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LIST OF ABBREVIATIONS

APA	American Psychiatric Association
AU	African Union
CMH	Centre for Mental Health
CMP	Criminal Mental Patient
DMP	Detained Mental Patient
DSM	Diagnostic and Statistical Manual
MIRA	Methods of Improving Reproductive Health in Africa
MSF	Medecins Sans Frontieres
NEPAD	New Partnership for Africa's Development
Qual	qualitative
Quant	quantitative
SPSS	Statistical Package for Social Sciences
ZPSSO	Zimbabwe Prison Service Standing Orders

CHAPTER 1
ORIENTATION TO THE STUDY

"I have no special talent. I am only passionately curious."
Albert Einstein (1952)

1.1 INTRODUCTION

Part of my area of speciality in the nursing profession in Zimbabwe is providing care to psychiatric patients in special institutions. In 2009 I enrolled for my master's degree at the University of Zimbabwe. What I did not realise then was that the desire to simply further my academic career would be the catalyst that would shift both my academic and professional goals forever.

The apparent discord between the authoritative dogma of the judicial system and the medical ideal of duty, care and compassion resulted in mayhem and chaotic rehabilitative service provision to incarcerated forensic psychiatric patients. The division in how these two professions dealt with forensic psychiatric patients in prison settings forced me to ask myself what the point of my learning really was. This question haunted me. The gulf between preserving justice and reconciling professional medical care and rehabilitation of psychiatric patients in special institutions seemed unbridgeable. Yet, it was exactly this medico-judicial paradox that led to the birth of my doctoral research study to develop a medico-judicial framework for the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe. I surmised that if there was a doable way to mesh the internal structures and hierarchies of the legal and medical systems, it would significantly augment the rehabilitation and reform of forensic psychiatric patients in special institutions in the country. I realised that only when finding an answer to the following question, would the purpose of this study be successfully achieved:

"What should a medico-judicial framework consist of for the rehabilitation of forensic psychiatric patients?"

The authors Hamaoui, Moussaoui and Okasha (2009:507) and Tataru, Marinov, Douzenis, Novotni and Kecman (2010:472) explain that the definition for forensic psychiatry was conceptualised by the American Board of Forensic psychiatry and the American Academy of Psychiatry and the Law as follows: “It is a sub-speciality of psychiatry in which scientific and clinical expertise is applied to legal issues in the legal context, embracing civil, criminal, correctional or legislative matters.” Expounding on this definition Arboleda-Florez (2006:87) allows for more explicitness by stating forensic psychiatry is “the branch of psychiatry that deals with the flow of mentally disordered offenders along a continuum of social systems”. In terms of the current study, the forensic psychiatric patients were the “mentally defective offenders” referred to and defined by Arboleda-Florez (2006:87).

Committing a forensic psychiatric patient to a special institution is fundamentally complex because of the estrangements that are inherent in those incarcerated for breaking social norms. Commitment to an institution is more than just spatial separation from the general community; it almost symbolises rejection (Austin, Goble & Kelecevic 2009:845). Commitment creates significant disconnection in which a rift is cultivated between offenders and the rest of the community. The thrust of forensic psychiatry is to work towards traversing this estrangement. This study sought to develop a more transparent research-based medical and judicial framework to improve therapeutic innovations, quality of life and recovery of forensic psychiatric patients in special institutions in Zimbabwe.

This first chapter presents the background to the research problem, statement of the research problem, aim of the study, and the research objectives and research questions. It also addresses the significance of the study, definition of terms, foundations of the study, overview of research design and method, scope of the study and outlines the chapters.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

According to Njenga (2006:97), many forensic psychiatric hospitals are located in "ghettos, often termed maximum security units, which are practically extensions of prisons". These hospitals function as 'orphan' or illegitimate units that do not belong to either the medical or prison systems. For example, in Zimbabwe, the location of a typical special institution is more than 30 kilometres from a central business district. In this hierarchy of confusion, controversies range from poor legal and policy frameworks to dichotomy in the administration of these institutions.

In Zimbabwe no psychiatric hospital existed before 1908. Gaols (prisons) served as detention institutions for psychiatric patients. Psychiatry evolved through the guidance of the Lunacy Ordinance Regulations of 1908, The Southern Rhodesian Mental Disorders Act of 1936 (which used the 1930 Mental Treatment Act of England and Wales as its template) and the Mental Health Act of 1976. These legislative instruments repealed each other (Jackson 1991:74-75; Zimbabwe Mental Health Act 1996:157). Currently, both general psychiatry and forensic psychiatry are driven by the Mental Health Act (Statutory Instruments15) of 1996; the Zimbabwe Mental Health Regulations (Statutory Instrument 62) of 1999 and the Zimbabwe National Mental Health Policy of 2004. Part 3 of the Zimbabwe Mental Health Act of 1996 addresses forensic psychiatric patients. The provisions made in Part 3 of this Act provide a port of entry for the rehabilitation of forensic psychiatric patients as functional members of society. These forensic psychiatric patients are admitted to what is called 'special institutions' in Zimbabwe and are hospitals located within a prison setting (Zimbabwe Mental Health Act 1996:212).

As Njenga (2006:97; Ogunlesi, Ogunwale, De Wet, Roos & Kaliski 2012:3) points out, the discord in forensic psychiatry is a wider problem that needs to be addressed in Africa, if not worldwide. The dichotomies inherent in forensic psychiatric practice that derive from inconsistent legislative instruments are a reality that this study will contribute in synchronising.

1.3 STATEMENT OF RESEARCH PROBLEM

Forensic psychiatric practice is generally shrouded in both mystery and confusion (Njenga 2006:97). Ogunlesi, Ogunwale, De Wet, Roos and Kaliski (2012:3) recently reported that forensic psychiatry has remained underdeveloped within the context of pervasive neglect in the provision of mental health services. The situation is compounded by the dearth of information about forensic services in the African continent.

Tataru et al (2010:476) and Ogunlesi et al (2012:3) observe the main problems concerning forensic psychiatry as the lack of coordinated initiatives in multidisciplinary teamwork, resocialisation programmes, the lack of psychiatrists, attitudinal problems of staff towards patients, and stress and burnout among staff. The authors go on to say that the general quality of care in places where forensic psychiatric patients are cared for is low owing to lack of compassion for suffering and degrading living conditions. A recommendation was made by these authors that research should focus on the development of adequate interdisciplinary work that could contribute basic evidence that is currently lacking, in the field of forensic patient care.

Austin et al (2009:840) add that forensic psychiatric professionals are guided by nonspecific and inapplicable codes of conduct in their practice. These authors note that this shortcoming appears to leave forensic psychiatrists and other practitioners without clear guidelines as to what is proper humane care and what is not. In support, Ogunlesi et al (2012:3) point out that in most African countries there are few coordinated initiatives to involve all stakeholders such as the police, departments of justice, prisons and hospitals in the development of forensic mental health services. According to Ogunlesi et al (2012:5), attempts should be directed at providing specific guidelines for practitioners in forensic psychiatry. The Zimbabwe National Mental Health Policy (2004:4) alludes to the aforementioned aspects by stating that comprehensive rehabilitation facilities for both forensic psychiatry and general psychiatry are very

scarce in Zimbabwe. The policy also calls attention to the need for stakeholders to come up with comprehensive rehabilitation programmes.

The Zimbabwe National Mental Health Policy (2004:9) specifies that a special institution has to be run by a team consisting of a resident psychiatrist, psychiatric nurse practitioner, general medical officer, clinical psychologist, social worker, and an occupational therapist and/or rehabilitation technician. Such a team currently exists in the system of psychiatry and is supposed to rehabilitate the forensic psychiatric patients. However, it is unclear what medico-judicial procedures related to rehabilitation are followed by the psychiatric team during the detention of forensic psychiatric patients.

Another aspect that compounds the problem is that patients are discharged from special institutions following the recommendations of the Special Boards and Mental Health Review Tribunal as specified in Part 9 and Part 10 of the Zimbabwe Mental Health Act (1996:197-200). These patients' port of exit is to a general psychiatric hospital for rehabilitation and not into the community as promulgated in the Zimbabwe Mental Health Policy of 2004. The forensic psychiatric patients often stay in these institutions for more than five years; in fact, some are sent back to special institutions after many years creating an endless 'revolving door' scenario.

The researcher observed that there were no guidelines in Zimbabwe for forensic psychiatric practice and no clear documentation on procedures to be followed in the rehabilitation process of the forensic psychiatric patient. In Zimbabwe the medico-judicial marriage at this point in time is blurred and discordant which makes it difficult for even the average Zimbabwean to comprehend the entry-exit process followed in the continuum of care for forensic psychiatric patients. This has been even highlighted by The National Health Strategy for Zimbabwe 2009-2013 (2008:75) where it specifically calls for stakeholders to strengthen and coordinate forensic mental health services.

1.4 AIM OF THE STUDY

The aim of this study was to develop a medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.

1.4.1 Research objectives

The research objectives were divided into three phases. These three phases and the objectives of each are given below.

1.4.1.1 Phase 1: Situation analysis - current trends and realities

The objectives of the first phase were:

- to conduct a literature review of the rehabilitation of forensic psychiatric patients in developed and developing countries
- to explore and describe the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe
- to review the documents of forensic psychiatric patients admitted in special institutions between 2005 and 2010 in order to identify the rehabilitative mental health services available to forensic psychiatric patients in two special institutions in Zimbabwe.

1.4.1.2 Phase 2: Development of a medico-judicial framework

Phase 2 had only one objective:

- to develop a medico-judicial framework based on the findings of the situation analysis.

1.4.1.3 Phase 3: Validation of the medico-judicial framework and guidelines

The objective of the third phase was:

- to validate the medico-judicial framework and guidelines by a group of experts and stakeholders.

1.4.2 Research questions

The study focused on answering the research questions presented below.

- *"What are the current trends in literature in developed and developing countries regarding the rehabilitation of forensic psychiatric patients?"*
- *"What are the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe?"*
- *"What rehabilitative mental health services are available to forensic psychiatric patients in the two special institutions in Zimbabwe?"*
- *"What should a medico-judicial framework consist of for the rehabilitation of forensic psychiatric patients in Zimbabwe?"*

1.5 SIGNIFICANCE OF THE STUDY

Taylor (2002:S60) argues that one cannot necessarily rely on information gathered in one country to inform practice in another. Ogunlesi et al (2012:4) advise that the Zimbabwe Mental Health Act of 1996 as well as the Zimbabwe Mental Health Policy of 2004 needs to be reviewed. Goal 13 of the National Health Strategy for Zimbabwe 2009-2013 (2009:75) includes the need to re-establish community-based mental health services with the aim of reducing the custodial concept of psychiatric care. But, for this strategy to be successful it calls for collaborative approaches with other stakeholders to assure integrated, accessible and effective forensic psychiatric rehabilitation services.

Hence, the current study sought to provide evidence and direction to this quest. The study would create a reservoir for local relevant scientific knowledge and a new awareness of forensic psychiatric practice. It was projected that this new awareness would realign forensic psychiatry to rehabilitation and practice mandates of stakeholders in the medical and judicial systems.

A medico-judicial framework was developed from this study. It was in line with the view of Simpson (2006:835) who projected that the future of forensic psychiatry will be such that any developed framework will foster a strong multidisciplinary engagement with patients including contributions from psychiatry, psychology, spiritual, social work, occupational therapy, nursing, education, recreation and the necessity of integrating security and therapy. The medico-judicial framework will remove the division and foster unity of function between the multidisciplinary health and the judiciary team; thus, marrying theory and practice.

The framework will also guide clinical nursing practice in forensic psychiatric settings with regards to what is exactly expected of nurses in those settings. The study is also ground breaking for forensic psychiatry research in Zimbabwe and will go a long way in creating awareness to researchers about realities of forensic psychiatry research. It is projected that in future; there will be a linear relationship between research, policy and implementation. Psychiatric nursing education will tape from the findings and results on the best way to adjust curricular that guide training of nurses that work in forensic psychiatric settings.

1.6 DEFINITIONS OF TERMS

1.6.1 Medico-judicial

Medico-judicial issues, commonly referred to as legal aspects of psychiatry, are viewed as the intersection between mental illness and the law (Nambi 2010:306).

In this study the term ‘medico-judicial ’referred to the link between the medical aspects of psychiatric care that is run by the Ministry of Health and Child Care in conjunction with the prison system and the judiciary system run by the Ministry of Justice, Legal and Parliamentary Affairs in Zimbabwe (Zimbabwe Mental Health Act 1996, Part XIV Section 107:212).

1.6.2 Rehabilitation

The term ‘rehabilitation’ refers to assisting someone to live a healthy, useful or active life again after they have been seriously ill or in prison (Dictionary of Contemporary English for Advanced Learners 2009:1466). According to the United States of America Psychiatric Rehabilitation Association cited in Stuart (2009:199) psychiatric rehabilitation is a “combination of services incorporating social, educational, occupational, behavioural and cognitive interventions aimed at long term recovery and maximisation of self-sufficiency”.

In this study ‘rehabilitation’ referred to the process of restoration of the forensic psychiatric patients by the multidisciplinary medical and judicial teams towards the former’s highest possible level of bio-psychosocial function where they can fulfil their roles as independently as possible.

1.6.3 Forensic psychiatry

‘Forensic psychiatry’ is defined by Mullen (2000:307) as the branch of psychiatry that intersects with the legal fraternity in executing its mandate. It is also concerned with the flow of mentally disordered offenders along a continuum of care of social systems (Arboleda-Florez 2006:87; Neil 2012:199).

In this study ‘forensic psychiatry’ referred to rehabilitation interventions, treatment modalities and services that were provided by the judicial and medical teams to forensic

psychiatric patients in special institutions with the aim of capacitating them to be as independent as possible in fulfilling their usual roles and functions in society.

1.6.4 Forensic psychiatric patient

A 'forensic psychiatric patient' refers to a person who has been acquitted, by reason of insanity, of a crime charged and thereupon found to be of substantial danger to other persons or to present a substantial likelihood of committing acts that jeopardise public safety or security unless kept under further control by the court or other persons or institutions (Coutts 2011:4; Davis 2012:15). In Zimbabwe such offenders are referred to as "forensic mentally ill patients" by The National Health Strategy for Zimbabwe 2009-2013 (2009:73) and "mentally disordered or intellectually handicapped persons in custody" by the Zimbabwe Mental Health Act (1996, Part 3:171). They are referred to as "Detained Mental Patients and/or Criminal Mental Patients" by the Ministry of Justice, Legal and Parliamentary Affairs in Zimbabwe (Zimbabwe Prison Service Standing Orders [ZPSSO] 1992, Part 2, Section 81:23).

In this study a 'forensic psychiatric patient' referred to any psychiatric patient who is acquitted but then sentenced to be admitted to a special institution under the Mental Health Act of 1996.

1.6.5 Mentally stable patient

Mental stability is a state of "well being in which the individual realizes his or her abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization 2005:XVIII). According to Townsend (2006:939), mental stability refers to an individual's capacity to successfully acclimatise to those stressful situations that originate either from within them or from the outside environment. This adaptation is shown by her or his overall behavioural patterns that are in line with the society in which the person lives.

In this study the term ‘mentally stable patients’ indicated patients who were psychologically stable and had effective coping ability which manifested itself in interaction between the internal and external environment of the patient. These patients were also able to understand and retain information. The term included patients for whom the psychiatrist had made a written report to the Special Board, or the Special Board had written a report to the Mental Health Tribunal to the effect that these patients were now mentally stable.

1.6.6 Special board

A ‘Special Board’ is a board established by the Minister of Health and Child Care in Zimbabwe “for the purpose of making any recommendations or report” that may be required for forensic psychiatric patients (Zimbabwe Mental Health Act 1996, Part 9 Section 73:199).

1.6.7 Mental Health Review Tribunal

The Mental Health Review Tribunal is a court established by the President of Zimbabwe for the purpose of attending to appeals and applications made to it. These applications or appeals are made by or on behalf of patients detained in special institutions in terms of Sections 75-76 of the Zimbabwe Mental Health Act (1996 Part 9 Sections 75-76:201).

1.6.8 Special institutions

According to Part 14, Section 107 of the Zimbabwe Mental Health Act (1996:107), a ‘special institution’ is a special psychiatric unit within a prison setting that is used for detaining patients In this study the term ‘special institutions’ referred to the only two “units” or “psychiatric hospitals” placed within prison settings in the southern and northern regions of Zimbabwe respectively.

1.6.9 Framework

A ‘framework’ is defined by Fisher (2007:126) as a set of “analytic schemes that simplify reality be selecting certain phenomena/ variables and suggesting certain relationships between them.” In this study ‘framework’ referred to the formally articulated mapping of medico-judicial services within and across the multidisciplinary health and judiciary teams with regard to rehabilitation of forensic psychiatric patients in Zimbabwe.

1.6.10 Prison

A prison is “a building where people are kept as a punishment for a crime or while they are waiting to go to court for their trial” (Dictionary of Contemporary English for Advanced Learners 2009:1379).

The term ‘prison’ in this study referred to a building that housed the special institution (which is a hospital for forensic psychiatric patients) for rehabilitation purposes.

1.6.11 Judiciary

According to the Dictionary of Contemporary English for Advanced Learners (2009:948), the term ‘judiciary’ refers to “all the judges in a country who, as a group, form part of the system of the government”.

In the current study the term ‘judiciary’ referred to the functional system and staff in the criminal justice system directly involved with processes involving forensic psychiatric patients. These included magistrates, public prosecutors and clerks of the court.

1.6.12 Judicial

The Dictionary of Contemporary English for Advanced Learners (2009:947) defines ‘judicial’ as “relating to law, judges or their legislative decisions”.

In this study 'judicial' referred to the judiciary and the functional systems and staff at the special institution (prison) directly involved with processes involving forensic psychiatric patients. These included the magistrates, public prosecutors, clerks of the court, officers in charge of special institutions, and the guards.

1.6.13 Multidisciplinary team

The multidisciplinary team is described by Stuart (2009:163) as "members of different disciplines who provide specific services to the patient". Townsend (2006:939) views the concept of multidisciplinary care as service provision to a client in which individual disciplines remain independent of each other in the process of providing that care. In this study, it refers to the psychiatrists, psychiatric nurses and social workers involved with forensic psychiatric rehabilitation. In the study, they were also referred to as the medical team.

1.7 FOUNDATIONS OF THE STUDY

This study embraced an exploratory sequential mixed method design with a constructivist grounded theory approach. The goal of the study was to develop a medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe. The use of the design and approach was projected to adequately answer the research question in line with the researcher's epistemological and ontological persuasion which is reflected throughout the thesis.

Being the dominant part, the qualitative phase of the study was expected to beam on and generate an idiographic reality elicited from the participants' experiences and contexts in the rehabilitation of forensic psychiatric patients in special institutions. The quantitative phase of the research study was fundamental in consolidating or balancing the medico-judicial framework by availing a nomological level of reality based on a retrospective review of patients' files/documents (Johnson, McGowan & Turner 2010:72).

1.7.1 Meta-theoretical grounding of the study

In this study the researcher's priority meta-theoretical approach was constructivism according to the Charmaz orientation. Charmaz's proposition was to digress from the ancestor-grounded theory approach because of its positivistic orientation. Charmaz (cited in Denzin & Lincoln 2005:509) argues for "building on the pragmatist underpinning in grounded theory and developing it as a social constructionist method". What this translates to is that she proposed at the time that the constructivist grounded theory focused on realities within the research process and the position of the researcher in that process. This would then result in participants and researcher co-constructing reality in view of how they would have defined and understood it. Charmaz's stance on this notion was put more clearly when she wrote: "Categories arise through our interpretations of data rather that emanating from them or from our methodological practices...thus, our theoretical analyses are interpretive renderings of reality, not objective reporting of it." (Charmaz cited in Denzin & Lincoln 2005:510).

In the process of operationalising constructivism, Charmaz (cited in Denzin & Lincoln 2005:521-525) offers five guiding steps to direct the researcher.

1. Establish intimate familiarity with the setting(s) and events occurring within it as well as with the research participants.
2. Focus on meanings and processes.
3. Engage in a close study of action.
4. Discover and detail the social context within which it occurs.
5. Pay attention to language.

Charmaz's assertion is supported by Crotty (1998:58) and Charmaz's (2014:14) view that constructivists are disciples of a subjective epistemology, in other words, the researcher and the participant co-create an experience and its meaning. In the constructivists' approach researchers such as Guba and Lincoln (cited in Denzin & Lincoln 1994:107), Crotty (1998:58) and Gardner, McCutcheon and Fedoruk (2012:67)

point out that meaning is understood, generated and co-created in the researcher's interaction with the data. The current study particularly utilised social constructivism. The drive of social constructivism is to uncover the ways in which individuals and groups participate in the creation of their perceived reality.

The rationale for constructivism is that a constructivist believes in multiple, experientially-based and socially constructed realities. Concepts are fashioned or invented from data. What constructivists find is what they make. Charmaz (2014:13) and Sandelowski and Barroso (2003:797) wrote that for constructivists, all human discoveries are creation. The current researcher therefore utilised the social construction of the experiences of forensic psychiatric patients, their relatives, and that of the medical and judicial teams to construct the medico-judicial framework. In this study the participants were asked questions about and played a significant role in developing the medico-judicial framework for the rehabilitation of forensic psychiatric patients in an attempt to socially construct a given reality.

A small portion of this study was guided by a positivistic approach. The positivistic approach was made specific to instrumentation. The research question: "What rehabilitative mental health services are available to forensic psychiatric patients in two special institutions in Zimbabwe?" guided variables that were studied. Positivism is actually a paradigm that is associated with objectivist epistemology and this paradigm is what the researcher utilised in the secondary document analysis in this study (Saks & Allsop 2007:21). Endeavouring to explain the positivist notion, Broom and Willis (in Saks & Allsop 2007:20) posit that at ontological level, positivism should embrace **determinism, objectivity, quantification, reliability** and **generalisability.**

The researchers Bowling (2009:137), Bryman (2008:13), Polit and Beck (2010:552). Broom and Willis (cited in Saks & Allsop 2007:20) expound on aforementioned five concepts. In their mutual view, **determinism** means that whatever is under study can be predicted by using scientific laws. **Objectivity** conveys that the researcher is independent from social construction meanings; in other words, she or he is detached

from the participant. **Quantification** implies that whatever data are gathered should originate from an entity that is quantified. **Reliability** in positivism means that the results of a research study can be extrapolated to a larger population regardless of whether the hypothesis was supported or refuted. **Generalisability** is whereby findings can be generalised beyond the accessible population because the data used would not have been biased. Finally, as regards positivism, Crotty (1998:27) concludes "whereas people ascribe subjective meaning to objects in their world, science 'ascribes' no meaning at all. Instead, it discovers meaning, that is, meaning is already inherent in the objects it considers. To say that objects have such meaning is, of course, to embrace the epistemology of objectivism. Positivism is objectivist through and through."

With all this credit that positivism is endowed with, it has nevertheless been criticised as being laden with theoretical ideologies. Researchers argue that no phenomenon is value free, objective or neutral. The other concern about positivism is that it does not suit studies focused on social dynamics or sentiment (Bowling 2009:141; Polit & Beck 2010:14; Broom & Willis cited in Saks & Allsop 2007:23).

1.7.2 Theoretical framework

The theoretical framework used as a point of departure for this study was conceptualised by Pierre Bourdieu, a French philosopher. The illumination of the constructed reality for participants in the study was aided by or borrowed from Pierre Bourdieu's conceptual canon (Grenfell 2004:27). Bourdieu's concepts of habitus, field and capital were used in the current study. These concepts which embody symbolic violence, symbolic suffering, and dominance provided both a 'thinking map' and a 'talking stick' to the current study. They were also important for their heuristic and ontological value in constructing the medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe. This is to say that the concepts enabled the researcher to discover and understand that which constitutes forensic psychiatric rehabilitation and what its realities are. Pierre Bourdieu's concepts derive from his

sociological theory since Bourdieu was a social philosopher. Bourdieu's concepts of habitus, field and capital were understood and applied as follows in this study:

- ***Habitus***

This study was based on the experiences of human interaction in the prison system, the judicial system and the medical system in the context of space and time. In this interaction, attitudes, norms and values were expressed. Pierre Bourdieu calls it "habitus" (Sullivan 2002:149). Habitus refers to the conceptualisation of these systems' practices and was used to analyse and describe the said practices and understandings held by these systems in this study.

The notion of the habitus explained above was put more abstractly by Bourdieu (cited in Karabel & Halsey 1977:487) who wrote in 1977: "This means that our object becomes the production of the habitus, that system of dispositions which acts as mediation between structures and practice; more specifically, it becomes necessary to study the laws that determine the tendency of structures to reproduce themselves by producing agents endowed with the system of dispositions which is capable of engendering practices adapted to the structures and thereby contributing to the reproduction of the structures." Bourdieu's abstract explanation of the habitus is further explicated by Cicourel (cited in Calhoun, LiPuma & Postone 1993:111) who states "habitus reproduces dominant beliefs, values, and norms through exercise of symbolic power and by bestowing cultural capital". In view of this perspective, Bourdieu's concept of habitus availed a tool for analysing power and domination in the practice of forensic psychiatry rehabilitation processes.

- ***Field***

Bourdieu emphasises that human interactions are not conducted individually and in a vacuum, but rather in a context called the 'social field'. A 'field' is a metaphor used by Bourdieu to refer to social space in which relations and positions are defined within that

space (Bourdieu 2005:148). Social fields therefore represent structures that stand to signify diverse social positions grappling to be recognised as more powerful than the other.

Pertaining to the current study, the structures included the prison system, the judicial system and the medical system. Inherent in these fields were representations of varying levels of activity coined by Bourdieu (1984c:13) as "this hierarchy includes...the objective relations between the various instances of legitimation." The prison, the judicial and the medical systems may be seen and analysed as a field. In a nutshell, the field of forensic psychiatric practice in relation to the rehabilitation of forensic psychiatric patients was therefore the focus of analysis in this study.

Bourdieu's conceptualisation was also relevant in understanding the phenomenon under study since it availed a flexible approach to develop the medico-judicial framework for the rehabilitation of forensic psychiatric patients. The flexible approach referred to here was based on Bourdieu's explication on issues of "social class" (Bourdieu 1987:1). Bourdieu explains that while over-deterministic perspectives can view social classes as existing by and for themselves, he views social class as a play field where relationships are represented in time and space and where dynamics of power are always at play (Bourdieu 1987:6). This flexible view about social class made it possible for the researcher to include different sets of participants with their varied realities and perspectives in the current study.

Bourdieu's concept of symbolic violence was also incorporated into this study by Schubert (cited in Grenfell 2008:183). Bourdieu closely ties symbolic violence to the concept of cultural arbitrary with his following statement: "In any given social formation...tends to impose recognition of the legitimacy of the dominant culture on the members of the dominated groups or classes, it tends at the same time to impose on them by inculcation or exclusion, recognition of the illegitimacy of their own cultural arbitrary." (Bourdieu & Passeron 1990:41). This notion is simplified by Thompson (1984:57) who explains that some social classes are given preferential treatment by

dominant systems and that this is a form of symbolic violence. The point is that if, in the case of the current study, the norms, values or beliefs were taken from the prison system, medical system or the judicial system – whichever might have been the dominant group – these norms, values and beliefs were otherwise arbitrary. In fact, arbitrariness enforces norms, values and beliefs systematically through power coalitions in such a way that either the prison system cultural arbitrary, the medical system cultural arbitrary or the judicial system cultural arbitrary was not perceived as arbitrary but as legitimate and in the long run reproducing and legitimising relations of domination. In other words, symbolic violence to forensic psychiatric patients became legitimate and the dominant system continued to operationalise this symbolic violence while viewing it as legitimate.

According to Grenfell (2004:185), the habitus and field serve beyond being thinking tools as they are also "epistemological matrices lying at the generative root of the action of knowledge formation itself". For example, the study sought to discover and understand the medico-judicial procedures that are followed when detaining a patient in the special institution and what the realities of participants in the processes involved were. Grenfell (2004:185) emphasises that using habitus and field are both dispositional and constitutive. This means that the concepts of habitus and field stalked the entire process of the current study endeavour. Mangez (2007:57) actually borrows from Bourdieu and points out that the "constructions of a representation of reality also hides other possible ways of understanding and make sense of the world". This then supports another of Bourdieu's perceptions that the world is constructed, and can therefore be reconstructed in other ways and in other words. The medico-judicial framework symbolises such a reconstruction of reality. Bourdieu's belief that the world is socially constructed was therefore aligned to the researcher's meta-paradigmatic perspective.

