rationale for using this test is to tap into the main (specific) educational difficulties or challenges that clients may be facing. It is also used to gain insight into the clients' strengths and weaknesses in specific areas.

#### **2) Bender Visual-Motor Gestalt Test**

The Bender Visual-Motor Gestalt Test (BVMGT) is a projective psychometric test that is used to measure visual-motor integration and perceptual-motor and cognitive development in individuals with suspected developmental delays (Foxcroft ,Paterson , Le Roux, & Herbst 2004:142). It is also used to assess for possible organic impairments.

### 3) Vineland Social Maturity Scale

Vineland Social Maturity Scale (VSMS) is a psychometric scale used to assess an individual's level of social maturity and adaptive functioning from birth to adulthood (Foxcroft et al. 2004:144). The scale also gives an indication of an individual's level of intellectual functioning. It is a form of a self-report questionnaire and is conducted with the assistance of a guardian and by engaging with the client.

### 4) Coloured Progressive Matrices

Coloured Progressive Matrices (CPM) test was designed to measure, as unambiguously as possible, educative and reproductive abilities (Foxcroft et al. 2004:146). It was designed for use with young children and old people or for those with poor language skills for whatever reason.

## **3.7 Data Analysis**

Data was entered into the Statistical Package for the Social Sciences (SPSS) version 28. The prevalence of IDD was calculated as the total number of offenders referred found with IDD divided by the total number of offenders referred for forensic observation. Data analysis involved several rigorous statistical tests including reliability tests, descriptive statistics and inferential statistics. Descriptive statistics were used to summarise the variables. Descriptive statistics were then used to

describe the age, sex, race, and other demographic characteristics of the offenders with IDD.

Categorical variables were presented as numbers, percentages, and charts. The SPSS Data analysis Software was used to analyse the data.

### **3.8 Validity and Reliability**

#### **3.8.1 Validity**

Swartz et al. (2016:151) describe validity as the extent to which the scale measures what it is supposed to measure (for example, one would not use a personality test to measure intelligence). In other words, if an individual has less of a characteristic than another person, a scale that measures that characteristic in a satisfactory manner will reflect this difference. The actual diagnosis of intellectual disability would have been confirmed by a clinical psychologist using valid and reliable psychometric tests. Therefore, the data collection tool was mainly for entering established diagnosis and capturing demographic profiles of the offenders and associated clinical factors.

#### **3.8.2 Reliability**

Reliability is the fact that consistent results will be given by a measurement instrument when a subject is measured repeatedly under near-identical conditions (Peers, 1996:3) Inter-rater reliability was assessed by conducting a pilot study that assessed whether different raters would come to the same findings using the data collection sheet designed specifically for this study.



In this study, the conditions remained the same since the study is a record review; therefore, reviewing the same clinical data, i.e. confirmed IDD cases, should lead to the same results.

### **3.9 Bias**

Bias refers to any deviation from the truth in data collection, data analysis, interpretation and publication that can cause false conclusions (Brink et al. 2009). Bias may occur when there are undetected influences on any stage of the research process that may influence relationships between variables (Swartz et al. 2016:44).

Types of bias include selection bias, information bias, measurement bias and bias due to confounding factors (Katzellenbogen, Joubert, & Abdool Karim 1997:127).

Selection bias could have been introduced into the study by virtue of the review of the available clinical files or the fact that the sampling method used in this study was convenience sampling, and of the patients who were referred for observation during the study period. It is possible that sampling of patients referred during a different study period could yield different results.

In this study, information bias could have been introduced through missing information, as this was a retrospective study. However, this could have been mitigated through the standard clerking form that has specific information that has to be entered directly on the form when the accused is being assessed.

Potential measurement bias was mitigated through strict inclusion criteria and having a clinical psychologist review the results, ensuring that assessment was done using standardised testing instruments.

### **3.10 Pilot Study**

A pilot study was conducted to ascertain the practicality and feasibility of the proposed approach. A total of ten files were randomly collected and assessed for completeness of the records and clinical information as per objectives of the study. More than half of the files contained all relevant parameters necessary for data analysis.

### **3.11 Ethical Considerations**

Anonymity of the patients whose files were reviewed was guaranteed as the study did not capture the names of the participants but only a specially designed identifying code that represented each patient. Confidentiality was attained by making sure that the files do not leave the hospital property and only the researcher had access to where they were stored. Permission to conduct the study as well as access to the medical files was granted by the Chief Executive Officer (CEO) of Thabamooopo hospital. Informed consent from the patients was waived because this study was a clinical record review, in which the actual patients were not interviewed. Ethical approval was obtained from the Turfloop Research and Ethics Committee (TREC) and the Limpopo Research and Ethics Committee. Upon completion of the study, findings will be shared with both CEO of Thabamooopo hospital and the Limpopo Department of Health.

## **CHAPTER 4: PRESENTATION AND INTERPRETATION OF FINDINGS**

### **4.1 Introduction**

Chapter 3 deals with the research design and methodology used for data collection in with the research problem and purpose. This chapter outlines the analysis, presentation and interpretation of the findings of this study. The findings are presented under the following headings: demographic data, clinical details, substance use, and forensic history.

### **4.2 Data Management and Analysis**

The management and analysis of the data were undertaken with the help of a biostatistician at the University of Limpopo. Following the conclusion of data collection, the data was imported from Excel to IBM SPSS version 28 in preparation for analysis. Tables and figures were used to analyse different variables and the Chi square test was used to determine the association between variables.

### **4.3 Research Results**

#### **4.3.1 Demographic data**

The demographic data analysis was provided in the form of figures that highlight the category of offenders with intellectual disabilities referred for forensic observations at Thabamopo Hospital, and included offender gender, age, marital status, level of education, and employment status. These characteristics are critical in describing the offenders.

A total of 377 patients were referred for forensic mental observation during the study period. Of these, 88 (23.3%) were found to have IDD.

#### 4.3.1.1 Age distribution

Eighty-eight offenders (n = 88) were included in the study. Most offenders were those between the ages of 21 and 29 years (31.8%), and the least number was for those in the more mature age group of 51–59 years, accounting for only 4.5% of the offenders (Figure 4.1).

