FORENSIC PSYCHIATRIC PRACTICE IN A SOUTH AFRICAN MENTAL HOSPITAL

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Weskoppies Hospital, like other South African mental hospitals, has 4 distinct sections: male and female, White and non-White. Significant differences in the medico-legal mode of admission to hospital and legal actions concerning patients while they are in hospital are apparent in the various sections.

Civil Legal Procedures

Among White patients civil matters, such as divorce, and legal actions in connection with curatorship are commonplace. Other types of civil legal procedures encountered are annulment of marriage, disputed testamentary capacity, and judicial enquiries into the reason for detention of certified patients under Section 19 and 20 of the Mental Disorders Act. Again, enquiries by statutory bodies into the mental condition of patients, e.g. by the Education Department and the Pharmacy Board, and procedures under the Children's Act, have been encountered, but no civil action involving a non-White patient has presented itself during the period reviewed (1951 - 1959). Gross differences in cultural and socio-economic status could possibly explain this finding.

The major civil legal procedure is ordinary certification. While equal numbers of male and female Whites are admitted, in the non-White sections there are 3 times as many non-White males as females (Tables I and II).

Criminal Legal Procedures

Patients who have faced criminal charges can be studied under two headings:

1. Governor-General's Decision patients (now called State President's Decision patients, and referred to in this article as 'decision' patients) and convicted criminals who have been found mentally disordered in jail (called 'criminal' patients).

2. Accused persons sent to the mental hospital for mental observation. If these are found to be not criminally responsible they are either reclassified into 'decision' patients or, if the charge is trivial, it is withdrawn and they become ordinary certified patients. The judgment as to triviality of the offence varies according to the personal views of the judicial officer concerned, but generally speaking patients who have faced serious crimes are admitted as 'decision' patients.

The number of female Whites who have been charged with criminal offences is negligible, whereas a quarter of the male non-Whites are 'decision' and 'criminal' patients (Table I). This figure is probably higher because many have had relatively trivial charges withdrawn and have been certified in the ordinary way.

TABLE I. THE HOSPITAL POPULATION IN TERMS OF RACE AND SEX

	Total no. of patients	*Total no. of decision patients and criminals*	*Percentage of decision patients and criminals*
Female: White	580	2	·3%
Male: White	447	21	5%
Female: non-White ..	358	30	8%
Male: non-White ..	977	249	25%
Total	2,362	302	13%

Certification

In ordinary 'certified' patients, 'observation' patients, 'decision' patients and 'criminal' patients, the mental-hospital psychiatrist has to assess the certifiability of the individual patient. This is not done in terms of the diagnosis of the psychiatric condition, but with reference to the behaviour and thought content of the patient. The report is drafted to indicate to a lay mind the necessity for depriving the patient of his liberty so that care, control, and treatment for the mental condition can be implemented. The definitions of mental disorder and defect are kept in mind (Section 2 of the Mental Disorders Act), viz. whether the patient is a danger to himself or

others or is unable to manage himself or his affairs. The examiner concentrates on objective evidence of mental disorder or defect rather than the subjective claims of the patient. The appearance of the patient, his attitude to his surroundings and his fellow inmates, his attitude to dress and clothing, and his emotional reaction to his detention and to the staff are all noted. After this general impression of his behaviour is gained, his thought processes are examined by the method of question and answer. Hallucinations, delusions, and memory defects are all assessed against the background of the patient's mood and behaviour in the ward. A brief biographical review of his life history is made and his emotional responses, when discussing family and work situations, are carefully noted. Ultimately an opinion regarding his judgment and insight is formed. A decision on whether a patient is certifiable or not is a value judgment. The line of demarcation between certifiable and non-certifiable behaviour slides on a scale in terms of social and cultural tolerance. For example, behaviour that would be conspicuous and unacceptable in an urban community could be tolerated in certain rural conditions. The examiner must be careful not to conclude that the question of certifiability necessarily follows from a psychiatric diagnosis. In a given social, cultural, and ethical order, certain diagnostic categories, arrived at by the practice of the scientific discipline of psychiatry, are generally 'certifiable', while others are not. Generally speaking, psychotic disturbances and severe mental defect are in the former category; and the psychoneuroses, psychopathies, and higher-grade mental defects are not. The final decision of 'certifiability' is made by a judicial officer assessing evidence submitted by medical and other witnesses. The rôle of the psychiatrist is to elicit signs and symptoms of mental illness in as objective a fashion as possible.