- ***Capital***

Bourdieu's concept of capital was also a central 'talking sick' in this study. The habitus and the field's logic and functional configuration revolve around capital Moore (cited in

Grenfell 2008:104). Capital can be economic, social and cultural. The position and trajectory within a field are determined or 'bought' by capital (Grenfell 2004:28). This means that either the judiciary, medical or the prison systems' positions or assertion of power as the dominant field were determined by three aspects: the capital they possessed, the capital they imposed on other fields, and which of the fields defined the capital.

In his work, Bourdieu establishes that if a researcher uses his work as a framework, particularly as an epistemological framework, three dimensions need to be addressed (Grenfell 2008:222). These three dimensions include that the research study should first examine the objective position of the field in relation to the field wielding power. Secondly, the research study should map out the objective structure of the relations of the positions held within the field and, lastly, the habitus of individual agents at play should be examined (Bourdieu & Wacquant 1992a:229).

The processes involved in carrying out the objectives of the current study technically revealed the position of the field and who or what the field of power was. The structure of relations and positions held within the field became obvious during the course of the study and when the habitus of the prison system, the judiciary and the medical systems were analysed in the process. In Chapters 4and 5 the nature of forensic psychiatric practice in relation to the rehabilitation of forensic psychiatric patients in special institutions as a social field is fully explained thus connecting the notion to the inherent social power.

The decision to use Bourdieu's concepts as a theoretical framework was decided upon after the open and axial coding of the data were done as emerging categories and themes seemed to 'talk' to the concepts mentioned above. In other words, Pierre Bourdieu was used during the interpretation of findings and not in the initial analysis. The other reasons for this decision included that the major thrust of the study was to understand the rehabilitation of forensic psychiatric patients in Zimbabwe; this is a behavioural process which is a defining feature of the grounded theory approach. Using

Pierre Bourdieu's concepts would also inform the mixed method design by availing a context of the processes and grounding the logic of why the findings and results came out the way they did (Creswell 2013:117; Johnson et al 2010:68). The focus of a mixed method and grounded theory approach was also to develop a framework grounded in the data from the field based on the views of the participants. The use of Bourdieu's concepts was also due to the fact that the discipline background, namely psychiatry, draws from sociology (Creswell 2007:78). This study particularly constructed the participants' reality using Bourdieu's conceptual terms in the course of the data analysis as well as the discussion of the findings.

1.8 RESEARCH DESIGN AND METHOD

The following section briefly describes the research design and method that was used in this study. A detailed account is given in Chapter 3.

1.8.1 Research design

A mixed methods design and a constructivist grounded theory approach were used in this study. This involved conducting the study in two phases that occurred sequentially but with the qualitative phase having the greater emphasis over the quantitative phase (Creswell & Plano Clark 2011:71). In other words, the study utilised an exploratory design that was sequentially timed. Mixed methods also allowed for the research questions relating the second quantitative phase of the study to emerge from the inferences from the qualitative phase (Mertens 2005:292).

1.8.2 Research method

The qualitative phase constituted of semi-structured interviews with the judicial team, the medical team, relatives of male forensic psychiatric patients, and male mentally stable psychiatric patients who met the selection criteria. The information elicited from the interviews was then used to develop a retrospective survey data sheet (see

Annexure 12) that was then used to implement the second part of the study which was the quantitative phase.

In the quantitative phase, retrospective collection of data from the records of patients admitted between 2005 and 2010 occurred. These documents were randomly selected as discussed fully in Chapter 3.

1.8.3 Population and sample

The population consisted of members of the multidisciplinary team, judicial team, relatives of forensic psychiatric patients, male mentally stable forensic psychiatric patients, and documents (records of patients admitted between 2005 and 2010). The sample was mixed because the study was conducted in different stages. The judicial team included the clerk of the court, mental health review tribunal, officer in charge, public prosecutors, an Attorney General and magistrates directly related to the commission of forensic psychiatric patients to special institutions.

Purposive sampling was initially used for the selection of the multidisciplinary health team which included all current psychiatrists, occupational therapists, medical social workers and psychiatric nurses. Theoretical sampling of other stakeholders and experts was then applied as the research study evolved. This is detailed in Chapter 3 of the study.

Proportional quota sampling was used to select 119 documents (20% of 598) as per Stoker (cited in de Vos, Strydom, Fouché & Delport 2011:225). This was followed by the systematic sampling of documents from each quota. The sampling strategies' thrust was to generate quantitative data to answer the pertinent research question (Teddlie & Yu 2007:97). A thorough discussion follows in Chapter 3 of this study. The selection criterion is also detailed in Chapter 3.

1.8.4 Data collection

Data were collected using semi-structured interviews of individual participants, memo writing, field notes and a researcher reflective diary in the qualitative phase. In the quantitative phase document review was used to collect data. After it was initiated during the very first interview, a memo-writing thread ran through the entire data collection process. Memo-writing eventually spilled over into the data analysis phase.

1.8.5 Data analysis

The analysis of the interview transcripts and field notes was done manually. The study used a constructivist grounded theory approach and was therefore aligned to the Charmaz convention whereby data analysis was conducted at the same time as the data collection in a process that was iterative and comparative of evolving data. This included open-coding, focused coding, axial coding and theoretical coding with memo-writing embedded in all these data analysis phases. The documented data were analysed using SPSS version 16.0. Descriptive statistics were employed to summarise and present the data.

1.9 RIGOUR IN RESEARCH

Rigour is a systematic way of handling the research process. It includes the careful and thorough collection, analysis and interpretation of the data in such a way that an independent researcher should be able to re-analyse the data using the same processes and come up with the same results (Bowling 2009:152). Rigour was obtained through trustworthiness of the qualitative data and validity and reliability of the quantitative data (Lincoln and Guba (1985:231).

1.9.1 Trustworthiness of the qualitative phase

The researcher sought believability in the study by following the specifications of Polit and Beck (2010:551). These authors set a standard for trustworthiness in qualitative research that parallels the standards of reliability and validity in quantitative research. These techniques include credibility, transferability, confirmability, dependability and authenticity. A detailed description is given in Chapter 3.

1.9.2 Validity and reliability in the quantitative phase

In this study the validity and reliability of the data sheet used to collect information from the documents of forensic psychiatric patients admitted in the special institution between 2005 to 2010 were done through pilot testing the instrument on documents that covered the period from (and including) 2004 to (and including) 2011. In Chapter 3 the details of how validity and reliability were ensured are presented.

1.10 ETHICAL CONSIDERATIONS

Ethical clearance for this study was granted by the University of South Africa, Medical Research Council of Zimbabwe, the Department of Research and Development in the office of the Commissioner of Prisons and Correctional Services, the Chief Executive Officer in charge of the national referral psychiatric hospital, the Attorney General's office in charge of public prosecutors and clerks of court, and the Judicial Service Commission in charge of magistrates and judge participants. (See Annexure 3, 4, 5, 6, 7 and 8). Individual voluntary participant consent was also obtained. (See Annexure 9, 10 and 11). No participant was remunerated for participating in this study.

Emotional or mental health problems render a person vulnerable. A person who is vulnerable is an individual that has been diagnosed with an illness which makes him or her unable to exercise autonomy that embodies self-determination (Keogh & Daly 2009:277). Forensic psychiatric patients involved in this study were perceived as

vulnerable persons. However, the male forensic psychiatric patients that were selected for interviews were those who were perceived as being able to sustain their autonomy and self-determination as specified in the inclusion and exclusion criteria in Chapter 3. These forensic psychiatric patients and other participants' inherent ethical issues are discussed next.

Ethical considerations, namely respect for persons, the process followed to obtain informed consent, beneficence, justice and confidentiality were addressed in each phase of the current study. Adhering to the ethical requirements for research presented no problem as far as the judicial team, the medical team and the relatives of forensic psychiatric patients were concerned. However, an ethical issue surfaced when the researcher needed to interview forensic psychiatric patients as participants.

Any researcher who seeks to interview forensic psychiatric patient participants like this researcher did is limited by the specification of Subsection 5 of the Zimbabwe Prison Service Standing Orders (ZPSSO) (ZPSSO 1992, Part VI, Section 129, Subsection 5:47) that applies to Grade 3 prisons and which stipulates that "all interviews [including research study interviews] shall be conducted in sight and hearing of a prison officer who shall understand the language spoken. The interview shall take place in a room or some form of enclosure. At least a table should separate the parties." This specification applied to the Grade 3 prison (special institution) in the southern region of Zimbabwe that was included in this study.

Subsection 6 of the Zimbabwe Prison Service Standing Orders applied to the Grade 4 prison (special institution) in the northern region where part of this study was done. This subsection specifies that "all interviews shall be conducted in sight and hearing of a prison officer understanding the language spoken. The interview is to take place in the visiting room, the parties being separated and battery screening used". It is further stipulated in the Zimbabwe Prison Service Standing Orders (ZPSSO 1992, Part VII, Section 138, Subsection 6:49) that "Class D prisoners [in this study these were the participants who met the inclusion criteria] will see one visitor per visit and the duration

shall not exceed 15 minutes. Each visit will be in the presence and hearing of the Prison Officer who understands the language. The parties will be separated by two sections of battery screening 1 metre apart. The area between the parties will be supervised by a Prison Officer and the prisoner will be under escort. The prisoner will be strip searched on entering and leaving the visitor's room."

These legalistic obligations imposed by the law technically violated the provisions of the Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe (2011:9) on which the Medical Research Council of Zimbabwe had based their consent and permitted the researcher to conduct this study. What this meant was that the researcher had to negotiate or navigate this assertion and legitimating of power by the prison system by using the social and ethical resources that she possessed. The primary resource was embodied in letters of approval from the office of the Commissioner of Zimbabwe Prisons and Correctional Services. (See Annexure 4, 5 and 7). The letters became very valuable, especially when considering that the researcher did not expect that at any one point during the study it would be needed to revoke the latent clauses included in the approval from the Commissioner of Zimbabwe Prisons and Correctional Services. The Commissioner had inherent authorisation to permit the interviewing of forensic psychiatric patients and the use of audio recorders. In other words, by granting permission for the research to be undertaken the implication was that every aspect of the research proposal, including the methodology where audio-recording was part of the data collection procedures, applied.

The secondary social resource hinged on the fact that the researcher had already been involved in the system of psychiatry and thus familiar with other players in the then current system related to forensic psychiatric care and practice. This justified her interest in forensic psychiatric rehabilitation. She was at least able to successfully negotiate the removal of guards during interviews but other barriers, for example, the table that had to be used to separate her from the forensic psychiatric patient participants, was not negotiable.

1.10.1 Respect for persons

According to the Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe (2011:7-9), particular ethical principles promote respect of persons. Individuals must be treated as autonomous agents. In this study the multidisciplinary health and judicial teams were considered as autonomous individuals but the male mentally stable forensic psychiatric patients were not. Beneficence and justice are other aspects associated with respect for persons. The following is an account of how these issues were dealt with.

1.10.2 The process followed to obtain informed consent

Consent is the prospective participant's confirmation that he or she is interested to be part of a study and obtaining it is mandatory in ethical research (Grove, Burns & Gray 2012:180). The participants in this study went through an informed consent process during which it was explained to the satisfaction of each participant exactly what the study would involve and what would be expected of him or her. The participants were involved in the study on a voluntary basis and had the right to decline participation. To this effect, there were relatives of patients who actually declined to be interviewed.

All potential participants went through the consent process with the researcher before participating in the semi-structured interviews. The researcher read the consent form out loud to the potential participants. When she was certain that the participants understood the study procedures (they asked no more questions and did not need additional clarification on any aspect) the researcher obtained written consent from each that they voluntarily participated. She also obtained permission from each to audio-record the semi-structured interviews. All this was conducted in English, Shona or isiNdebele. It is important to take note that one key participant refused to sign the consent form for personal reasons; however, this participant agreed to give verbal informed consent and the verbal consent was audio-recorded forthwith. The researcher indicated this development in the consent form. The researcher then signed the consent

form on behalf of and in the presence of the key witness. An independent witness voluntarily countersigned also in the presence of this key witness. The interview was subsequently recorded.

The participants were not included in this study without their knowledge and agreement. The researcher provided written feedback to the participants on the general study findings and its implications.

1.10.2.1 Protection of the vulnerable participant

Capacity to give consent was made on the basis that the patient was stable as indicated by the fact that he was waiting for a review by the Special Board or the Mental Health Review Tribunal. If a patient was waiting for the Special Board or Mental Health Review Tribunal it meant that they were ready to be discharged. If the participant was unable to understand and retain information about the study, could not use that information to make a decision about participation or could not communicate that decision, they were considered not to have the capacity to consent to participation and were therefore excluded from the study.

The forensic psychiatric patients who met the eligibility criteria were invited to participate in the study. Written informed consent (Johnson & Christensen 2008:109) was obtained from each participant prior to participation. Transparency was upheld in terms of the objectives of the study, types of data to be collected as well as the benefits to the participants.

1.10.3 Beneficence

Deriving from the Belmont Report (1979) and the Declaration of Helsinki (2013) adopted in 1964 and last amended in 2013), Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe (2011:5) spells out that beneficence is the obligation to not do harm to the participant and to maximise benefits to her or him. Based on this

assertion, the researcher's obligation in this study was to protect the participants from unnecessary discomfort and harm (Polit & Beck 2012:152). The authors observe that risks may be physical, emotional, social or financial.

The researcher did not perceive that any major risks could be posed to members of both the multidisciplinary health and judicial teams as well as to the forensic psychiatric patients. Hillbrand (2005:296) points out that there are minimal risks in forensic psychiatry research. However, the fact that the results of this study were taken out of their scientific context and communicated to the policy makers that would validate the development of the medico-judicial framework, might have put the image of the forensic psychiatric patients at risk.

Forensic psychiatric patients are vulnerable because they are placed in coercive institutions where they are perceived as unable to protect their interests. To address this, participants participated in this study on a voluntary basis where only interviews with no intervention were done. The researcher attempted to build a relationship of trust with all participants before the interviews through having an attitude of respect, being open to alternative views and using facilitative communication techniques. Participation was voluntary and withdrawal was without penalty.

The overall benefit of the study was that it could contribute to the development of a more transparent research-based medical and judicial framework that would improve therapeutic innovations, quality of life and recovery of forensic psychiatric patients in special institutions in Zimbabwe.

1.10.4 Justice

The right to fair treatment holds that each person should be treated fairly and receive that which they are supposed to receive. Justice also encompasses the right to privacy which can be practically expressed as confidentiality (Grove et al 2012:159; Polit & Beck 2012:155).

1.10.4.1 The right to fair treatment

The right to fair treatment was ensured by adhering to rigorous procedures. The researcher made certain that the participants' contributions were handled professionally and respectfully without violation of their rights. She informed participants of the right to access professional assistance if desired and the right to clarify what the participants did not understand. The right to fairness was also observed by the selection processes of sites, participants and documents. The special institutions were selected for the study so that concerns from both regions of the country could be addressed. All medical and judicial staff directly involved in the rehabilitation process of forensic psychiatric patients was included in the study. Forensic psychiatric patients who met the inclusion criteria were included in the study. Relatives of the forensic psychiatric patients also participated. Documents that were reviewed were selected using systematic sampling after nesting them into years spanning from 2005 and 2010.

1.10.4.2 The right to privacy

Polit and Beck (2012:156) note that a researcher must ensure that there is minimal intrusion and that the participants' privacy is maintained throughout the study. In the context of this study, it meant that the researcher was to interact with the participants without any disturbances and keeping all details surrounding the interviews as private as possible. The right to privacy in this study was observed by using codes instead of participant names. There were no identifiable features on the final script. Names of the admitting institutions were referred to in expansive terms to protect their anonymity, for example, 'special institutions'. Privacy was further observed by conducting the semi-structured interviews in the privacy of the doctor's consulting room where there were minimal intrusions and/or interruptions. At the time the study was conducted the doctor's consulting room in the special institutions was kept locked on Wednesdays since the reviews were done only on these days.

Before the interviews participants were informed that all the information they gave would be gathered, collated and stored within a system that would operate in the strictest of confidence.

1.10.5 Confidentiality

Participants involved in a study have the right to confidentiality; hence, any information they share must be kept strictly confidential (Polit & Beck 2012:158). Confidentiality was addressed by the researcher when she and the participants agreed that all the information recorded during the interviews would not be shared in a way whereby a participant could be identified. The interviews were audio-recorded. The digital recording machine and the transcripts were locked in the safe in principal tutor's (researcher's) office. Identifiable information such as interview transcripts was not kept on the researcher's personal computer.

It is projected that the data pertaining to this current study will be destroyed when it is no longer of functional value. This is projected to be five (5) years from the date of publication of this study. The researcher will personally destroy the audio-recordings used during the semi-structured interviews. All records stored on the computer's hard drive will be erased using commercial software designed to remove data from the storage device. The USB drive will be physically destroyed. A record stating when, how and which records were destroyed by the researcher will also be kept.

1.10.6 Meeting ethical considerations involving document and records

Documents or records refer to "official documents deriving from the state or deriving from private sources" (Bryman 2008:515). It is further explained by Saks and Allsop (2007:58) and Bowling (2009:448) that records can be produced by a third party like, for example, in a hospital setting where the storage of patients' notes can be built up over time. The documents referred to in the study were patients' files generated by the judicial system and kept by the prison system at special institutions.

Permission to review documents of forensic psychiatric patients admitted in special institutions between 2005 and 2010 for the second phase of the study was sought from the University of South Africa (Unisa), the Medical Research Council of Zimbabwe and the Commissioner of Zimbabwe Prisons and Correctional Services respectively. The researcher was aware that gaining approval from the ethical review committee of University of South Africa and the Medical Research Council of Zimbabwe was no guarantee that she would gain access to the data. Therefore, she requested the Commissioner of Zimbabwe Prisons and Correctional Services, to extend the secrecy that governs the release of confidential data in the prison system (where special institutions are housed) to her. This involved transferring secrecy from this authority to the researcher through approval letters. (See Annexure 4, 5, 7 and 8). This then meant that the researcher had the responsibility of protecting the data. The data were subsequently stored in a high security safe in the researcher's second inner office which was only accessible to her.

1.11 OUTLINE OF THE CHAPTERS

The outline of the chapters in this study follows below.

CHAPTER 1: Orientation to the Study

CHAPTER 2: Literature Review

CHAPTER 3: Research Design and Methods

CHAPTER 4: Qualitative Findings

CHAPTER 5: Quantitative Results

CHAPTER 6: Discussion of the Current State of Forensic Psychiatric Rehabilitation in Zimbabwe

CHAPTER 7: A Medico-Judicial Framework for the Rehabilitation of Forensic Psychiatric Patients

CHAPTER 8: Summary, Conclusions, Limitations and Recommendations

1.12 SUMMARY

In this chapter the background to the research problem, statement of the research problem, and aim of the study were discussed. The significance of the study, definition of terms and foundations of the study were also addressed. The research design and methods, rigour in the qualitative phase of the study, validity and reliability of the quantitative phase of the study, and the ethical considerations were briefly mentioned.

An extensive literature review as regards the global perspective on rehabilitation in forensic psychiatry is presented in Chapter 2.

CHAPTER 2
LITERATURE REVIEW

"We are certainly getting ahead; if I am Moses, then you are Joshua and will take the promised land of psychiatry, which I shall only be able to glimpse from afar."
Sigmund Freud (1909)

2.1 INTRODUCTION

This chapter presents a global perspective of the literature related to rehabilitation in forensic psychiatry. The literature review is a process in which a researcher organises in writing that which has already been published by other scholars (Bowling 2009:147; Bryman 2008:81; Jones cited in Saks & Allsop 2007:32; Saunders, Lewis & Thornhill 2009:58). This chapter focuses on the literature related to the evolvement of forensic psychiatry and the legal procedures followed in the detention and treatment of forensic psychiatric patients in developed countries as well as in developing countries. The study was conducted in Zimbabwe, an independent developing country in sub-Saharan Africa.

2.2 APPLICATION OF LITERATURE IN THE STUDY

Literature relevant to the current study was initially reviewed to identify areas of forensic psychiatric care that had already been explored. The literature review also sought to shape the research questions and provide insight and reflective focus throughout this study (Bryman 2008:81). This decision to apply literature in this manner derived from Glaser (1998:67) who posit that "Grounded theory's very strong dicta are a) do not do literature review in the substantive area and related areas where research is to be done, and b) when grounded theory is nearly completed during the sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison."

Literature was therefore meant to contextualise the research study. After the findings, a literature control was done in order to 'ground the data' so as to develop a credible medico-judicial framework (Dunne 2011:121; Johnson & Christensen 2008:66; Polit & Beck 2010:170; Tritter cited in Saks & Allsop 2007:302).This was also in line with Charmaz (2006:165) who points out that "the intended purpose for delaying literature review is to avoid importing preconceived ideas and imposing them on your work. Delaying the review encourage you to articulate your ideas". This then basically means that the preliminary literature identified gaps for the research in relation to forensic psychiatric practice while extant literature controlled the findings of the study. This is to say findings in this Grounded theory based study were considered to be the 'researcher's ideas' as already alluded to by Charmaz. Extant literature therefore "earned its way into this narrative (findings)" as posited by Charmaz (2006:126).This means that as study data analysis evolved, I engaged in literature that explained or refuted the emerging categories and themes to maximise on the rigor and quality of the analysis that eventually led to the development of the medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.

Figure 2.1 is a graphic presentation of how the literature review was used in this study. It highlights how preliminary and extant literature was applied to the development of the medico-judicial framework.

Although the literature review pertaining to the developed countries centred on the United Kingdom (UK), references to other foreign medical and judicial systems was also included. Velinov and Marinov (2006:98) point out that variations exist around the globe with regard to the forensic psychiatric practice, services and treatment modalities that are available to forensic psychiatric patients. One reason for highlighting the UK as representative of other developed countries in this respect, is that it is viewed as highly developed by Bourget and Chaimowitz (2010:160) as well as the European Commission (2005:135) thus rendering the UK a role model for forensic psychiatric practice.

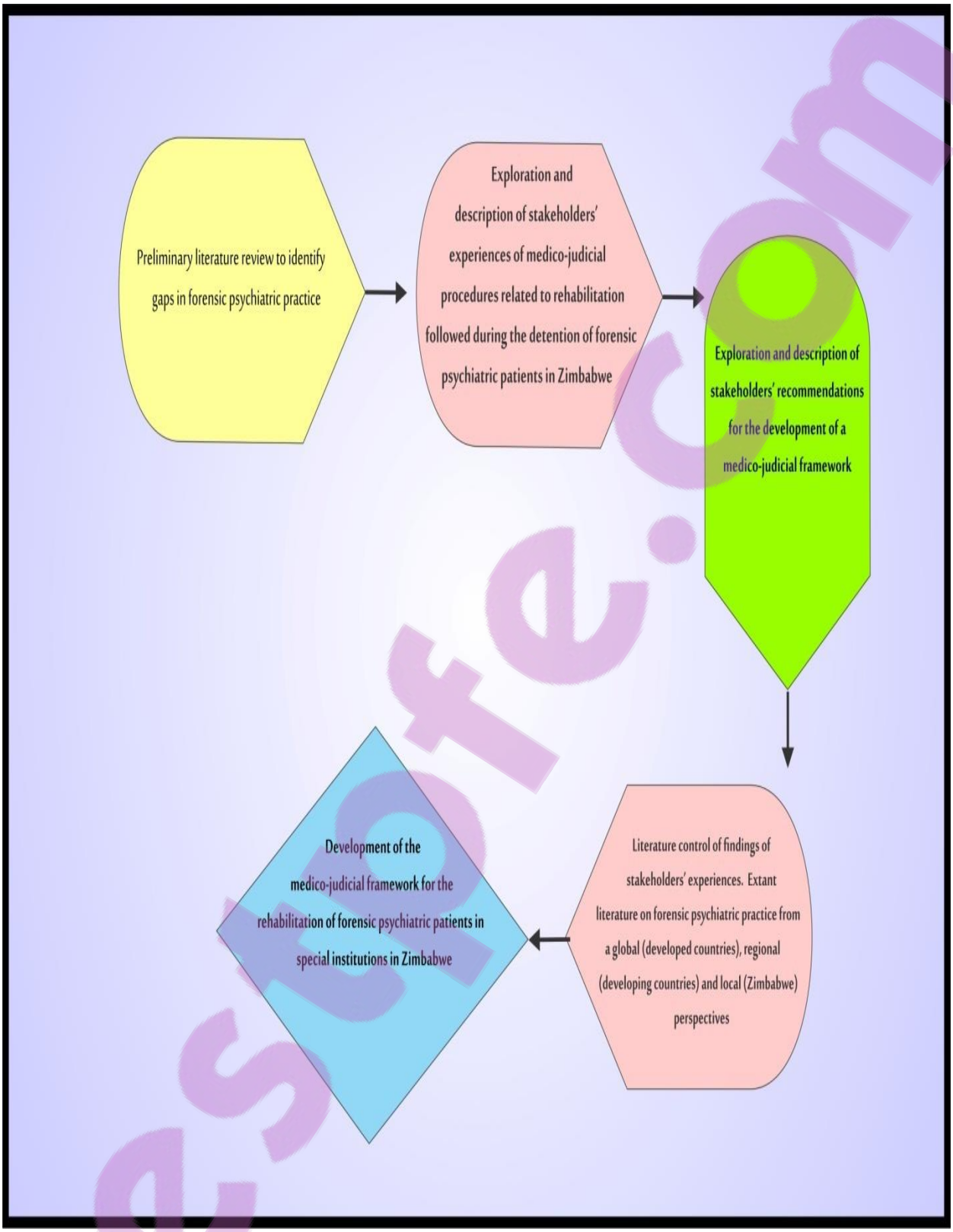

FIGURE 2.1: Application of preliminary and extant literature in the study

Another reason is that, as a former British colony, Zimbabwe modelled its medical practice after the UK model. The conception of psychiatry in Zimbabwe was also controlled by British legal frameworks. For example, it is the then British government that passed the Lunacy Ordinance of 1908 to regulate psychiatry in Southern Rhodesia (now Zimbabwe). This Ordinance was later revised to become the Southern Rhodesian Mental Disorders Act of 1936. This particular Act was derived from the 1930 Mental Treatment Act of England and Wales. The Southern Rhodesian Mental Disorders Act of 1936 was also used (Jackson 1991:74). The Mental Health Act of 1976 became functional afterwards. These instruments were the ones used in psychiatry in Zimbabwe which, until 1980, was known as Southern Rhodesia. After independence when Southern Rhodesia changed its name to Zimbabwe, the Mental Health Act of 1976 was yet again repealed by the currently used Zimbabwe Mental Health Act of 1996 (Zimbabwe Mental Health Act 1996:157).

It can be posited that uncertainties experienced in forensic psychiatric practice in Zimbabwe today could be as a result of decisions made in the past. In fact, this may be the reason why current information on forensic psychiatry directly relevant to Zimbabwe is scarce and medico-judicial frameworks have not yet been fully explored in forensic psychiatric practice literature in Zimbabwe. It was therefore necessary to rely heavily on foreign sources throughout this study.

2.3 HISTORICAL OVERVIEW OF FORENSIC PSYCHIATRY IN DEVELOPED COUNTRIES

A historical overview of forensic psychiatry was done from the perspectives of both the developed and developing countries and this was conceptualised as the world. This section describes how forensic psychiatry evolved in the developed world.

Gutheil (2005:250) draws a sinister picture of the drastic measures used in forensic psychiatry around 180 AD. This was in the time of the rulership of Marcus Aurelius, Roman Emperor and scholar. During that time a mentally ill person was restrained but if

he or she escaped and injured other people, his or her family was executed. Gutheil (2005:259) also gives earlier rudimentary symbolic features of forensic psychiatry by relating a legend that involves a retired Roman general by the name of Cincinnatus. The legend tells that the general came to know that authorities were on their way to meet with him. It was his belief that they would order him to once again lead the army. To avoid this possibility, the general hitched up his plough and started sowing salt as seed. Witnessing the general's strange behaviour did not convince the authorities and so they ordered an infant grandchild of Cincinnatus to be put in the path of the plough. The general naturally turned the plough away and was accused of malingering (you cannot be diagnosed as malinger but accused of malingering) because he pretended to be mad to escape his duty. Expanding on the phenomenon of pretending to be mentally ill, Gold (2012:249) adds that in 1844 Acland published a book on this condition entitled, *Feigned insanity: How most usually simulated and how best detected*.