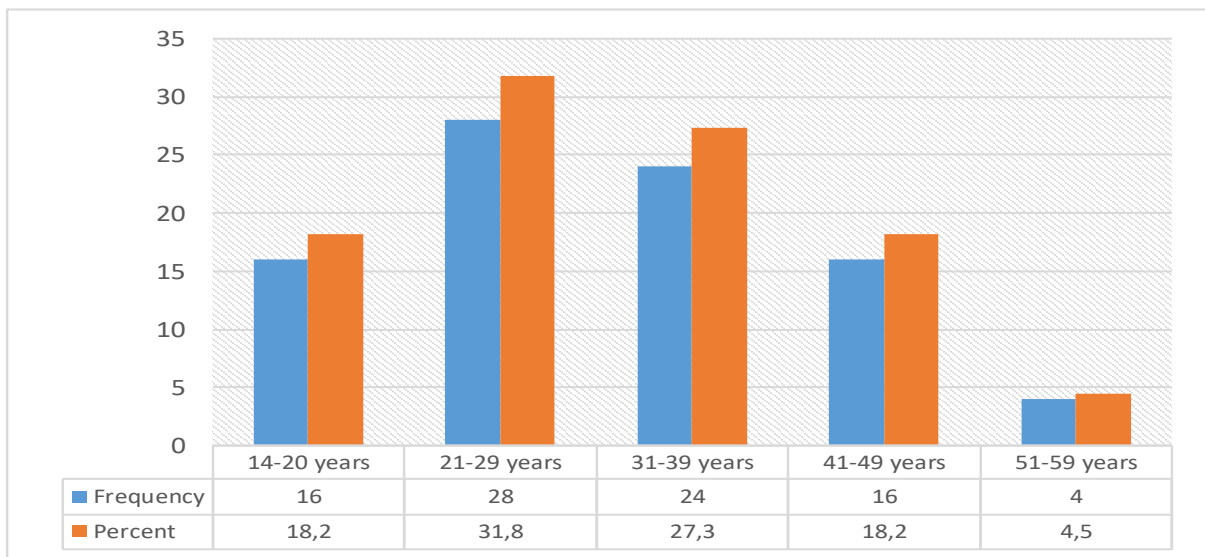
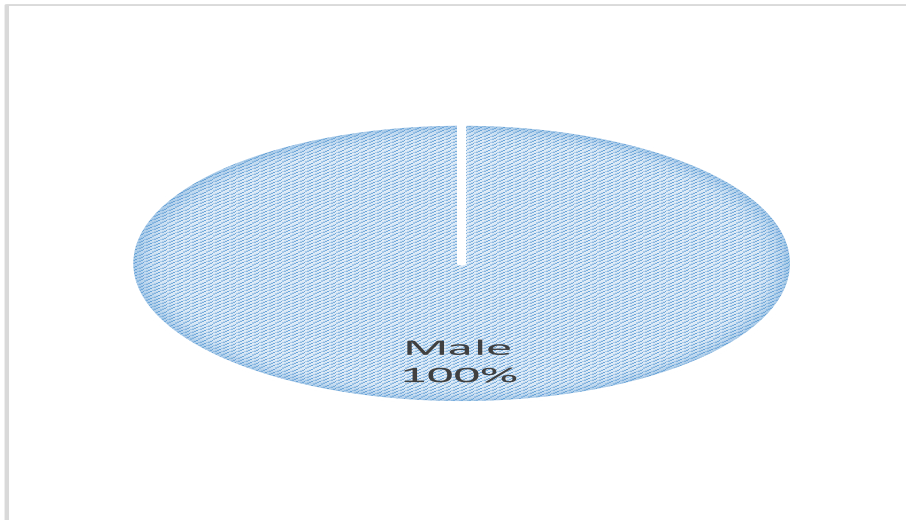


Figure 4.1: Age distribution.

#### 4.3.1.2 Gender distribution

Although the forensic observation services are open to all, in the present study, only males were referred for observations (Figure 4.2).



**Figure 4.2: Gender distribution.**

#### **4.3.1.3 Marital status**

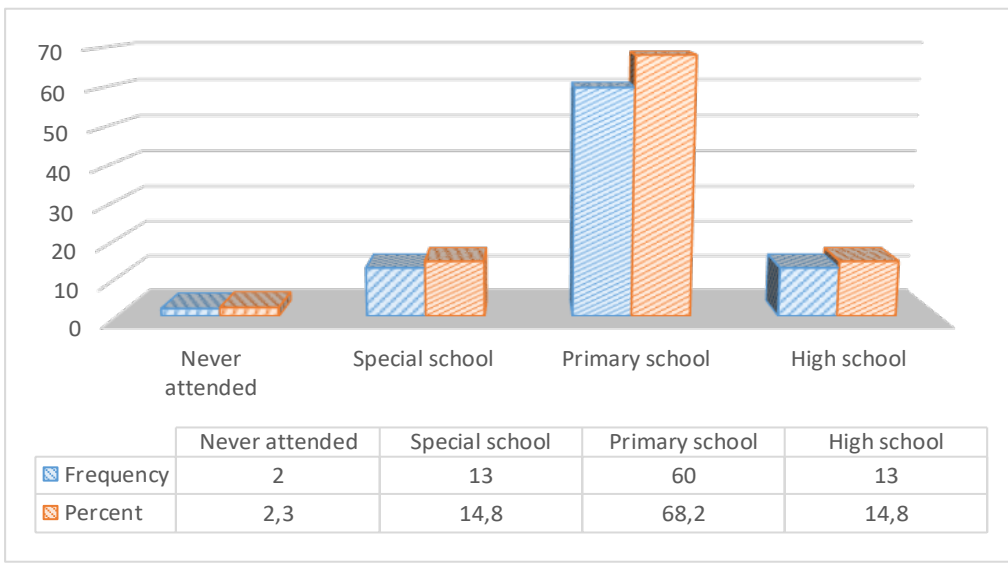
Findings concerning the marital status of the accused, presented in Table 4.1, indicate that all of the accused were single at or around the time of the alleged offence(s) and during the forensic mental observation period.

**Table 4.1: Marital status.**

	N	%
Single	88	100.0%

#### **4.3.1.4 Level of education**

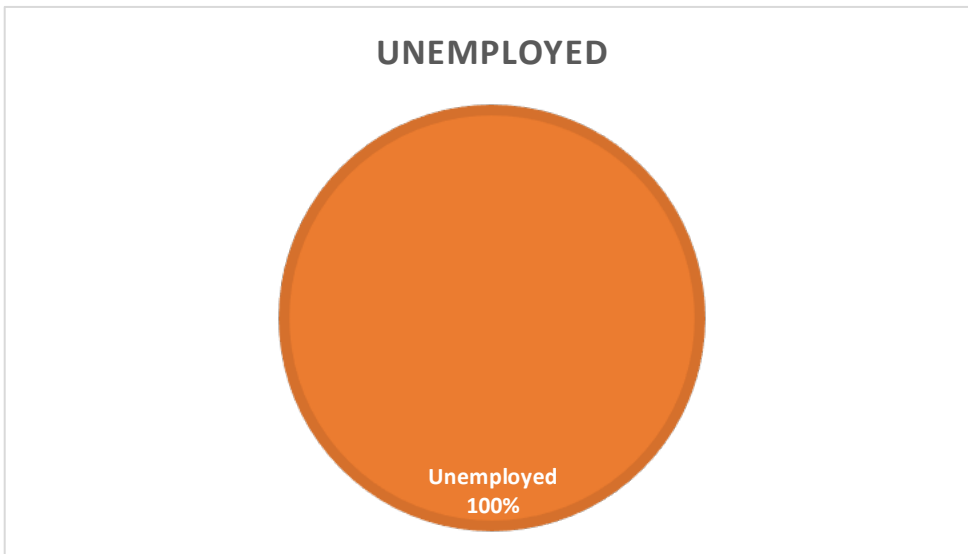
As it is often difficult for the intellectually impaired to access appropriate schooling, 14.8% of the offenders attended special schools. The majority of the offenders (68.2%) attended mainstream schooling. A small number 13 (14, 8%) eventually managed to achieve a high school level of education. On the other extreme, 2.3% of offenders had never attended any form of schooling (Figure 4.3).



**Figure 4.3: Level of education.**

#### **4.3.1.5 Employment status**

While having a job might be protective against the risk of involvement in criminal acts, Figure 4.4 illustrates that all the offenders in this study were unemployed.



**Figure 4.4: Employment status.**

### 4.3.2 Clinical details of offenders

Although research findings are often conflicting, some reports suggest that certain clinical features in people with IDD make them more likely to commit criminal offences. It is, therefore, important for mental healthcare practitioners to look into the clinical characteristics of these offenders.

#### 4.3.2.1. DSM-5 diagnosis

The presence and the severity of any psychiatric diagnosis impact on the social functioning of all persons in the general population. This is especially important within the intellectually disabled. Almost two-thirds (65, 9%) of the offenders were diagnosed with a mild intellectual disability, whereas 22.7% met the criteria for moderate IDD category. Only 10 (11. 4%) were found to suffer from the severe form of IDD (Figure 4.5).

