An Analysis of Offenders Referred for Forensic Observation in Limpopo from January 2005 to December 2006.

Monicah Ndala

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By

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Submitted in partial fulfillment of requirements for the Degree of Masters of Medicine in the Department of Psychiatry at the University of Limpopo, Medunsa Campus.

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DECLARATION

I declare that this dissertation hereby submitted to the University of Limpopo for the Degree of Masters of Medicine – Psychiatry, has not been previously 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 here has been truly acknowledged.

Signed at the University of Limpopo on the 17th of February 2009.

Monicah Ndala

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The secretaries in the department, Ms Zodwa Rikhotso and Poppie Mtshweni, what would I have done without you?

Last but not least I want to thank God who gave me the strength the times I would grow weary.

DEDICATION

I dedicate this research to my family for the support given towards reaching my dream of becoming a Psychiatrist.

Table of Contents

ABSTRACT

INTRODUCTION

There seems to be an increase in the crime rate in South Africa with substantial regional variations as the crime rate and trends differ between provinces and cities with Limpopo being hailed the safest province.

In South Africa a defendant in a criminal case can be referred for 30 days of psychiatric observation at any stage of the process.

This is to assess whether the accused has a mental illness or defect in terms of the Criminal Procedure Act (Act 51 of 1977) Section 79(2) as amended in the Criminal Matters Amendment Act 1998 (Act 68 of 1998).

There is a perception that most of the accused referred for psychiatric observation are known Mental Health Care Users.

OBJECTIVE

To establish a profile of offenders referred for psychiatric observation in Limpopo from January 2005 to December 2006.

METHOD

A descriptive retrospective study was done. Information was collected from the computer database available in the Psychiatry Department Polokwane/Mankweng Hospital Complex. The study population consisted of all 678 reports referred by the courts for observation during the period January 2005 to December 2006. Data were analyzed and summarized using frequencies and percentages.

RESULTS

Over 80% (85% in 2005, 86% in 2006) of the observations were done on an outpatient basis. Of the offenders referred 94% were males. The majority was in the 21-30 age groups. Mopani District had the highest number of referrals and the majority of them were found to be mentally ill.

Of the offenders sent for observation in 2005 and 2006, 53% had previous psychiatric contact versus 47% with no previous psychiatric contact.

- Of the offenders found **fit** to stand trial 41% had previous psychiatric contact.
- Of those found **not fit** to stand trial 67% were known Mental Health Care Users.
- Of those found **not fit** to stand trial 33% had never received any formal psychiatric treatment and entered the system through the criminal justice system.

Most common mental disorders diagnosed were schizophrenia (42%), substance related disorders (33%) and mental retardation (19%). The majority of offences were assault with intent to cause grievous bodily harm and malicious damage to property. This reflects the behaviour usually reported on by relatives of relapsed male Mental Health Care Users on admission to psychiatric hospitals or units in the Province.

Of the witchcraft accusation offences 70% were committed by mentally ill mental health care users.

CONCLUSION

The majority of offenders referred for forensic observation had previous contact with the mental health services, yet 41 % of those Mental Health Care Users were found not mentally ill in relation to the alleged offence.

Mopani District had the highest number of referrals who were found to be mentally ill. This finding needs to be further evaluated in terms of relationship to the effectiveness and accessibility of the Primary Health Care Service to Mental Health Care Users in Mopani.

CHAPTER 1

1 INTRODUCTION AND BACKGROUND

In South Africa a defendant can be referred at any stage whilst awaiting trial or during the trial period in terms of section 79(2) of the Criminal Procedures Act (Act 51 of 1977), as amended in the Criminal Matters Amendment Act (Act 68 of 1998) for 30 days of psychiatric observation to assess whether the accused was suffering from mental illness or defect in relation to the alleged offence and if the accused is fit to stand trial.

Section 77 deals with the capacity of accused to understand proceedings. Section 77(1) states: if it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defense, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.
Section 78 deals with mental illness or mental defect and criminal responsibility. Section 78(1) states: a person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable-

(a) of appreciating the wrongfulness of his or her act or omission; or
(b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such an act or omission.

Section 78(2) states: if it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall in the case of an allegation or appearance of mental illness or mental defect, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79, as amended in Act 68 of 1998.[1]

There seems to be an increase in crime rate in South Africa with substantial regional variations as the crime rate and trends differ between provinces and cities[2].

Du Plessis cited key factors from other reports which drive high levels of crime in South Africa including youthful population, urbanization rate, inequality and alcohol abuse amongst others. Higher reporting rates could also be a contributing factor to the perceived increase in crime, due to heightened awareness of the policing and criminal justice systems.

Limpopo has been hailed the safest province in South Africa following the release of statistics by the South African Institute for Race Relations[3]. It is reported that in 2006/07 Limpopo's murder rate was 14.1/100 000 which is significantly lower than the national average of 40.5/100 000, with the Western Cape having the highest murder rate at 60.7/100 000. In terms of rape, Limpopo was at 80.6/100 000 which is below the national average of 111/100 000, with the Northern Cape having the highest rape statistics at 142.8/100 000.

Despite the province being hailed the safest in South Africa Limpopo has been known as the Province of witchcraft related and Muti murders[4]. News reports in the most recent years indicate an increase in family and partner murders and assaults, and rape especially of children.

1.1 RATIONALE OF THE STUDY

Since Forensic Psychiatry has been introduced in Limpopo in 1998 the number of referrals for psychiatric observation has increased steadily. There is a perception that most referred offenders are known Mental Health Care Users.

1.2 HYPOTHESIS

Most offenders referred for psychiatric observation in Limpopo are known Mental Health Care Users.

CHAPTER 2

2 LITERATURE REVIEW

It is widely accepted that there is a close relationship between mental illness and crime but few South African studies have been published on this subject[5]. Changes in political, social and economic status of the country have led to changes in other areas.

Significant change has occurred in the Health Care System in South Africa with commitment to community service and primary health care. Due to the world wide move towards deinstitutionalization of the mentally ill, many of the afflicted and previously confined mental health care users are now in the community. The question of the criminalization of the mentally ill has been raised by eminent psychiatrists on many occasions and has become a social and political problem in many countries. Torrey E. F stated that quietly but steadily, jails and prisons are replacing public mental health hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illnesses in the United States.[6]

Following the Rumpff commission in 1967 which was appointed after the murder of the Prime Minister Dr Verwoerd by Dimitrio Tsafendas in 1966, the Criminal Procedure Act 51 of 1977 was enacted, and amended in 1998.

In terms of section 79(1) of the Criminal Procedure Act 51 of 1977[1], a court can issue a directive under section 77(1) or 78(1) for a relevant enquiry to be conducted. The referral process is in terms of section 79(2) where the accused is committed to a psychiatric hospital or to any other place designated by the court, for periods not exceeding thirty days at a time.