Incidence of Certifiability in 'Decision' Patients, 'Observation' Patients and 'Ordinary' Patients

In order to study the incidence of 'certifiability' in 'decision' patients, accused persons admitted for 'observation', and 'ordinary' certified patients at Weskoppies

TABLE II. COMPARISON OF PATIENTS

Sex	*Decision patients 1947 - 1955*		*Observation patients 1954 - 1959*		*Ordinary patients 1951 - 1959*	
	Certifiable	*Not cert.*	*Cert.*	*Not cert.*	*Cert.*	*Not cert.*
Columns	1	2	3	4	5	6
Female: White	5	0	3	7	426	45
Male: White	14	43	84	104	422	56
Total %	31%	69%	44%	56%	89%	11%
Female: non-White ..	20	6	10	22	272	34
Male: non-White ..	192	84	189	87	800	90
Total %	70%	30%	69%	31%	90%	10%

Hospital, I collected material as set out in Table II.

The two columns headed 'decision patients 1947 - 1955' were arrived at by a study of the records of all the 'decision' patients who had been resident in hospital between those dates. The clinical record of their psychiatric condition on admission was reviewed and a decision made as to whether I would have certified them in the same way as I had personally done in the patients in columns under 'ordinary patients 1951 - 1959'. That is to say, the criminal aspect of the case was ignored and a decision made on the necessity for care, control, supervision and treatment under Chapter I of the Mental Disorders Act. The accused persons dealt with under the heading 'observation patients 1954 - 1959' were considered in the same way at the end of the period of their observation.

In all the observation patients whom the hospital medical staff regarded as 'certifiable', the court confirmed this finding, but some of the 'not certified' patients were admitted to hospital as 'decision' patients because the court found that the accused had been disordered at the time of the crime. In other words, the court found that these people had had an episode of mental disorder.

It is apparent from Table II that the incidence of 'certifiability' varies according to the reason for admission to the mental hospital. In ordinary civil patients the incidence of 'certifiability' is greater and there is no significant race or sex difference to be found. In observation and decision patients the incidence of 'certifiability' is smaller, and this difference is much more marked in the 'White' series.

Episodic Mental Disturbance

The 'not certified' patients under 'ordinary patients 1951 - 1959' (Table II) suffered from *an episodic mental disturbance* which had cleared up between the time that the outside medical practitioners had certified the patient and the week or so in hospital before the confirmatory certificate was submitted. As already indicated, no race or sex difference in incidence is detectable. Obviously, some of the 'not certified' persons in the 'observation' and 'decision' groups also fall in this category, and further investigation is necessary to decide what proportion had in fact suffered from genuine episodic disturbance and why the proportion should be so much higher in the White cases.

Socio-economic Factors

The availability of mental-hospital beds is different in the 2 racial groups. For Whites there are ± 3 beds per 1,000 of population in mental hospitals, and the figure for non-Whites is ± 1 per 1,000. In a previous study Lamont and Blignault[1] reported that, in a series of 258 male non-White admissions to Weskoppies Hospital in 1952, only 39 could be considered non-urgent. The symptomatology of mental disorder in non-Whites has to be more florid before steps are taken to deal with it by both relatives and the authorities.

In a study of 14 European countries, Penrose[2] found that the more mental hospital beds available in a country the less the convictions for homicide and murder, and *vice versa*. This is probably true for all crimes of violence.

I found in the study of 364 'decision' patients, who had been at Weskoppies between 1947 and 1955, that 103 non-White and 7 White patients, charged with the crimes of murder and assault, were obviously mentally disordered and in need of hospital treatment when they were admitted.

Violent and Non-violent Crimes

Table III shows the 1951 - 1959 'decision' patients classified according to crime alleged to have been committed, and divided into violent and non-violent crimes.

TABLE III. DECISION PATIENTS CLASSIFIED ACCORDING TO CRIME COMMITTED

Race and sex	*Male non-White*	*Female non-White*	*Total non-White*	*Male White*	*Female White*	*Total White*	*Grand Total*
Violent							
Murder and culp. homicide	110	19	129	14	2	16	145
Assault	54	4	58	6	0	6	64
Rape and attempted rape	31	0	31	5	0	5	36
Mal. injury to property	19	1	20	1	1	2	22
Total violent	214	24	238	26	3	29	267
Non-violent							
Theft	43	3	46	3	0	3	49
Housebreaking	27	0	27	6	0	6	33
Arson	12	1	13	1	0	1	14
Sex crimes	4	0	4	5	1	6	10
Miscellaneous	16	2	18	9	1	10	28
Total non-violent	102	6	108	24	2	26	134
Grand total	316	30	346	50	5	55	401

Certifiability in Violent and Non-violent Crimes

In the 1947 - 1955 'decision' patients it was found that the non-Whites committed more than double the number of violent crimes than non-violent crimes, and in the Whites the figures are equal. Also, in the non-Whites the incidence of certifiability is higher in the non-violent series, while in the Whites it is equal. A possible explanation could be that non-White patients who commit less serious crimes have to be more obviously disordered to be detected by lay officials.