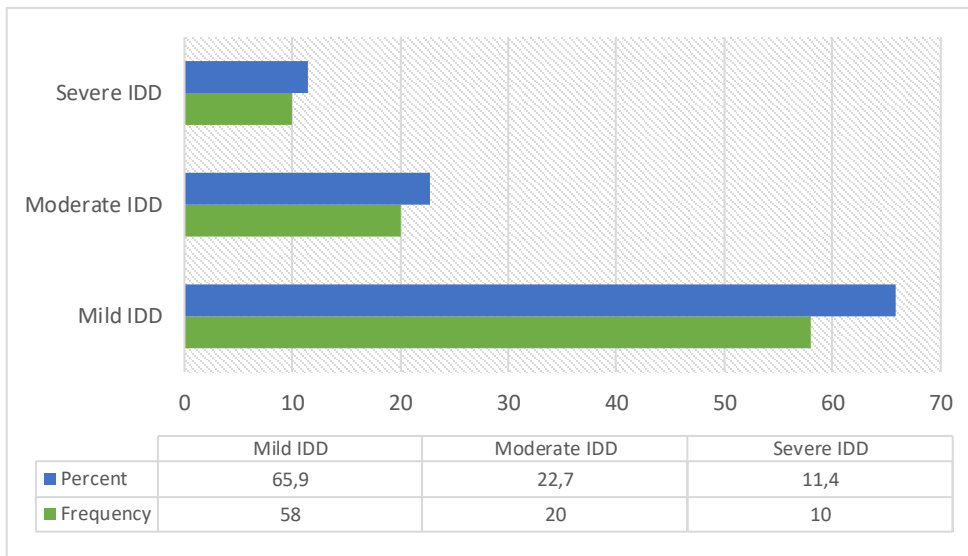
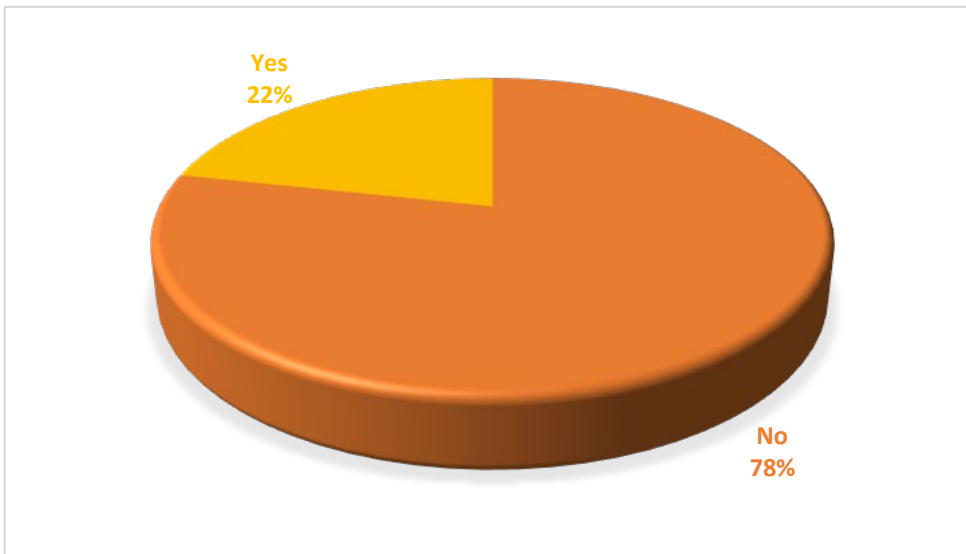


Figure 4.5: DSM-5 diagnosis of the offenders.

#### **4.3.2.2 Method of diagnosis**

Formal psychometric testing is conducted by clinical psychologists, even for forensic mental observations. This testing may often be difficult to conduct in intellectually impaired individuals. Figure 4.6 indicates that the majority (78%) of individuals with IDD were diagnosed through the formal psychometric assessment and that only 22% were clinically diagnosed.

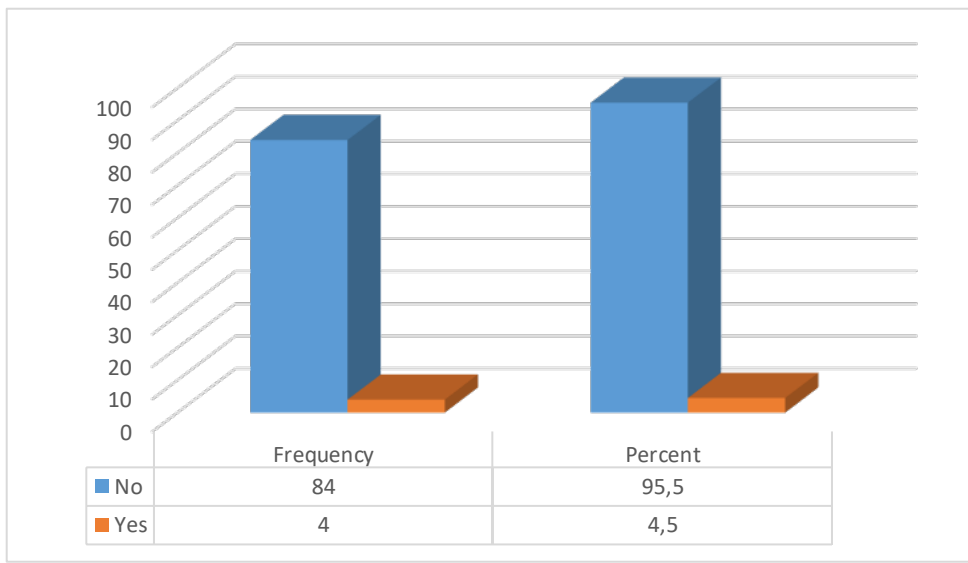


**Figure 4.6: Psychometric tests vs clinical diagnosis of IDD**

#### **4.3.2.3 Physical abnormalities and IDD**

IDD often occurs in a syndrome-type presentation where the intellectual impairment is associated with physical abnormalities. Figure 4.7 illustrates the relationship of physical abnormalities with IDD in this study.