In the book "Psycholegal Assessment in South Africa" Kaliski S. Z[7] notes that "there is no requirement that every referral remains for the full 30 days, and indeed most leave after 12 days. The accused should remain in the hospital for as long as it takes to complete a full assessment."

Given the limited resources and lack of manpower, specialized forensic assessment units have become increasingly strained under a growing burden of patients sent for observation, with some units having long waiting lists.

Meyer S J et al[8] has reported an alternative system in the Free State which evolved during the early 1980's in order to try and reduce the number of observation patients. The system functions along the same lines as other forensic referrals with the major difference being that the accused is not sent for an observation period, but for a brief evaluation. This system is only used where there is no doubt that the accused is

suffering from a mental illness, in other words when the accused is exhibiting signs of a psychotic illness. If in any doubt, the accused will be referred for the 30-day observation period, or will be evaluated by a psychiatrist during a short court evaluation after which a decision is taken as to which route to follow.

An alternative system has been practiced since 1998 in Limpopo Province whose forensic observations prior to that year were done in Weskoppies in Gauteng. The only state employed psychiatrist of Limpopo in 1998 employed a strategy utilizing her previous forensic work experience in the Eastern Cape to implement observation predominantly on an outpatient basis. In "Forensic Psychiatric Services for Africa: The model of Limpopo Province " Weiss E A[9] reports that observations are done predominantly as outpatients on a specific day set aside for forensic work. On the said day police bring the accused, with the prosecutor's report, docket and relatives for collateral history. Medical officers and/or registrars clerk the patient, which includes a physical and mental state examination and collection of collateral information, then present the case to the psychiatrist in the presence of other multidisciplinary team members like social workers, nurses and clinical psychologists.

Units closest to offenders' homes like Thabamoopo, Tintswalo, Elim, Hayani and Polokwane Mankweng hospitals are used to avoid language problems and to have access to previous hospital records. Cases admitted are those very psychotic in the police cells, those the team feels that a longer observation period is indicated or those not suitable for custody for other reasons (physical or psychiatric). Offenders not admitted are those with a serious criminal history, those with obvious severe personality disorder, serial killers or rapists and those considered to be dangerous due to nature of crime or attitude during interview. These patients are considered for review in prison or on another forensic day, or are referred to a 36 bedded maximum security unit in Hayani, Venda. The efficiency and impact of this approach has been monitored since its inception and has proven to be sustainable and effectual with no waiting lists. Reports are written within a week of evaluation and mentally ill accused are treated throughout the process from evaluation to admission or trial depending on the findings.

Calitz F.J.W et al[5] tabled findings in his review of local studies which show that the percentage of offenders found to be mentally ill ranged from 42% to 57% in the Free

State Psychiatric Complex. According to Meyer et al[8] the diagnosis most often made was schizophrenia followed by mental retardation in the observation patients seen at the Free State Psychiatric Complex.

Motojesi A. A et al[10] in a study done at Weskoppies showed that 9,2% of observations done over a two year period involved mentally retarded persons. In a study also at Weskoppies which focused on mental illness as a defense against murder Joubert P M et al[11] found out that the majority (63,39%) of those considered to lack criminal responsibility had a diagnosis of schizophrenia followed by psychotic disorder not otherwise specified (12,5%).

In a study conducted at Sterkfontein hospital over an eighteen month period Vorster M[12] reported that 68% of accused referred for observation were fit and responsible. Vorster M also reported from available records an increasing trend for violent offences over twelve years from 1984 to 1996.

Calitz F.J.W et al[5] reviewed some international articles which showed that in England schizophrenia (41%) is the most common psychiatric condition associated with violent crimes, followed by mental disability (35%), personality disorders (12%) and affective disorders (8%).

Calitz F.J.W et al[5] in the Free State South Africa found that the majority of offenders were male (94.6%) and single (66.3%). The median age of the group was 30 years. The unemployment rate was 60%. The main offences were theft (27.8%), murder (18.9%), assault (18.1%) and rape (16.2%). The most common mental disorder diagnosed was schizophrenia (23.0%). Nearly half of the offenders 48.6% were found to be fit for trial and accountable.

A similar analysis to be done in Limpopo would assist the Department of Health and Social Development towards planning and improving mental health and forensic services in the province.

2.1 OBJECTIVE

To establish a profile of accused referred for psychiatric observation in Limpopo from January 2005 to December 2006.

2.2 QUESTIONS

a. What is the demographic profile of offenders sent for observation in Limpopo?
b. What proportion of offenders are known mental health care users, and were they on treatment or not when committing the alleged offence?
c. What are the psychiatric disorders associated with the offenders?
d. What are the main offences committed?
e. How many cases were found fit to stand trial and/or criminally responsible?

CHAPTER 3

3 RESEARCH DESIGN AND METHODOLOGY

3.1 STUDY DESIGN

A descriptive retrospective study was done.

3.1.1 POPULATION

The population consisted of all reports of offenders referred by the courts for observation during the period of January 2005 to December 2006.

3.1.2 SAMPLING AND SAMPLE SIZE

A total of 678 cases are recorded as having been referred for observation. Information was collected from the centralized forensic psychiatric computer database available in the Department of Psychiatry Polokwane Mankweng Hospital Complex.

3.1.3 STUDY SETTING

Forensic Psychiatric Observations are conducted on specific days in various units throughout the Province to avoid language problems and make the process easier for police and relatives. This also means that old records will be available if the accused has been treated in one of the psychiatric units before.

The hospitals involved are Thabamoopo in the South, Tintswalo in the East, Hayani and Elim in the North and Polokwane/Mankweng Provincial hospital centrally.

Thabamoopo Hospital is the main centre where assessments are done every Wednesday by a multidisciplinary team which includes a psychiatrist, medical officers, registrar(s), a social worker, nurses and intern psychologists.

At other hospitals the psychiatrist schedules monthly meetings and is joined by that particular hospital's available team members. The assessment includes psychiatric interviews, mental state examination, collateral from relatives, review of facts from the prosecutor's report and the docket.

Severely psychotic offenders are admitted to the psychiatric unit at one of the main psychiatric hospitals. Where a decision cannot be made about the mental status of an offender, admission or review are considered. Where there is no doubt and the team is in agreement, the accused is sent back to the police cells with a preliminary report and a final report is submitted within a week. Medication for use in the police cells is prescribed for all offenders in need of maintenance treatment and follow-up dates at local facilities are given to the investigating officer or police. Serious cases like murder and rape are assessed during separate appointments by a panel which comprises three psychiatrists – two state psychiatrists and one private psychiatrist.

3.1.4 **ANALYSIS**

The data were summarized using frequencies and percentages.