Gutheil (2005:260) reports on the situation in medieval Europe where views of the time revolved around the belief that forensic psychiatric patients had "sold themselves to the devil" and hence developed mental illnesses. In support of Gutheil's work, Gordon and Lindqvist (2007:421) observe the development of forensic psychiatry in "European countries and also particularly in Russia (Central Asia)" was marred by the ruling system's tendency to use psychiatry in incarcerating "religious and political dissidents". Nedopil (2009:226) explains that in the Middle Ages, Continental Europe did not exempt the mentally ill from prosecution after they had committed crimes. This ideology changed during the "Age of Enlightenment"' when the Catholic Canon Law began to support the ancient Greek and Roman (Graeco-Roman) view that led to the conception and birth of forensic psychiatry (*Concise Oxford English Dictionary* 2006:617). Swanepoel (2009:126) believes that much of the Graeco-Roman terminologies pertaining to psychiatry are still being used today. According to Nedopil (2009:226), one of the first medical practitioners to trigger the development of forensic psychiatry was Dr Paolo Zacchia (1584-1659) who held an advisory role within the governance of the Roman Catholic court.

Gutheil (2005:260) writes that the evolvement of forensic psychiatry was greatly impacted by philosophers like Kant and Kraepalin. In the 1790s Immanuel Kant's Diagnostic and Statistical Manual focused on issues that were relevant to forensic psychiatry. Gutheil (2005) names Emil Kraepalin as the initiator of the classification of forensic psychiatry as a medical science and criminal behaviour as a mental illness.

Simon and Gold (2010:7) narrate that before 1800 the legal system did not solicit medical opinions in criminal cases because mental illness was steeped in cultural beliefs. This situation was reversed when Edward Oxford was tried for firing at Queen Victoria in 1840. When he pleaded guilty by reason of insanity, the prosecution, despite its initial objections, eventually accepted medical witnesses' opinion that a mental illness could be the catalyst for committing a crime. The 1843 M'Naghten trial, one of the earliest forensic psychiatric cases in England, is also mentioned by both Gold (2012:247) and Nedopil (2009:226) as a turning point in forensic psychiatry. Mendelson (2002:303) observes that developments such as the aforementioned in forensic psychiatry resulted in the founding of The Lancet by Thomas Wakley in 1923. It was a scientific medical journal that was meant to address the legal, ethical and educational reform of the medical profession in England. The efforts of The Lancet have prevailed to this day.

Ciszewski and Sutula (2000:549) inform us that in Poland more than twelve psychiatric hospitals had already been providing forensic psychiatric services before World War II (1939-1945). Mullen (2000:308) explains that the history of forensic psychiatry has until recently been shrouded in geographical and professional isolation. Geographically, the patients were nursed in insane asylums and prisons and split from mainstream mental health services. Professional isolation came from the observation that primary caregivers were nurses who opted to function as prison guards instead of recognising themselves as separate from the functionality of the criminal justice system. Gordon and Lindqvist (2007:421) mention that in other parts of the world, like Germany, forensic psychiatry was destroyed or retrogressed by the 12-year rule of the Nazi regime

between 1933 and 1945. The integration of comprehensive forensic psychiatric services was only realised after 1990 when West and East Germany had been unified.

2.4 CURRENT LEGAL PROCEDURES FOLLOWED IN THE DETENTION AND TREATMENT OF FORENSIC PSYCHIATRIC PATIENTS IN DEVELOPED COUNTRIES

This section explains how forensic psychiatric patients come into contact with the criminal justice system at present. It also explains the procedures involved in the detention and treatment of forensic psychiatric patients in developed countries as shown in Figure 2.2. One country, British Columbia is going to be used as an example. This section will also highlight the assessment of forensic psychiatric patients in the developed countries.

Tarbuck, Topping-Morris and Burnard (1999:40) give a four-avenue picture of how mentally defective offenders divert into forensic care. Contact may be when a person in a police cell is perceived as mentally ill either by the custody sergeant or police surgeon. The person may already be in police custody and referred by either the court clinics, the clerk of the court or referred from remand to a forensic psychiatric hospital for assessment. The situation could also be that the person is in custody and is referred as a psychiatric emergency while in prison; there could be a request for an assessment while the person is serving a sentence or she or he may be referred from prison clinics. The person could also be on probation and referred by the probation officer or from a bail hostel.

The findings of a study focusing on forensic psychiatric processes revealed that 29% of forensic psychiatric patients had been admitted from a prison, 56% were transferred from a remand prison while 22% were transferred directly from the court (Rutherford & Duggan 2007:9). This is added to by Henderson (2003:16) who points out patients are brought into forensic psychiatric care after having been apprehended by police, during imprisonment, and directly from the community where they live.

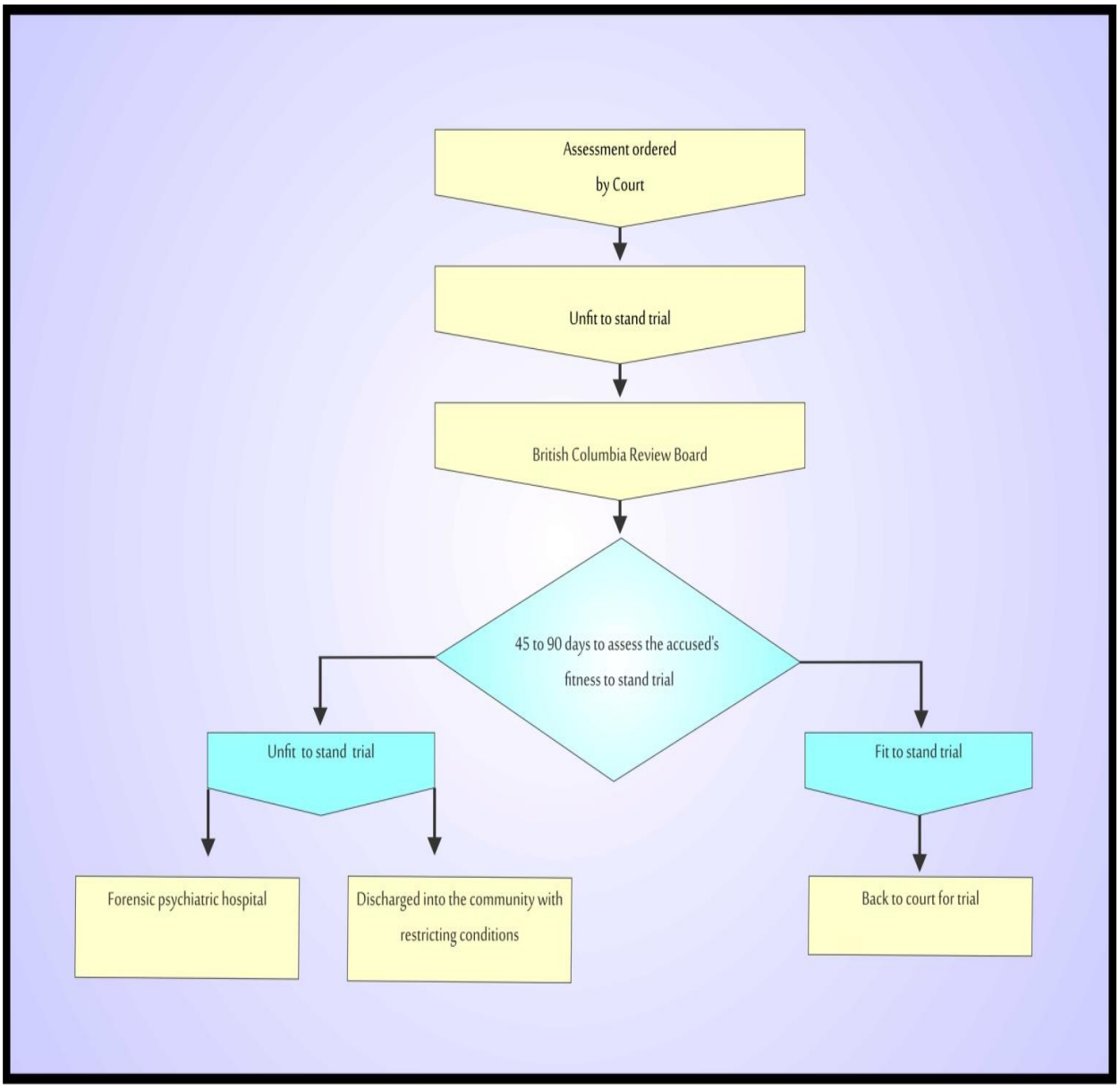

FIGURE 2.2: Procedures followed in the detention and treatment of forensic psychiatric patients in British Columbia

Using British Columbia as an example, Figure 2.2 is a diagrammatic outline of the services and procedures followed to detain and treat forensic psychiatric patients in a developed country. The diagrammatic outline is followed by a discussion on the assessment, fitness to stand trial, services at the forensic psychiatric hospital, medical team at the forensic psychiatric hospital, and therapies for forensic psychiatric patients at present.

2.4.1 Assessment of a forensic psychiatric patient

Figure 2.2 demonstrates the flow of legal events that include the assessment, treatment, parole, bail or probation orders. According to the British Columbia Schizophrenia Society (2011:6) and Henderson (2003:16), assessments are ordered by the court when it is apparent that the accused person could be mentally ill and her or his ability to testify in a court of law may be affected. The mandate for doing forensic psychiatric assessments is given to the forensic psychiatric services commission at the forensic psychiatric hospital. The assessments involve both subjective and objective data about the person.

After the person has been assessed, it is then determined whether he or she is fit to stand trial. According to the British Columbia Schizophrenia Society (2011:7), for a person to be considered fit to stand trial he or she must be in a position to follow and understand the charges levelled against him or her and what the implications of those charges are. The accused person must also understand what the judge or crown counsel represents in court. He or she should also be able to communicate with his or her legal representative so that the latter can prepare a case. A person who cannot meet these requirements is considered unfit to stand trial. This means that the person is not accountable for committing the offence and is coined as “Not Criminally Responsible on account of Mental Disorder” (Eastman, Green, Latham & Lyall 2013:79; Gordon & Lindqvist 2007:421; Livingstone, Nijdam-Jones & Brink 2012:347; Mason 2006:68). Such a patient is handed over to the British Columbia Review Board (British Columbia Schizophrenia Society 2011:7) that is mandated to call for a hearing within 90 days. If the person is fit to stand trial, he or she is returned to court and the trial continues. However, if he or she is found unfit to stand trial, the accused is sent to a forensic psychiatric hospital for care and treatment.

2.5 HISTORICAL OVERVIEW OF FORENSIC PSYCHIATRY IN DEVELOPING COUNTRIES

The African Union/New Partnership for Africa's Development (AU/NEPAD) Action Plan 2010-2015 (2009:1) describes Africa as a developing continent in view of its economic climate that reflects a general lack of resources as "compared with other areas of the developing world". It is also important to note that it is in the continent of Africa that Zimbabwe is situated.

The following part describes how forensic psychiatry developed in Africa. It also discusses the current legal procedures followed in the detention and treatment of forensic psychiatric patients in developing countries. South Africa will be used because it is a model for developing a country (Fosu 2013:14). This is followed by the historical perspective of forensic psychiatry in Zimbabwe and its attendant legal processes.

Gutheil (2005:259) explains how forensic psychiatric issues were dealt with in Africa in early times by making use of the "truth pellet". The author explains that those in Africa who were suspected of having committed heinous crimes were given a magic pellet of truth in the form of a scrap of leather that was said to be poisoned. During an emotionally charged ceremony the suspects would be given truth pellets to keep in their mouths. When the pellet was removed, the person whose pellet was not moist would be found guilty of the offense. As Gutheil (2005:259) posits, it could be quite possible that a guilty person's mouth would have become dry because of the fear of being caught.

Services that were rendered to forensic psychiatric patients evolved around the 1880s when West Africa was under colonial rule (Ogunlesi et al 2012:3).These authors write that Chapter 79 of the Lunacy Asylum Order of the Gold Coast (now known as Ghana) at the time guided the care of forensic psychiatric patients. The authors further observe that the Lunacy Ordinance of 1916 and the federal law in 1948 directed forensic psychiatric services in Nigeria where care places at the time were referred to as "asylums". Asylums such as the Calabar (established in 1903), the Yoba (established in

1907) and the Lantoro (established in1944) operated as what the authors refer to as "quasi-mental health institutions" and it was indicated that they were functionally related to prisons.

Ogunlesi et al (2012:3) emphasise that psychiatrists in Africa who are in government services currently have the responsibility of assessing forensic psychiatric patients. Egypt, for example, admits convicted patients to general hospitals while in North Africa, Tunisia and Algeria are the only countries with substantive forensic psychiatric hospitals. It is, however, important to note that in the whole of North Africa certified programmes in forensic psychiatry are non-existent.

2.6 CURRENT LEGAL PROCEDURES FOLLOWED IN DETENTION AND TREATMENT OF FORENSIC PSYCHIATRIC PATIENTS IN DEVELOPING COUNTRIES

The following is an account of the legal procedures that are followed in the detention and treatment of forensic psychiatric patients in developing countries. South Africa is going to be used as an example.

Fosu (2013:14) states that as a developing country, forensic psychiatric issues in the Republic of South Africa (SA) are dealt with in accordance with Sections 77, 78 and 79 of the Criminal Procedure Act (51 of 1977). The forensic psychiatric issues are specifically dealt with in Chapter 13 of this Act which is entitled: "Accused: the capacity to understand proceedings: mental illness and criminal proceedings." The sections that are specific to this Chapter are 77, 78 and 79. Section 77 deals with issues of the accused person's "capacity to understand proceedings". Section 78 focuses on issues to do with "mental illness or defect and criminal responsibility" and Section 79's thrust is to give parameters for a "Panel for the purposes of inquiry and report under sections 77 and 78." The major players include the South African Police Services, court magistrates or prosecutors, and medical personnel who are required to give expert opinions (Burns, King & Saloojee 2007:32). Figure 2.3 is a graphic presentation of the procedures

followed in the detention and treatment of forensic psychiatric patients in SA (Kaliski 2011:2).

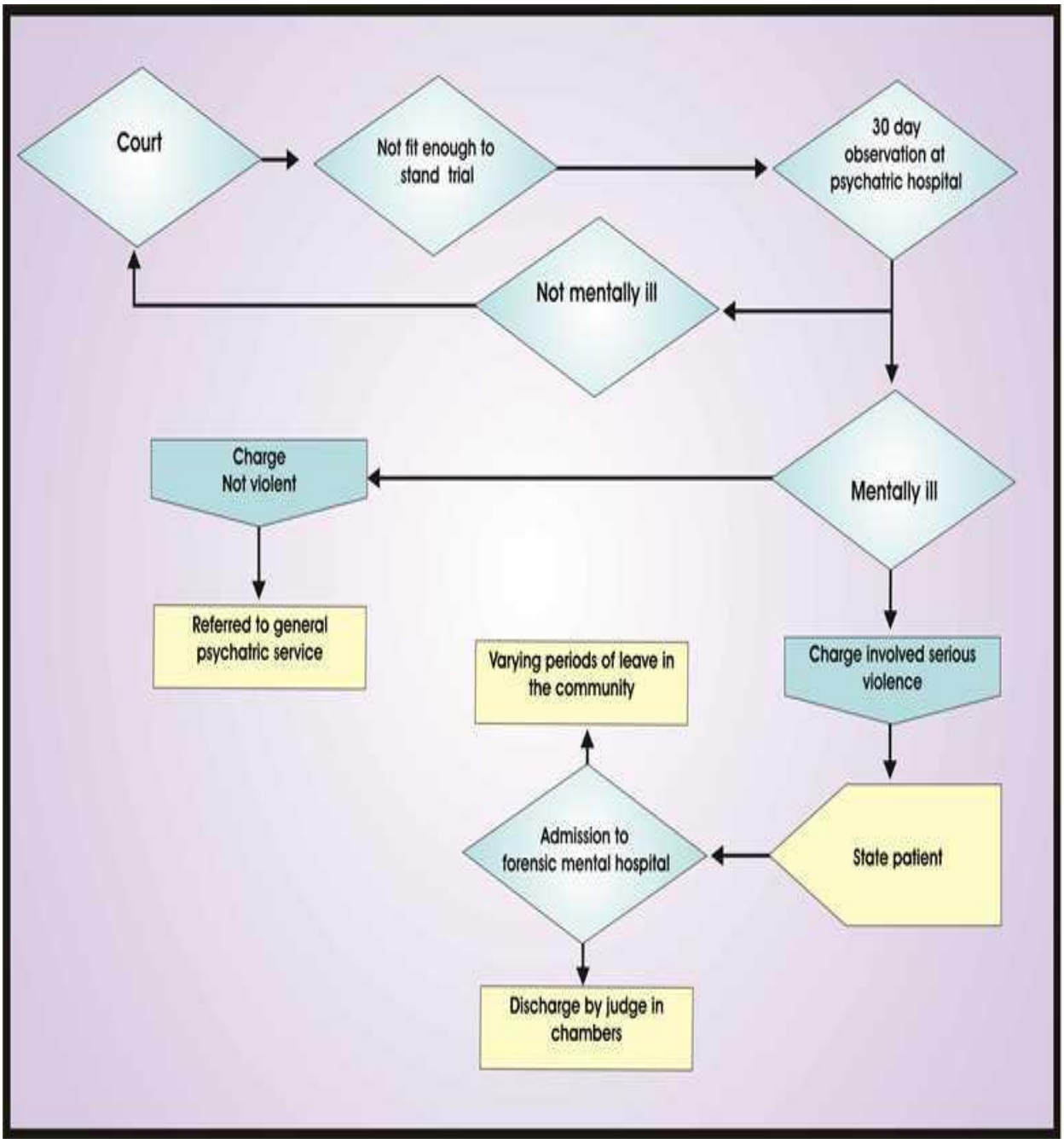

FIGURE 2.3: Procedures followed in the detention and treatment of forensic psychiatric patients in Africa with reference to the Republic of South Africa (SA)

As can be seen in Kaliski's presentation of Forensic Mental Health Services from 29 to 30 November 2011 at a workshop on norms and standards (Figure 2.3), in the process of handling forensic psychiatric patients in SA two types of populations emerge: the observation cases and the state patients. The observation cases are translated from prisoners who are still in custody and whose trials are pending. They are observed for a period of 30 days in a civil psychiatric hospital. After the 30-day period a detailed report is submitted to the court. The court has the mandate to subpoena the information that has been collected and submitted to them by the clinical observers.

Kaliski (2011:2) explains that the other group is classified as state patients because they would have committed heinous crimes such as murder or rape. State patients can be admitted to a forensic mental hospital for as long as 20 years. The judge bases her or his verdict of a state patient on the discretion of the team that would have been caring for the accused over time. Besides getting a straightforward discharge, the person may be given parole which technically means leave is granted to her or him to be returned to the community on the condition that she or he will continue portraying acceptable behaviour.

However, Mars, Ramlall and Kaliski (2012:246) note irregularities exist in the flow of forensic patients in the system especially because of a deficiency in skilled professionals. In an effort to curb these problems, a research study was done by Mars et al (2012:245-246) in which it was suggested that what is referred to as "forensic telepsychiatry" might be a possible solution. These authors therefore recommended that the African forensic psychiatric community should use forensic telepsychiatry. Forensic telepsychiatry is defined as the utilisation of "telecommunication technology to provide mental health services in a medico-legal context" (Mars et al 2012:245). Contained within this definition are forensic psychiatric evaluations, clinical consultations and patient education. Mars et al (2012:246); Chipps, Brysiewicz and Mars (2012:240) believe that using forensic telepsychiatry would reduce time and costs for transporting the accused to specialists, curb their unwarranted admissions to hospitals, and increase their access to specialist services.

2.7 HISTORICAL OVERVIEW OF FORENSIC PSYCHIATRY IN ZIMBABWE

Before 1908 the whole of British South Africa did not have any facilities to address and provide mental health services to mentally ill persons (Jackson 1991:74). Those who were mentally ill were called “lunatics” and were either held in prisons or transferred to the Transvaal and Cape Colony in SA. In 1903 a medical director, Dr Flemming, pushed motions to the Legislative Council highlighting that it was not cost-effective to send patients to SA for treatment. Subsequently, the Legislative Council built the Ingutsheni asylum that became functional in June 1908. This asylum was, however, meant only for African patients as the Legislative Council continued to send white patients to South Africa. This asylum was staffed with personnel similar to that in the prisons where patients had been referred from. It consisted of the non-resident medical superintendent, the assistant medical director, head keeper, two male keepers and an assistant keeper.

In the same year, 1908, the Legislative Council passed the Lunacy Ordinance which allowed any magistrate or constable with information on any “lunatic” to send that “lunatic” either to a prison or the asylum. The same magistrate or constable was mandated to give a legal way forward for the incarcerated patient. The Ordinance also allowed custodial care of “lunatics”. At the time, it was also possible to send a problematic patient back to prison after they had been admitted and treated in the asylum (Jackson 1991:75). Unfortunately, this approach has not changed much since then. As described in the aforementioned scenario, vestiges of the historic views and perceptions of forensic psychiatry remained embedded in how the problem was addressed in Zimbabwe; but, it became even more apparent when Dr Flemming insisted that patients suffering from delirium tremens and syphilis be cared for separately from “genuine criminals” (Jackson 1991:74).

Currently, the rehabilitation of forensic psychiatric patients is done at special institutions in Zimbabwe (The National Health Strategy for Zimbabwe 2009-2013 2008:73). A special institution is a prison facility manned by guards and nursing staff seconded from

the psychiatric referral hospital. The facility is visited by a psychiatrist three times a week. The only two special institutions in Zimbabwe were gazetted in Parliament: the one in the southern region in 1978 and the one in the northern region in 2000. The gazetting was based on the approval and understanding between the then Ministers of Justice, Legal and Parliamentary affairs and the Minister of Health and Child Welfare as specified in Part XIV, Section 107 of the Zimbabwe Mental Health Act (1996:212). According to The National Health Strategy for Zimbabwe 2009-2013 (2008:73), the care of forensic psychiatric patients has been affected by the fact that the Special Boards and the Mental Health Review Tribunal are not able to carry out their duties as required. The document also recognises that comprehensive forensic psychiatric care requires multisectoral, multidisciplinary, community as well as corporate involvement and participation.

Currently, both general psychiatry and forensic psychiatry in Zimbabwe are guided by the Zimbabwe Mental Health Act of 1996 (The National Health Strategy for Zimbabwe 2009-2013 2008:73). This Act is operationalised by the Zimbabwe Mental Health Regulations of 1999.According to Sections 27 to 30 of the Zimbabwe Mental Health Act (1996), if a person in custody is suspected to be intellectually handicapped, the court orders an assessment of such a person by two medical practitioners. If the person is found to be mentally stable, the court proceeds with legal prosecution. The process is reported to the Secretary of Health and Secretary of Justice, Legal and Parliamentary affairs by the presiding judge or magistrate (Zimbabwe Mental Health Regulations 1999:274). If the person is found to be mentally ill, the charges are withdrawn by the Attorney General and he or she is sent to a special institution for care and treatment in accordance with Section 32 of the Zimbabwe Mental Health Act (1996). While detained in the special institution, the psychiatric team at the institution will write periodic reports to the Secretary of Health (Section 33) (Zimbabwe Mental Health Act 1996). When patients admitted specifically under Sections 27 and 28 are due for discharge from the special institution, notice of this intention is given to the Attorney General. On receipt of the communication the Attorney General may either proceed with prosecution of the forensic psychiatric patient or drop the charges against the patient as per specifications

of Section 31 of the Zimbabwe Mental Health Act (1996:180). For patients whose charges have been dropped (Sections 27 and 28) and for those who would have been admitted under Sections 26, 29 and 30, Special Boards make reports to the Mental Health Tribunal. The Mental Health Tribunal either transfers the patient to another institution for further treatment or may directly discharge the patient as stipulated in Section 35 of the Zimbabwe Mental Health Act (1996:181).

It is also important to note that while the patients are admitted in the special institution, instruments other than the Zimbabwe Mental Health Act of 1996 and the Zimbabwe Mental Health Regulations of 1999 also apply to the same patients. These are the Zimbabwe Prison Act (1996:467) and the Zimbabwe Prison (General) Regulations of 1996 (1996:24). These two instruments are operationalised by what is known as the Zimbabwe Prison Service Standing Orders or the Commissioner's Standing Orders of 1992. Section 21 subsections 1 of the Zimbabwe Prison Act Chapter 7:11 empower the Commissioner of Prisons in consultation with the relevant Minister of Justice, Legal and Parliamentary Affairs to make Standing Orders without necessarily going through publication in the gazette. So the Commissioner of Prisons has the power to incorporate Standing Orders that may have been made previously for the smooth administration of the prison. In fact, this arrangement seems to be the source of the chaos in the care of forensic psychiatric patients in special institutions in Zimbabwe.

2.8 FORENSIC PSYCHIATRIC REHABILITATION IN DEVELOPED COUNTRIES

Lindqvist and Skipworth (2000b:322) advocate for rehabilitation to start soon after admission to ensure that the forensic psychiatric patient gets as much exposure to treatment modalities as possible. The authors explain that rehabilitation should make the patient perceive admission as a way of preventing further admissions and as a strategy to improve their quality of life.

The British Columbia Schizophrenia Society (2011:11) prescribes that as soon as a forensic psychiatric patient arrives at an institution a team of experts must be assigned

to her or him. The team includes the psychiatrist who leads the team, the case management coordinator, the primary nurse, social worker, psychologist, vocational services staff as well as the staff responsible for therapeutic leisure activities, the occupational therapist and a pastor. The goal of having this team is to design and execute a plan that will assist with the reintegration of the forensic psychiatric patient into the community.

According to Skipworth (2005:71) and (Lindqvist & Skipworth 2000b:321), when the health, public and political systems enable and provide forensic psychiatric patients with a variety of staff, it fosters trust and cohesion that is sustainable and has an overall effectiveness in the long-term care and treatment of such patients. Reaffirming this assertion the Irish Mental Health Commission for Forensic Mental Health Services for adults (2011:21) additionally predicts that it maximises the effectiveness of care to an individual forensic psychiatric patient. Ciszewski and Sutula (2000:552) propose that departments utilise psychologists whose core business in forensic psychiatric rehabilitation is the patient's therapy. Psychiatrists are viewed by Ciszewski and Sutula (2000:552) as contributing less because they function as consultants who visit the patients once or twice a week.

2.8.1 Multidisciplinary team in a forensic psychiatric hospital

Multidisciplinary teams in forensic psychiatric settings coordinate with other stakeholders to ensure patient support; hence, ensuring public safety (Eastman et al 2013:4).This part of the literature review defines the roles of medical team members who are likely to be engaged in the process of forensic psychiatric rehabilitation.

2.8.1.1 Clinical psychologist

To Fortinash and Holoday-Worret (2008:17) and Eastman et al (2013:4) the clinical psychologist is a cadre in the multidisciplinary team who is responsible for conducting psychometric assessments of forensic psychiatric patients. The clinical psychologist

also coordinates various treatment modalities that underline psychotherapeutic interventions

2.8.1.2 Psychiatric nurse

According to Addo, Byrt, Coffey, Doyle, Kettles, and Woods (2008:4) and Fortinash et al (2008:17), psychiatric nurses form the backbone of the multidisciplinary medical team because they coordinate therapeutic interventions for forensic psychiatric patients at individual level, at family level and at community level. This reduces forensic psychiatric patient morbidity and recidivism.

2.8.1.3 Social worker

A social worker is the person who makes sure that the individual (the forensic psychiatric patients in the context of the current study), the group, families and communities access comprehensive services by participating in legislative processes that improve or provide social and health services. The core business of the social worker also includes a thorough assessment of the psychiatric patients' social support systems and identifies community resources that these patients can utilise (Fortinash et al 2008:17; Townsend 2006:187).

2.8.1.4 Occupational therapist

The American Occupational Therapy Association (2002:610), College of Occupational Therapists (2012:9) and Townsend (2006:187) agree that the mandate of an occupational therapist is to guide the psychiatric patient's performance of daily activities. These activities are meant to enable the clients to engage in occupations that are meaningful and productive to them. Occupational therapy is expected to then foster an increased self-esteem and benefit the general wellbeing of the patient.

2.8.1.5 Psychiatric nurse practitioner

According to Townsend (2006:187) and Stuart (2009:9), the psychiatric nurse practitioner is a specialist clinical nurse whose mandate is to avail consultation and administrative services in the implementation of psychiatric services to forensic psychiatric patients.