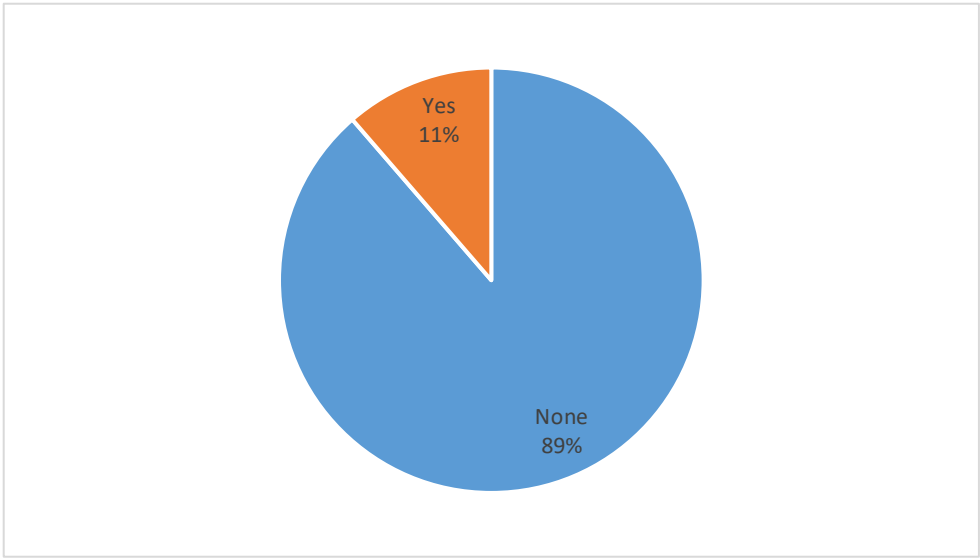




**Figure 4.7: Physical abnormalities associated with the patients with IDD.**

#### **4.3.2.4 Clinical comorbidities**

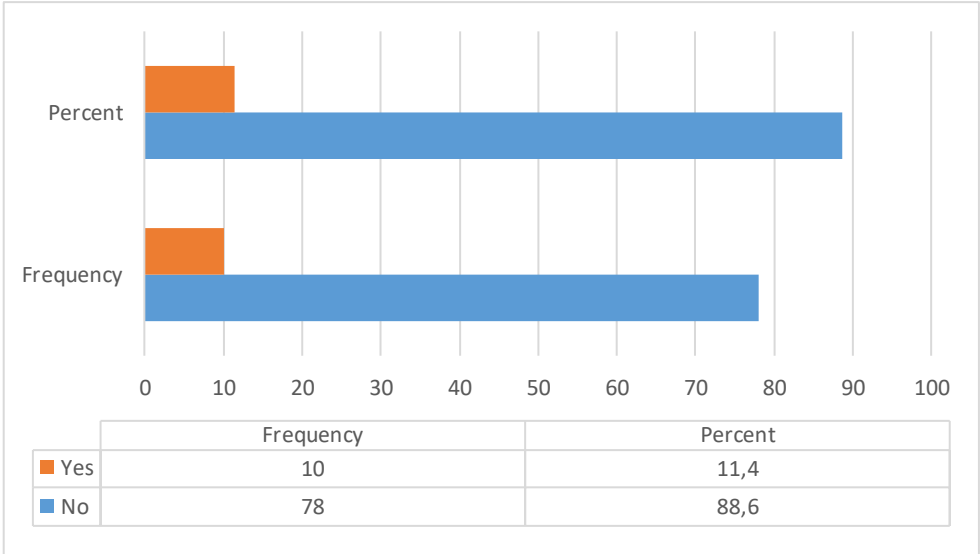
During forensic mental observation, the accused are also examined to detect other physical comorbid conditions they have. This allows the assessing team to manage the physical problems the accused may have. Figure 4.8 indicates that in addition to IDD, 10(11%) of the offenders had other medical problems that may or may not have played a role in their assessment and/or its outcomes. The medical comorbidities included diabetes mellitus, hypertension, epilepsy and cerebral palsy.



**Figure 4.8: Medical comorbidities.**

**4.3.2.5 Treatment details**

The history of medical intervention indicates that some of the offenders might have been assessed and treated. Figure 4.9 indicates that all offenders with additional diagnoses were on treatment prior to them being subjected to forensic mental observation.



**Figure 4.9: Treatment details.**

### 4.3.3 Substance abuse

#### 4.3.3.1 Substance use history

With regard to substance use, 39.8% of offenders reported no current or previous substance use. Of those using substances (60.2%), alcohol seemed to be the most preferred substance among the offenders, at 20.5% followed by a combination of alcohol and nicotine where 14.8% preferred both substances. 10.2% of the offenders shared preference of either nicotine or cannabis over a combination of the two substances. A small number (n = 4), used both cannabis and alcohol (Figure 4.10).

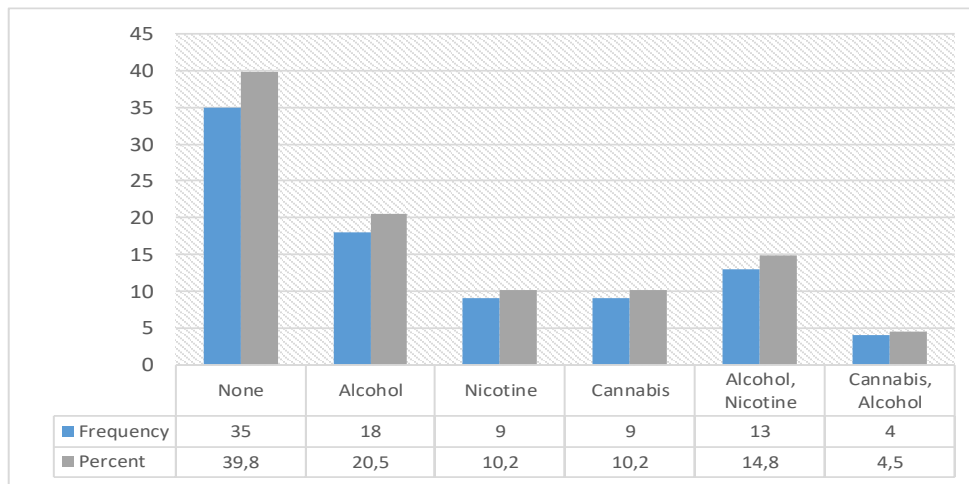


Figure 4.10: Substance of abuse.

#### 4.3.3.2 Substance abuse vs DSM-5 diagnosis

Most offenders (68%) with mild IDD were noted to be more likely to use one or more substances, as presented in Table 4.2. The least number of substance usage was for those with Severe IDD, with only 3 (23%) of them engaging in substance use.

Table 4.2: Substance abuse vs DSM-5 diagnosis.

		DSM-5 Diagnosis							
		Mild IDD		Moderate IDD		Severe IDD		Total	
		N	%	N	%	N	%	N	%
Substance									
abuse	None	18	31.0	10	50.0	7	70.0	35	39.8
	Alcohol	14	24.1	3	15.0	1	10.0	18	20.5
	Nicotine	7	12.1	1	5.0	1	10.0	9	10.2
	Cannabis	6	10.3	2	10.0	1	10.0	9	10.2
	Alcohol, Nicotine	10	17.2	3	15.0	0	0.0	13	14.8
	Cannabis, Alcohol	3	5.2	1	5.0	0	0.0	4	4.5
	Total	58	100.0	20	100.0	10	100.0	88	100.0

Table 4.3 indicates that there is no statistically significant relationship between the substance use and the clinical diagnosis ( $p > 0.05$ ).

**Table 4.3: Association between substance abuse and DSM-5 diagnosis.**

Chi-Squared Tests			
	Value	df	Asymptotic Significance (two-sided)
Pearson's Chi-Squared	8.107 <sup>a</sup>	10	.618
Likelihood Ratio	9.897	10	.450
Linear-by-Linear Association	3.521	1	.061
No. of Valid Cases	88		

a. 12 cells (66.7%) have expected count less than 5. The minimum expected count is .45.

### 4.3.4 Forensic history

#### 4.3.4.1. CPA sections under which offenders were referred

The Criminal Procedures Act 51 of 1977 (CPA) gives guidelines regarding the kind of enquiry that should be done. The appropriate J138 E court order specifies the section under which the accused is being referred for observation (section 77, section 78 or both). Figure 4.11 indicates that majority (60%) of the referrals were made in terms of sections 77 and 78, whereas 26.1 % were referred for a full assessment and reporting. Only 12 offenders were referred for confirmation of triability which is addressed only under section 77.