In any case, the non-Whites who committed non-violent crimes showed a greater degree of psychiatric invalidism when ranked according to degrees of insight into their condition and their surroundings (Table IV).

TABLE IV. DECISION PATIENTS RANKED ACCORDING TO INSIGHT (OCTOBER 1958)

Degrees of insight	*Male White*		*Male non-White*	
	Violent crimes	*Non-violent crimes*	*Violent crimes*	*Non-violent crimes*
1	10 } 22	2 } 18	46 } 81	15 } 26
2	12 }	16 }	35 }	11 }
3	4 } 7	6 } 8	51 } 157	26 } 82
4	3 }	2 }	106 }	56 }

The following scale was used:

1. Full insight. Know they are in hospital and the reason.
2. Know that they are in a mental hospital and that their fellows are mentally disordered, but cannot apply the circumstances to themselves. Very occasionally a similar degree of insight deficiency was found when the patients realized that they were mentally ill, but could not detect abnormality in their fellows.
3. Can speak in a reasonably rational way, but cannot give the reason for their own or their fellows' presence in the hospital.
4. Inaccessible — mute or completely incoherent.

Categories 3 and 4 fulfil the requirements of 'McNaughton madness', i.e. the patients do not know what they are doing or, if they do, they do not know whether it is wrong or not.

The proportions of these grossly disturbed patients are much higher in the non-White series than in the White series. This finding is more obvious in non-violent crimes in the non-White series. This confirms the contention that more seriously disturbed criminal patients are being admitted in the non-White section. In November 1959 I had occasion to review all patients at Weskoppies and found that 796 out of 1,026 White patients were 'McNaughton mad'. The figure for non-Whites was 1,107 out of 1,335. Thus, more severe psychiatric invalidism is a feature of the non-White hospital population generally.

Deaths, Discharges and Escapes

In October 1955, in the 1947 - 1955 'decision' patient series, 12% non-Whites and 8% Whites had died. Nine per cent non-Whites and 24% Whites had been discharged. Two per cent non-Whites and 23% Whites had escaped. This left 77% of the non-Whites and 45% of the Whites still in hospital.

The high discharge and escape rates in the Whites and low corresponding rates in non-Whites again point to advanced psychiatric invalidism in the non-White series. Escape demands initiative, which deteriorated patients do not have.

Type of Crime and Psychiatric Diagnosis in Decision Patients

Tables V and VI show the various major diagnostic categories of the patients according to race and sex in violent and non-violent crimes.

TABLE V. CRIMES OF VIOLENCE

Diagnosis	*Male non-White*	*Female non-White*	*Total non-White*	*Male White*	*Female White*	*Total White*	*Grand Total*
Organic psychosis	14	0	14	2	0	2	16
Manic depressive psychosis	1	2	3	3	0	3	6
Schiz.-paranoid	135	14	149	9	1	10	159
Epilepsy	38	3	41	4	1	5	46
Defective	18	4	22	6	1	7	29
Not mentally disordered	8	1	9	2	0	2	11
Total	214	24	238	26	3	29	267

TABLE VI. NON-VIOLENT CRIMES

Diagnosis	*Male non-White*	*Female non-White*	*Total non-White*	*Male White*	*Female White*	*Total White*	*Grand Total*
Organic psychosis	9	1	10	5	0	5	15
Manic depressive psychosis	1	1	2	1	0	1	3
Schiz.-paranoid	70	4	74	7	1	8	82
Epilepsy	8	0	8	1	0	1	9
Defective	14	0	14	10	1	11	25
Not mentally disordered	0	0	0	0	0	0	0
Total	102	6	108	24	2	26	134

In both series the schizophrenia-paranoid psychoses are the most important in both racial groups and both sexes. As previously reported,[3] epilepsy is more important in crimes of violence. This condition recedes in importance in non-violent crimes, with mental defect and the organic psychoses moving up. Manic depressive psychosis is unimportant in both series; the depressed form is known to be rare in the African race, but it is prevalent in White (ordinary) patients.[5]