3.1.5 BIAS

Selection bias was eliminated because the whole population was included in the study. Rater bias could be a factor but was minimized because assessments were done as part of the multidisciplinary team.

3.1.6 RELIABILITY AND VALIDITY

This is a retrospective study utilizing already existing data and records, meaning the results can be easily reproduced by another researcher. Validity of data is ensured by

the fact that all the reports have been submitted and were used in court, and all copies are available.

3.1.7 ETHICAL CONSIDERATION

Approval was sought and granted from the Research and Ethics Committee, Faculty of Health Sciences, University of Limpopo and also from Department of Health and Social Development Limpopo's Research Ethics Committee.

Permission to do the research was obtained from the clinical manager of Polokwane Mankweng Hospital Complex.

Offenders' names were kept anonymous and confidentiality was maintained.

3.1.8 LIMITATIONS

Data for only two years were analyzed which may not be able to show trends. However, the data were put into context of other available data from previous years to enable the assessment of trends for planning future services and facilities.

CHAPTER 4

4 RESULTS

4.1 STUDY SETTING

4.1.1 LIMPOPO POPULATION DISTRIBUTION

With a total area of 125 755 square kilometers, Limpopo is the fifth-largest of the country's nine provinces, taking up 10.3% of South Africa's land area and with a mid-2006 population of 5.4-million people.

Indigenous languages in Limpopo are Sepedi (52%), Xitsonga (22%) and Tshivenda (16%). Limpopo is a predominantly rural Province with only one major town (Polokwane) and a few peripheral rural towns (Mokopane, Tzaneen, Thohoyandou and Louis Trichardt)

4.1.2 DISTRICT MAP

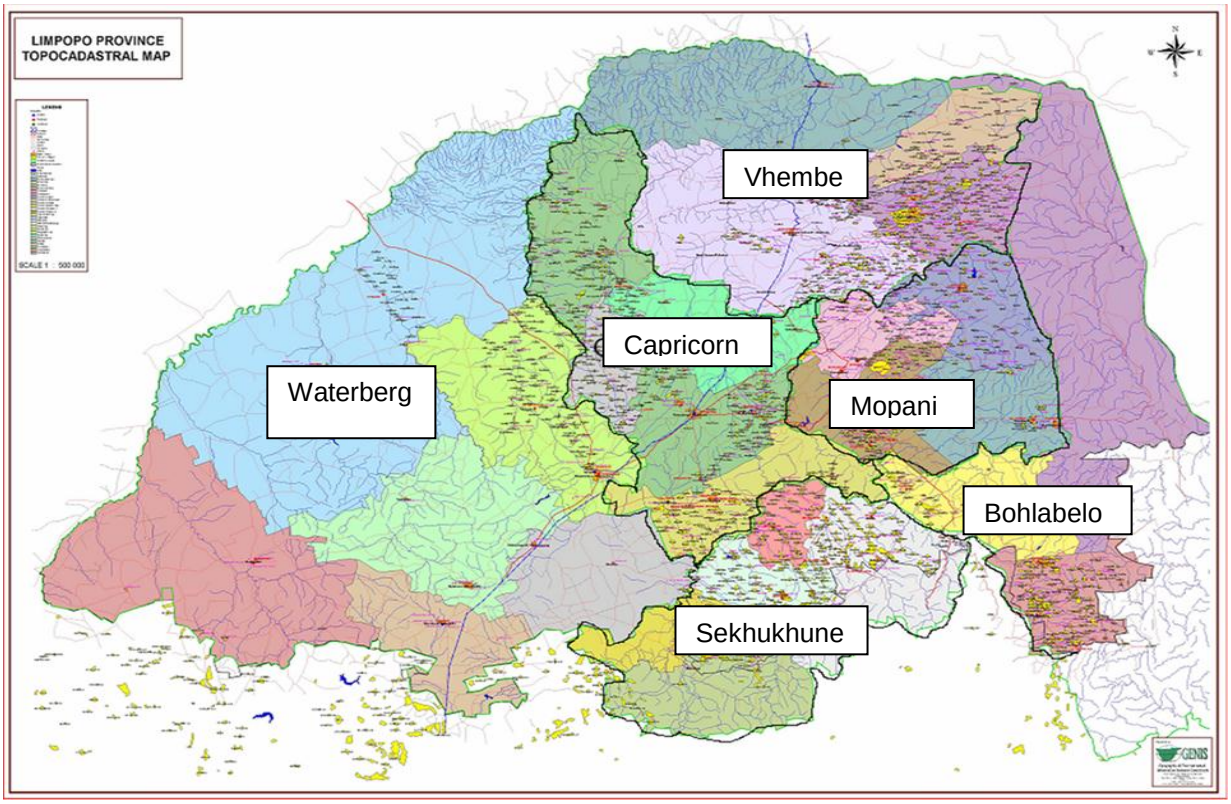

Figure 1

During the study period Limpopo had six districts. After Bohlabelo District was re-demarcated to fall under Mpumalanga Province forensic psychiatric services continued to be done in Limpopo due to lack of psychiatrists in Mpumalanga.

4.1.3 POPULATION DISTRIBUTION

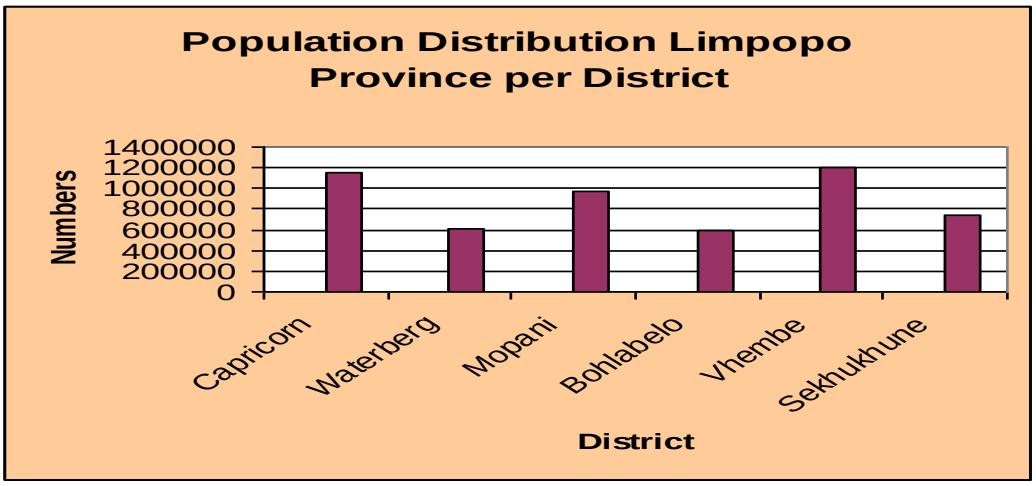

Figure 2
The most densely populated districts are Vhembe and Capricorn with over a million inhabitants each.