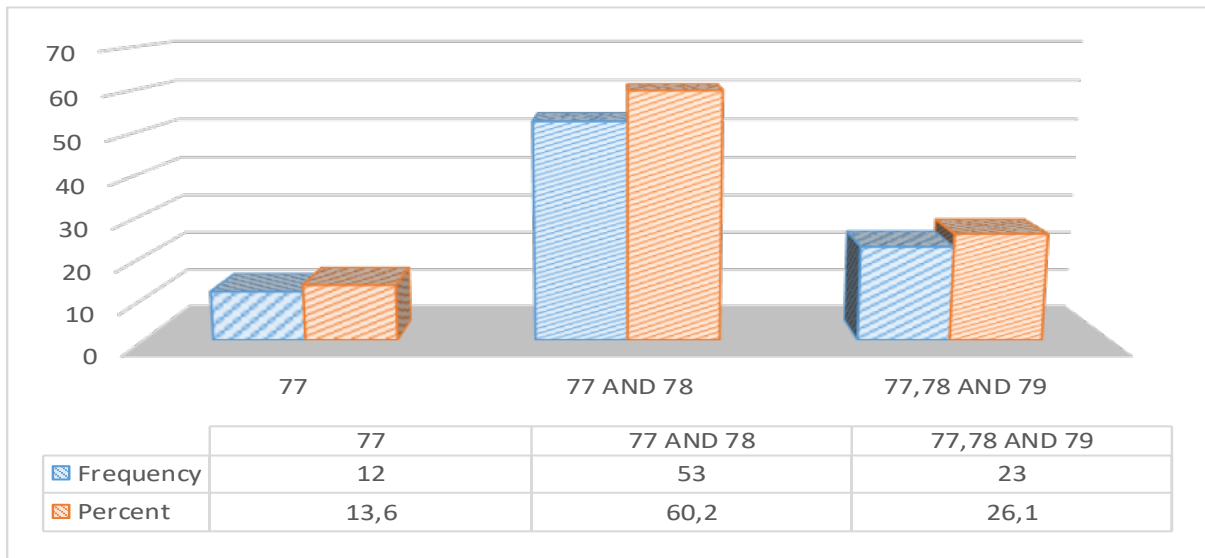
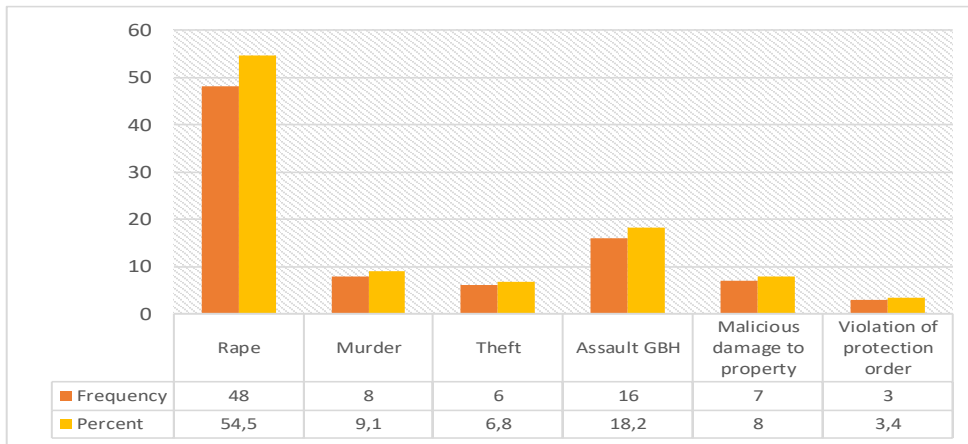


Figure 4.11: CPA sections under which the accused were referred.



**Figure 4.12: Nature of the offence(s).**

#### **4.3.4.2 Nature of the offences**

Figure 4.12 highlights the findings concerning the alleged offences that the accused allegedly committed. Intellectually impaired offenders were observed mostly for committing serious offences such assault GBH, murder, and rape. Murder was the third commonest alleged offence with eight incidents (9.1%), whereas assault GHB was second at 18.2%, and rape dominated the offences and accounting for 54.5% of the observed cases. Amongst the less serious crimes, malicious damage to property was the highest (8%), followed by theft (6.8%). Violation of protection orders accounted for the least reported offences, with only 3 (3.4%) of the offenders allegedly having committed this particular crime.

#### **4.3.4.3 Nature of the offence(s) vs DSM-5 diagnosis**

Table 4.4 summarises the relationship between the nature of the alleged offences and the actual clinical diagnosis according to the DSM 5.

**Table 4.4: Nature of the offence(s) vs DSM-5 diagnosis.**

		DSM-5 Diagnosis							
		Mild IDD		Moderate IDD		Severe IDD		Total	
		N	%	N	%	N	%	N	%
Charges	Rape	32	55.2	12	60.0	4	40.0	48	54.5
	Murder	5	8.6	1	5.0	2	20.0	8	9.1
	Theft	2	3.4	4	20.0	0	0.0	6	6.8
	Assault								
	GBH	11	19.0	2	10.0	3	30.0	16	18.2
	Malicious damage to property	5	8.6	1	5.0	1	10.0	7	8.0
	Violation of protection order	3	5.2	0	0.0	0	0.0	3	3.4
	Total	58	100.0	20	100.0	10	100.0	88	100.0

Of the rape cases (n = 48), most (66%) were committed by the offenders with mild IDD, followed by those in the moderate IDD category, committing 12 (25%) of these particular cases. Only four cases of rape were recorded as those committed by offenders with severe IDD (Table 4.4).

Data presented in Table 4.5 indicate no statistically significant relationship between the nature of the offence(s) and severity of the IDD ( $p > 0.05$ ).

**Table 4.5: Association between the nature of the offence and the diagnosis.**

<b>Chi-Squared Tests</b>			
	Value	df	Asymptotic Significance (two-sided)
Pearson's Chi-Squared	12.318 <sup>a</sup>	10	.264
Likelihood Ratio	12.223	10	.270
Linear-by-Linear Association	.020	1	.888
No. of Valid Cases	88		

<sup>a</sup> 13 cells (72.2%) had an expected count less than 5. The minimum expected count was .34.

#### **4.3.4.4 Observation outcome**

Figure 4.13 denotes the observation outcome. The majority of the offenders (53%) were found to be triable or fit to stand trial. The remainder of them (47%) were found to be unfit to stand trial and thus not accountable for the crimes they had allegedly committed.



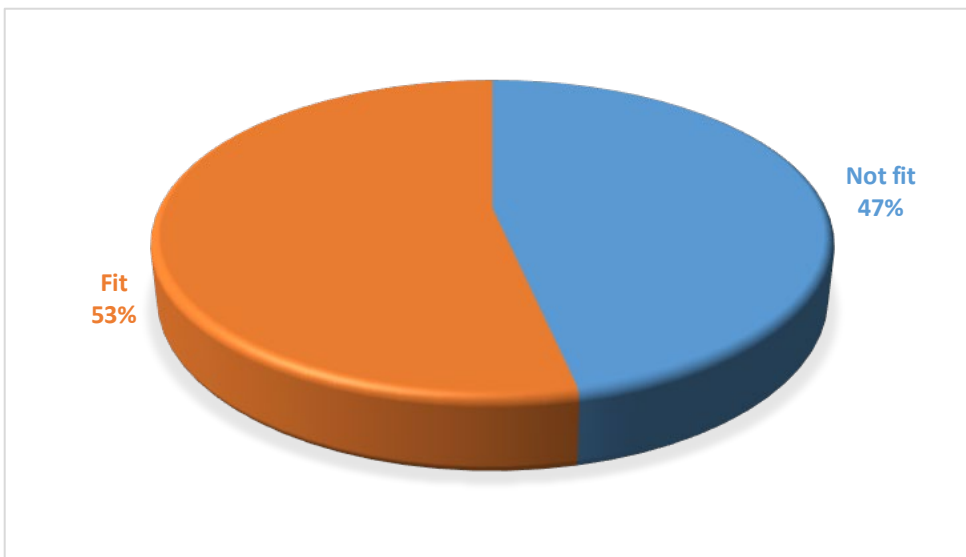


Figure 4.13: Observation outcome.

#### 4.3.4.5 Observation outcome vs DSM-5 diagnosis

Table 4.6 presents the breakdown of the association between IDD severity and the associated observation outcome. The Mild IDD category accounted for the majority (43%) of those found to be fit to stand trial. Offenders with severe IDD were all (n = 10, 100%) found to be untriable and not criminally responsible.