2.8.1.6 Psychiatrist

A psychiatrist is seen by Wolfson, Holloway and Killaspy (2009:26), Townsend (2006:187) and Stuart (2009:164) as a specialist member of the multidisciplinary team who takes the leading role in the care and treatment of forensic psychiatric patients. The psychiatrist also conducts a thorough assessment to establish a diagnosis to facilitate a comprehensive psychotherapeutic prescription for treatment of patients afflicted by mental disorders.

2.8.2 Therapeutic interventions

Forensic psychiatric patients are diagnosed with a wide range of mental disorders that include substance related psychiatric disorders, severe psychosis, anxiety, alcohol and substance abuse, schizophrenia, bipolar disorders, schizoaffective disorders and personality disorders (Fazel & Grann 2004:2131; Kalmbach & Lyons 2006:277; Reid 2001:56 ; Gordon & Lindquist 2007:421; Hornsveld 2005:404; Hornsveld, Nijman, Hollin & Kraaimaat 2008:224; Neil 2012:119; Newhill, Vaughan & De Lisi 2010:206). It is predicted by the aforementioned authors that in the present and future treatment of forensic psychiatric patients, management will be complicated by a triangulated relationship of comorbidity of psychiatric disorders, substance abuse disorder and criminal offense.

In a study conducted by Livingston et al (2012:349) to develop strategies that would propel forensic psychiatric care, the participants included staff, forensic psychiatric

patients and other service partners. The findings pointed to the fact that patient-centred care in forensic settings is beneficial if it addresses issues of fear and safety among health workers. The study also revealed that personal patient recovery depended on how empowered the patient was and also on how low her or his internalised stigma was. The results further indicated that placing the emphasis on recovery-oriented care in forensic psychiatric practice significantly improves patient engagement and compliance to services that are rendered to them.

Ciszewski and Sutula (2000:551) report on a study that was done in Poland in 1994. The findings showed that forensic psychiatric patients were cared for in generic psychiatric hospitals in combination with patients admitted for medical reasons only. The wards in which these forensic psychiatric patients were admitted had no security; it was in fact so inefficient that 7% of the patients reportedly escaped. Additionally, rehabilitation, resocialisation and treatment were ineffective because the hospital did not have any therapeutic programme besides psychotropic medication. The study results support the observation of Mason (2006:200) who challenge the mental health professionals working in forensic psychiatric settings by stating that they have become too dependent on use of psychotropic drugs; in fact, to the extent that the utilisation of psychotherapeutic interventions has become obscured.

The Irish Mental Health Commission (2011:45) tables a philosophy of forensic mental healthcare that would address the problems highlighted by Mason, Ciszewski and Sutula. The aspects embodied by this philosophy are presented below.

- Every patient is supposed to have a care plan that is specific to his or her psychiatric, psychological, psychosocial and spiritual needs.
- Forensic psychiatric patients are to be involved in the process of caring for them in such a way that the care plan reflects their individual circumstances and expected outcomes.
- An advocacy system should be available to the patients which should be structured to accommodate these service users.

- Forensic mental healthcare should avail a map of continuum of care such that there is a fluid movement of patients through the rehabilitation process.
- The families of forensic psychiatric patients should be offered a peer support system so that they interact and assist each other.
- A forensic psychiatric patient is supposed to have a key worker who is expected to coordinate all activities of that particular patient's care as for long as he or she is still admitted. This key worker also facilitates the flow of the patient through the system as the patient is either transferred or discharged.
- The philosophy also spells out that the forensic psychiatric patient should play a part during multidisciplinary reviews of their own care.

The therapies available to the forensic psychiatric patients in developed countries at present are described next.

2.8.2.1 Aggression Replacement Therapy

Hornsveld, Nijman, Hollin and Kraaimaat (2008:223) describe Aggression Replacement Therapy as one of the cognitive-behavioural theory-based interventions used in decreasing violent behaviour in forensic psychiatric patients. It is composed of "anger control, social skills and moral reasoning" sessions that are aimed at reducing recidivism. The therapy is also meant for forensic psychiatric patients who display reactive aggression whereby the individual becomes emotional, defensive and hot-tempered when they are confronted with a situation. Patients demonstrating proactive aggression and those who are calculating and cold can also benefit from Aggression Control Therapy.

2.8.2.2 Aggression Control Therapy

According to Hornsveld (2005:403-404), Aggression Control Therapy is a treatment modality that evolved from Aggression Replacement Therapy. It is a therapy based on the social learning theory. It is most suitable for patients with antisocial personality

disorder on Axis II or psychotic disorder on Axis I combined with an antisocial personality disorder on Axis II as specified in Diagnostic and statistical Manual(DSM) IV of the American Psychiatric Association (APA) of 2000 (APA 2000:29). Hornsveld (2005:404) explains that this therapy is composed of “anger management, social skills, and moral reasoning and self-regulation sessions”. The thrust of this therapy is to deal with aggressive criminogenic tendencies and foster socially adaptive behaviours.

2.8.2.3 Forensic Psychotherapy

In the view of Palijan, Kovac, Kovacevic and Radeljak (2010:65), Forensic Psychotherapy is the mainstay of medical staff. Medical staff includes clinical psychologists, psychotherapists, social workers, social educators and occupational therapists. The aim of Forensic Psychotherapy is to give patients insight into their state of health from a bio-psychosocial perspective. Individual psychotherapy, dialectical behavioural therapy, group therapy and cognitive analytic therapy are part of Forensic Psychotherapy in that they play a preceding supportive role in forensic psychotherapy.

2.8.2.4 Arts Therapy

Smeijsters and Cleven (2006:37) explain that forensic psychiatric patients who are diagnosed with psychosis, personality disorders and addiction benefit from Art Therapy that is composed of drama therapy, music therapy and dance movement therapy. The team that should implement Art Therapy is made up of the psychiatrist, psychologists and art therapist(s) (Compton Dickson 2006:840). Drama therapy is meant to teach forensic psychiatric patients to be able to differentiate between their own and someone else’s point of view. Music therapy is focused on teaching self-control and minimising acting out behaviour which is considered to be maladaptive and therefore negative. Dance movement therapy enables the patient to learn to individuate. The process of individuation is purported to relax the patient such that the result is social behaviour that reflects adaptation to both his environment and to himself (Smeijsters & Cleven 2006:43).

2.8.2.5 Schema Focused Cognitive Therapy

Bernstein, Arntz and de Vos (2007:169) describe Schema Focused Cognitive Therapy as an approach to forensic psychiatric care that encompasses the cognitive, behavioural, psychodynamic, object relations and existential or humanistic perspectives. This approach was originally designed for borderline personality disorder and later generalised to other personality disorders since they are prevalent in forensic psychiatric patients.

Key issues include what is referred to as “limited re-parenting” and “empathetic confrontation” (Bernstein et al 2007:177-178). In limited re-parenting the therapist re-socialises the patient to more adaptive coping strategies that would have failed to develop because caregivers would have failed to meet the childhood needs resulting in intra-psychic frustration. It is then this frustration that manifests as a personality disorder.

2.8.2.6 Community reintegration

Henderson (2003:14) suggests that a comprehensive forensic psychiatric service is mandated to provide continued support after the patient has been transferred to community forensic services. This involves having a system that links the forensic psychiatric patients to health and welfare services and expert practitioners to provide outreach programmes.

Mullen (2000:308) brings to attention that almost all forensic psychiatric patients expect that the care they receive will lead to their return to the community. Lindqvist and Skipworth (2000b:322) confirm Mullen’s statement by saying that every patient has it within themselves to want to lead a normal life and be in harmony with his or her environment. The British Columbia Schizophrenia Society (2011:12) addresses the possibility of fulfilling this expectation by explaining that the forensic psychiatric team is responsible for preparing and recommending a patient’s discharge. The reintegration

process is in the form of initially giving the patient a few hours' leave–but together with an escort –followed by a "visit" leave of 60 days. However, the final discharge decision lies with the Review Board that may choose to send a patient to a community clinic close to where the patient lives or to treat the patient as an outpatient. The responsibility of the community clinic is to provide case management and liaise with local day programmes to which the patient can be referred.

Henderson (2003:23) supports the British Columbia Schizophrenia Society by emphasising that forensic psychiatry should focus beyond health assessment on admission and inpatient services to providing a continuum of care that spreads right through to community forensic services. Henderson proposes that there should be case advocates who link forensic psychiatric patients to available health, welfare and mobile services. The Irish Mental Health Commission (2011:15) emphasises that community forensic mental health teams are expected to work with forensic psychiatric patients in a manner that facilitates assertive engagement and persistent follow-ups. Such close interactions is purported to enable early identification and management of conditions at grassroots level. Lindqvist and Skipworth (2000b:322) summarise the statements and views on community reintegration by saying rehabilitation is successful if the patients perceive their future as safe from real or imagined threats and when they feel no obligation to harm themselves.

2.9 FORENSIC PSYCHIATRIC REHABILITATION IN DEVELOPING COUNTRIES

Contrary to the orderliness with which forensic psychiatry rehabilitation is rendered in developed countries, Njenga (2006:97) ascertains that countries in sub-Saharan Africa (which includes Zimbabwe) is still at a level where neither the medical nor prison systems have yet embraced responsibility for forensic psychiatric care and rehabilitation. The author argues that forensic psychiatric care is at a level where judicial procedures in a court of law relating to forensic psychiatric patients are a source of amusement for lawyers and an entertainment for people with "nothing to do". Forensic

psychiatric care is still wallowing at a level where suicide and homosexuality are considered as criminal offences (except in South Africa) which qualify a person to be admitted to a special institution. Sub-Saharan Africa is still at a level where a typical psychiatrist worsens the situation by first advocating for a patient who, for example, has attempted suicide to be sent to hospital instead of a prison and thereafter coerce the same patient into submitting to a full evaluation by warning him or her that if he or she does not cooperate, he or she will be reported to the police (Njenga 2006:97). (It is possible because the reality of sub-Saharan Africa is that a person with a mental disorder can be sent to prison if there is no psychiatrist's expert intervention that pronounces this person as mentally ill.) On this level literature is scarce and limited regarding the treatment modalities offered and specifications of what the psychiatric team should do in special institutions.

What the literature does provide is information about the inconsistent legal framework; however, it does not provide information on the actual services provided to the forensic psychiatric patients once they have been committed to the special institutions. For instance, explicit mentioning of the actual services provided at each level of forensic psychiatric care in some countries is made. Lee (2003:289) also observes that adequate detail is not shown about the provision of treatment programmes available to forensic psychiatric patients. Henderson (2003:23) is more specific on this issue and points out that forensic psychiatry should provide a continuum of care beyond referral to a forensic psychiatric hospital. Examples mentioned are health assessment on admission, inpatient services, rehabilitation and on-going support on community forensic psychiatric care.

Ogunlesi et al (2012:5) even recommends that there should be initiatives that encapsulate the Department of Justice, the police as well as the correctional services in all African countries. Conversely, these authors highlight that cultural, religious and linguistic limitations in African countries make it difficult to apply psychiatry in judicial systems. Lee (2003:291) further advocates for forensic psychiatric care to be intrusive, extensive and continuous. It may result in the reduction of re-offenses and curbing of

serious crimes as indicated by the findings of an 11-year follow-up study conducted by the author to trace community treated and discharged forensic psychiatric patients.

In a study done in Zimbabwe by Wintersteen, Mupedziswa and Wintersteen (1995:97), the focus was to identify support needs for Zimbabwean families of the mentally ill. The findings reflected that the respondents were indeed not aware of the services available to their relatives. After the researchers had explained about available services to participant families, the families indicated that they were not willing to take care of their relatives on a long-term basis. 'Most' of the families were, however, in favour of having their mentally ill relative go to either a halfway home or become engaged in a residential psychiatric rehabilitation programme. This way, both the family and the patient would benefit. Families also preferred day time programmes with a vocational orientation.

Previous research in Africa has revolved around court cohorts in prisons, retrospective analyses of expert evaluations of mentally ill offenders, case reports of infanticide, matricide and cases of heinous homicide (Ogunlesi et al 2012:5). In the developed world, as posited by Glancy (2008:2), previous researches have focused on evidence-based practice of which the principles are perceived to be counter-intuitive and reductive. This is due to the fact that evidence-based practice is dependent on randomised control trials on selected patients that may be different from those in special institutions.

2.10 DISCOURSES IN FORENSIC PSYCHIATRY

Anthony, Cohen, Farkas, and Gagne (2002:3) view psychiatric rehabilitation through a lens that expects it to be characterised by a "research base, conceptual foundation, underlying philosophy and technology". These authors' view translates to well-trained medical teams, well-developed care protocols, sustainable monitoring and evaluation tools, and perpetual research activities. In such a system there will be the assurance that comprehensive mental health and psychiatric systems will be in place and implemented in the rehabilitation of forensic psychiatric patients.

The aforementioned expectation is met by the developed world (for example, in British Columbia) because from the discussed literature, developed countries already have definite pathways of seeking forensic psychiatric care from both the judicial-legal and medical points of view. Zimbabwe and other African countries, on the other hand, have a rudimentary judicial-legal structure with little or no adherence to existing specifications. In fact, in developing countries a patient can spend many years at the same level of the judicial continuum of care.

On the medical aspect of care the developed world has a specific and concise research-based system of care as reflected in the literature. Examples from literature show that in such a research-based system the medical team knows who attends to patients on admission, who the psychiatric team consists of, what the responsibilities of each team member are, what services are rendered to the forensic psychiatric patients, what therapies are available, what the discharge procedures involve, and what community services and structures are available. All these aid the recovery of forensic psychiatric patients and help them to become functional members of society (Tarbuck, Topping-Morris and Burnard 1999:40; The British Columbia Schizophrenia Society 2011:11).

Therefore, a gap remains between this discourse and forensic psychiatric practice in special institutions in Zimbabwe. Swanepoel (2009:125) asserts that research should focus on the relationship between the legal fraternity and psychiatry. The current research study therefore sought to close this gap by developing a systematic, scientific framework that will guide the adoption of a therapeutic jurisprudence approach in special institutions in Zimbabwe. It was envisaged that a sense of direction for overall programming would be reflected in the medico-judicial framework; that this framework would bring out the broader role of the medical team seconded to special institutions thereby contributing to the improvement of the patients' quality of life and bringing order to the field of forensic psychiatry in Zimbabwe and beyond.

2.11 SUMMARY

Literature related to forensic psychiatry was reviewed with regard to how it evolved in the developed world, in the African region and in Zimbabwe. Forensic psychiatric practice is reflected as being highly developed in the United Kingdom while it is perceived as inconsistent in other parts of the developed world. On the African continent, including Zimbabwe, literature has shown there are efforts related to the legal framework in the process of committing patients to forensic psychiatric institutions. Frameworks or guidelines for forensic psychiatric practice, that is, what exactly should be done to forensic psychiatric patients, are totally absent. This study sought to fill the existing gap on the need to integrate legal (judicial) frameworks with possible medical practice avenues that would evolve from the study.

CHAPTER 3
RESEARCH DESIGN AND METHODS

"The opening of public discourse to multiple voices and perspectives calls into question the very notion of a single standpoint from which a final overriding version of the world can be written."
Smith (1989)

3.1 INTRODUCTION

This chapter describes the research methodology that was used to develop a medico-judicial framework for the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe. This setting was chosen because it was the only provider of forensic psychiatric services in Zimbabwe. The design is discussed followed by a discussion of the methods used to conduct this study.

3.2 RESEARCH DESIGN

A research design is a general plan about how a researcher will answer the research question (Saunders et al 2009:136). These authors note that the design contains clear objectives, exacting how the researcher collected data and addressed ethical issues. Polit and Beck (2012:487) suggest that the research question should drive the inquiry together with its designs and methods. The research question, "What should a medico-judicial framework consist of for the rehabilitation of forensic psychiatric patients in Zimbabwe?" directed this study. The discussion on the design begins with comments on the choice of a partially mixed sequential dominant status design after which the grounded theory approach is discussed.

3.2.1 Mixed sequential dominant status design

The sequential design is the most commonly used mixed research design in under-researched areas (Srnka & Koeszegi 2007:33). According to Srnka and Koeszegi (2007:33), using this design for the preliminary stages of the qualitative approach makes it possible for the researcher to develop instruments of measurement for the quantitative study.

Figure 3.1 presents a layout of the partially mixed sequential dominant status design (QUAL/quant) that was used in the current study to develop the medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.

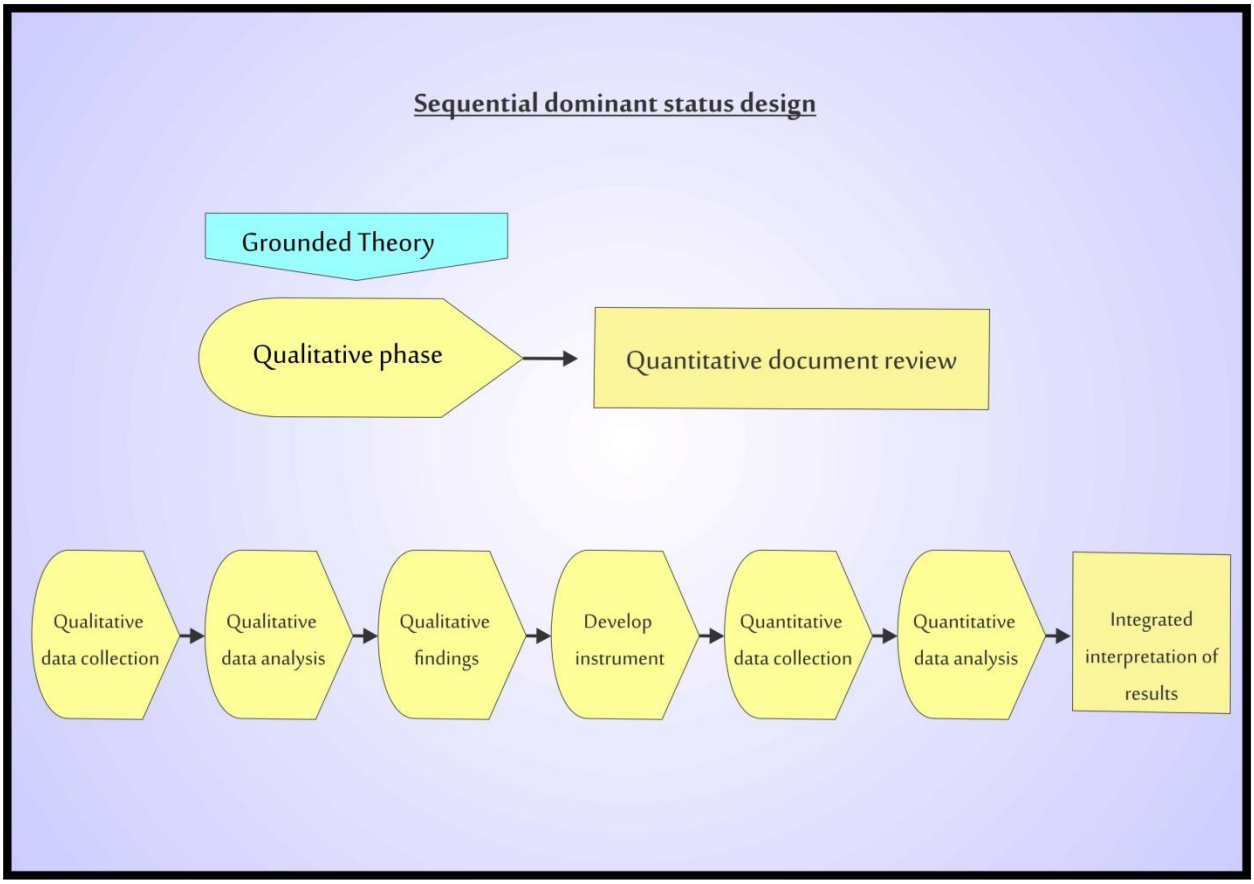

FIGURE 3.1: Sequential dominant status design (Adapted from Creswell & Plano Clark 2011:124)

The qualitative phase (QUAL) preceded the quantitative phase (quant) (Wao & Onwuegbuzie 2011:118). Priority or weight was given to the qualitative approach because the researcher's primary interest was to gain an in-depth understanding of the experiences of the judicial team, multidisciplinary health (medical) team, relatives of forensic psychiatric patients and the stable male forensic psychiatric patients regarding the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe (Creswell & Plano-Clark 2011:71). The qualitative aspect was viewed as a mapping exercise that was meant to inform the overall design and quantitative part of the study (Johnson & Christensen 2008:51).

The researcher followed the counsel of Srnka and Koeszegi (2007:35) who mapped a way for sequencing the qualitative and quantitative data. In the first stage, the researcher sourced material by collecting qualitative data through semi-structured interviews from the judicial team, multidisciplinary health team, the stable male forensic psychiatric patients and the relatives of general forensic psychiatric patients. The researcher proceeded to the second stage where she obtained transcription material by copying the data into written form following the rules of transcription. The third was a stage of unitisation where material was divided into units of coding and analysis. After following the rules of unitisation, units that could be codified started to emerge. In the following stage, categorisation was made where preliminary coding was developed inductively to come up with a category scheme. Final coding was done where codes were assigned to units. This exercise resulted in availing nominal data. The final output was clear categories that were used to formulate questions in the quantitative phase of the study.

The compatibility of the qualitative and quantitative methods is a major tenet of the mixed methods approach. The idea is that both numerical and text data, collected sequentially, should assist the researcher to understand the research problem (Creswell & Plano Clark 2011:2) Three issues were considered in designing this study. These included priority, implementation and integration (Tritter cited in Saks & Allsop 2007:303). Priority was meant to address which method was to be given more

emphasis between qualitative and quantitative approaches in the study. Implementation specified the sequence of data collection and analysis in the study while integration highlighted the phase in the research process where cohesion or connection of the qualitative or quantitative data would occur. These three principles are operationalised in Chapters 4, 5 and 6.

Triangulation was meant to enhance the credibility of the study findings. It also sought complementarities in which case results from the qualitative aspect of the research were clarified and illustrated by applying the qualitative findings during the development of the quantitative document review instrument and data collection and analyses processes (Johnson, Onwuegbuzie & Turner 2007:115; Patton 2002:22). Qualitative and quantitative data were collected and analysed in sequential order. This made it possible for the research questions for the quantitative phase of the study to evolve from the inferences of the qualitative phase which was basically exploratory. The quantitative phase then became confirmatory (Cameron 2009:145). This notion is supported by Brannen (2005:22) who confirms that qualitative methods that come before quantitative methods can be used to develop coded questions that can be used in a survey.

The disadvantage of the partially mixed sequential dominant status design is that the researcher in this study had to be competent in using both qualitative and quantitative designs of which the researcher was. There was also a need for resources that underlined extensive data collection processes in this method (Cameron 2009:145).

3.2.2 Grounded theory approach

Martin and Turner's (1986:141) description of grounded theory as a methodology that allows researchers to discover phenomena that they can link directly to the data that they would have gathered in the field is supported by Jones and Alony (2011:1). In other words, data are collected and analysed after which a theory is developed that is 'grounded' in the data (Johnson & Christensen 2008:411; Strauss & Corbin 1994:46). It is, however, important to note that the grounded theory approach embraced by this

study was the Charmaz persuasion built on a pragmatist underpinning with a social constructivist orientation. As such, whilst simultaneous data collection and analysis was observed, the emphasis was on the phenomenon of interest (the rehabilitation of forensic psychiatric patients) rather than on the methods used to study it.

Debates regarding research have been raging to the effect that mixed methods can be positioned in pragmatism. This notion therefore fits the grounded theory approach in investigating the realities of forensic psychiatry rehabilitation in special institutions in Zimbabwe (Feilzer 2010:6; Morgan 2007:48). The researcher chose the grounded theory approach because her study was an exploratory qualitative dominant mixed method research study. This translated to the notion that it was appropriate to weave it to the grounded theory approach because of its constructivist orientation which is considered to be appropriate for a qualitative epistemology (Johnson et al 2010:68). The researcher also aimed to have a detailed, rigorous insight into the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe. She therefore envisaged that the explained combinations would assist her to gestalt the findings and results of the study to obtain a comprehensive picture.

An example that used a mixed method with a grounded theory approach orientation is a study that was conducted by the MIRA Team composed of Sahin-Hodoglugil, van der Straten, Cheng, Montgomery, Kacanek, Mtetwa, Morar, Munyoro and Padian in 2009. The team did a randomised controlled clinical trial of a mixed method orientation to study the effect of diaphragm as a low cost HIV prevention method. These researchers invoked an iterative process whereby the quantitative and qualitative methods informed each other. The idea was to empower women on having control on HIV being transmitted to them. During the qualitative phase of the study, the complexity of the method implementation was revealed when it became apparent that the women concerned could not operate covertly without disclosing to their partners. In a similar manner, the current study initially used a constructivist grounded theory (qualitative) approach in which the narrated experiences of the judicial, medical, patients and relatives regarding the rehabilitation of forensic psychiatric patients were subjected to

inductive and comparative analyses during the constructing reality process. The findings of the approach were 'disputed' by the quantitative results; especially by the medical participants. This is based on the fact that there was little evidence documented to confirm services that the medical team claimed to have been giving to forensic psychiatric patients in the patients' files. This deep and broad reality of forensic psychiatric rehabilitation would not have been illuminated if the qualitative inquiry had not been corroborated by the quantitative part of the study which elicited a more nuanced analysis of this phenomenon of forensic psychiatric rehabilitation (Johnson et al 2007:123).

Key issues related to the rehabilitation of forensic psychiatric patients evolved from the opinions and experiences expressed by participants (Millis, Bonner & Francis 2006:2). A multiplicity of truths from the judicial team, medical team, male mentally stable forensic psychiatric patients and relatives of forensic patients made it possible for the researcher to analyse the data and develop a framework that was reflective of the situation and experiences at special institutions. Grounded theory was also appropriate in this study because it insists that interpretations must include the "perspectives and voices of the people who were studied" (Millis et al 2006:4).

Bowen (2005:217) supports the current researcher's beliefs that the ontology and epistemology of the constructivist grounded theory research knowledge is fluid because it keeps on evolving. The transformation of this knowledge can only be interpreted by the participant and the researcher. In this study, grounded theory offered the researcher the capacity to interpret the issues and constructed experiences of the participants. It enabled her to put together and sort evolving concepts into patterns and saturations right through to abstraction (Jones & Alony 2011:97). Systematic data collection and analysis illuminated the rehabilitation of forensic psychiatric patients. The insight then assisted in developing a medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.

3.2.2.1 Qualitative phase

This first phase of the study was primarily based on a qualitative, constructivist and interpretive view of the research process while at the same time appreciating the benefit of the quantitative approach to the research (Johnson et al 2007:124; De Lisle 2011:93). Patton (2002:39) defines qualitative research as that which concludes its findings from real world situations where phenomena of interest occur naturally instead of using statistical parameters. In this study the qualitative phase was immersed in the participants' lived experiences. The researcher endeavoured to make sense of the participants' views, experiences and beliefs (Shank 2002:25). Advantages for using this approach were that it illuminated forensic psychiatry rehabilitation practice that has been dismissed by mainstream research in Zimbabwe. The reason for using the qualitative phase was that it allowed the researcher to follow and explore unexpected routes of ideas that emerged from the study. The researcher let the data speak as she discovered and reconciled the meaning of the rehabilitation of forensic psychiatric patients that has not been understood before in Zimbabwe (Shank 2002:11).

The qualitative phase assisted the researcher to describe in detail the rehabilitation of forensic psychiatric patients as it is situated and embedded in special institutions. The approach gave the researcher an awareness of the emic or insider's point of view as she described personal experiences of the judicial, medical, the forensic psychiatric patients and the relatives of forensic psychiatric patients (Johnson & Onwuegbuzie 2004:19). Having a more insightful understanding of the participants' personal experiences enabled the researcher to develop the medico-judicial framework from the perspective of the these participant stakeholders rather than trying to develop it from those that lived outside the experience of the rehabilitation processes in special institutions (Ospina 2004:9). It was possible because the qualitative phase allowed the researcher to understand how the participants interpreted constructs. In addition, the study itself was responsive to the situation and conditions in special institutions where the needs of the judicial, medical and forensic psychiatric patients are (Johnson & Onwuegbuzie 2004:19).

A qualitative approach was also considered relevant for the analysis of the concepts and themes derived from the exploration of the medico-judicial procedures related to the rehabilitation process followed during the detention of forensic psychiatric patients. With this approach the concepts that explored the stakeholders' recommendations for the development of the medico-judicial framework could be analysed. The weakness of a qualitative approach is that results cannot be generalised beyond the population with which the study was done. It is also believed that researcher idiosyncrasies and bias may influence the research outcomes (Johnson & Onwuegbuzie 2004:19). These weaknesses were addressed by triangulation of paradigms (Creswell & Plano Clark 2011:211).