The Murder and Homicide Patients

The murder and homicide patients are classified according to diagnosis in Table VII. Schizophrenia and epilepsy are the two conditions which should be studied in parti-

TABLE VII. DIAGNOSIS OF HOMICIDE CASES

Diagnosis	*Female White*	*Male White*	*Total White*	*Female non-White*	*Male non-White*	*Total non-White*	*Grand Total*
Senile and arteriosclerotic					2	2	2
Cerebral syphilis					2	2	2
Alcoholic psychosis							
Toxic and exhaust. psychosis ..					3	3	3
Manic dep. psychosis				1	—	1	1
Schiz. simplex		1	1	—	—	—	1
Schiz. catatonic		1	1	10	38	48	49
Schiz. hebephrenic	1	—	1	1	11	12	13
Schiz. paranoid	—	3	3	—	13	13	16
Paraphrenia	—	—	—	—	—	—	—
Paranoid states	—	1	1	—	6	6	7
True paranoia	—	—	—	—	—	—	—
Schiz. (unclassified)	—	—	—	—	—	—	—
Epileptic psychosis	—	2	2	2	24	26	28
Defective	1	4	5	4	6	10	15
All other psychoses	—	—	—	—	—	—	—
Not mentally defective	—	2	2	1	5	6	8
Total	2	14	16	19	110	129	145

cular in this type of crime, and I have selected the 110 male non-White patients for further study.

EPISODIC BEHAVIOUR DISTURBANCE IN THE MALE NON-WHITE MURDER AND HOMICIDE SERIES

There is a continuum in the manifestations of mental disease from acute episodic disturbance with intermissions, on the one hand, to the insidious commencement and unrelenting deterioration to deep dementia and invalidism, on the other.[4] All types are found, from patients with a single attack in a life-time, at the one extreme, to individuals in their teens who progress without intermission to complete disintegration of psychic function, at the other extreme.

Hebephrenic Schizophrenia

Eleven out of the 68 male non-White schizophrenic-paranoid patients who committed homicide were hebephrenics, i.e. 16%, which is significantly lower than the proportion in the corresponding non-criminal, male non-White schizophrenic population. Here there were (in October 1959) 181 hebephrenics out of a total of 656 schizophrenic patients (28%).

These patients correlate highly with the one extreme in the continuum: They usually present a steady deterioration and, although impulsive, seldom have normal intermissions in the course of their illness.

At the other extreme of the continuum patients suffering from catatonic schizophrenia and epilepsy are found, and they exhibit *par excellance* features of the 'episodic behavioural disturbance' with intermissions, although in both instances they eventually tend to deteriorate in 'the staircase-with-landings' fashion.

Catatonic Schizophrenia

The proportion of catatonic schizophrenics in this murder-homicide schizophrenic-paranoid series was 55% (38 out of 68), and this is significantly higher than the total non-criminal schizophrenic male non-White population (296 out of 656 — 45%).

Epilepsy

Twenty-two per cent of the male non-White murder-homicide patients were epileptics (24 out of 110). In the non-criminal male non-White hospital population the percentage of epileptics was significantly lower — 9% (67 out of 728).

Paranoid Schizophrenia and Paranoid States

It is submitted that these patients are on the 'episodic behavioural disturbance' side of the continuum, because, generally speaking, they give a normal impression, but they may react impulsively in terms of their delusional thinking. Paranoid schizophrenia tends to come on earlier in life than the paranoid states and the victims tend to deteriorate more rapidly and to a greater degree, but the main feature of both these conditions, in the earlier stages at least, is a preservation of reason although it is sidetracked. In civil cases difficulty is often encountered in persuading the curator-ad-litem that the patient is disordered. The paranoid patient is usually *au fait* with his affairs, and often his delusional thinking is so systematized and logical that only by probing his whole life situation do we find that he is out of touch with the real world. Patients suffering from the various paranoid conditions are sometimes dangerous, and they are the only group of the total male non-White murder-homicide series in which motivation is important. In 93 out of the 110 patients no motive for the crime was apparent from the record. Eight of the 19 paranoids were motivated in terms of their delusional thinking. Twenty-eight per cent (19 out of 68) of the male non-White homicide schizophrenics were paranoids. In the non-criminal male non-White schizophrenic population there were 99 'paranoids' out of 656 schizophrenics — 15%. Again, in the paranoid patients in our series a large proportion was charged with homicide before admission.