4.1.4 SERVICE POINTS FOR FORENSIC PSYCHIATRY 2005/2006

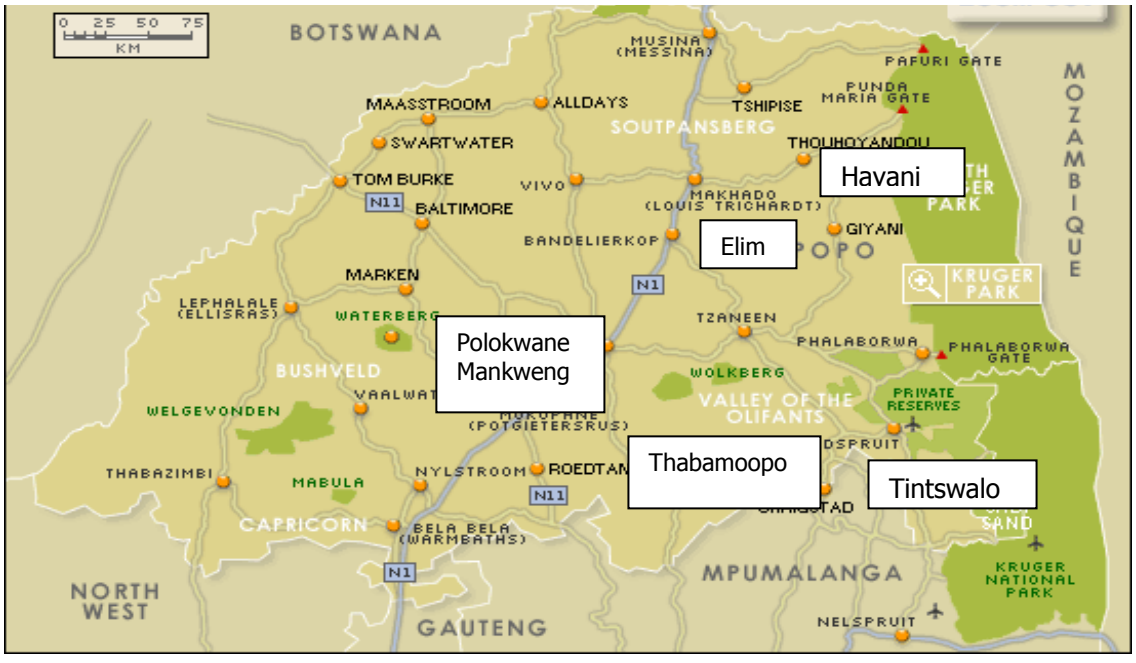

Figure 3
Multiple Service Points facilitate communication (different language groups: Venda, Xitsonga, English, Afrikaans and Pedi), make access easier for the police and relatives and distribute the work load amongst different multidisciplinary teams.

4.1.5 OVERVIEW OF FORENSIC OBSERVATIONS LIMPOPO PROVINCE 1999-2006

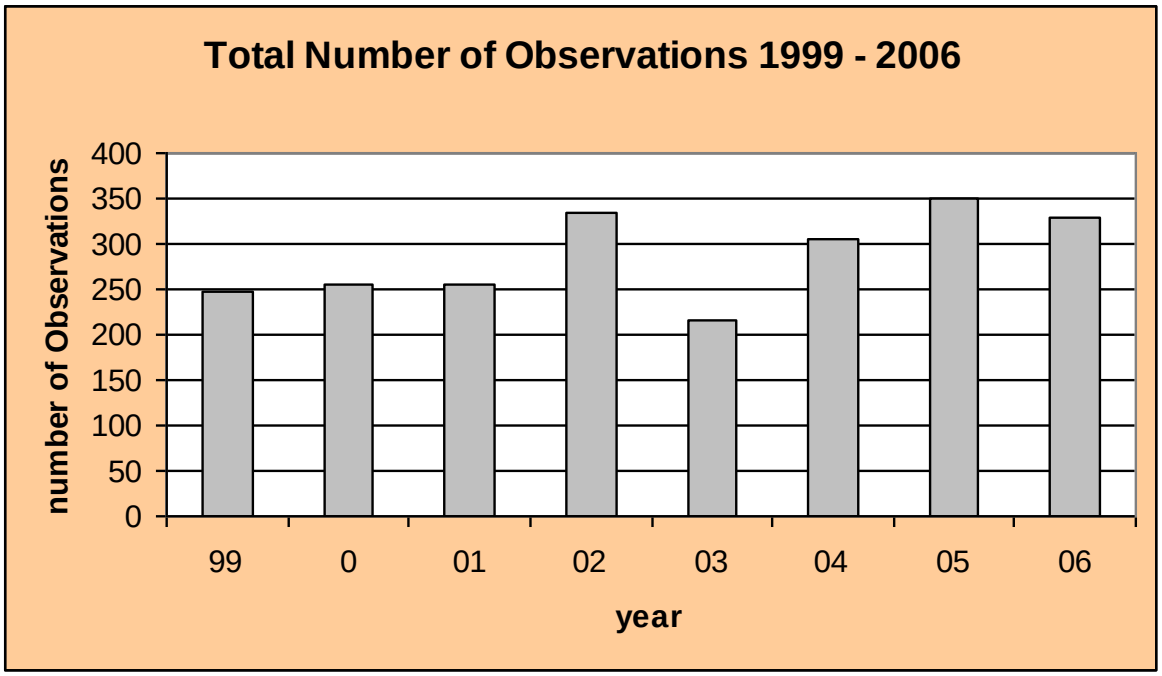

Figure 4.
Figures have been available from 1999 when services were started and are reported on an annual basis. There has been an increase in referrals of accused for forensic observation between 2004-2006.