3.2.2.2 Quantitative phase

In the current study a quantitative instrument construction followed the qualitative phase. This was in the form of a data sheet for a survey. The instrument was meant to collect information from documents of forensic psychiatric patients admitted in special institutions from 2005 to 2010. In this grounded theory research study these documents were considered as extant texts and the researcher was not involved in their construction (Charmaz 2014:45). These extant documents were purported to assist in answering the research question. This smaller quantitative component came second in sequence because it was not the priority approach to answering the research question; the quantitative data were used to enhance and complement the qualitative findings (Brannen 2005:22). This part of the study gave a documented complementary picture of current trends and realities in the rehabilitation of forensic psychiatric patients. The document review also identified the rehabilitative mental health services available to forensic psychiatric patients in two special institutions in Zimbabwe. As indicated above the quantitative phase was based on a limited variable. As such it was considered as complementary data to the narrative data (themes) in the qualitative part of the study (Wao & Onwuegbuzie 2011:118).

The qualitative findings and quantitative results were then integrated and interpreted collectively. Bryman (2008:7) points out that “the key issue is whether in a mixed project the end product is more than the sum of individual quantitative and qualitative part”. The point of employing this strategy was to use quantitative data and results to complement the interpretation of the qualitative findings. The primary focus was threefold: to explore and describe the stakeholders’ experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe. Secondly, it was to explore and describe stakeholders’ recommendations for the development of a medico-judicial framework. Finally, to develop an instrument to review the documents of forensic psychiatric patients admitted in special institutions from 2005 to 2010 in order to identify the rehabilitative mental health services available to forensic psychiatric patients in two special institutions in Zimbabwe.

This approach was advantageous because the researcher was able to explore the rehabilitation of forensic psychiatric patients in special institutions and it was possible to expand on the qualitative findings. The approach was appropriate in building the medico-judicial framework for the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe. The largely qualitative study was made more believable to the quantitative oriented audience owing to the approach under discussion. The overall limitation of this partially mixed sequential dominant status design was that using two approaches required a long time to complete both data collection phases.

3.3 POPULATION AND SAMPLING

According to Johnson and Christensen (2008:223), a population is a typical element or individual. Polit and Beck (2012:273) further breaks down the concept ‘population’ to say the target population is the aggregate of cases about which the researcher would like to make generalisations. The accessible population is that part of the target population that is accessible to the researcher (Grove et al 2012:351).

The population for this study included the judicial team and the multidisciplinary health (medical) team. The members of the judicial team consisted of a senior public prosecutor, a member of the Mental Health Review Tribunal, magistrates, public prosecutors, a regional clerk of the court and an officer in charge of the prison directly related to the commission of forensic psychiatric patients to special institutions. All members of the judicial team were 9 (nine) in total. The medical team comprised of psychiatrists, psychiatric nurses, and medical social workers. These were 11 (eleven) in total. The male mentally stable patients admitted in special institutions were also included in the study. Males were chosen because they formed the bulk of forensic psychiatric patients and are cared for separately from criminal offenders. There were four (4) male mentally stable patients in total. Relatives of forensic psychiatric patients were also theoretically sampled into the study and were 5 (five) in total.

Validation of the medico-judicial framework added experts to this pool of participants. To clarify further, there were three levels of participation from the medical and judicial teams. Firstly there were participants from the judicial and medical teams who participated only in Phase 1 of the study where the objective was: *'To explore and describe the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe'* was addressed.

Secondly, there were judicial and medical participants that participated in both Phase 1 and also during the validation exercise in Phase 3.The objective addressed by Phase 3 was: *'To validate the medico-judicial framework by a group of experts and stakeholders'*. The participants are specified in Section 3.9.1 of this chapter.

Thirdly there were those participants that took part only as experts during the validation exercise in Phase 3. The experts included the lecturer at the University of Zimbabwe, the Chief Occupational Therapist and the Principal Nursing Officer of the civil psychiatric hospital which is a national referral hospital for psychiatric disorders in Zimbabwe; thus three (3) participants in total. This aforementioned population was specific to the

qualitative phase of the research study. The target population for the quantitative phase of the study included 598 records of patients committed to the special institutions between 2005 and 2010. Of these, 119 documents were reviewed.

3.3.1 Sampling

Sampling is a process of selecting events, a group of people or other typical elements that can be used to conduct a study (Grove et al 2012:364). Literature avails and differentiates between two types of sampling, namely probability and non-probability sampling. Non-probability sampling is a process of sampling in which not every element of the population stands a chance of being included in the sample. In qualitative studies the sample design can be used by the researcher to select those participants who can avail extensive information about the experience being studied (Grove et al 2012:371). The four types of non-probability sampling identified by Polit and Beck (2012:515) and Babbie (2010:193) are the quota, snowball, judgemental and purposive sampling methods. In this study purposive sampling was employed in the qualitative phase for the selection of the judicial and medical teams as well as for selecting the mentally stable male forensic psychiatric patients.

3.3.1.1 Purposive sampling

In purposive sampling the researcher specifies the attributes of a population of interest. The researcher then tries to locate the individuals who have those characteristics (Johnson & Christensen 2008:239; Polit & Beck 2012:515). The thrust of purposive sampling is to identify information rich individuals that will be instrumental in bringing out useful manifestations of the phenomenon of interest (Johnson & Christensen 2008:393).

The sampling criteria (also known as the eligibility criteria) include a list of typical attributes that are fundamental to the study. The sampling criteria contain an element of inclusion as well as exclusion criteria. Inclusion criteria are those attributes in a participant that should be present for him or her to be included in the study. Exclusion

criteria are those characteristics that will render a participant not eligible for inclusion in the study (Grove et al 2012:364).

After the preliminary transcripts and field notes had been made available in the current study, the initial analysis was fed back into the data collection such that the sampling shifted from purposive to theoretical sampling. This was done to tie up any loose ends identified in the initial data through constant comparison (Gilbert 2008:85).In other words, theoretical sampling was employed during the study for constant comparison of the data that evolved.

Charmaz (2006:95; 2014:26) suggests that as tentative categories emerge the researcher needs to take a step back and revisit the empirical world to collect data that verifies the evolving categories and themes. In view of this advice, participants who had not been originally purposively sampled for this study were included because they needed to clarify some issues or grey areas that were raised by the mainstream participants. Theoretically sampled participants included relatives of the forensic psychiatric patients, a regional clerk of the court, an officer in charge of the special institution, a member of the Mental Health Review Tribunal and nurses from the unit in the civil psychiatric hospital who received forensic psychiatric patients from the special institution.

Inclusion criteria for the **judicial and medical teams** included that participants should share the characteristics listed below.

- They had to be directly involved in the care, rehabilitation or legal aspects relating to the forensic psychiatric patients.
- They had to be able to express themselves in Shona, isiNdebele or English
- They should not have been directly involved in the care, rehabilitation or legal aspects relating to forensic psychiatric patients but being an expert in forensic psychiatric rehabilitation practice.

The exclusion criteria pertained to:

- Medical staff and members of the judicial team who were not directly involved in the care, rehabilitation or legal aspects relating to the forensic psychiatric patients and were also not experts in forensic psychiatric rehabilitation practice.

The inclusion criteria for **forensic psychiatric patients** are set out below.

- Male patients who had already been admitted to the two special institutions at the time of the study. Males were chosen because they formed the bulk of forensic psychiatric patients and were cared for separately from criminal offenders.
- Patients had to be older than18 years. Special institutions in Zimbabwe do not admit any forensic psychiatric patients under the age of 18.
- The patients had to be mentally stable. The attending psychiatrist of the patients assessed each patient's mental state to determine whether he was mentally stable. Only patients, for whom the psychiatrist presented a written report to the Special Board to the effect that they were now mentally stable, were included as participants.
- Patients for whom the Special Board had written to the Mental Health Review Tribunal to the effect that they were ready for discharge.
- Patients had to be able to express themselves in Shona, IsiNdebele or English.

The exclusion criteria related to **forensic psychiatric patients** are presented next.

- Patients not admitted to special institutions were excluded because the focus of the study was on special institutions only.
- Mentally unstable psychiatric patients as indicated by the psychiatrist's report; in other words, those patients for whom the psychiatrist had not yet written a report to the Special Board to the effect that they were stable at the time of the study.
- Forensic psychiatric patients who had relapsed despite having a psychiatrist's report written to the Special Board to the effect that they were stable at the time of the study.

- Female forensic psychiatric patients were excluded because they were mixed with female criminal offenders making them not homogenous to their male counterparts.

3.4 SAMPLING IN THE QUANTITATIVE PHASE

According to Gilbert (2008:287), documents are material that can be read and which relate to certain or particular issues in the social world. In the current study the documents in special institutions provided supplementary data for the rehabilitation of forensic psychiatric patients. Quota sampling was used to identify the target population of 598 records of male forensic psychiatric patients committed to the special institutions between (and including) 2005 and 2010. Systematic sampling was used to identify the accessible population of documents from which data were obtained.

3.4.1 Quota sampling

Polit and Beck (2012:516) describe quota sampling as a non-probability sampling method in which the researcher identifies population strata and determine how many of those with the attribute of interest are needed from each stratum. The point is to ensure that diverse segments are adequately represented in the sample. In this study the documents were nested within six quotas as in years 2005, 2006, 2007, 2008, 2009 and 2010. This translated to 598 documents.

Documents (20% of 598) as per Stoker (1985) cited in de Vos et al (2011:225) were used as the accessible document population. Proportional quota sampling (Dongre, Deshmukh, Kalaiselvan & Upadhyaya 2009:2) was used to obtain the 119 documents. The documents were selected proportionally to the total number of 598 documents. In Table 3.1 the distribution of the documents for the period from 2005 to 2010 are illustrated.

TABLE 3.1: Distribution of documents between 2005 and 2010

Year	Number of documents	Proportion of documents to be reviewed
2005	72	14
2006	94	19
2007	94	19
2008	142	28
2009	142	28
2010	54	11
Total	**598**	**119**

After determining the proportion for each year, the documents were randomly selected through systematic sampling (Teddlie & Yu 2007:80).

3.4.2 Systematic sampling

According to Onwuegbuzie and Collins (2007:285), systematic sampling is conducted by sampling every *kth* item in a population after the first item has been selected at random from the *k* list. In this method, the size of the population is divided by the size of the sample that is wanted to determine the distance between selected elements. The first element is picked using the simple random method. From that number every *kth* (interval) number is chosen until the desired sample is obtained (Polit & Beck 2012:282). Next, the systematic sampling method is explained with reference to how it was applied in the current study.

There were 142 records (N) in 2009 and a sample size of 28 records (n) was needed. The *kth* record was therefore calculated as N/n. This means that 142/28 = 5. Every fifth record was reviewed. The first record was picked at random. If record number 19 was picked at random, records to be included in the sample were 19, 24, 29, 33 and so forth until a sample size of 28 records was obtained. This method was applied to all the quotas until a final sample of 119 records was obtained.

The following inclusion and exclusion criteria were applied to the **document selection**:

Inclusion criteria

Documents to be included were files of patients admitted from 2005 to 2010.The documents were those of male forensic psychiatric patients because they were cared for separately from ordinary criminal offenders.

Exclusion criteria

- Documents of patients admitted before 2005 and after 2010.
- Documents of female forensic psychiatric patients were not reviewed because they were cared for together with ordinary criminals. This could have resulted in the documented care not giving a true picture of exclusive forensic psychiatric care.

3.5 DATA COLLECTION

Data were collected using semi-structured interviews (see Annexure 13 and 14), field notes and a researcher reflective diary in the qualitative phase. In the quantitative phase document review was used to collect data. Polit and Beck (2012:532) highlight that data collecting methods should be of a high quality so that the evidence is viewed as authentic by other researchers.

In the qualitative phase data were gathered using semi-structured interviews. The total interview time was 792.75 minutes. The average length of each interview was 25 minutes. Contextual challenges influenced the interview time. These challenges included participants being highly heterogeneous and the circumstances of their settings; their vulnerability in either the medical, judicial or social circumstances was different. Their level of education and ability to express themselves were also different. In general, some participants seemed to be unfamiliar with the area of study (forensic psychiatry) and they were therefore not as interactive as expected. One judicial

participant verbalised that it was the first time in his career that he was requested to be interviewed for a research study regarding forensic psychiatric patients.

The study context was also a highly sensitive area both socially and politically. The prison setting where the special institutions were housed seemed to be a politically protected area. A researcher who went in there was viewed with suspicion as evidenced by participant 8 (who was one of the key participants) insisting on being anonymous, refusing to sign the consent form for using the audio recorder before the interviews commenced. This was despite the fact that the researcher had presented the particular consent form in her proposal to the Zimbabwe Prison Services Commissioner's office. On the same note, the office presiding over prosecution gave the researcher permission to interview public prosecutors verbally but refused to commit the self on paper. However, participants who could express themselves took a longer duration as they narrated their experiences with forensic psychiatric rehabilitation. Those who were vulnerable or disempowered in some way seemed not to engage with the study and therefore took less time during the interviews.

3.5.1 Qualitative data collection

The qualitative data were collected using semi-structured interviews where facilitative communication skills were utilised to elicit the required information. The role of the researcher in qualitative research will firstly be discussed followed by the data collection methods.

3.5.1.1 The role of the researcher in qualitative data collection

The researcher in qualitative research is the primary instrument of data collection (Creswell 2013:45). For the researcher to contribute meaningfully to the research, it is necessary for her or him to identify personal values, assumptions and biases at the beginning of the study (Creswell & Plano Clark 2011:267). This researcher's perception of forensic psychiatry has been shaped by personal experiences. From 2001 to 2005

she served as a psychiatric nurse at district level. From 2006 to date she has been teaching both theoretical and practical forensic psychiatry for individuals reading various diploma programmes in Psychiatric Nursing. In 2009 she had a three-month association with forensic psychiatry at one of the only two special institutions in Zimbabwe. She was on forensic attachment as a Master's student from the University of Zimbabwe.

The researcher believes this understanding of the context and role boosted her sensitivity and awareness to issues encountered in the current study. It assisted her to work with certain information that arose in this study. She further brought knowledge of educational, clinical and administrative psychiatry into the study. Conversely, it also means that she possibly brought biases to the study that might have influenced the way she perceived, understood and interpreted the data. However, every effort was made to ensure objectivity. This was done through a bracketing interview (Polit & Beck 2012:532) before data collection commenced and a debriefing interview (Onwuegbuzie, Leech & Collins 2010:706) after the preliminary data collection and analysis. Both of these interviews were conducted by the study supervisor. It should also be remembered that the study utilised a constructivist approach which in itself elicits researcher reflexivity. The researcher therefore also kept field notes and a reflective diary that assisted in the co-construction of her reality and that of the participants (Polit & Beck 2012:533; Gardner et al 2012:67). The researcher was also open to alternative views and conveyed respect and trust to the participants.

3.5.1.2 Semi-structured interviews

Green and Thorogood (2009:94) and Bryman (2008:192) agree that an interview is a face to face interaction in which the researcher seeks spoken answers from participants. Qualitative interviewing is a deliberate strategy of discovering how people feel and think about their world including their experience of their world. Specific areas are explored during these interviews (Creswell 2013:173).

Semi-structured interviews were conducted with individual participants and the interviews were audio-recorded as directed by Charmaz (2006:26) and Creswell (2013:168). The researcher had a list of questions that served as what researchers refer to as an 'interview guide' (see Annexure 13 and 14). An interview guide is a plan of specific topics that the interviewer takes to the interview session. The plan usually consists of open-ended questions that will be directed to the interviewee (Johnson & Christensen 2008:208). The researcher did not always follow the exact order of the guide in this study because she responded to the direction the interviewee (participant) took. For example, sometimes the participants would answer the question during the narration of their experience before it could be asked. Also, at times questions that were not included in the guide were asked to pick up on relevant and important aspects that were mentioned by the participant (Bates, Droste, Cuba & Swingle 2008:2; Bowling 2009:285; Creswell 2013:163; DiCicco-Bloom & Crabtree 2006:315). An example was: "Please explain youre selling of medication in remand because of hunger."

When a researcher is conducting a semi-structured interview, she or he remains focused on the specific information that she or he requires without imposing a rigid structure to the interview (Turner 2010:757). In the current study the researcher endeavoured to gain insight into the knowledge and views of the participants' world (Charmaz 2014:57; Bowen 2005:217).

Semi-structured interviews have advantages and disadvantages. They are advantageous in that they are appropriate for exploring the subject of interest and providing the researcher with opportunities to probe for required information and to clarify answers. Much or in-depth information was shared in this study because of the use of open-ended questions (Polit & Beck 2012:13). Using semi-structured interviews also allowed for gaps in the data to be anticipated and dealt with (Johnson & Christensen 2008:205). At the outset, freestyle memo writing was also done (Charmaz 2014:186). The initial memos focused on the sequence and manner in which the researcher captured evolving categories from the data being collected. Later on the memos began to identify salient, liminal cues and nuanced statements that reflected

deeper complexities in the process of rehabilitating forensic psychiatric patients. Memo writing was continued right through to the data analysis. It is the latter memos that initiated the adoption of Pierre Bourdieu's concepts as the theoretical framework for this study because it seemed from the analytic memos that it was the less obvious issues that were reality rather than the overt issues.

The limitations or disadvantages of using semi-structured interviews in this study included the fact that some participants declined to answer or changed their prevailing enthusiasm if sensitive questions were asked. An example would be when the researcher asked a patient who might have been admitted for committing murder who he had murdered. Sometimes it was a parent or a spouse and this seemed to be a very sensitive area. For example, the participant would answer in a very low tone of voice, saying, *"I came here because I killed two people from the line...* (In my neighbourhood)*".* The researcher managed this through self-introspection and by being cautious and sensitive when asking such questions. Another disadvantage of semi-structured interviews is that salient topics may have been missed during the interviewing process (Johnson & Christensen 2008:205). However, the researcher of the current study focused on listening carefully to what was said and used facilitative communication techniques.

3.5.1.2.1 Facilitative communication techniques

Johnson and Christensen (2008:203) emphasise that an interview is "an interpersonal encounter" and as such facilitative communication techniques were used when the researcher conducted the semi-structured interviews. The aim was to encourage the participants to relax and freely give as much information as possible about their feelings and experiences without feeling judged or pressured (Bowling 2009:411). During the interviews, the researcher noted and recorded proxemic, chronemic, kinesic and paralinguistic non-verbal communication modes that were projected by the participants (Onwuegbuzie et al 2010:700). Adhering to Charmaz, the researcher generally asked questions in a manner that did not impose her preconceived ideas about rehabilitation

of forensic psychiatric patients in special institutions. She therefore used the facilitative communication techniques described in the next section.

Establishing rapport

Essential to collecting quality data is the establishment of rapport and trust. Modesty, honesty, openness, empathy, respect, and unconditional acceptance was established and maintained throughout the interviewing process (Bowling 2009:340). Distraction in the interview environment was managed through interviewing in a private area with a notice put on the door that read 'Do not disturb'. At the beginning of the interview the researcher explained the purpose and duration of the interview and discussed issues of confidentiality. The participants were not judged and were assured that there were no right or wrong answers.

Kvale (1996:133-135) suggests nine kinds of questions for a qualitative interview. The current researcher followed these nine examples. This questioning sequence was helpful in obtaining quality data. Kvale's suggestion is supported by Berg (2001:70), Johnson and Christensen (2008:207), Turner (2010:758) and Bowling (2009:414). Examples given in this text refer to any of the participants, namely, the judicial or medical team members, male forensic psychiatric patients as well as relatives of forensic psychiatric patients.

Introducing questions

These are questions that allow the conversation between the interviewer and the participant to begin. For example: "Tell me about how you came to this institution...'' or "What activities are helping you to live a healthy, useful or active life again since you were admitted at this institution?"

Follow-up questions

These are questions meant to encourage the participant to elaborate on what they are trying to explain. For example: “What makes you as parents uncomfortable about his being there?” or “What does that mean? Can you explain that?”

Probing questions

This refers to a phrase, gesture or neutral question that focuses the participant to explain the how and why of their answers. For example: “... you have recommended the patient to go to the special institution, what are your expectations?” The use of silent probes, echo probes, direct probes and indirect probes was integrated into the interview process when the researcher was using this line of questioning.

Specifying questions

These are questions that demystify an ambiguous response that would have been given by a participant. For example: “As a psychiatrist, why have you committed the patient there?” or “When you send the patient to the special institution as a magistrate, what are your expectations?”

Direct questions

These are questions that were straight to the point and came towards the end of the interview. Bringing them in earlier would have pre-empted and overshadowed other important issues in the interviewing process. An example is: “What community services are available to you after your discharge?”

Indirect questions

Indirect questions are important because they give the participant more scope for answering the question; thus, some issues that could have been missed by other types of questions could possibly surface. The following is an example from this study: “What do most of your colleagues think about the discharge procedure of forensic psychiatric patients in this institution?”

Structuring questions

These allow the interview to re-focus and progress, for example, “I would like us to move to the procedures that you do after a patient has been given a special verdict.”

Silences

Silence is a signal that communicates the interviewer’s wish to let the participant reflect and add more to the answer already given.

Interpreting questions

These are summarising questions that indicate the interviewer is following and understanding the participant’s line of conversation. The following is an example of an interpreting question used in this study: “Can you explain what you mean by saying that it’s just work that needs to be done?”

3.5.2 Pilot interviews

Pilot interviews were conducted. A pilot interview is a trial run or smaller version of interviewing done in preparation for a major study and is conducted to refine the methodology (Grove et al 2012:343; Polit & Beck 2012:351). The purpose of doing a pilot interview assisted the researcher to identify possible problems that could arise

during the data collection process (Turner 2010:757). It allowed the researcher to revise the methods and the instruments before the actual study was conducted (Bowling 2009:301).

Pilot interviews were conducted with male ex-forensic psychiatric patients who were in their first week of post-transfer from a special institution to a civil psychiatric hospital outlet unit. The medical staff who participated in the pilot interviews included staff that had previously been rotated to special institutions. These groups of participants were considered to be fairly homogenous to those participating in the main study. These pilot participants, however, did not participate in the main study. The data derived from the pilot study were not used in the write up of the main study. Thabane, Ma, Chu, Cheng, Ismalia, Rios and Goldsmith (2010:6) position that "pilot studies are primarily for assessing feasibility". In the same instalment, they also mention that data from a pilot study can be combined with the data of the main study provided that the sampling frames were similar. In this study, however, the pilot study was mainly for determining feasibility and for pilot testing the instrument. It is also important to note that the sampling frame for the pilot study participants (forensic psychiatric patients and psychiatric nurses) was derived from the civil psychiatric hospital whilst the same main study participants were sampled from the special institutions. For the reasons explicated above, the data could not be combined.

3.5.3 Field notes

According to Polit and Beck (2012:533) and Mulhall (2003:311), field notes represent the effort made by the researcher to capture information in order for him or her to make sense of the data. Van Maanen's (1988:233) view is that "field notes are gnomic, shorthand reconstructions of events; observations and conversations that took place in the field that are composed well after the fact". In this study the researcher took field notes during each interview that was conducted in various settings (special institutions, judicial offices, relatives' homes) in an effort to contextualise the data. This endeavour

also sought to provide a background for the life experiences of the judicial and medical teams, the forensic psychiatric patients as well as their relatives.

The types of field notes made complied with Mulhall's (2003:311) idea that field notes should cover structural and organisational features. Considering Mulhall's idea, the researcher noted what the special institutions' infrastructure appeared like and how they functioned. She also noted how the judicial team, medical team and the forensic psychiatric patients conducted themselves and how they dressed and interacted. Daily activities were noted with regard to how it was processed. Important events such as the psychiatrist's visit were noted. An additional reflective diary that explained how the researcher felt about being in the field was also kept. Observational, analytic and methodological notes were recorded in the field (Polit & Beck 2012:534).

Observational notes were notes the researcher recorded about the events that occurred during a particular interview session. For example, the first judicial participant that was interviewed was not the one the researcher had originally scheduled to be interviewed first. The researcher interviewed the second judicial participant first because the first one on the appointment list was absent and the second then volunteered to be interviewed. The one with whom the researcher had scheduled the first appointment with was attending a child friendly court. When he finally arrived for the interview, he answered the questions but also solicited advice from the researcher for a case he was handling involving a criminal he suspected to be epileptic. This assisted the researcher to capture significant data that would be relevant to the data analysis (Tjora 2006:448; Green & Thorogood 2009:163). Making observational notes about the voluntarily added information from the second interviewed judicial participant was in line with definition of Schatzman and Strauss (1973:100) of observation notes being statements "bearing upon events experienced through watching and listening". The following is an excerpt of field notes.

Date: *07/06/13*

Time: *0915hrs*

Site: *XX Building*

This is a building that houses courts and offices for judicial staff. I arrived at 0800 for a 0830 interview with Participant 3.The place is crawling with prisoners and guards that have come to attend different courts. At the reception I'm told that Participant 3 will arrive shortly since he is expecting me. Participant 3 is the first magistrate that I want to interview with regards to processes involving forensic psychiatric patients. I wait while the secretary in the magistrates' offices at the reception busies herself. It's now 0930 and Participant 3 is still not here.

At around 0933am, Participant 2 with whom I have an appointment the following week walks into the reception area and seems to be happy to see me. He informs me that Participant 3 is attending a Victim Friendly Court. Participant 2 invites me to his office and suggests that I can as well interview him since he has time on his hands. He is off duty today. I agree.

In the middle of the interview session, Participant 3 phones from his office asking Participant 2 to tell me that he is back. As soon as I finish with Participant 2, I go to the next office where Participant 2 is. Participant 3 immediately tells me about a court case he is handling that involves a person he suspects to be mentally unstable. He is soliciting for my expertise in the case, albeit unofficially. He says that he is particularly interested in this study because of that. Participant 3 says in the 19 years of judicial service no-one has ever interviewed him about the patients he handles and he has so many unanswered questions himself about 'these people'. He says he is relieved that at least someone is doing something about it.

Participant 3 avails a very rich and informative interview session and clarify a myriad of issues that were previously raised by the participants in the prosecution department. This is becoming more interesting…

Things to follow up

The magistrates seem to be unfamiliar with areas that are important in the processes involving patients…like they do not seem to have expectations after they give the treatment order. They say that the psychiatrist should know what to do; this office has done its work. This means that I should further understand the position of psychiatrists…

Date: *03/06/13*

Time: *0915hrs*

Site: *Special institution 1*

Event: *Doctor's round*

The medical and prison staff members are waiting in the courtyard for the psychiatrist to arrive. I arrived about 30 minutes earlier. The sister in charge of the male section explains to me that the Doctor's round we are waiting for is usually done upon the availability of the psychiatrist from the civil psychiatric hospital. Ideally, she should come 3 times a week. The psychiatrist comes in hurriedly. I notice that she is white and speaks in a heavy foreign accent. I can't follow what she is saying to the medical staff as she disappears into the tiny room where reviews are done. Immediately, patients that are recognised as 'staff' arrange patients that are due for review in the queue. A guard informs me that these 'staff' includes patients who have recovered and are due for discharge.

The guards arrange themselves in such a manner that they completely surround the patients outside the doctor's room. The patients in the queue are all waiting while in squatting position. A guard explains to me that this is a form of etiquette that 'prisoners' are expected to follow. In the meantime, 'staff' is coaching patients due for review on how to answer the doctor's questions. This is happening in full view of the guards and nurses. As we join the psychiatrist, she is already finishing with the first patient. I notice that patients are marshalled in or escorted into the round by 'staff' who sometimes answer on behalf of the patient. This does not seem to bother the nurses. 'Staff' is

bringing in files of patients under review from the adjoining room. No-one seems to be supervising them. As the psychiatric examinations progress, the 'staff' that brought the patient remain in the interview room. The psychiatrist is using the sister in charge as a translator since patients, even English speaking patients, cannot understand her accent. Questions that are being asked in the psychometric examination include the patient's sexual life …and everyone, the nurses, patients who are bringing in files and the 'staff' that escorted the patient is listening…

After about 30 minutes, the psychiatrist is picking up her things ready to leave. She reviewed five patients today in a unit with around 174 patients. The sister in charge explains to me that this is normal because the psychiatrist has other responsibilities and she is overwhelmed…..

Things to follow up

The officer in charge needs to clarify how this works around here. What is the ultimate fate of these patients in a situation like this?

Bernard (2006:395); Bryman (2008:419) view **methodological notes** as notes that focus on data collection procedures in a given qualitative research study. The researcher wrote methodological notes during the fieldwork to reflect the relevance of the grounded theory semi-structured interviews to collect data. These notes kept her focused on asking relevant questions and using the necessary facilitative communication skills to elicit quality data from the participants.