Periodicity

All the records of the murder-homicide patients were studied for evidence of 'periodicity', i.e. episodic attacks of mental disturbance with relatively normal intermissions. As expected, the catatonics showed a higher tendency in this regard than the hebephrenics (19 out of 38 catatonics had relatively normal intermissions and only 1 out of the 11 hebephrenics showed this tendency). In these cases 21 out of the 38 catatonics and 6 out of the 11 hebephrenics had been violent in hospital since admission. In this respect there is no significant difference between these two groups in hospital, but if the patients were in their home environment, violence could be expected from the hebephrenics. who continuously show mental aberration while catatonic patients are more unpredictable.

Tendency to Violence in Hospital

In the total 110 cases in the male non-White murder-homicide series, 38 showed 'periodicity', i.e. they had relatively normal intermissions. Of these 27 (71%) had a record of violence in hospital; this is much higher than in the patients who show a consistently severe mental disturbance. Twenty-four of the 72 (33%) in the latter group showed violence in hospital. This shows that, although there were less patients showing an episodic disturbance, they are more dangerous. It is interesting to note that 73% of the patients with episodic mental disturbance killed members of their families (27 out of 37). In the non-periodicity cases the figure was 48% (32 out of 67). (In 6 cases there is no record of who the victim was.) Three of the hebephrenics killed members of their families, which is a small proportion compared with the

26 out of 38 catatonics, 12 out of the 24 epileptics, and 11 out of the 19 paranoids.

The hebephrenics are the more obviously bizarre patients, and presumably their relatives expect impulsive behaviour, whereas patients in the other 3 categories can appear relatively normal except for outbursts of mental disturbance, at least in the earlier stages of the illness.

The 110 murder-homicide patients showed a much higher tendency to violence in hospital — 46% compared with 10% of the non-criminal male non-White hospital population. The presence of hallucinations was found to be significant. In those patients who were violent in hospital, 41% suffered from hallucinations, whereas only 25% of the non-violent patients gave evidence of hallucinations.

This review of male non-White patients at Weskoppies, who have been alleged to have committed murder or homicide, can be summed up as follows: It deals with a group of seriously disturbed psychotics who have committed motiveless attacks on members of their families. It seems that the number of patients exhibiting episodic mental disturbance is greater in this series than in the corresponding non-criminal hospital population.

Patients whose Diagnosis was in Doubt in the Murder-Homicide Cases

In 28 of the 145 'decision' and 'criminal' patients the question of mental disorder was in doubt on admission. Six (of a total of 14) were male White, 1 (of a total of 19) was a female non-White, and 21 (of a total of 110) were male non-White patients. Subsequent to admission 16 eventually developed into typical mentally disordered patients, and 13 of these were of the 'episodic behavioural disturbance' variety. Of the 16 patients, 9 were catatonic schizophrenics, 1 epileptic, 3 paranoid schizophrenics, and 3 hebephrenic schizophrenics.

These 16 comprised 15 male non-Whites and 1 male White patient. We are thus left with 12 doubtful patients to account for: 5 male White, 1 female non-White and 6 male non-White patients. Of the non-Whites, 3 were apparently genuinely ill — they had been confused at the time of the crime as a result of physical illness. Two had been given the benefit of the doubt on a history of epilepsy supported by abnormal electro-encephalographic findings. (No clinical evidence of epilepsy became evident subsequent to admission.) One had been diagnosed as a hebephrenic schizophrenic with subjective evidence of hallucinations, which did not recur subsequent to reclassification, and one appeared to be a dagga (*Cannabis sativa*) smoker on a psychopathic basis. Of the 5 male White patients, 2 were borderline, high-grade defectives, and 3 showed no indication of any recognizable form of mental disturbance.

This review shows that the vast majority of murder-homicide 'decision' patients fall into typical psychiatric clinical 'entities'. A knowledge of the natural history of the psychoses is valuable in deciding if an individual exhibiting behaviour abnormality is 'responsible' or not. It seems that the margin of error in the series of non-White murder-homicide patients is small.

SUMMARY

A description is given of forensic practice in a South African mental hospital with special reference to differences in White and non-White patients.

REFERENCES

1. Lamont, A. M. and Blignault, W. J. (1953): S. Afr. Med. J., **27**, 637.
2. Penrose, L. S. (1939): Brit. J. Med. Psychol., **18**, 1.
3. Lamont, A. M. and Moffson, A. (1954): S. Afr. Med. J., **28**, 372.
4. Reid, D. D. (1960): W. H. O. Public Health Papers, No. 2.
5. Lamont, A. M. (1948): *A study of racial and socio-economic influences on mental disease in a South African mental hospital*, M.D. Thesis, University of Glasgow.