4.1.6 OBSERVATIONS SEEN AS INPATIENTS/OUTPATIENTS

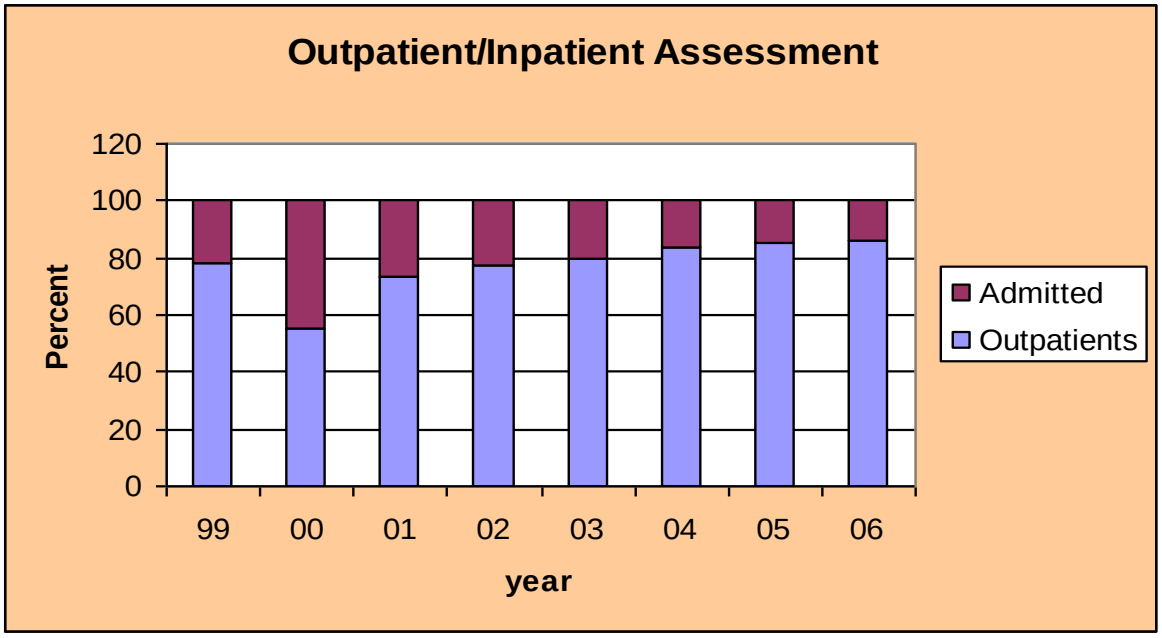

Figure 5
The number of patients seen as outpatients has stabilised just above 80% (85% in 2005 and 86% in 2006).

4.2 DEMOGRAPHICS

4.2.1 GENDER DISTRIBUTION

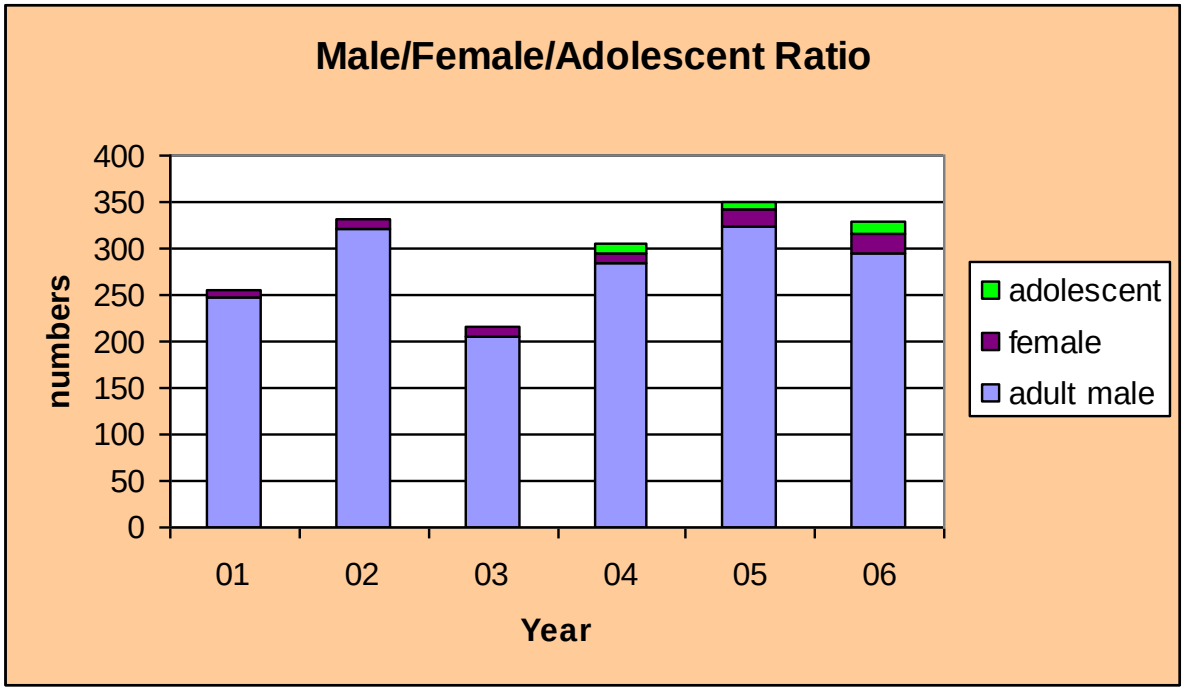

Figure 6.
Of offenders referred for observation during the study period 94% were males. Predictably there were consistently few females and adolescents referred for observation.

4.2.2 AGE DISTRIBUTION OF OFFENDERS OBSERVED 2005-2006

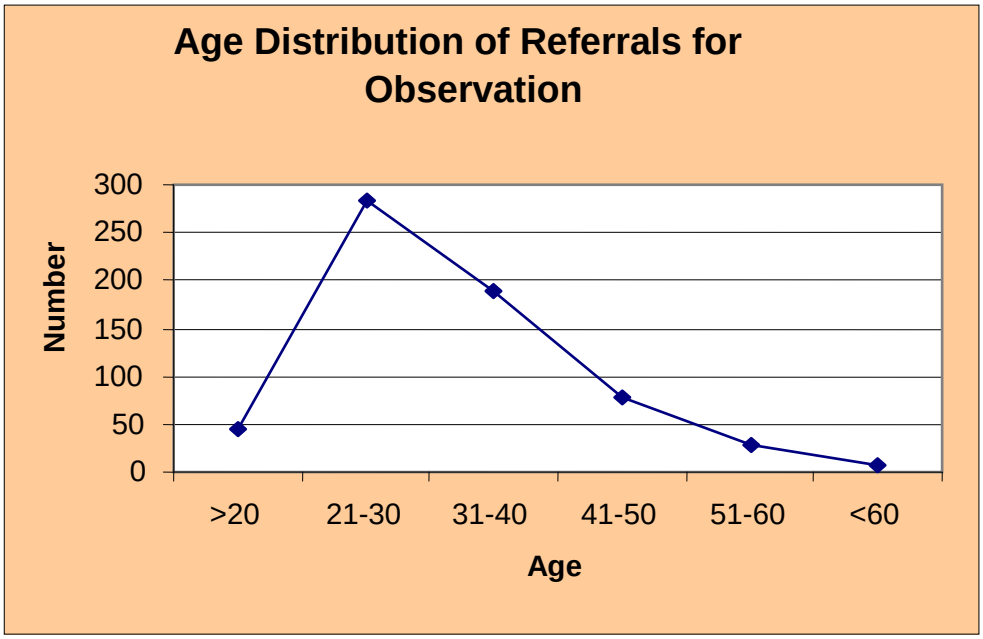

Figure 7
The majority of offenders sent for observation are in the 21-30 age groups.