Analytic notes make the researcher reflect on how she/he perceives the field being studied in terms of its organisation and functionality (Bernard 2006:398; Silverman 2010:210). The researcher constructed analytic notes about how she thought the participants' social constructions were organised and wrote memos to provide more substance to the developing categories in the data. For example, one of the judicial participants consistently questioned the fact that forensic psychiatric patients (known as

Detained Mental Patients in special institutions because they attended a trial for the crime they had committed) were cared for together with Criminal Mental Patients as part of the patient group in a special institution although the latter had not been tried yet. These notes were a product of observational and methodological notes.

The strategies used for note taking included salience hierarchy and comprehensive note taking (Tjora 2006:432; Wolfinger 2002:90). With reference to the salience hierarchy the researcher attempted to describe events that seemed peculiar and deviant from what would normally have been expected. Deviant situations that culminated in salient data included, for example, that special institutions were also staffed by prison officers that interacted with forensic psychiatric patients as if they were ordinary criminals**.** This was influenced by the researcher's understanding that interactions between patients and staff at the special institution are expected to be therapeutic instead of punitive.

The strategy of comprehensive note taking was used to describe the noted events systematically and temporally. For systematic note taking, the researcher was guided by Lofland and Lofland's (1984:48) advice on typical questions for researchers to ask themselves during their first field trip. For example, "Why are forensic psychiatric patients referred to by using derogatory names?" and "What happens if a forensic psychiatric patient escapes from this institution?"

Temporally organised note taking was done in such a way that the researcher recorded events in the sequence in which they occurred (Berg 2001:139; Wolfinger 2002:91). The researcher wrote the field notes at the end of the day. On average, this was approximately within six hours after the interview had been concluded. The objective was to prevent the researcher from forgetting details of the events and actions that had occurred during the interview (Mulhall 2003:311).

3.5.1.3 Reflective diary

Reflexivity is the process of analysing and evaluating oneself as to how one's views, beliefs and values as a researcher influence the collection and interpretation of data (Polit & Beck 2010:110). Harrison, MacGibbon and Morton (2001:325) sees reflexivity in the qualitative research paradigm as that which needs to be "presented in ways that make clear how the researchers' own experiences, values and positions of privilege in various hierarchies choose to do their research and ways they choose to represent their research findings". These authors' view is supported by Ortlipp (2008:695) who explains that the aim of a reflective diary is to enable the reader to trail how the researcher might have constructed the study findings; it also provides the context of how the researcher came to make the decisions and choices during the research process. Mruck and Breuer (2003:3) are more direct on the same issue, emphasising that researchers have the mandate and responsibility to expose their presuppositions, choices, actions and experiences that could have influenced them during the research process.

The strength of having a reflective diary is that it increases self-awareness on the part of the researcher in such a way that he or she can make professional decisions that are more informed. The insight of the researcher is imperative, especially on interpersonal and implicit processes that may affect or influence the outcome of the research (Berg 2001:139; Johnson & Christensen 2008:275; Silverman 2010:123). As the researcher became more informed on views related to data gathering in the current study, changes were made regarding the data gathering. For example, she had planned in the research proposal that the quantitative part would precede the qualitative aspect in the partially mixed sequential dominant status design. However, as she delved into the research methodology, she decided to change the sequence and start with the qualitative aspect. This was envisaged to answer the research question without pre-empting the crucial part of data collection.

According to Grove et al (2012:371) and Polit and Beck (2012:532), data saturation occurs when no new information can be elicited from the participants or when there is

redundancy of previously collected data. For this reason, semi-structured interviews were conducted until data saturation was reached within each participant group.

3.5.4 Quantitative data collection

Quantitative designs insist on convincing researchers that the world is constructed on observable, measurable facts (Bryman 2008:22; Golafshani 2003:600). The approach of the design works on the assumption that phenomena can be quantified; it recognises reality in the environment as objective and external. In this study the researcher attempted to fragment and narrow the rehabilitation of forensic psychiatric patients into categories that were relevant to the development of the document review survey form (see Annexure 12). These measures were standardised to fit documented forensic psychiatric care into a limited number of predetermined response categories (Patton 2002:14). Examples of the categories included the study setting, category of admission under the Zimbabwe Mental Health Act of 1996 (Zimbabwe National Health Strategy 2009-2013 2008:73), the number of previous admissions, diagnosis, previous mental illness, age group, marital status, level of education, criminal charge, source of referral, rehabilitative interventions, and service outcome.

The study setting referred to specific special institutions. The category of admission under the Zimbabwe Mental Health Act of 1996 included a choice of Sections 26, 27, 28, 29, or 30 (Zimbabwe National Health Strategy 2009-2013 2008:73). These sections reflect the position of the patient when he was admitted to the special institution. For example, a patient admitted under Section 26 would have been awaiting trial, in remand at the time of admission, while one admitted under Section 30 would have already been serving a sentence at the time of admission.

The number of previous admissions had a choice of ‘Once’; ‘Twice’; ‘Thrice’ or ‘More than three times’. On diagnosis the possible answers included ‘Psychotic disorder’; ‘Affective disorder’; ‘Substance induced mental illness’; ‘Anxiety disorder’; ‘Personality

disorder'; 'Mental retardation' or 'No mental disorder'. Previous mental illnesses were either assessed to be 'Present'; 'Not present 'or 'Not known'.

The age group for the documented forensic psychiatric patients were categorised into groups of '18 to 21 years'; '22 to 30 years'; '31 to 40 years'; '41 to 50 years'; '51 to 60 years' and those older than 60. On assessing their marital status the documented forensic psychiatric patients were 'Single'; 'Married'; 'Divorced'; 'Widower' or 'Separated'. The variable on the level of education indicated whether the patient had 'No formal education', had 'Primary education'; 'Secondary education' or 'Tertiary education'.

The assessment of the criminal charge identified whether the crime was 'Violent' or 'Non-violent'. The criminal charges considered included violent that could be 'Murder'; 'Attempted murder'; 'Rape and indecent assault'; 'Assault with grievous bodily harm' or 'Robbery'. Non-violent crimes included 'Theft'; 'Housebreaking'; 'Shoplifting fraud 'and 'Fraud'. On either of the categories of the charge, the researcher gave an option of 'Any other 'in case the documents had another category that had not been captured in the predetermined data sheet.

The options for source of referral for the documented forensic psychiatric patients were either from the 'Court'; 'Civil hospital'; 'Criminal prison' or 'Family'. This part also accommodated any other source as specified by the document and not captured on the data sheet. Rehabilitative intervention choices included 'Cognitive therapy'; 'Therapeutic community'; 'Family therapy'; 'Medical drug interventions' and 'Psychosocial interventions'. In each of these cases, specifications were sought on what exactly was offered to the patient.

Service outcomes were the last category in the document review. The possible outcomes related to the quality of life which was described as the patient's capacity to express future goals. Self-esteem was described as a service outcome in which the

patients were expected to have been committed to a social group, occupation, or to have had a reason to live.

Recidivism outcome was measured in two ways: recidivism non-violent and recidivism violent. A non-violent outcome in this area meant that the patient had a reoffending that was not violent or sexual in nature while violent recidivism referred to reoffending that was violent or sexual in nature. The suicide outcome meant that the patient named in the document had either killed himself or had attempted to do so. Substance abuse service outcome was described as that in which the documented patient remained addicted to a substance despite intervention.

Mental state service outcome sought whether the documented patient had evidence of persisting mental illness or not. Cognitive function assessed was described as the patient's ability to problem-solve, remember, and plan. Other service outcomes assessed included 'Relationship with family'; 'Compliance with therapy'; 'Readiness to change the situation'; 'Social involvement in day to day activities' and 'Contact with members of the multidisciplinary team'. The latter was described as an outcome in which the patient felt they had been rehabilitated enough to be reintegrated into society and the employment market.

Data screening were done before the statistical analysis was conducted (Bowling 2009:373). The screening of data was done on the descriptive statistics of all variables on the survey data sheet. Missing data information, linearity and homoscedasticity, normality, multivariate outliers, multicollinearity and singularity were aspects that were also screened from the data.

After the data collection, a descriptive analysis of the data was done where a frequency analysis of the identified categories was done. For example, how many times the forensic psychiatric patient was admitted or which rehabilitative outcome was prevalent and why. This was followed by an exploratory analysis where frequencies were calculated per document for each main and subcategory. The last step was cross

validation. This was a process in which the qualitative procedure of content analysis was combined with the quantitative analysis to develop the medico-judicial framework.

3.6 DATA ANALYSIS

This section of the study presents the data analysis procedures that the researcher followed for both the qualitative and quantitative data. This was based on Saks and Allsop's (2007:410) definition that the data analysis is "what is done with qualitative and quantitative research information once it has been gathered".

3.6.1 Qualitative data analysis

Polit and Beck (2012:556) highlight that qualitative data analysis involves fitting data together, making that which is not obvious visible, linking and attributing consequences to antecedents. The qualitative data analysis process followed the grounded theory tenets transcription, open coding, focused coding and theoretical coding:

- ***Transcription***

In the current study a verbatim transcription preceded the data analysis and the researcher endeavoured to make sure that the transcriptions were an accurate reflection of what had transpired during the interviews. This was done by thoroughly listening to the audio-recordings coupled with on-going feedback from peers and the supervisor (Polit & Beck 2012:534).

The study used a grounded theory approach and therefore grounded theory analysis was applied to the qualitative data. The analysis of interview transcripts and notes were guided by an approach focusing on deriving patterns in the data by means of thematic codes. Bowen (2005:218) and Johnson and Christensen (2008:413) explain that data analysis in grounded theory is done through the constant comparative method and involves constant interplay among the researcher, the data, and the developing theory.

In this study, the method involved line, sentence and paragraph segments of the transcribed interviews. Bowen (2005:217) states inductive analysis means that the patterns, themes and categories of analysis come from the data.

The coding of the transcripts in this study was done manually. This facilitated control and ownership of the data. Being intimate with the data through manual coding allowed microanalysis in that the data could be seen and codes could be assigned at the same time (Bazeley 2007:92, Saldana 2009:22).

- ***Open coding and focused coding***

Line by line coding and analysis, as favoured by Charmaz (2006:50), made it possible for the researcher to compare new data with that which she had already coded. A grounded theory was used in this study that embraced social constructivism. Both of these concepts are endorsed by Charmaz (2014:16). It was important for the researcher not to lose sight of the hidden and less obvious networks that linked the data. The use of software would have obliterated or missed the hidden networks or liminal and nuanced statements which were the inherent reality of the data (Charmaz 2006:73).

During coding a particular phenomenon was identified through the use of specific indicators in the data. This indicator was borne out of a code label assigned to objects, incidents, or situations in the data. The evolving phenomena or codes from the data were then analysed for recurring themes. These themes were regrouped and abstracted to a higher level, in other words, a higher order label was assigned to these themes. This process continued until a sub-category of data emerged (Walker & Myrick 2006:549). The sub-categories developed into major categories. The categories were then integrated into the main theme from which the central storyline evolved. This was done for each participant group (the judiciary team, medical team, the forensic psychiatric patients, and the relatives of the forensic psychiatric patients). This is explained in detail in Chapter 4.

- ***Axial coding***

The main themes and central story lines from each participant group were abstracted to form codes that formed what Strauss (1987:64) refers to as "a dense texture of relationships around the 'axis' of a category". Axial coding was therefore developed around the main themes from each participant group. The texture of relationships emerging from the findings was anchored on, or constructed around, Pierre Bourdieu's concepts that were related to the findings. Bourdieu's (1991a:502) concepts seemed to directly speak to the emerging findings, for example:

- discordant engagement of the judicial team or participants to the system of rehabilitation of forensic psychiatric patients
- dichotomous reality in which nurses' responsibility is abdicated
- prohibitive processes negatively affect overall patient care and recovery for psychiatrists.

All the above themes revolved around Bourdieu's concept of symbolic power (Bourdieu 1991a:502). Another example is the themes mentioned below.

- Patients experience life in the institution as a "prisoner" and not as a "patient "with ensuing physical, emotional, social and occupational challenges.
- Negative perception of the rehabilitative context by patients' relatives.

The themes related to forensic psychiatric patients and relatives of forensic psychiatric patients revolved around objectification, disempowerment, symbolic violence, and symbolic suffering.

These concepts assisted in specifying *conditions* that influenced the current realities in forensic psychiatric rehabilitation in special institutions. The conditions included power underlined by a system of dominance and its reproduction. Bourdieu's (1989:15) concepts also illuminated the *actions* or *interactions* that made up the participants'

experiences both without and within the special institutions. These included objectification of forensic psychiatric patients and disempowerment of the relatives of forensic psychiatric patients, nurses, and forensic psychiatric patients themselves. The *consequences* or *outcomes* of the participants' interactions and actions also evolved and were laid on Bourdieu's concepts that functioned as a framework. These included symbolic violence that resulted in symbolic suffering of patients and relatives and the voicelessness of nurses in the system.

- ***Theoretical coding***

Theoretical coding eventually led to the construction of the axial codes to reflect the integrated relationship between these codes and the preceding family codes (open codes) (Charmaz 2006:63). The main theme that evolved from the theoretical coding was the web of intricate relationships that revolved around issues of power which was represented by a system of dominance. Contextualisation of the relationships was further done by utilising field notes and the researcher's reflections as she interacted with both the participants and the data. Using Pierre Bourdieu's concept of symbolic power as a theoretical framework, the data analysis was integrated and dimensionalised to create an understanding of the intricate realities of the current rehabilitation of forensic psychiatric patients and was then used as a basis for developing an alternative to the status quo. The researcher's interpretation of the abstracted information therefore provided the context against which the preferred future medico-judicial framework for rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe was developed. The data were co-coded by the supervisor after which a consensus discussion was held to verify the meanings and codes.

3.6.2 Quantitative data analysis

This section explains how the quantitative data were analysed. The quantitative data were in the form of a document review.

3.6.2.1 Document review

Data were analysed using SPSS version 16.0. Descriptive statistics were employed to summarise and present the data. Data screening was done before the conduction of a statistical analysis (Bowling 2009:373). The screening of the data was done on the descriptive statistics of all the variables on the survey data sheet. Missing data information, linearity and homoscedasticity, normality, multivariate outliers, and multicollinearity and singularity were aspects that were also screened from the data (Grove et al 2012:531; Tabachnick & Fidel 2008:71-88).

After collection of the data, a descriptive analysis of the data followed. Frequency analyses of the categories that were identified were done, for example, how many times the forensic psychiatric patient was admitted or which rehabilitative outcome was utilised and why. This was followed by an exploratory analysis where the frequencies were calculated per document for each main and subcategory using measures of central tendency and dispersion (Burns & Grove 2009:463). An exploratory analysis of data gives the researcher insight to a set of data; it extracts variables that are significant in the study and detect outliers and other anomalies (Grove et al 2012:542). Graphs and tables were used to assist the researcher with identifying patterns in the data that enabled her to interpret the exploratory findings.

The last step was cross validation (Burns & Grove 2009:494; Sale, Lohfeld & Brazil 2002:50; Terrell 2011:264). This was a process in which the qualitative procedure of content analysis was combined with the quantitative analysis to develop the medico-judicial framework.

3.7 TRUSTWORTHINESS OF THE QUALITATIVE PHASE

Seeking the believability of the study, the researcher followed the standards for trustworthiness of qualitative research set by Polit and Beck (2012:268) that parallel

standards of reliability and validity in quantitative research. These are credibility, dependability, confirmability, transferability and authenticity.

3.7.1 Credibility

Credibility deals with how congruent results are with reality (Morrow 2005:252; Shenton 2004:63). Credibility in the current study was ensured by early familiarisation with the culture of the two special institutions before the first data collection processes took place. This was done through preliminary visits by the researcher to the two institutions. Frequent debriefing sessions with the supervisor were done. It was a way of making the research findings credible as well as availing professional support, encourage involvement, and boosting researcher confidence (Maritz & Jooste 2011:974). The supervisor was used as a sounding board to test developing ideas and interpretations to help contain researcher bias. Peer scrutiny by colleagues and peers was done through scientific conferences such as the Tenth International Congress for Qualitative Inquiry held at the University of Illinois in Urbana-Champaign in the United States of America (USA), the Annual Nursing Education Conference that congregated at Emperors Palace, Gauteng in South Africa and at the Third International Conference and Exhibition on Neurology &Therapeutics held at the Hilton Philadelphia Airport Hotel in the USA (Kvale 2007:125; Kvale & Brinkman 2009:253).

Member checks on the accuracy of the data were done whereby participants were asked to read any transcripts of dialogues in which they had participated (Bloor cited in Emerson 2001:393; Creswell 2009:191; Fielding & Fielding 1986:43; Patton 2002:561). This was done immediately after the data analysis process as well as at the end of the study. Discussions with the participants provided them with an opportunity to add material, make changes, and offer possible different interpretations if necessary. Discussions with colleagues and the supervisor took place as a form of member checking. A literature control of previous studies assisted the researcher to assess the degree to which the research results were in line with those of past studies (Creswell &

Plano Clark 2011:209; Charmaz 2014:289; Green & Thorogood 2009:255; Shenton 2004:69).

Prolonged engagement included spending sufficient time in collecting data to understand the views of the multidisciplinary team and to test for misinformation and distortions. Prolonged engagement also ensured saturation of important categories. Building trust and establishing rapport through spending time with the participants was part of the reason for prolonged engagement. Engagement with participants for 10 months also ensured saturation of the data (Krefting 1991:217; Lincoln & Guba 1985:301; Loh 2013:5; Shenton 2004:73).

Triangulation of the data sources included the participants themselves who included judicial participants, medical participants, forensic psychiatric patient participants, relatives of patients as participants, and experts (during validation) with whom semi-structured interviews were conducted, field notes, and a reflective diary. Information from the participants was confirmed by reviewing documents of patients admitted to special institutions between and including 2005 and 2010.

3.7.2 Dependability

Dependability refers to showing that if the study was repeated in the same context, similar results would be obtained (Gasson cited in Whitman & Woszczynski 2004:92; Lincoln & Guba 1985:317; Morrow 2005:252; Patton 2002:546; Shenton 2004:71). This was achieved in the current study through the use of two methods, namely, semi-structured interviews and a document review.

To ensure dependability, the researcher also reported processes within the study in detail in an effort to inform the next researcher to repeat the study. In this study, for example, the research design and its implementation, the operational details of data gathering, and a reflective appraisal of the study were included.

3.7.3 Confirmability

Gasson (cited in Whitman & Woszczynski 2004:93), Morrow (2005:252), Lincoln and Guba (1985:318) and Shenton (2004:72) agree that a study's findings should be the result of the experiences and ideas of participants rather than the characteristics and preferences of the researcher. To ensure confirmability, method triangulation was done. The audit trail was also availed to trace the course of this study. A bracketing interview was also done with the supervisor for purposes of confirmability as well.

3.7.4 Transferability

Transferability refers to the extent to which the findings of one study can be applied to other situations (Gasson cited in Whitman & Woszczynski 2004:94; Morrow 2005:252; Lincoln & Guba 1985:317; Shenton 2004:69). The findings of this qualitative study were specific to the two special institutions in Zimbabwe. Purposeful sampling of participants and proportional quota sampling of documents were used. The results were recontextualised in the literature. However, despite this effort, it may be difficult to demonstrate that the results are applicable to other situations. Nevertheless, interested parties who may wish to invoke the transferability of this study should consider the number of institutions that took part in the study, the number of participants involved, and the time over which data were collected (Morrow 2005:252).

3.7.5 Authenticity

Authenticity is a qualitative research strategy that ensures the trustworthiness of results in that it expresses the extent to which the researcher accurately reflected participants' feelings and experiences as they are lived (Onwuegbuzie et al 2010:706; Polit & Beck 2012:582). When a researcher collects data from participants and keeps audit trails of participants' lived experiences, authenticity is ensured. Debriefing interviews, documenting the growth and empowerment of the participants during the interview

process, and documenting the researcher's progressive subjectivity were strategies used to create an audit trail (Onwuegbuzie et al 2010:709).

Authenticity embraces the following five facets: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Onwuegbuzie et al 2010:705; Qazi 2011:15). Fairness refers to that part of research integrity which mandates the researcher to seek and respect different constructions. The researcher endeavoured to uphold fairness by member checking the participants' constructions. Contradictory experiences presented by the judicial team, medical team and the forensic psychiatric patients were identified and clarified with a different stakeholder group. Issues that were difficult to resolve were addressed in debriefing interviews (Guba & Lincoln cited in Denzin & Lincoln 2005:207).

Ontological authenticity refers to the extent to which the participants' conscious experience of their world has been impacted by their involvement in the study (Qazi 2011:15). To estimate this impact, the researcher kept audit trails of the participants' insights into their own lives. The audit trails were developed from debriefing interviews that helped the researcher to dig deeper into the participants' experiences. As the participants narrated their experiences, stories and opinions, their level of awareness was revealed.

Educative authenticity refers to the extent of awareness of variance in the participants' constructions and how the involved stakeholder groups view these differences (Onwuegbuzie et al 2010:708). Debriefing interviews were utilised to reflect the degree to which the participants were aware of these differences.

Catalytic authenticity speaks to the degree to which a particular participant group has formed new constructions about another participant group's position that is also involved in the study (Morrow 2005:253). The researcher attempted to assess catalytic authenticity by collecting testimonies from the judicial and medical teams to document the resolution on the conflict that they reflected regarding their roles. One example

encountered in this study would be that of staff working in the judicial offices to process the papers that would have been submitted from the special institution via the Special Boards and Mental Health review Tribunal pending a patient's discharge. This group was held responsible for delaying patient discharge. On the other hand, the judicial offices were highlighting that the delay was due to chaotic documentation by the medical staff working at special institutions. Debriefing interviews were used to increase catalytic authenticity in these stakeholder groups.

Tactical authenticity is a level of research integrity that hinges on the results of the study and on how much participants might have been empowered by the study to act (Onwuegbuzie et al 2010:706). The researcher addressed this through debriefing interviews that documented the level of empowerment demonstrated by participants during the study. She further planned to do a follow-up in the future to assess what the judicial team, medical team and the forensic psychiatric patients have done to improve the rehabilitation system in special institutions.

3.8 RELIABILITY AND VALIDITYOF THE QUANTITATIVE PHASE

This section describes how validity and reliability were ensured in the quantitative aspect of the study.

3.8.1 Reliability

Reliability refers to the precision of information that has been collected from a study and the fact that it cannot be changed (Bowling 2009:162; Polit & Beck 2012:236). Reliability is considered a measure of the amount of random error in the measurement technique and is concerned with characteristics such as dependability, consistency, accuracy, and compatibility (Grove et al 2012:389). Reliability testing was done on the research instrument before conducting this study. It was done through a pilot study. Documents on which the instrument was pilot tested were those of forensic psychiatric patients admitted in special institutions in 2004 and in 2011. These were considered as

homogenous to the actual study documents of forensic psychiatric patients admitted between 2005 and 2010.

A pilot study is a miniature version of the actual research study that is done to refine the study methodology (Bowling 2009:301). The researcher modified parts of the research instrument where necessary. For example, on the category of admission under the Zimbabwe Mental Health Act of 1996, the researcher had to add an 'Other specify' admission section because some of the forensic psychiatric patients were admitted outside the specifications of Sections 26, 27, 28, 29 and 30 of the Zimbabwe Mental Health Act of 1996.On mental illness (diagnosis), she added 'No mental disorder' because in some instances patients were admitted without a diagnosis.

Epilepsy was added because in the pilot study it was apparent that temporal lobe epilepsy was one of the reasons for admission, but on the previous research instrument mental illness had 'Not known' added to the given choices. Regarding the age group, marital status, and level of education a 'Not indicated' was added because there were some files in which these variables were not indicated. The variable identifying the criminal charge was modified to accommodate 'Malicious injury to property'. On the service outcome variable, a column was added to show that information sought was 'Not indicated in the patient's file' because there had been no documentation.

Reliability was also ensured by the test-retest method (Calnan cited in Saks & Allsop 2007:180). This was operationalised through item to item correlation of the variables that were being measured by the data sheet/survey for documents of patients admitted between 2005 and 2010. It involved the strength of statistical relationships between the variables of interest that were measured. Unreliable items on the data/survey sheet were removed after testing and were done through the use of multi-item indicators. For example, inter-items correlations that were below 0.20 or above 0.40 (Bowling 2009:164). To clarify this, a correlation of 0.14, for example, showed that the particular variable or item failed to measure what was being measured by other items and therefore needed to be removed (Bowling 2009:164). Reliability was additionally

ensured by going through the questions; revising, restructuring, and rephrasing them with experts like peers and the supervisor.

3.8.2 Validity

Validity is how credible the research evidence is and the extent to which evidence elicits inferential support (Polit & Beck 2012:236). The instrument is said to be valid when it has been repeatedly tested on the population to which it is targeted (Bowling 2009:166). Calnan cited Saks and Allsop (2007:180) describe four types of validity, namely, content validity, face validity, criterion validity, and construct validity.

Content validity is the degree to which an instrument accurately reflects the characteristics of what it is meant to measure (Calnan cited Saks & Allsop 2007:180). Content validity demonstrated the extent to which the data sheet/survey items and scores from these questions represented all possible questions about rehabilitation services available to forensic psychiatric patients admitted in special institutions between 2005 and 2010. The supervisor also examined the data sheet/survey questions to ensure their validity.

Face validity refers to how the instrument presents itself at a glance, for example, whether the questions have been phrased as they are supposed to by using appropriate language. This was scrutinised and confirmed by the supervisor and peers. Criterion validity refers to the extent to which the instrument is accepted as a "gold standard" or valid (Bowling 2009:167). The data sheet that the researcher had designed for this study was compared regarding the consistency of the results with other existing instruments that have been used by other researchers to measure the rehabilitation of forensic psychiatric patients. An example is the Ward Atmosphere Scale by Rudolf Moos (1989) which was designed to evaluate psychiatric services that are institution based. The Scale basically measures that which is expected and preferred what the reality is in the context in which the Ward Atmosphere Scale is being used (Brunt 2008:223).

Construct validity refers to the degree to which the instrument measures the basic variable that it has been set out to measure (Bowling 2009:166; Golafshani 2003:599). Research studies that are related to rehabilitation services available to forensic psychiatric patients were compared to the results of this study. An example was a study done by Brant and Rask in 2005 that compared patient and staff perceptions of the atmosphere in a maximum-security forensic psychiatric hospital in Sweden. The study involved thirty-five service users (Brunt & Rask 2005:264).

3.9 PHASE 2: DEVELOPMENT OF A MEDICO-JUDICIAL FRAMEWORK

The objective of the second phase was to develop a medico-judicial framework based on the findings of the situation analysis once the data had been analysed and literature control had been done. The literature control provided a framework and a benchmark for comparing and contrasting the results that were represented by categories in this study with other findings related to this research study (Creswell 2013:187). The literature control also assisted in interpreting the results of the current study.

The findings of the two phases were then integrated and interpreted collectively. The point of employing this strategy was to use the quantitative data and results to complement the interpretation of the qualitative findings. The primary focus was threefold. In the first place to explore and describe the medico-judicial rehabilitation procedures followed during the detention of forensic psychiatric patients in Zimbabwe. Secondly, the focus was to explore and describe the stakeholders' recommendations for the development of a medico-judicial framework and, thirdly, to develop an instrument to review the documents of forensic psychiatric patients admitted in special institutions between 2005 and 2010 in order to identify the rehabilitative mental health services available to forensic psychiatric patients in two special institutions in Zimbabwe. The integrated findings were then able to show a pattern that could be followed both in the judicial and medical systems when rehabilitating forensic psychiatric patients. The findings also reflected the processes in the mentioned systems that were prohibitive and leading to chaos. These were discarded.

3.10 PHASE 3: VALIDATION OF THE MEDICO-JUDICIAL FRAMEWORK

The third phase of the study was to have the medico-judicial framework validated by a group of stakeholders and experts. This was done through conducting validation interviews that the researcher organised with stakeholders and experts from forensic, general psychiatry and judiciary fields to validate the medico-judicial framework. The stakeholders who participated in the validation exercise were those participants that were considered by the researcher to be key role players in the rehabilitation of forensic psychiatric patients. The stakeholders included the following office bearers: one senior public prosecutor, one junior public prosecutor, one magistrate, one psychiatric nurse, one member of the Mental Health Review Tribunal, the national psychiatric coordinator for Zimbabwe Prison Services, and the psychiatrist responsible for the special institution in the northern region. The experts included a lecturer from the University of Zimbabwe, the Chief occupational therapist and the Principal Nursing Officer. The last two experts were from the National referral psychiatric hospital. All stakeholders and experts involved in the validation exercise confirmed the relevance of the developed medico-judicial framework to forensic psychiatric practice in special institutions in Zimbabwe.