Table 4.6: Association between IDD severity and the forensic outcome.

		DSM 5 Diagnosis							
		Mild IDD		Moderate IDD		Severe IDD		Total	
		N	%	N	%	N	%	N	%
<b>Observation</b>									
<b>Outcome</b>	Not fit	15	25.9	16	80.0	10	100.0	41	46.6
	Fit	43	74.1	4	20.0	0	0.0	47	53.4
	Total	58	100.0	20	100.0	10	100.0	88	100.0

The above association was further evaluated using the non-parametric chi-squared test, as illustrated in Table 4.7.

The data indicated a clear relationship between the severity of IDD and the outcome of the forensic observation ( $p < 0.05$ ). This explains why the majority of the offenders with mild IDD found to be fit whereas those with the severe form of IDD were found to be unfit.

**TABLE 4.7: Association between IDD severity and the forensic outcome.**

Chi-Squared Tests				
		Value	df	Asymptotic Significance (two-sided)
Pearson's Chi-Squared	Chi-	30.450 <sup>a</sup>	2	<.001
Likelihood Ratio		35.262	2	<.001
Linear-by-Linear Association		28.644	1	<.001
No. of Valid Cases		88		
a. One cell (16.7%) had an expected count less than 5. The minimum expected count was 4.66.				

#### **4.3.4.6 Reoffenders**

Table 4.8 presents data on the history of reoffending amongst the offenders. Information regarding the previous criminal activities was not readily available. Only

1.1% of the offenders in this study were noted to have had previous criminal offences.

**Table 4.8: History of reoffending.**

<b>History of reoffending found</b>	<b>N</b>	<b>%</b>
<b>No</b>	<b>87</b>	<b>98.9%</b>
<b>Yes</b>	<b>1</b>	<b>1.1%</b>

#### **4.4 Overview of the Research Findings**

The overall results confirm that males dominated the sample and that most of the subjects were diagnosed with mild IDD. A significant number of the offenders were found to be using substances, with alcohol being the commonest substance of abuse. The nature of alleged offences that were committed ranged from minor offence to serious crimes such as murder, with rape being the most common alleged serious offence, followed by murder and assault GBH. More than half of the offenders were found to be responsible for the crimes; this was in keeping with the finding of some of the studies conducted elsewhere. The most frequent degree of intellectual disability was mild IDD. There was no statistical significance between nature of the offence(s) and severity of the IDD ( $p > 0.05$ ). However, there was a clear relationship between the severity of IDD and the outcome of the forensic observation ( $p < 0.05$ ).

With the findings outlined in this chapter, it is evidently clear that people with IDD do commit criminal offences and end up within the criminal justice system. However, there are those who cannot be held responsible for their criminal behaviour and those who had clear intentions when committing those acts. Chapter presents these findings within the background of previous research conducted on intellectual disability and forensic mental observation locally and globally.



## **CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

### **5.1 Introduction**

This chapter outlines the present study's results. It discusses study findings, against the literature review that was conducted on the same subject nationally, locally, and internationally. The study's conclusion and recommendations are then made following the findings of the study. The discussion first focuses on the prevalence of intellectual disability amongst offenders who were referred for forensic mental observation to Thabamooopo Hospital in terms of the CPA, and then on factors associated with the intellectual disability in these patients.

### **5.2. Prevalence of IDD**

The prevalence of IDD amongst offenders referred for mental observation during this study's period was 23.3%. This is higher than the prevalence of IDD within the incarcerated population at a correctional facility in Kroonstad in the Free State, South Africa, where the prevalence of IDD was found to be 4.7%. It is also higher than the 3.9% prevalence reported by Verster and Van Rensburg (1999) (cited in Calitz et al.2007:148) in their analysis of offenders referred to the Free State Psychiatric Complex. This is also higher than the findings of Pretorius et al, (2007), who found that 6.7% of the offenders in their study were intellectually disabled. However, the higher prevalence rate of intellectual disability in this study still falls within the 2%-40% prevalence rate found by various studies (Holland; 2004 Lindsay et al.2002). The prevalence of IDD amongst individuals referred for forensic mental observation in this study is also higher than that found by Edberg et al.(2008) found that 7.7% of the individuals referred during their study period had intellectual disability.

### **5.3. Gender Distribution**

Consistent with previous local findings in which the majority of the offenders were men, and of the male gender was said to be the predictor of violent and criminal behaviour among the mentally ill population (Sirotich 2008), the present study found that only male offenders (100%) were referred for forensic mental observation during the study's period. This may be explained partly by the fact men with or without IDD are more likely than women to get involved in criminal activities. These findings are almost similar to those of Mosotho, Bambo, Mkhombo, and Mgidlana (2020), who found that 95.8% of the offenders with IDD were male.

#### **5.4 Age of Alleged Offenders**

The highest percentage of offenders was in the age group of 21-39 years, accounting for 52% of the offenders. This is in keeping with the findings by Calitz et al. (2007:148), who found that the mean age of the intellectually disabled individuals in their study was 27 years. This is an important finding when one considers the fact that Calitz et al. (2007) conducted their study in the Free State Province, whereas present study's setting is in the Limpopo Province. The present study's finding of the alleged offenders being mainly in the age group of 21–39 years is also in keeping with the study by Mosotho et al. (2020), who found the median age of offenders with intellectual disability to be 26 years.

#### **5.5 Marital Status**

Contrary to the findings of Barret et al. (2007), that 11.3% of the participants were married, all of the offenders in our study were single or had never married. This is in keeping with the nature of offenders' mental illness, which often makes it difficult for them to reach expected social maturity and appropriate adult-hood-related milestones. Furthermore, this finding can partly be explained by the fact that the average age at which South Africans marry went up from 35 years in 2015 to 37 years in 2019 (Stats SA 2021). Another explanation could be that people with IDD

generally struggle with social integration in communities; this leads to their social withdrawal (Budlender et al. 2004).

## **5.6 Level of Education**

One of the features of IDD is poor scholastic performance and the inability to advance very far with education. People with IDD often struggle to access appropriate education, especially after confirmed diagnosis of intellectual impairment. The majority (68%), of the offenders in this study attended school, with at least 13% achieving some secondary level of education. This is higher than the finding of Calitz et al. (2007), in which 26% had never attended school.

The fact that 13% of the offenders with IDD reached a secondary level of education may be linked to the fact that 65.9% of the offenders were found to have a mild intellectual disability. People with mild intellectual disability are known to be educable and to achieve some level of formal education. This could explain the fact that 13% of the offenders with IDD reached high school.

## **5.7 Employment**

Despite 14% of the offenders having attended special schools and probably acquiring some skills, the overall unemployment in the study was 100%. This is not surprising considering the level of unemployment in the country during the period 2016–2018. At that time StatsSA (2014) estimated unemployment figures at 26.91%. With the overall unemployment figures skyrocketing, people with illnesses such as IDD tend to suffer more when the limited job opportunities open up and fare poorly in the open labour market. Despite the high unemployment rate amongst the offenders with IDD in this study, as well as the lack of jobs or unemployment acting as a motive for committing certain crimes, theft only accounted for 6.8% of the alleged offences committed in this study.

## **5.8 Degree of Intellectual Impairment**

Concerning the diagnoses of the offenders with IDD, two-thirds (65.9%) of the offenders were diagnosed to have mild intellectual disability, and 22.7% met the criteria for the Moderate IDD category. Only 10 (11.4%) were found to suffer from severe IDD. No individuals were found to have *profound* IDD; which was similar to the finding of Calitz et al (2007). In their study, Calitz et al. (2007) found that the majority (62.5%) of the subjects had been diagnosed with mild mental retardation, and fewer were found to have moderate mental retardation. The majority (78%) of the offenders were formally assessed and diagnosed through psychometric testing by the clinical psychologists. Only 22% of the diagnoses were made clinically because of severity of the conditions for which formal assessment was not possible.