4.2.3 REFERRALS PER DISTRICT 2005-2006

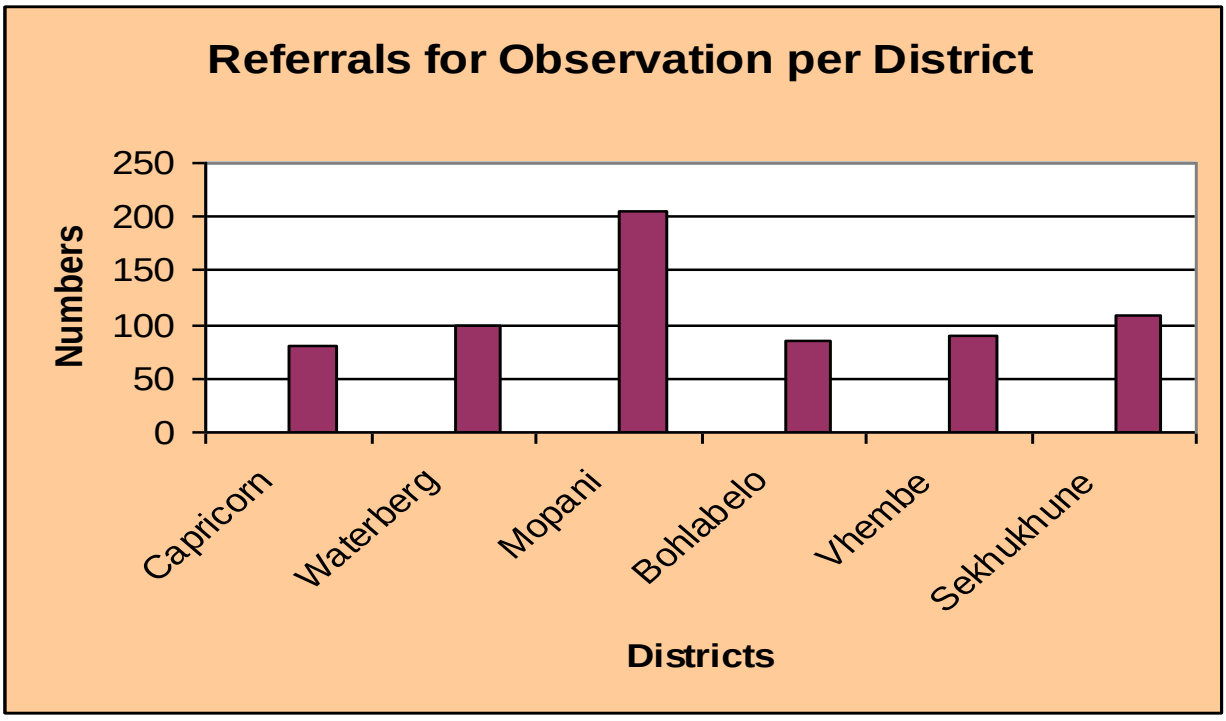

Figure 8
The majority of the referrals are from the Mopani District despite the fact that it is not the most densely populated district.

4.2.4 ACCOUNTABILITY/FITNESS TO STAND TRIAL TRENDS

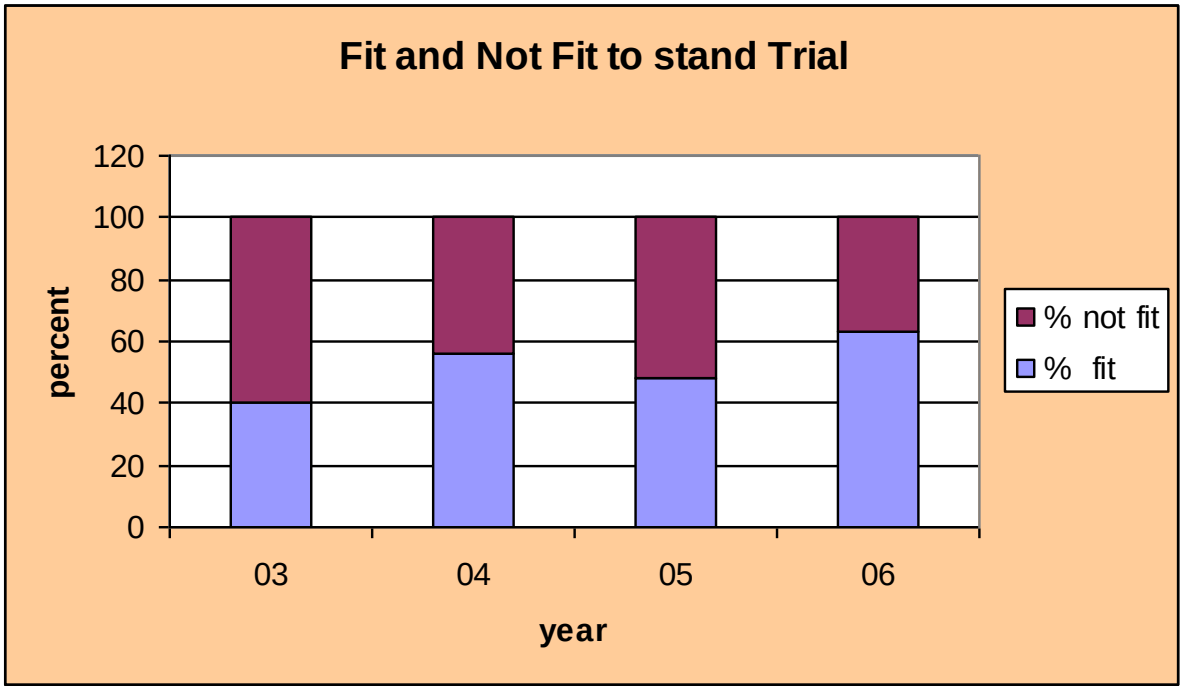

Figure 9
In 2006 37% of accused were found not fit to stand trial as compared to 52% in 2005.

4.2.5 HISTORY OF PREVIOUS PSYCHIATRIC CONTACT 2005 AND 2006

Total number of referrals	678	
Previous Psychiatric Contact	358	53%
No Previous Psychiatric Contact	320	47%

4.2.6 RELATIONSHIP BETWEEN PREVIOUS PSYCHIATRIC CONTACT AND FINDINGS OF **BEING FIT TO STAND TRIAL** 2005 AND 2006

Total fit for trial	374	
No Previous Psychiatric Contact	220	59%
Previous Psychiatric Contact	154	41%

41% of known Mental Health Care Users were returned to Court.