3.11 SUMMARY

This chapter discussed the research design, the population, sample, and sampling design. The data collection instruments, data collecting processes, and the pilot interviews were explained. The data analyses for the qualitative and quantitative data were also thoroughly discussed as were the trustworthiness of the qualitative phase and the reliability and validity of the quantitative phase. Chapter 4 presents the findings of the qualitative phase of the study.

CHAPTER 4
QUALITATIVE FINDINGS OF THE STUDY

"It is hard to train for freedom in a cage."
Morris and Rothman (1995)

4.1 INTRODUCTION

The study utilised the mixed method sequential dominant status design. The dominant part of the design was qualitative and followed a grounded theory approach. The second objective of this study was to explore and describe the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe.

The following presentation addresses this objective through an analysis of the texts using descriptive open-coding and focused coding for a grounded theory approach. In the presentation, only two or three verbatim quotes are provided. The quotations are those that the researcher perceived to be most descriptive of the participants' emic points of view. Verbatim quotes are given in *italics*. Additional quotes are provided in Annexure 1. Verbatim quotes are used to give the reader an idea of how themes and categories evolved during the process of constant comparison of the data. Using quotes also empowered research participants by demonstrating the value of what they had said in moving towards the development of the medico-judicial framework for the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe (Corden & Sainsbury 2006:13).

It is important to note here that to protect the anonymity of all participants and guarantee that confidentiality is upheld, the researcher does not mention the specific member of the judicial or the medical teams (nurses) whose statement is quoted, but instead uses codes, for example, 'Participant 11'. The designations of all 32 participants

and the codes applicable to each are given in Annexure 2. Secondly, the term ‘patient’ as used in this chapter refers to the ‘forensic psychiatric patient’.

4.2 DESCRIPTION OF THE DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

The research study comprised of 32 participants. The categories of participants are outlined below:

Participants 1 – 9 constituted the judicial team
Participants 10 – 20 constituted the medical team
Participants 21 – 25 constituted relatives of the forensic psychiatric patients
Participants 26 – 29 constituted forensic psychiatric patients
Participants 30 – 32 constituted experts in forensic psychiatric rehabilitation in Zimbabwe

With the exception of one, all the participants were black. One interview from a forensic psychiatric patient was not used in the study because despite meeting the criteria in other areas, he had relapsed while awaiting the decision of the Mental Health Review Tribunal for discharge.

4.3 DISCUSSION OF FINDINGS

The central storyline, themes, categories and sub-categories that emerged are presented and discussed in five sections. Section A comprises the central storyline, themes, categories and sub-categories derived from the judicial participants. Section B consists of the central storyline, themes, categories and sub-categories that emerged from the nurses’ qualitative data analysis. In Section C the central storyline, themes, categories and sub-categories pertain to the data collected from the forensic psychiatric patients. Section D consists of the central storyline, themes, categories and sub-categories that emerged from analysing the data obtained from the families of forensic psychiatric patients. In Section E the verbal contributions made by the psychiatrists are

presented and discussed according to theme, categories and sub-categories. The themes, categories and sub-categories that emerged from the judicial and medical teams, the relatives of the patients, the psychiatric patients and the psychiatrists are presented and discussed next. The participants were analysed separately because of their differences in exposure and social situatedness. Johnson (1987:174) explains that with regard to social situatedness, “meaning is always a matter of human understanding, which constitutes our experience of a common world that we can make sense of”. This then translates to the fact that in this study the social order and experiences of the mentioned groups of participants regarding the rehabilitation of forensic psychiatric patients was highly heterogonous; thus it was necessary to analyse them differently.

Finally, tables summarising the recommendations on the way forward with regards to rehabilitation of forensic psychiatric patients from each participant group are availed.

4.4 SECTION A: CENTRAL STORYLINE AND THEMES FOR JUDICIAL TEAM

The central storyline that emerged from the judicial team revealed that the judiciary was discordantly in tune with the system of rehabilitation of patients due to prohibitive processes and the general negative attitudes of the judiciary on the overall rehabilitation process. The judicial linguistic habitus and its selective reinterpretations were digressive to the discourse of patient rehabilitation. The role of the family was generally viewed in a negative light. Table 4.1 provides a summary of the findings from the judicial participants in the form of emerging themes, categories and sub-categories.

TABLE 4.1: Themes, categories and sub-categories of the judiciary

THEME	CATEGORY	SUB-CATEGORIES
4.4.1 Theme 1: Discordant engagement of the judiciary to the rehabilitation system	4.4.1.1 Category 1: Prohibitive processes to patient recovery	4.4.1.1.1 Prohibitive procedures of committing and discharging patients from special institutions 4.4.1.1.2 Lack of appropriate technology 4.4.1.1.3 Mixing of Criminal Mental Patients and Detained Mental Patients altering assessment procedures 4.4.1.1.4 Loss of documents 4.4.1.1.5 Relapses in remand prison 4.4.1.1.6 Psychiatrist's report does not inform courts because of language and cultural barriers
	4.4.1.2 Category 2: Negative attitudes of the judiciary impact on the overall rehabilitation processes	4.4.1.2.1 Judiciary focuses more on "political" cases than "mental" cases 4.4.1.2.2 "The system has always been like this." (Dominance and its reproduction)

THEME	CATEGORY	SUB-CATEGORIES
		4.4.1.2.3 Limited interaction between the judiciary and the special institutions 4.4.1.2.4 “Mental patients cannot be rehabilitated.” 4.4.1.2.5 ‘“Patients deteriorate in special institutions.”
	4.4.1.3 Category 3: The judicial linguistic habitus and its selective interpretation were digressive to patient rehabilitation	4.4.1.3.1 Patient referred to as an “accused person” 4.4.1.3.2 Dehumanisation of the patient 4.4.1.3.3 Rehabilitation referred to as “an investigation” 4.4.1.3.4 Admission referred to as “committing” or “incarceration” 4.4.1.3.5 Special institutions referred to as “prisons”
	4.4.1.4 Category 4: The role of family in the recovery process	4.4.1.4.1 Uncooperative relatives 4.4.1.4.2 Manipulation of the system to evade justice

4.5 DISCUSSION OF FINDINGS

Four themes emerged from the collected data. Each theme with its categories and sub-categories are discussed in detail.

4.5.1 Theme 1: Discordant engagement of the judiciary to the rehabilitation system

The judiciary had an obligation to participate in the processes involved with forensic psychiatric patients in special institutions as required by Sections 26 – 36 of the Zimbabwe Mental Health Act (1996:172-182). Their engagement, however, seemed at variance with that which would enable patient recovery; their engagement came across as prohibitive and discrepant.

4.5.1.1 Category 1: Prohibitive processes to patient recovery

Prohibitive processes to recovery were conceptualised to include the following: procedures of committing and discharging patients from special institutions; lack of appropriate technology; mixing Criminal Mental Patients with Detained Mental Patients altering assessment procedures; loss of documents; relapses in remand prison; psychiatrist's report not informing courts because of language and cultural barriers.

4.5.1.1.1 Prohibitive procedures of committing and discharging patients from special institutions

Prohibitive processes emerged in the light of procedures of committing and discharging patients from special institutions. The process a typical patient experiences through the system is as follows: after being arrested the first port of call is the police station. The accused person is then placed in remand for trial. In the following statement Participant 1 explains the process through the system.

> *"Generally we receive cases from the police and if one, if an accused person is mentally unstable, we get that information from the police, they tell us that they have received information either from the relatives or just by his appearance you can tell that this person is unstable. We refer those to court if they have committed criminal offenses and we then make an application for them to be mentally examined by two doctors, then they are remanded in custody to XX* [special institution] *and then they go for their examination by two doctors."*

After the court proceedings or the trial, the 'person' (who at this stage is neither a patient nor a prisoner) may be sent to prison as an act of omission or oversight on the part of the judiciary (he could already have been a patient but the judiciary is not aware of the fact that he is, in fact, a patient). While in custody (serving a sentence), the person may relapse as voiced by Participant 4:

> *"Some are prosecuted if it is missed that they are suffering from a mental illness. I have to say that then it only comes up when they are now in prison*."

The participants indicated that it was important at the level of initial judicial assessment for the judiciary to apply their minds or to be thorough so that such acts of omission do not happen. Some patients can also be missed because their condition of mental illness is not obvious. Alternatively, the person may appear to be mentally ill during trial. He may be sent back to remand for assessment, and brought back to court for a decision. If the patient is found to be stable he will then go to prison; if he is mentally ill, he is sent to a special institution for treatment and rehabilitation.

After the patient has recovered, his case is sent to the Attorney General's office. There are three decisions that can be made regarding the case. The patient can be discharged, given a Special Verdict or the Attorney General may decide to proceed with the trial. Participant 6 referred to these available three options as follows:

"After that patient has been treated ... the senior public prosecutor [has] *to direct us what to do. If the senior prosecutor is of the mind that that person should be prosecuted, then what we will do is then we proceed to provide that case with trial … the accused person is tried."*

Participant 2 explained what a 'Special Verdict' implies:

"We can still return what we call a Special Verdict ... I think it will be through the Ministry of Justice up to the President, that's when they [the patient] *will be released once they are satisfied that he has now fully recovered.*"

When the patient receives a special verdict, he is returned to the special institution where he awaits the Special Board to meet and deliver their observations to the Mental Health Review Tribunal as specified in Section 39 of the Zimbabwe Mental Health Act (1996:185). The Mental Health Review Tribunal will either discharge the patient or it may transfer him to the civil psychiatric hospital. The expectation is that the patient will be discharged from the civil psychiatric hospital. The Attorney General's office may also decide to proceed with the trial in which case the patient is sent back to remand to await trial. It was noted in the current study that it was at this point that some patients relapsed because they were no longer taking medication. Participant 1 commented as follows on this issue:

"... then they are taken back to the remand prison. There is no one taking care of them because when they go back to the remand prison, that is a prison not a hospital, those prison officer[s] *won't continue giving these patients medication but these people* [patients] *are supposed to be on medication because we have had cases where people are supposed to, where these accused person*[s] *are supposed to be tried and by the time they get to their destination for that trial they would have relapsed."*

If the Attorney General's office decides to continue with the trial, the patient again proceeds to court and can be sentenced or, if noted as mentally unstable, the whole process begins again; hence, forming an endless 'revolving door' scenario.

4.5.1.1.2 Lack of appropriate technology

Lack of appropriate technology in this study referred to what the public prosecutors perceived as the tools of their trade. An electroencephalograph, for example, to measure and record the electric activities of different parts of the accused's/patient's brain (Aljazaery, Ali & Abdulridha 2011:329).

Another issue mentioned was the lack of recorders that public prosecutors can use to make sure the accused or the patient as well as witnesses are held accountable by a record and not keep on changing their statements. The judiciary indicated that a lack of appropriate technology prohibits timeous expedition of court procedures. The measuring of brain activity, for example, could expedite the doctor's assessment. In this regard, Participant 4 said: *"If we had* [the] *technology that we see on television, that they use overseas*, [that] *measure brain activity…"*. Participant 5 commented on the inconvenience of not having access to appropriate technological support by stating, "*It's very unfortunate that if there is need for* [a] *second opinion* [in which an electroencephalograph machine needs to be used; for example]*, one has to be taken to Harare."*

4.5.1.1.3 Mixing Criminal Mental Patients and Detained Mental Patients altering assessment procedures

It was found in this study that there were two groups of patients in special institutions in Zimbabwe: the Criminal Mental Patients waiting to be examined by the psychiatrist and the Detained Mental Patients (forensic psychiatric patients) whom the psychiatrist had reviewed and confirmed to have a mental illness. The judicial participants expressed there was the possibility that the Criminal Mental Patient could imitate the behaviour of

the Detained Mental Patient, leading to erroneous assessment outcomes. Participant 2 voiced this concern as follows:

> *"There are some* [Criminal Mental Patients] *who are just pretending ... it develops when they are in custody when they are awaiting trial that's when you hear someone … when the person appears initially, the person is alright but come trial date, when given a trial date … they talk about the President, owning airplanes."*

Participant 7 verified this finding and suggested separating the Criminal Mental and the Detained Mental Patients.

> *"I don't think it's conducive, already there are accused persons who have been there, who have been committed long back and they haven't been assessed ... So I think they* [Criminal Mental Patients and the Detained Mental Patients] s*hould be separated*."

4.5.1.1.4 Loss of documents

The documents refer to those of the person or patient within the criminal justice system. These documents were basically handled by the regional clerk of the court; it was the same clerk who handled the documents for all other ordinary criminals in the system. The documents got lost in the system. Participant 3 reported on the loss of documents as follows:

> *"... our system needs a special office. For instance, here we must have a clerk who would concentrate on that: mental patients, registers, follow-up you know ... he does not apply his mind and his effort to these people* [patients] *because he is also overwhelmed and he tends to forget … the risk is high to forget some or even to do the papers properly."*

According to Participant 2, *"if they* [the documents] *go missing, it will be with the prosecution not magistrates* [who lose it]." The participant here meant that he acknowledged the loss of documents but blamed that possibility to another department of the judiciary.

4.5.1.1.5 Relapses in remand prison

Relapse referred to the return of psychiatric symptoms in a patient who had experienced a period of remission of symptoms while they were still in the judicial system. In the current judicial system, a patient who had recovered at the special institution was removed from that institution to remand prison if the trial was to proceed. There were no nurses at the remand prison and patients relapsed as described by Participant 1:

> *"There is no one taking care of them* [Detained Mental Patients] *mental*[ly] *because when they go back to remand prison officers won't continue giving patients medication because we have cases where people are supposed to be on medication;* w*here these accused person*[s] *are supposed to be tried and by the time they get to their destination they would have relapsed ... and the process starts again*."

The verbatim quotes indicated that Participant 3 was in agreement. This participant voiced that "*when they* [Detained Mental Patients] *were in remand, they relapsed and started* [going through] *the system again*."

The words of Participant 2 reflect that this participant was somewhat concerned about the fact that the Detained Mental Patients (forensic psychiatric patients) kept on going round and round in the system.

"*So it's a matter of how long the prosecutor takes*[s] *time* [to] *set the matter down for trial; that's why the person may relapse and then he starts suffering again."*

4.5.1.1.6 Psychiatrist's report does not inform the courts because of language and cultural barriers

The findings of the study indicated that the judicial participants were concerned about the accuracy of the psychiatric examination in the southern region. This emanated from the fact that the psychiatrist was a foreign national and it was possible that there could be cultural and linguistic barriers inherent in the assessment procedures. Participant 1 communicated as follows on this issue:

"… because our psychiatrist is a white person ... it was just an observation that maybe our doctor does not appreciate the type of patients she is dealing with. They [accused persons/ patients] *just come and tell her stories and she believes what she has been told when it's not* [the truth]*."*

Participant 5 stated the following:

"… there is [the] *question of language barriers there is a question of customs... Because how can someone, someone from Russia really understand Ndebele custom?"*

Then participant 4 endorsed this statement by saying that "… *differences in culture, you know ... and they* [accused persons] *are trying to be mad, you know. You* [the psychiatrist] *won't know that."*

4.5.1.2 Category 2: Negative attitudes of the judiciary impact on the overall rehabilitation process

The study reflected that the judiciary participants seemed to have a predisposition to respond unfavourably towards forensic psychiatric patients' judicial processes. This seemed to affect the rehabilitation process for the forensic psychiatric patients in a negative way.

4.5.1.2.1 Judiciary focuses more on "political" cases rather than "mental" cases

The judiciary seemed to focus more on political cases than on cases that involved people with mental problems. This generally meant that the judiciary prioritised court cases that give them social standing, professional recognition or on cases that could result in monetary gain for them. They were seemingly less interested in 'human rights' cases. This means that persons or patients who have mental health problems take longer than would be expected in the criminal justice system because they are not viewed as priority cases. This finding suggests that the preferred political cases rendered more monetary gain than the humanitarian based mental cases. Participant 4 spoke about this aspect as follows:

> *"... even lawyers when they come, these human rights cases, they don't go for these cases, they go for political cases so I think everybody in the legal framework set-up needs to conscientise themselves* [become conscientious and do what is right] *on these people* [and] *their existence, and it's like they* [Detained Mental Patients] *are a forgotten."*

Participant 3 acquiesced that there were problems in the judicial system by stating:

> "*Okay it means that our system is not adequate for the purposes of catering for mental patients. We have shortfalls; we have inadequacies in our system..."*

4.5.1.2.2 "The system has always been like this." (Dominance and its reproduction)

It was found in this study that there was a general feeling of apathy in the criminal justice system because the status quo was taken for granted. The participants did not expect any changes to occur nor did they see the need to question the status quo. Participant 5 verified this finding.

> *"... the framework which is in existence because this thing has been there for decades. The people who are in trouble with the law have been there since time immemorial."*

The contribution of Participant 8 to the dominant role played by the current judicial system was that it was "*a system that we have found being here so I don't know how we can chip in and help."*

4.5.1.2.3 Limited interaction between the judiciary and the special institutions

When a treatment order was given through the judicial system for a patient to be admitted to a special institution, the assumption was that the judicial system had expectations from that order in that the mental stability of the patient would improve. Some form of professional intercourse with the site of order was expected. The study findings, however, revealed that there was limited interaction between the judiciary and the special institutions. The judiciary seemed unclear as to what actually happened to a person once he had become part of the judicial rehabilitation system as the following verbatim transcribed words of Participant 1 relayed:

> *"I am not sure whether they go to XX* [special institution] *remand or they go straight to XX; but I want to believe they go to XX once a special verdict has been given, that is where we* [the judiciary] *like end."*

According to the Participant 9 "*the judiciary haven't been able to follow up those patients ... as XXXX we felt that the members* [of the judiciary team] *also had to be oriented to the environment at XX* [special institution] [and the] *environment at XX* [special institutions where patients are rehabilitated].*"*

Participant 4 also confirmed that there was little interaction between the judiciary and the special institutions:

> *"The problem is I think my… my perceptions of XX* [special institution] *are a bit very narrow because I haven't interacted with the setup* [at the special institution]*."*

4.5.1.2.4 "Mental patients cannot be rehabilitated"

Rehabilitation is the restoration of the patient's former skills and functionality so that they can successfully adapt to their environments (Anthony et al 2002:3). An unexpected finding emerged from one judiciary participant who argued that it was not possible for a forensic psychiatric patient to be rehabilitated because he would not have been aware that he did wrong. Therefore, according to Participant 5, rehabilitation could only be done to correct a wrong; but technically forensic psychiatric patients did not do anything wrong because they were found not guilty at trial by reason of insanity. This meant that the judiciary participant's understanding of rehabilitation was different from that of the medical team. The statement made by Participant 5 in this regard was:

> *"XX* [special institution] *is not for rehabilitation, it's a mental institution. Is not for rehabilitation ... no, no, it's not for rehabilitation because* [with] *treatment you are bringing to normalcy. Rehabilitation you are saying no, the way you have been living a criminal life when you were in your proper senses. But you can't rehabilitate someone who would have these, if that person committed an offence, when that person was not normally what? Stable. What is there to rehabilitate? Because there was an element of intention which is* [was]

lacking. We are rehabilitating people who are supposed to be rehabilitated are those who intentionally did an offense, yes."

4.5.1.2.5 Patients deteriorate in special institutions

The participants expressed that the patients "*get worse"* after admission to the special institution facility. According to some judiciary participants, the symptoms that patients had presented with before admission worsened after admission to a special institution. They pointed out that the special institutions were more of a prison and did not offer services that aided the recovery of the patients. Quotes to confirm this finding are given next. Participant 3 said:

"Most of these people get worse ... I have seen people who would have appeared before me in a moderate state but you see he is not in a position to articulate himself for the trial. But then when we meet them in a prison sometime, you realise he is in a worse off situation."

Verbalising his view, Participant 9 made the following observation:

"The reason why these patients have to be sent through a civil hospital is because with high security institutions like XX [special institution] *the environment might not be conducive for rehabilitation."*

The third judicial participant who commented on the inability of special institutions to play a significant role in the rehabilitation of forensic psychiatric patients was Participant 4 who stated:

''I have been there for a few visits and I find that the place [special institution]*, it doesn't look like a place of rehabilitation. It looks more like a prison...'*

4.5.1.3 Category 3: The judicial linguistic habitus and its selective interpretation were digressive to patient rehabilitation

The researcher noted from the findings that there were myriad linguistic differences from the judiciary. The language that was used for an ordinary criminal was the same language used for a patient even after it had been confirmed by the medical examination or psychiatric assessment that he was now a forensic psychiatric patient. Examples that verify the researcher's observation and also corroborate the findings in this category are presented in the next section as sub-categories.

4.5.1.3.1 Patient referred to as "accused person"

If a patient receives a medical report confirming that he is 'positive', in other words that he has a mental illness, it is implied in the Zimbabwe Mental Health Act (1996:180) that he ceases to be 'an accused person' because he is not guilty by reason of insanity in accordance with Section 31 of the Act. Despite this stipulation, the judicial participants referred to patients as "accused persons" at all levels of interaction. During the interview, Participant 7 voiced the following:

> *"What normally happens is as soon as the accused person recovers from his illness, the Attorney General will simply take the matter for this person to be brought to court as soon as possible."* (I emphasise).

Participant 6 also referred to the "accused person" during his interview with the researcher:

> *"Let's say that report e-eh, assuming the report comes and the doctor is of the opinion that the accused person is now of stable mind … the doctor must indicate whether at the particular time when that particular offense was committed, whether that person was mentally sick or not."* (I emphasise).

4.5.1.3.2 Dehumanisation of the patient

It was found that the patients were deprived of their human quality and rendered mechanical. The study findings indicated that the judiciary dealt with the paperwork and not the patient. That seemed to translate to the fact that patients were viewed as a 'case' or 'file'. Participant 2 confirmed this finding by stating: "*Normally, there is a form that they send to us to indicate that the person has recovered and is now fit to stand trial; then we proceed."* (I emphasise)

The words of participant 7 also conveyed the message that the patients were seen merely as names that appeared on papers:

> *"So simply the magistrate having seen that report, if he feels the accused person needs to be committed to XX* [special institution]*, then we facilitate the committal papers; that is* [are] *the charge sheet, the state outline, the record or evidence."* (I emphasise)

A senior judicial officer Participant 1 verbalised that *"the docket is brought in; you decide you are not going to prosecute."* (I emphasise).

4.5.1.3.3 Rehabilitation referred to as an "investigation" or "examination"

In this study the words 'investigation' and 'examination' were conceptualised differently because the period of treatment and rehabilitation was generally regarded by the judiciary as an "investigation" or "examination". Participant 4's statement verified this finding:

> *"At XX* [special institution]*, now that is the part of the sentence based on the recommendations of the psychiatrist ... we make an application to go to a psychiatrist for an investigation now and the psychiatrist will then tell us e-eh whatever investigation that she is going to do."* (I emphasise).

Also, Participant 1 (a senior judicial officer) said:

> *"It depends on the seriousness of the offense that they have committed. If it's a serious offense at times the examination takes longer, usually within three months we get that report from the psychiatrist."* (I emphasise).

4.5.1.3.4 Admission referred to as "committing" or "incarceration"

It was found that the process of admitting the patient was referred to by the judiciary in the same manner, namely as "committing" or "incarceration". Participant 1 used "incarcerated" when he spoke about the suffering of the patients; incidentally, the term "accused person" was used in the same statement as seen below:

> *"Ya-a the problem is that these accused persons are unnecessary suffer*[ing] *by being incarcerated."* (I emphasise).

Participant 2 also referred to "committing" patients to special institutions:

> *"Once they say the person is mentally ill and must be detained to an institution, normally sometimes they indicate the name of the institution and we simply commit the patient to the institution concerned."*

4.5.1.3.5 Special institutions referred to as "prisons"

The special institutions where patients are taken care of were referred to as "prisons" by participants. The name PRISON was also written at the entrance of special institutions despite their being gazetted as per specifications of Section 107 of the Zimbabwe Mental Health Act (1996:212) as SPECIAL INSTITUTIONS in 1978 and 2000 respectively. The same judicial participants who referred patients to special institutions in terms of the Act still referred to the special institutions as "prisons". Participant 6 used it in the following sentence transcribed verbatim from his interview:

> *"…* [patient] *is remanded in custody then is taken to <u>prison</u> where you* [researcher] *are talking about*." (I emphasise).

A second example in support of this finding lies within the wording of the sentence uttered by the Participant 7. During his interview with the researcher he referred to the special institution as a "prison" and, similar Participant 6, he also referred to "committing" the forensic psychiatric patients:

> *"A-ah, normally, I haven't visited XX* [special institution] *<u>prison</u>, I don't know the setup, whether they* [forensic psychiatric patients] *are going to mix with other detainees or not but simply we just <u>commit</u>* [them]." (I emphasise).

4.5.1.4 Category 4: The role of family in the recovery process

The study revealed that the family is expected to be part of the judicial processes where the patients are concerned. The family seems to determine whether the patient is or is not sent to a special institution, and is apparently also expected to be involved in the assessment and the discharge processes.

4.5.1.4.1 Uncooperative relatives

It was found that the judiciary viewed the support of the patients' families as a critical element in the latter's recovery process. Participant 4 supported this finding by stating the following:

> *"It was because of the sister who was saying he asked me to lie... Then when she got into court she changed the statement; unfortunately I couldn't hold back to that*."

The following quote of Participant 1 also endorsed this finding:

> *"There is no-one* [relatives] *to … to take them home and to make sure that they are taken to a doctor or a psychiatrist."*

4.5.1.4.2 Manipulation of the system to evade justice

Manipulation of the system means that the person or patient may misinform the courts so that a different decision is made about the crime he committed (Potter 2006:140). The judicial participants felt that decriminalisation of mental patients is being used by the public to manipulate the criminal justice system. This finding is verified by the following two quotes from Participant 4 and Participant 5 respectively.

> *"But the unfortunate thing also is that we also have people* [forensic psychiatric patients] *that abuse the system... So they made sure they were moved from that other place to XX* [special institution] *and then they escaped."*

> *"He* [psychiatrist] *just went on there, got the story from the, from this tsotsi* [manipulator] *of a, whatever, pretending, that 'I started hearing voices when I went to South Africa', yes, but e-eh, that was at XX* [special institution] *then he* [psychiatrist] *says 'ha-a no', at the time of commission of the offense,* [he, the psychiatric mental patient] *can't be held accountable."*

4.5.2 Section B: Central storyline and themes for the nurses

The central storyline from the medical team, specifically the nurses, reflected that they experienced a dichotomous reality in which responsibility was abdicated as a 'disturbing phenomenon'. The reality referred to their role, care for patients, and responsibility. The perceived power issues and the nurses' expectation for rehabilitation, the reality of giving hope versus a 'brick wall' of hopelessness were key issues raised by the nurses.

Their perceived responsibility versus the actual reality constituted the package that contained the 'dichotomy'. Nurses were working in an environment in which what they were professionally expected to do was mutually contradictory to the context in which they were practising. This dichotomy was perceived to be perturbing, disquieting and causing the nurses anxiety and disillusionment because of its significance and complexity.

A summary of the emerging themes, categories and sub-categories regarding nurses' experience of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe is presented in Table 4.2.

TABLE 4.2: Themes, categories and sub-categories of nurses

THEME	CATEGORY	SUB-CATEGORIES
4.2.1 Theme 1: Dichotomous reality in which responsibility is abdicated	4.2.1.1 Category 1: Perceived role	*4.2.1.1.1 Nurse versus guard*
	4.2.1.2 Category 2: Perceived power issues	*4.2.1.2.2 Nurse voiceless and disillusioned in the system*
	4.2.1.3 Category 3: Expectations for rehabilitation	*4.2.1.2.3 Definition of rehabilitation inconsistent among nurses*
	4.2.1.4 Category 4: Giving hope versus a 'brick wall' of hopelessness	*4.2.1.2.4.1 Patients get worse after admission because of despair* *4.2.1.2.4.2 Patients never get home after discharge to civil hospital*
	4.2.1.5 Category 5: Perceived responsibility versus actual reality	*4.2.1.5.1 Greater emphasis on physical care (bath, feeding, medication)*
		4.2.1.5.2 Lack of financial and human resources

THEME	CATEGORY	SUB-CATEGORIES
		4.2.1.5.3 Lack of knowledge and understanding on the part of the multidisciplinary team
		4.2.1.5.4 Issues around family systems (resistance and lack of knowledge)
		4.2.1.5.5 Limited or no rehabilitation resulting in 'revolving door' scenario

One theme comprising five categories emerged from the nurses' data.