The large number of offenders with mild IDD correlates with more interactions with the rest of the general population due to their slightly high level of adaptive skills, independence, and ability to function in the open society. This made it possible for them to commit the alleged offences. As expected, the moderate and severe group had lower representation owing to their limited social inclusion and high level of dependence.

## **5.9 Comorbid Mental and Medical Disorders**

Intellectual developmental disorder may be co-morbid with other neurodevelopmental disorders. In this study, 11% (n = 10) had other psychiatric and medical disorders, in the form of cerebral palsy, epilepsy, diabetes mellitus, and hypertension. None of these comorbid disorders had influenced the type of crimes committed or the outcome of the observations.



## 5.10 Substance Use

Smoking cigarettes, drinking alcohol and the use of illicit drugs, particularly by young people, have long been seen as key public health concerns (Fuller 2015). Greater normalisation and deinstitutionalisation for people with intellectual disability brings with it greater access to tobacco, alcohol, and drugs (Kiewik, Van Der Nagel, Kemna, Engels, & DeJong 2016), and there is growing concern about the number of people with intellectual disability who have access to such substances (Taggart & Temple, 2014). The use of illicit substances has been associated with increased levels of criminal behaviour amongst the general population. With their cognitive deficits and suggestibility, individuals with IDD who abuse substances are even more vulnerable to committing criminal offences.

Alcohol use has been recognised as a major contributor to the global burden of disease, with an even greater detrimental effect in low and middle-income countries and people living in poverty. South Africa has one of the highest rates of alcohol consumption globally and alcohol consumption per capita has risen over the last decade (World Health Organization (WHO) 2014).

This study demonstrated that alcohol usage was 20.5% among offenders, which is similar to the findings of Wennberg et al. (2000), which indicated a 17% to 42% usage of alcohol. Of the 20.5% of the offenders with IDD who used alcohol, 77.8% were diagnosed with mild IDD.

Contrary to the findings made of Strydom et al. (2011), regarding the use of nicotine and cannabis, where 29.6% and 66.7% of their participants were used the two substances, respectively, the present study found that only 9% of participants used either nicotine or cannabis. Variables found to influence smoking in international studies included social pressure (particularly for those with mild IDD, who live with a smoker, or who live in a less restrictive residential setting), being male (Kalyva 2007),

poverty, less punitive child management practices, and the level of psychosocial stress of the guardian of person's with IDD (Emerson & Turnbull, 2005). Additional reasons suggested for increased substance use are inadequate coping skills for stress (Didden et al. 2009), and a desire to fit in or increase social inclusion and overcome loneliness (Christian & Poling 1997), stigmatisation, and limited social skills (Degenhardt 2000).

Taken together, substance users with IDD are more likely to have behavioural problems that may include offending. Information on the use of substance prior to committing an offence maybe important when the fitness to stand trial is assessed. However, most offenders are only assessed for few days to weeks following the commission of the offence; this makes it difficult to ascertain the role of the substances in the offence. The present study indicated no statistically significant relationship between the use of substance, severity of IDD, type of crime, and the observation outcome.

### **5.11 Types of Offences Allegedly Committed**

According to Day (1993), sexual offending and arson are the offence categories that have traditionally been most linked with offenders with IDD. In this study, the alleged serious offences committed by the offenders with IDD included rape, assault with the intent to do grievous bodily harm (assault GBH), and murder. Rape dominated offences committed by offenders with IDD as rapes were recorded as accounting for more than half (54.5%), which was higher than the 45.8% recorded by another local study (Strydom et al. 2011). However, the rape rate of 54.5% by the offenders with IDD is almost similar to the 53.8% rape rate among offenders with IDD that Calitz et al. (2007) found. Most of the alleged rape offences (55.2%) were committed by offenders diagnosed with mild IDD. However, statistical analysis indicate no statistically significant association between the severity of the IDD and the nature of

the offence allegedly committed. Offenders with IDD allegedly committed murder in 9.1% of the cases.

With regard to other alleged offences committed by the offenders with IDD, there were 7(8%) cases of malicious damage to property. However, there were no cases that involved arson. A significant percentage (18.2%) of the offenders committed assault GBH, which is in keeping with the lower frustration tolerance amongst patients with IDD in the general population. Theft was only committed by 6.8% of the offenders, which is around the 5% rate of theft committed by the State patients at Sterkfontein Hospital (Marais & Subramaney 2015).

### **5.12 Outcomes in Terms of Sections 77 and 78**

The majority of the referrals (60%) were made in terms of sections 77 and 78 of the CPA; this is lower than findings of Calitz et al. (2007), who reported that 85% of the offenders were referred according to the two sections. The majority of the offenders (53%) were found to be triable or fit to stand trial and criminally responsible, in keeping with a local study by Du Plessis (2017), where 66% of their offenders were found to be fit to stand trial.

Offenders diagnosed with mild IDD accounted for 43 (74.1%) of 47 cases of that were found to be triable. None of the offenders diagnosed with severe IDD were fit to stand trial or found to be criminally responsible for the crimes, indicating a statistically significant relationship between severity of the IDD and the observation outcome.

### **5.13 Reoffending Patterns**

Only a smaller number (1.1%) of the offenders were found to be reoffenders. This small percentage is in keeping with the study conducted by Marais and Subramaney (2015), who found a 4% rate of recidivism amongst State patients with intellectual disability at Sterkfontein. The low recidivism rate is also in keeping with the finding of Edberg et al. (2020), a low rate of recidivism amongst individuals with IDD in Sweden. Possible reasons for the reporting of low reoffending behaviour could be explained by Marais and Subramaney who reported lack of information from SAPS, amongst other reasons. Other possible reasons could be offenders' or relatives' withholding of information with the fear of influencing the outcome of the current assessment.

#### **5.14 Summary of the Study's Findings**

This study yielded specific findings about offenders with IDDs who were referred to the Thabamopo Hospital for forensic mental observation in terms of sections 77 and 78 of CPA. The study demonstrated the following:

All the offenders were male and that most of them were single and had never married.

Most of the offenders with IDD were young; this was a finding similar to those of other studies.

Contrary to findings of other studies, some of the offenders had received some secondary education.

All of the alleged offenders were unemployed, in keeping with the high unemployment rate in South Africa, even for the general population.

Most of the offenders were found to have mild IDD, with very few being found to have severe IDD.

Alcohol was found to be the substance most used by the offenders with IDD; this was in keeping with other studies in South Africa.

Rape was the commonest offence allegedly committed by the offenders with IDD, followed by assault GBH and murder.

None of the offenders with severe IDD were fit to stand trial, whereas the majority of those diagnosed with mild IDD were found to be fit and responsible for the alleged crimes. Data analysis of these two variables indicated a clear relationship between the severity of the IDD and the observation outcome i.e. those with mild IDD were more likely than those with severe IDD to be found fit to stand trial.

The recidivism (reoffending) rate amongst offenders with IDD was low, in keeping with other studies.

Most of the offenders were referred in terms of sections 77 and 78 of the CPA.

The majority of the alleged offenders were found to be fit to stand trial, whereas 47% were found to be unfit to stand trial.

Based on the findings of our study, it is clear that individuals with IDD do; commit serious crimes, abuse substances and end up in the justice system. Lack of employment opportunities afford them free time to consider getting involved in criminal activities. Stigma and social isolation make it difficult for them to learn interactions that are socially and legally acceptable.