4.2.7 RELATIONSHIP BETWEEN PREVIOUS PSYCHIATRIC CONTACT AND FINDINGS OF **NOT FIT TO STAND TRIAL** 2005 AND 2006

Total not fit to stand trial	304	
No Previous Psychiatric Contact	100	33%
Previous Psychiatric Contact	204	67%

A third of offenders found not fit to stand trial due to mental illness entered the mental health care system through the courts.

4.2.8 FINDINGS ACCORDING TO DISTRICTS 2005-2006

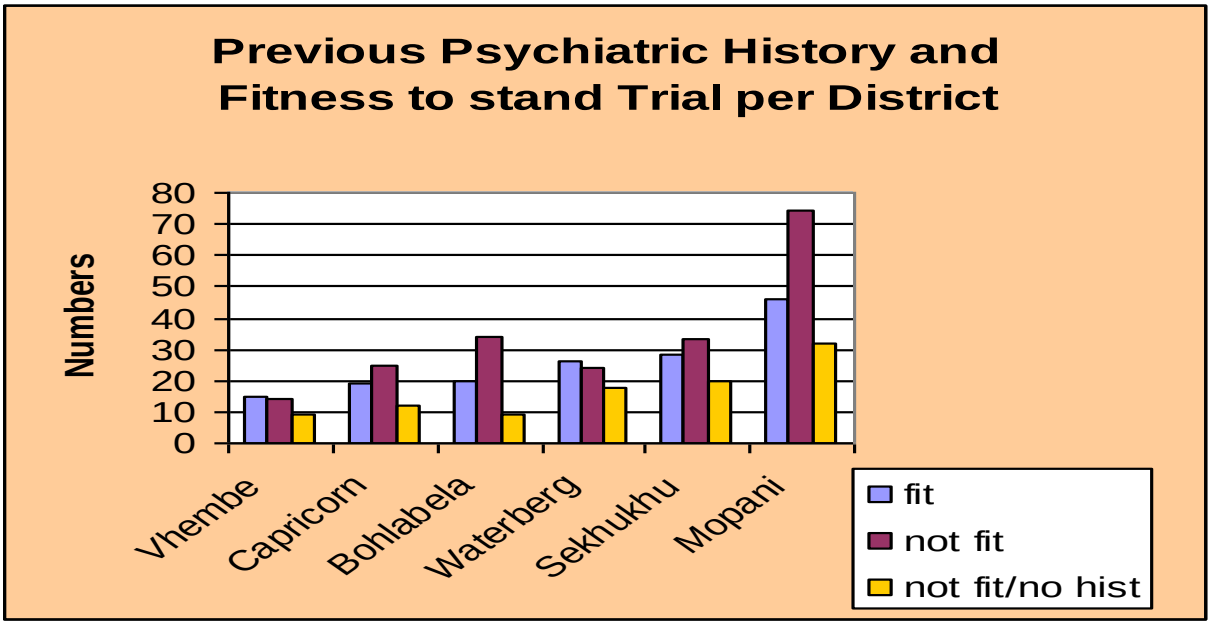

Figure 10
The majority of offenders found to have had previous contact with psychiatric services and those assessed not fit to stand trial due to mental illness were from Mopani District which also had the highest number of undiagnosed referrals with psychiatric illness.

Of the cases sent for observation and found fit to stand trial, 41% had a background of mental illness. The majority, 42% of offenders found fit to stand trial had schizophrenia in remission followed by substance related disorders, 33% and mild mental retardation, 19%. Of note is that 59% of accused sent for psychiatric observation and found fit to stand trial had no history of psychiatric contact, a finding similar to that found by Calitz et al (54.3%) in the Free State.

From the available data it could not be elicited whether the users had defaulted treatment or not.

4.2.9 MAJOR OFFENCES COMMITTED BY THE ACCUSED FOUND TO BE MENTALLY ILL: 2005 -2006.

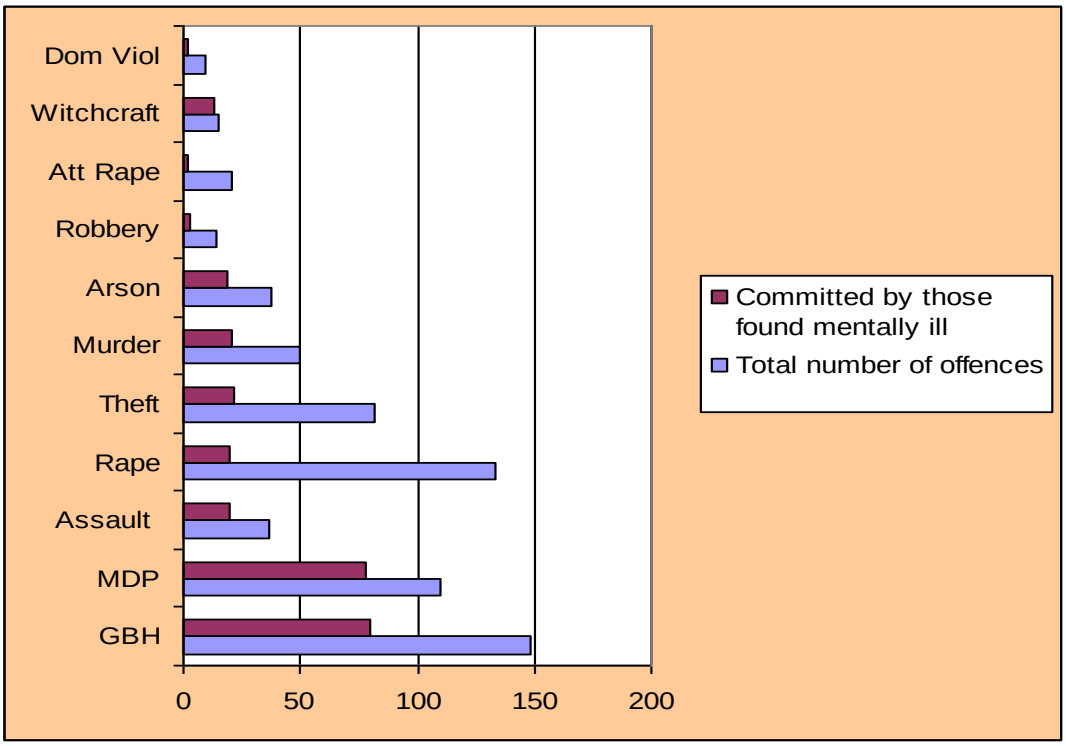

Figure 11

The major offences committed by the offenders were assault with intent to cause grievous bodily harm and malicious damage to property which are in keeping with common presentations to hospitals of male psychotic patients in Limpopo Province. Of the witchcraft accusation offences 70% were committed by mentally ill offenders.

CHAPTER 5

5 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

The model of Limpopo Province Forensic Psychiatric Services compares well with the system employed since the 1980's in the Free State with over 80% of patients seen as outpatients during 2005 and 2006. The majority of offenders sent for observation during the study period were male (94%), which is similar to findings by Calitz et al in the Free State Psychiatric Complex study. Most of the offenders were in the 21 to 30 age group and is similar to the median age of 30 years found by Calitz et al.

Mopani District sent the highest number of offenders for observation and most of them were found to be mentally ill. This needs to be further investigated. Though Mopani does have a small psychiatric inpatient unit, there is no medium stay facility. Patients suffering from psychosis are discharged back into the community and into their families after brief periods of admission with no rehabilitative measures applied. Relapses are frequent and families lay charges with the police when they can no longer tolerate the destructiveness and violence imposed on them by the Mental Health Care User. Mopani is a vastly rural area with strong adherence to traditional beliefs. Patients take a long time before they present, often only after they have committed a crime.

Of those committing crimes and sent for observation in 2005-2006, 53% had previous contact with Psychiatric Services but 41% of them were returned to court. As soon as the court is made aware of the possibility of mental illness currently, previously, treated or untreated, the accused is referred for observation. In absence of screening procedures this causes an overload in the system, which has been addressed by the outpatient assessment in Limpopo. There have been discussions about not prosecuting persons suffering from mental illness when they have committed minor offences. The fact that almost half of the accused who have had contact with psychiatric services previously are returned to court is an indication that mental illness is not and should not be taken as an excuse to avoid prosecution and conviction.

For those found not fit and not accountable, non-compliance with medication, adherence to religious and cultural practices, problems with accessibility of services and poor social support systems may be the major reasons for Mental Health Care Users ending up in the Criminal Justice System.

The hypothesis that most offenders referred for forensic observation in Limpopo are known mental health care users is supported, though lower than expected considering the presence of highly violent mentally ill patients amongst ordinary hospital populations. Others come into the psychiatric services via the judiciary system, indicating a large pool of patients living in the communities untreated and only presenting after committing offences.

There is a high rate of referrals with no previous psychiatric contact and found not mentally ill (59%), which puts a strain on the available forensic psychiatry services. These referrals need to be separately evaluated in order to ascertain, what percentage of those referrals was justified. These may include accused malingering in court, epileptics with or without seizure activity, mute clients, accused hard of hearing and those who are overwhelmed by the process when appearing in court without legal representation.

Most common psychiatric conditions associated with offenders were schizophrenia, substance related disorders and mental retardation.

Main offences committed are those in keeping with psychotic illnesses as observed in the Limpopo psychiatric population, malicious damage to property, assault with intent to cause grievous bodily harm, common assault and arson. The increase in referrals of rape cases for observation is in keeping with the country-wide increase in rape statistics, though it could be due to an increased awareness as previously many cases went unreported. Again this needs to be evaluated to gain a better perception of the emerging pattern as far as Mental Health Care Users are concerned.

Of those found fit to stand trial, 41% had previous psychiatric contact, with the majority being schizophrenics in remission followed by substance abusers.

The fact that a significant number (33%) of mentally ill offenders came into contact with the psychiatric services only after committing a crime calls for accessibility and visibility of psychiatric services, anti-stigma and advocacy campaigns and management of the afflicted, starting with the Mopani District which has the greatest mental ill health burden in the Limpopo. Intervention by police services when approached by relatives of relapsed

Mental Health Care Users or the community could assist in preventing offences. This has improved in some areas, but police is still reluctant to assist in many instances.

There is also a need to educate the judiciary system in an effort to reduce unnecessary referrals.

The Forensic Psychiatric experience in Limpopo has shown that 85% of accused can be assessed as outpatients. Screening processes therefore could reduce the waiting lists for patients referred for observation and assist the court with finalizing cases more quickly.

A high percentage of mentally retarded people (19%) referred for observation shows a gap in the provision for services for this population group. Educational, Rehabilitation and Care facilities should be provided at community level to address issues arising from the diagnosis of Mental Retardation.

Considering that this is a Province with limited human and physical resources, the system implemented and found sustainable for psychiatric court evaluations has contained the possible overload of Mental Health Care Users in the police cells and prisons. The system has also improved the collaboration with the police and justice departments, and created a platform for teaching Forensic Psychiatry to Medical Officers, Registrars and Specialists.

With a central data base for the whole Province and regular annual reports it will be possible to monitor developments in terms of number of accused referred for observation, number of accused returned to court and major referral areas. It will allow for early intervention should an escalation of referrals occur. This will also assist in the planning of psychiatric facilities in the Province especially with the provision of medium term care facilities.

6 REFERENCES

1. Criminal Procedure Act of 1977 (Act No 51 of 1977) as amended by Criminal Matters Amendment Act 68 of 1998.

2. **Du Plessis A, Louw A.**
   Crime and Prevention in South Africa- 10 years on.
   http://commonwealth.sas.ac.uk/resource/Aduplessis.pdf pg1-24.

4. **Sakoana T.**
   Limpopo hailed as safest province in South Africa
   http://www.buanews.gov.za/view.php?ID=07080812451001&coll=buanew07

5. **Ralushai N. V.**
   Report of the Commission of Inquiry into Witchcraft Violence and Ritual Murders in the Northern Province of the Republic of South Africa (1996).

6. **Calitz F.J.W, Van Rensburg P.H.J.J, Fourie C, Liebenberg E, Van den Berg C.**
   Psychiatric evaluation of offenders referred to the Free State Psychiatric Complex according to section 77 and/or 78 of the Criminal Procedures Act. SAJP 2006; 12(3): 47-50.

7. **Torrey E. F.**
   Jails and prisons-America's new mental hospitals. American Journal of Public Health 1995, 85, (12) 1611-1613.

8. **Kaliski S Z.**
   Psycholegal Assessment in South Africa; chapter 6 pg 96

9. **Meyer SJ, Slabber M, van Rensburg PHJJ, Nel M**
   Use of the Judicial section 9 Certification in the Free State. SAJP Dec 2004; 10 (4); 104-108.

10. **Weiss E A**
    Forensic Psychiatric Services for South Africa – The Model of Limpopo Province (unpublished paper).

11. **Motojesi A.A, Rataemane S.T.**
    The pattern of criminal offences allegedly committed by patients with mental retardation admitted for psychiatric observation at Weskoppies Hospital from January 2003 to December 2004. (14th National Psychiatry Congress Presentation)

12. **Joubert P.M, van Staden W.**
    Mental illness as a defense against murder in a South African setting. SAJP September 2006; 12 (3); 71

13. **Vorster M.**
    Forensic Psychiatry. The Leech, Journal of the Medical and Allied Medical Students of the University of the Witwatersrand. May 1998. 67(1) 18-20