### **5.15 Recommendations**

Even though this study was conducted in one facility, it is very likely that the problem is wide spread across the Limpopo Province. Because forensic mental observations are also conducted at the Hayani Hospital, further studies should be conducted also at this health facility in order to assess whether the current study's findings will be replicated. It is therefore recommended that future studies should consider covering the entire Limpopo Province, including correctional facilities, with improved inclusivity and larger sample size.

Individuals with Mild IDD may be missed by the Justice Department and lead to the incarceration of these individuals, with some of them ending up in correctional facilities. It is thus important that future studies on intellectually disabled offenders should also be conducted at correctional facilities.

It is necessary for policy-makers to consider strategies to help minimise the undesirable consequences of offending amongst individuals with IDD. These strategies may include educating communities about IDD, thus improving social inclusion of individuals with IDD and reducing their feeling of isolation; providing them with skills to improve their opportunities in the work places, and accommodating those with limited skills in sheltered employment programmes.

The Department of Health and the department of Social Development should improve services available to individuals with IDD, and these should include community facilities. Intersectoral collaboration for offenders with IDD must also be put in place, so that there is a holistic and multi-disciplinary approach to the problem.

Where possible, crime-specific interventions may be implemented; for example, education about sexual intimacy for sexual offenders and anger management for culprits of malicious damage to property. Lastly, community-based rehabilitation programmes for those engaging in substances might be helpful.

## **5.16 Study Limitations**

Although this study made notable findings, care should be taken in terms of generalisation, for the following reasons:

The study was conducted at Thabamooopo Hospital only, a single facility in a province with referrals predominantly coming from the same districts of the province, namely Capricorn District, Sekhukhune District, Waterberg District and parts of the Mopani Districts. The study may thus not be generalizable to the whole Limpopo Province.

The sample was also limited to male offenders and thus may not be generalisable to the entire Limpopo Province.

The sample size ( $n = 88$ ) was inadequate for most of the chi-squared tests, and the association between certain variables could not be realised.

This study was a retrospective clinical record review. Information bias could have been introduced through missing information. This could be remedied through a prospective study that would yield more information.





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## ANNEXURES

### Annexure 1: Data collection sheet

DEMOGRAPHIC DATA						
PARTICIPATION CODE						
AGE	14-20	20-29	30-39	40-49	50-59	≥60
GENDER	MALE		FEMALE		OTHER	
MARITAL STATUS	SINGLE	MARRIED	DIVORCED	WIDOWED	SEPARATED	OTHER
LEVEL OF EDUCATION	NEVER ATTENDED SCHOOL	SPECIAL SCHOOL	PRIMARY SCHOOL	HIGH SCHOOL	TERTIARY	
EMPLOYMENT STATUS	EMPLOYED		UNEMPLOYED		GRANT	
CLINICAL DETAILS						
AETIOLOGY KNOWN		YES		NO		
If yes, what was the cause						
PHYSICAL ABNORMALITIES		YES		NO		

If yes, what is the abnormality							
<b>DSM 5 DIAGNOSIS</b>							
<b>METHOD OF DIAGNOSIS</b>		<b>CLINICAL</b>			<b>PSYCHO METRIC TESTS</b>		
<b>PSYCHOMETRIC TEST CONDUCTED</b>							
<b>COMORBIDITIES</b>							
<b>TREATMENT</b>		1.					
		2.					
		3.					
<b>SUBSTANCE ABUSE</b>		<b>YES</b>			<b>NO</b>		
<b>IF YES, WHICH SUBSTANCE</b>		<b>ALCOH OL</b>	<b>CAN NABI S</b>	<b>NIC OTI NE</b>	<b>NYAOPE</b>	<b>CO CAI NE</b>	<b>OTHER</b>
<b>HISTORY OF AGGRESSION</b>							
<b>IF YES, WHAT SORT OF AGGRESION</b>		<b>YES</b>			<b>NO</b>		
		<b>TOWARDS PEOPLE</b>			<b>TOWARDS PROPERTY</b>		
<b>FORENSIC HISTORY</b>							
<b>SECTION OF THE CPA UNDER WHICH REFERRED</b>		<b>77</b>	<b>78</b>	<b>79</b>			
<b>NATURE OF THE OFFENCE/S</b>							



<b>OBSERVATION OUTCOME</b>	<b>FIT TO STAND TRIAL</b>		<b>CRIMINALLY RESPONSIBLE</b>		
	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	
<b>REOFFENDER</b>	<b>YES</b>		<b>NO</b>		
<b>IF YES, PREVIOUS OFFENCE</b>					

## Annexure 2: Limpopo Department of Health Research and Ethics Committee approval



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

### Department of Health

Ref : LP\_2022-02-016  
Enquires : Ms PF Mahlokwane  
Tel : 015-293 6028  
Email : [Phoebe.Mahlokwane@dhsd.limpopo.gov.za](mailto:Phoebe.Mahlokwane@dhsd.limpopo.gov.za)

**DR M.S MATLOU**

#### **PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES**

Your Study Topic as indicated below;

#### **PREVALENCE AND CHARACTERISTICS OF OFFENDERS WITH INTELLECTUAL DISABILITY REFERRED FOR FORENSIC OBSERVATIONS AT THABAMOPO HOSPITAL, LIMPOPO**

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
  - a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
  - b. This permission is Only for Thabamopo Hospital
  - c. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
  - d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
  - e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
  - f. The approval is only valid for a 1-year period.
  - g. If the proposal has been amended, a new approval should be sought from the Department of Health
  - h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

pp **Head of Department**

14/03/2022

**Date**

Private Bag X9302 Polokwane  
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.  
Website: <http://www.limpopo.gov.za>

***The heartland of Southern Africa – Development is about people!***

### Annexure 3: Thabamooopo Hospital CEO Permission



CONFIDENTIAL

**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH  
THABAMOPOPO HOSPITAL

Ref : LP\_2022-02-020  
Enquires : CEO'S OFFICE  
Tel : 015 632 9004  
Date : 22/03/2022

To : DR MATLOU M.S

**RE: PERMISSION TO CONDUCT RESEARCH IN THABAMOPOPO HOSPITAL.**

1. Permission to conduct research study as per your research proposal in Thabamooopo Hospital is hereby granted.
2. Kindly note that after completion of study, the institution is requesting copy of your research.
3. The institution is encouraging you to share your research findings upon completion.
4. All ethical principles should be adhered to at all times during the research period.
5. Please note that the approval is for 1 year period.
6. Kindly note that the institution can withdraw the permission at anytime.

Kind regards

  
Acting Chief Executive Officer

22/03/2022  
Date



PRIVATE BAG X37, CHUENESPOORT, 0745  
Tel: (015) 632 9000, Fax: (015) 632 5205

## Annexure 4: TREC Ethics Clearance Certificate



**University of Limpopo**  
Department of Research Administration and Development  
Private Bag X1106, Sovenga, 0727, South Africa  
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

**TURFLOOP RESEARCH ETHICS COMMITTEE**  
**ETHICS CLEARANCE CERTIFICATE**

**MEETING:** 08 December 2021

**PROJECT NUMBER:** TREC/333/2021: PG

**PROJECT:**

**Title:** Prevalence and Characteristics of Offenders With Intellectual Disability Referred for Forensic Observations at Thabamooop Hospital, Limpopo.  
**Researcher:** MS Matlou  
**Supervisor:** Dr PJ Mokoena-Molepo  
**Co-Supervisor/s:** Dr ME Mafona  
**School:** Medicine  
**Degree:** Master of Medicine in Psychiatry

**PROF P MASOKO**  
**CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE**

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

**Note:**

- i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
- ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
- iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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