4.5.2.1 Theme 1: Dichotomous reality in which responsibility is abdicated

4.5.2.1.1 Category 1: Perceived role

Nurses perceived their roles and responsibilities in the special institutions as 'blurred'. They seemed to feel underutilised because of their unsolicited overdependence on the prison system.

- ***Nurse versus guard***

The findings of the study pointed at the fact that for nurses to do their duties, the presence of a guard was mandatory. The power of the guard seemed to derive from the Zimbabwe Prison Act (1996:467) that was operationalised by an instrument called the Zimbabwe Prison Service Standing Orders of 1992. The prison system operationalised this instrument by assigning prison numbers to forensic psychiatric patients and classifying them according to the crimes they had committed. The classification was specifically derived from the Zimbabwe Prison Service Standing Orders of 1992, Part IX, Section 164, sub-section 4 (1992:57). The majority of forensic psychiatric patients

admitted in special institutions had either committed murder or rape and were therefore classified as D-class prisoners. A D-class prisoner was not allowed to leave the ward. This translated into the scenario of 'no guard, no rehabilitation'. Participant 16 explained the scenario as follows:

> *"No, it depends, like it depends on the day if, for example, if I'm putting on prison attire* [prison guard uniform], *I can escort but if I'm putting on white attire* [nurse's uniform], *I have to ask for a prison officer to escort us to the, to our garden ... because what it means is that if someone is in white that day and there are no prison guards to escort, it means they* [nurses] *are not taking the patients to the site* [garden]*."*

Participant 14 added:

> *"If one has committed murder, they will classify him as DMP D-class* [Detained Mental Patient D-Class]*. A D-class inmate is not supposed to go out of prison or for any rehabilitative activity; we may want to indulge* [give services] *on this patient."*

The next statement was made by Participant 12:

> *"At a prison setup, at times when you want to take patients outside, there will be no prison officers to escort. So you cannot do what you want with patients at* [in] *your own time."*

4.5.2.1.2 Category 2: Perceived power issues

Nurses perceived an undercurrent of unspoken power issues that interfered or that defined what they could do and what they could not do in the rehabilitation process for patients. This resulted from their unspoken subordinate role in the prison system.

- ***Nurses voiceless and disillusioned in the system***

The nurses expressed that they were ignored in the prison system where the special institutions were housed. As a result, the nurses seemed to feel disempowered and had lost hope that the system would ever change. Their disillusionment emerged clearly in the following quote of Participant 11:

> "*You get there and you are trying to explain yourself. Sometimes you kind of lose it because it seems like they* [judiciary and prison system management] *don't really understand where you are coming from ... they are like the law is the law, come and see, it's like, even if I come and see, it wouldn't change a thing. ... No one cares ... that's how it always has been. You go to your own immediate boss, immediate boss also says that's how it's always had been... I think if you are exposed to this system long enough... I think maybe you might even thinking start like it's not going to change anything."*

Participant 16 said:

> *"If you are somebody who is doing something, you should be able to see the results ... but then you are stuck with them* [forensic psychiatric patients], *they have nowhere to go."*

Of significance is the words uttered by Participant 13 that mirrored the nurses' disillusionment and feeling of disempowerment:

> *"It's a dead end situation; nobody likes them* [forensic psychiatric patients] *so they will stay here."*

4.5.2.1.3 Category 3: Expectations for rehabilitation

The expectations for rehabilitation meant that nurses were expected to conceptualise or express the concept of rehabilitation in a way that was in line with their professional training. As nurses responded to what rehabilitation was, it became clear that there was no professional uniformity in the definition of rehabilitation.

- ***Definition of rehabilitation inconsistent among nurses***

The participating nurses had no uniformed definition of rehabilitation. It also seemed as if within the system, there were no guidelines pertaining to the definition of either rehabilitation or treatment. If they did offer an explanation of the concept, it was very basic and limited. This finding was disconcerting as their training was expected to have equipped them with the specificity inherent to the rehabilitation concept.

The contribution of Participant 11 reflected nurses' uncertainty and even confusion as to what exactly was expected of them with regard to the rehabilitation of the forensic psychiatric patients. To the participant, it meant trying to get the patients "back" to where they could distinguish between right and wrong; thus to render care in such a way that they came to have an understanding of that what they did was 'wrong' and, by going "back" to the 'wrong', hopefully they would grasp what was 'right':

> *"If we are rehabilitating someone ... I think you have observed that this person has a problem somewhere or a deficiency, something that they used to be able to do that they can't do anymore, so you are trying to get them back into that um-m what can I say? You are trying to get them back to where they were like to say they couldn't do this now let's try and get them to do it again."*

Participants 16 and 14 shared that, as trained professional nurses, the nurses' role in the rehabilitation process of a forensic psychiatric patient was almost viewed as non-

existent and insignificant. According to Participant 16, little if any psychiatric care was rendered to the patients and the latter was kept busy with menial domestic tasks:

> *"... rehabilitation wise, there isn't much but mostly they* [forensic psychiatric patients] *are involved in activities of daily living like generally cleaning their department*."

Although the nurses had no (or little) institutional guidelines defining their role in the special institutions, they still seemed to feel the need to help with the rehabilitation of the patients. Participant 14 explained that the nurses, of their accord, initiated activities and socialisation.

> *"Ok, it is where, a process whereby we involve these patients in activities, which will help them we are trying to sort of rejuvenate the, what can I say, how can I explain it? Only to define rehabilitation but maybe I'm... We do offer the projects we can do like e-eh gardening ... activities like just playing soccer, playing whereby they will be socialising*."

4.5.2.1.4 Category 4: Giving hope versus a 'brick wall' of hopelessness

At the core of psychiatric nursing care is giving patients hope for the future. The study findings presented a contradicting picture in that the psychiatric nurses were not able to fulfil this obligation, but instead faced a dead end situation in their practice that fostered hopelessness in the patients under their care.

- ***Patients get worse after admission because of despair***

In this study the nurse participants observed that patients actually got worse during admission. This was presumed to be caused by unfavourable prison conditions. At the special institutions under study, the researcher noticed that patients lived in overcrowding conditions – there were as many as 35 in a single cell that had been

designed to hold only a maximum of three prisoners (Zimbabwe Prisons (General) Regulations 1996:27). Each had all their belongings in the tiny cell. Privacy was non-existent. The toilet was situated inside the cell separating it from where patients slept by a half-a-metre high wall. Patients slept extremely close together such that there wasn't even turning space between them. The cell door was locked from the outside at 17h00 in the afternoon only to be opened at 08h00 the next morning. If one patient had become violent during the night, it would only be discovered the next morning.

Participant 11 referred to the conditions that could affect patients' conditions negatively as follows:

> *"Some do actually do get worse ... prison setup, nobody wants to be here. I wouldn't want to be here either... If someone maybe comes with some mild personality disorder I am sure they would leave here with depression as well*."

Participant 16 expanded on the probability of violence because of the unfavourable conditions:

> *"Like others will have physical aggression... I think because why they are always enclosed you know, this monotonous life, you wake up, you eat porridge, you wake up, you bath, you eat porridge, there isn't much activity going on*."

Participant 13 added:

> *"In the system … and sometimes the patient relapse because ... emotionally when they feel 'I should be going home' but they can't … eventually they relapse again and sometimes they become violent."*

- ***Patients never get home after transfer to civil psychiatric hospital***

When a patient was transferred from a special institution to a civil psychiatric hospital by the Mental Health Review Tribunal, they were expected to undergo further rehabilitation and be discharged to go home. Seemingly, these patients seldom got home. When the patients were due to be discharged, relatives either made it clear that he was not welcome or they simply ignored the communication to the effect that they should collect the patient and take him home. This resulted from the complexity of crimes the patients had committed before being committed to the system. The other factor was that the system did not have enough resources to return patients to their destinations of origin. According to participant 13, the situation was *"like hitting on a brick wall".*

> *"It's like hitting on a brick wall because they are referred to this department so that they are rehabilitated and then sent home but then they are not going home... Some of them came in as early as* [the] *1980s and some of them in the 90s, so if someone has been here since, for example, more than a decade now in the ward ... yes, until they die*."

Participant 16 mentioned that there were *"no relatives and there is no way to resettle them."* She continued that the nurses at the special institutions "*are stuck with them like I said earlier on … 'Till death do us part'* [laughs]." In the view of Participant 14, it "*becomes a vicious cycle whereby the patients remain in the system...*".

4.5.2.1.5 Category 5: Perceived responsibility versus actual reality

The nurses perceived that they had a duty and obligation to render quality nursing care to patients. The reality of the context in which they had to provide this care was not conducive because they did not have control over their mandate.

- ***Greater emphasis on physical care (bath, feeding, medication)***

When asked about the services they offered to patients, it appeared that the nurses gave even less than custodial care. They supervised baths, feeds, and medication. The researcher's observation notes indicated that patients were 'nursed' in cells without beds where they slept close together on mats on the floor, their belongings with them. The bucket system toilet was separated from the space where they slept by a half-a-metre high wall. During the night the doors were locked from outside and opened by guards the following morning. The nurses voiced that in this context it was extremely difficult and almost impossible to provide anything but physical nursing care. Participant 16 put it across as:

> *"... this monotonous life, you wake up, you eat porridge, you wake up, you bath, you eat porridge, there isn't much activity going on. Of course they watch TV, they can play draft, they can play cards but you know, they want go out, out, out there and also lead a normal life because once they are in hospital, there isn't much that is going on."*

Participant 10 said the nursing care they could render to the patients involved *"feeding, bathing, administration of medication";* thus taking care of the patients' physical needs. The participant even went further to compare care delivered to male patients' side with that of female patients:

> *"Rehabilitation, I think the girls have it good* [have resources] *this side. They watch TV almost everyday then listen to music. They play netball. Also I think it's also a case of numbers. The females are much, much less than the males are. I have hardly seen numbers in the female section going to* [the] *male* [section]. *So the females are much better rehabilitated than males are and even the environment is more comfortable for them. I think looking at who leaves off worse*, *the males are getting it rough* [are disadvantaged]."

Participant 12 explained that the nurses did try to provide more than physical care only: "*We do treat patients, medical problems and also give medication…"* According to this participant, the nurses "*also assess patient's mental status"* and observed *"patients during feeding and bathing".*

- ***Lack of financial and human resources***

The nurse participants agreed that the lack of both financial and human resources had a negative impact on the care they were able to give to the patients. For example, the researcher's field notes indicated that in a special institution with 174 patients there were four psychiatric nurses and one visiting psychiatrist. The nurses were far outnumbered by prison guards. In the special institution in the northern region there were 260 patients with five psychiatric nurses, two social workers and one visiting psychiatrist. The psychiatrist could see an average of only five patients who were either acutely psychotic, had acted out or were new admissions per week depending on whether the psychiatrist was available.

Participant 15 stated:

> *"Ha-a, starting from resources even if you want to check e – eh where we haven't got enough, what can I say? Umm – enough tools like hoes and the other thing there is water shortage here in XX* [special institution] *... if they* [non-governmental organisation] *don't bring seeds for us then us from prison, we won't get anything"*

Participant 14 voiced the following:

> *"The difficulties are that in most cases what we were expecting is to see various rehabilitative activities in these institutions but due to lack of resources e-eh that is material resources for the rehabilitation activities … it's a challenge"*

- ***Lack of knowledge and understanding on the part of the multidisciplinary team***

Nurse participants expressed that the multidisciplinary team seemed to lack knowledge and understanding about the healthcare that should be delivered to forensic psychiatric patients in special institutions. The multidisciplinary team in this study referred to all professionals who were involved in the processes of assisting the forensic psychiatric patients; hence, the judicial and medical teams.

Participant 11 stated the following:

> *"Honestly speaking, you kind of, you do get dejected. You rant and you rave and you almost seem like you are also a psychiatric patient sometimes... You know, you are trying to get maybe to see the public prosecutors at XXX* [name deleted for anonymity]*, the court system and the judicial system. You get there and you are trying to explain yourself ... they are like, 'The law is the law, come and see', it's like, even if I come and see, it wouldn't change a thing … You feel like you are not doing enough."*

Participant 13 added:

> *"They say like, for example, in occupational therapy they could say we cannot help someone who has committed murder... Also the psychologist, they want someone who is 'stable'. They say, 'We want a stable patient; we don't want someone who is confused'."*

Participant 12 voiced her experience on this aspect as follows:

> "*I was thinking that if the patient commits a crime outside, the judiciary should assess the gravity of the crime before sending the patient to prison. They should at least assess if it's just a minor crime, the patient should be sent to a*

civil hospital like XXX [name not used for anonymity] *for treatment because most of them would have defaulted treatment. So they should go back to XXX* [civil psychiatric hospital]*, get treated and sent home* [rather] *than that they will be sent to XX* [special institution]."

- ***Issues around family systems (resistance and lack of knowledge)***

The families of patients were often unwilling to take their relatives back after the latter had committed crimes and had been detained. This was particularly the case if a family member had been discharged from either the special institution or the civil psychiatric hospital. Their reluctance to have a relative return home emanated from the nature of the crime committed, cultural beliefs about implications of the crime, or the failure of the systems. Participant 13 shared the following with regard to issues that the nurses encounter with relatives unwilling to accommodate and support forensic psychiatric patients after discharge:

"… and also like you mentioned the social services department, they are supposed to assess the home situation, do extensive counselling of relatives, so that eventually this patient goes home but when they go there, they also meet resistance. Sometimes that resistance it's a genuine resistance, a genuine feeling, for example, someone who has raped their [his] *mother. The family is not comfortable living with that person so when social services meet that resistance, they say, 'A-ah this one is a dead end'."*

Participant 16 spoke about the influence of culture on the relatives' reluctance to receive the patient back home:

"Like culturally, people in our culture, people they believe that when ... once you murder someone, there is a 'ngozi' [malevolent spirit] *that will come and haunt the family... So the patient remain in hospital because once he comes he will do 1, 2, 3. And another thing maybe the … for example, if that person*

murdered maybe somebody from another family that family will maybe make it clear that once that person returns, 'We are going to take action', so the relatives are sort of protecting [the patient when they don't want him discharged]. *Because we have an example of someone who murdered his brother's wife and improved but other daughters-in-law in that family are saying, 'Once this man returns, we are all going to pack our bags and go'."*

- ***Limited or no rehabilitation resulting in 'revolving door' scenario***

In view of the context of rehabilitation (prison setting), the number of patients in need of rehabilitation (434 patients) and available resources for rehabilitation (nine psychiatric nurses, two psychiatrists and two social workers) and no access to occupational therapy and psychotherapy at the civil psychiatric hospital, the research findings suggested that there was no rehabilitation for forensic psychiatric patients in special institutions in Zimbabwe. At the end of the day, patients remained trapped in the system, revolving between courts, the special institution and the civil psychiatric hospital and back to the special institution. The next three verbatim quotes verify this finding.

Participant 11:

"That's quite a challenge [rehabilitation]. *Honestly I would say, none really because, ok, fine they say that there is* … [there is] *actually a small little garden* [at the special institution] *but if we are looking at the number of patients we have and the number of patients who actually participate in that little small rehabilitative gardening project, I am almost tempted to say none because* [out of] *patients 170* [out of 170 patients] *only 6 going to the garden."*

Participant 13 added:

"*They* [occupational therapists and psychologists at civil hospital] *say like, for example, in occupational therapy they could say, 'We cannot help someone*

who has committed murder...'. They don't get appropriate rehabilitation because the person who is supposed to help is afraid of the patient."

Participant 16 contributed the following troublesome fact:

"Like I said, a-ah, currently out of the 30 or 29 that are there, there is only one who goes regularly to attend occupational therapy outside the ward."

4.5.3 Section C: Central storyline and themes for the forensic psychiatric patients

The central storyline that transpired from the data analysis of the forensic psychiatric patients' data was that these patients experienced life in the special institution as that of being a "prisoner" and they were not "patients" due to the breakdown or misalignment in the judicial and health systems. This culminated into physical, emotional, social, and occupational challenges for the patients. An underlying dynamic of power was noted among the prison system, the judiciary and the medical fraternities in the management of patients.

TABLE 4.3: Themes, categories and sub-categories of forensic psychiatric patients

THEME	CATEGORY	SUB-CATEGORIES
4.3.1 Theme 1: Patients experience life in the institution as being a "prisoner" and they were not seen as "patients" –	4.3.1.1 Category 1: Judicial system fails patients resulting in prolonged stays	*4.3.1.1.1 Lost documents* *4.3.1.1.2 Lack of human resources resulting in process delays* *4.3.1.1.3 Lack of monitoring and supervision*

THEME	CATEGORY	SUB-CATEGORIES
physical, emotional , social and occupational challenges ensued		
	4.3.1.2: Category 2: Health system failure resulting in relapse	*4.3.1.2.1 Physical challenges* • Food insecurity • Rehabilitation largely focused on chemical therapy *4.3.1.2.2 Emotional challenges* • Anxiety and uncertainty Patients perceive power issues in the process of their management *4.3.1.2.3 Social challenges* • Support systems limitations result in loss of social functioning *4.3.1.2.4 Occupational challenges* • Uncertainty related to social functioning after discharge • Challenges during admission • The concept of a patient being 'staff' as a form of rehabilitation

THEME	CATEGORY	SUB-CATEGORIES
		• Limited access to rehabilitation services • Lack of effective communication with patients

From the participating group comprising of forensic psychiatric patients, Section 3, one theme and two categories emerged.

4.5.3.1 Theme 1: Patients experience life in the institution as being a "prisoner" and they were not seen as "patients" – physical, emotional, social and occupational challenges ensued

The theme that emerged indicated that the processes currently in place by which a person who has committed a crime is found to be mentally ill, seem to be objectionable and condemning to this person right from the courtroom. In court he is referred to as an "accused person" by the judiciary and is "incarcerated" as is referred to admission to the special institution by the judiciary. When this person reaches the special institution he is classified by the prison system as A, B, C or D according to the Zimbabwe Prison Service Standing Orders (1992:56). The fundamental truth is that this person, who is now a patient, experiences the life of a "prisoner" ("a person legally committed to prison"; "a person captured and kept confined" [*Concise Oxford English Dictionary* 2006:1141]) in the special institution instead of being cared for as a "patient" ("a person receiving or registered to receive medical treatment" [*Concise Oxford English Dictionary* 2006:1049]).

4.5.3.1.1 Category 1: Judiciary system fails patients resulting in prolonged stays

The patients who participated expressed that the judiciary failed them. This failure, according to them, occurred in the form of documents being lost, a lack of human and

other resources that could otherwise propel the processes, and a lack of the monitoring and supervision of patients, especially in remand prison.

- ***Lost documents***

The patients voiced that documents got lost in the system. This issue was also brought up by the judicial participants albeit from a different angle. Patients were convinced that the prosecution department deliberately removed some documents because they [judiciary] would be angry at the nature of the crime. The participating patients believed that documents also got lost between the Special Board and the Mental Health Tribunal. This resulted in delays in the patients' progress in the system. In this respect, the patients made the following statements. Participant 26 said:

> *"Prosecutors are just angry with the case and say, 'It's just a rape, okay, let me give you what? A sentence...?' They know … there is a patient … they know that he is a patient but they take the doctor's affidavit and remove it and give the magistrate just a docket, prosecute him, but the doctor's affidavit has been removed*."

Participant 28 mentioned the following personal experience he had:

> *"Yes, the Tribunal, when I was told that 'you are not going home...' because my state outline was missing... They* [documents] *were no longer there; I don't know why they were not there."*

- ***Lack of human resources resulting in process delays***

The human resource base was perceived as deficient by the patients. These included nurses, psychiatrists, the judiciary staff, and social workers. These professionals were all expected to play their respective parts in the rehabilitation processes and facilitate

patients' progress. In the study, the processes were said to be slow because of the deficiency in this resource base.

Participant 26 made the following comment:

> "*A-ah there is no social worker ... other days nurses are not there every day and we remain with that guard. So we stay almost the whole day without medication because the nurse is not around."*

According to Participant 27, there were not enough judges or psychiatrists:

> *"They can provide maybe a lot of judges because some people are staying a long time without being seen or being given a special verdict. They go off to court for a long time. Maybe it's the shortages of magistrates or judges, we don't know what is taking place there ... the psychiatrists are not enough. They have got only one psychiatrist who is coming here. So if there were a number of psychiatrists, the situation was going to be faster."*

- ***Lack of monitoring and supervision***

From the perspective of patients as participants, it seemed as if there was no supervision and monitoring in the system. Patients relapsed, especially in remand prison, while awaiting trial or after having been transferred there from the special institution. The special institution itself lacked monitoring as medicines were given without prescription; at times, it was even handed out or administered by guards. Participant 26 voiced the following:

> *"… but the monitoring of taking medication at remand is poor because at remand they don't give us like here. They give us say in the morning and you keep your medication so that the mental patients don't take medication, they throw it away. So I, in 2008 and 2009, I relapsed in 2009."*

Participant 26 went on to bring out the issue that:

> *"Ya-a, here* [at special institution] *nurses are not allowed to give medication ... the officers* [guards give medication] … *Our nurses are not allowed. I don't know why."*

Participant 28 admitted that he had also had a relapse:

> "*When I was here* [in custody of special institution] *I was ill again... Ya-a, I relapsed*."

According to Participant 27, the psychiatrist's visits to the patients were unpredictable and they just had *"to wait for her to come maybe*". The same participant also said: "[We] *are given some medication that is not prescribed... so no-one is seeing the patients as it is the duty of a psychiatrist".*

4.5.3.1.2 Category 2: Health system failure resulting in relapse

The health system in this context referred to the nurses, psychiatrists, social workers, and staff from the unit in the civil hospital which was purported to be the exit point for forensic psychiatric patients. They were perceived by the patients as failing to play their role and executing their duties properly; this resulted in physical challenges the patients faced such as food insecurity. Other failures were attributed to the fact that treatment largely focused on chemical therapy.

- ***Physical challenges***

The physical challenges referred to those physical limitations that implicitly impacted on the recovery of the patients. For example, in this study it was discovered there were food shortages both in the special institution and at the remand prison.

- ***Food insecurity***

Food insecurity in the study particularly resulted in behavioural changes that were inclined purely towards survival for some patients. The effect of the survival strategy was negative and led to a relapse as confirmed by Participant 26.

> *"Ya-a, there is no food at remand. No food. In 2008, 2009, there was no food, so other times, like CPZ* [Chlorpromazine] *other people, prisoners like it, so I was selling it... yes, I was selling it to get food. There was no food... Yes, they came to me with food then I gave them CPZ* [Chlorpromazine]*."*

Patient 27 complained that the food they were *"eating is not well cooked. Sometimes no oil; sometimes no sugar as we are experiencing now, no sugar in porridge. We are eating sugarless porridge. No cooking oil."*

- ***Rehabilitation largely focused on chemical therapy***

The patients' understanding of rehabilitation was psycho-pharmacotherapy. They were not familiar with other possible treatment modalities like occupational therapy and psychotherapy. Participant 29, for example, noted that, *"When you will be under treatment ... they give some drugs for treatment".*

Participant 26 said he *"was taking medication from 2006 to 2008 but when I went back to court ... and she gave me FD* [fluphenazine deaconate] *and another medication. I started taking the medication. I was okay."*

- ***Emotional challenges***

The patients were subjected to emotional challenges emanating from anxiety and uncertainty about their predicament. They also experienced emotional trauma because of an undercurrent of conflict of power that they perceived.

- ***Anxiety and uncertainty***

The patients expressed anxiety over their uncertainty about what was happening to them at present; they were similarly stressed and extremely worried about what would happen to them in the future. It seemed as if the processes that they perceived to be blurred in both the judicial and medical systems elicited apprehension among them. Participant 28 reflected on his anxiety and fears as follows:

> *"I was expecting that I'm going for board there at the clinic there. It is done there at the hospital. We were called one by one and only four guys, we were six, and only four guys were called. I was surprised to see that a-ah, these guys* [Special Board members] *are going out again... I was troubled. I didn't know what to do, then I asked our sister in charge why is it that I am not called? 'Hanzi ha-a",* [she said] "*no...we are not yet sure of the date* [for another board review]."

The confusion about his situation is clearly reflected in the next verbatim quote of Participant 29:

> *"I came at first as a CMP* [Criminal Mental Patient] *then back to court, after that the court said you are not able to go home. Go back and go and get more drugs and you will come... e-eh, according to me, I don't know but according to the nurses, a-ah I don't know what are they thinking about if they see me*."

- ***Patients perceive power issues in the process of their management***

The patients expressed discomfort about the power plays between the prison system and health staff working in the special institutions and between the psychiatrist and the judiciary. This was to the effect that patients felt they were on the receiving end of these

silent dynamics of power in terms of not being cared for as expected and being sentenced wrongly after treatment in the special institutions. Participant 27 stated:

> *" … this institution as my point of view, it was not supposed to be in a prison... This institution was supposed to have its own site and its own management... The life in prison, we are experiencing the life of prisoners not the life of the patients... Prison says this is our place, then nurses say these are our patients so there is mixing. There is no good result there."*

Participant 26 expanded on the patients' perception of being treated in an inappropriate manner as follows:

> *"Ya-a, here nurses are not allowed to give medication.... Our nurses are not allowed. I don't know why ... when a patient comes, say, 'I have got a headache', when the nurse cures there, but was talking to guard, the guard says, 'I am not a nurse'..."*

- ***Social challenges***

It was expressed by the patients that their fate was dependent on the social support from relatives. Apparently, not all patients seemed privileged to have such support. This then posed as a social challenge particularly to these patients.

- ***Support systems***

Support systems referred to those people who could possibly look out for the forensic psychiatric patient before, during and after admission to a special institution. The support could be availed in the form of finding a legal practitioner to speed up the patient's case or it could be in form of visits that reassured the system that continuity of care was possible beyond the special institution. Participant 26 substantiated the positive consequence of familial support:

"... my parents looked for a legal practitioner and the legal practitioner represented me and my case was finished."

Participant 27 added:

"Difficulties such as we are experiencing that relatives must come often, every time so that they can sign affidavit so that they can write that this person is our relative, is my son or is close relative to them and I have to take care of you but if you don't have relatives, you stay here forever, because the doctor says without relatives we can't release you."

- ***Occupational challenges***

Before admission to a special institution, the patients would have been employed somewhere or would have had a skill that they were utilising to survive. Patients expressed fear that the skills they previous had could become obsolete.

- ***Uncertainty related to social functioning after discharge***

Some patients indicated that they had plans for the future but were uncertain of the applicability of those plans after discharge. They expected that their relatives would probably assist them. To curb this uncertainty, some expressed that they could be given survival skills while still in the system. Participant 26 explained this uncertainty in his own words:

"*I am a … my profession is motor mech* [mechanic]. *Yes. I used to do mechanics in my father's home. So when I go out, I will go and do what I was doing last time ... but I hear now officers saying that outside there is no business in fixing cars because vehicles are now advanced … so it's hard now to see the customer coming to say my vehicle is now damaged ... I didn't go to school, actually I don't have any qualifications so, it's hard."*

Participant 27 wished for an opportunity to acquire new skills in the special institution:

> *"We are supposed to have something to do here. Maybe to be taught how to use our hands to do maybe a lot of things so that when we go out we have something to do for our lives."*

- ***Challenges during admission***

Rehabilitation and treatment of the patients was the mainstay of being at the special institution. The participants revealed that there were challenges to that effect.

- ***The concept of a patient being 'staff' as a form of rehabilitation***

A very important observation was made on the notion that some patients are related to as 'staff'. Making a patient 'staff' was considered to be a form of rehabilitation and was perceived as such by the patients themselves. Being 'staff' meant that the patient could handle other patients' files, give them to psychiatrists, nurses, social workers or whoever needed them. It also meant that such patients could supervise medication rounds and the feeding of other patients. The 'staff' could also marshal other patients in and out of the duty room during the doctor's rounds. The question arises: "Is it prescriptive to allow 'staff' to take such responsibilities?" They handle records and documents (which, as mentioned, gets lost in the system), they have insight into other patients' private information (anonymity and confidentiality becomes a major issue), and they take on responsibilities on behalf of others who are more knowledgeable, experienced and trained to handle these responsibilities.

Another interesting observation was that all the patients who met the selection criteria were 'staff'. These patients were all fluent in English and all of them had engaged lawyers to assist them with reaching the stage where they were waiting for the Special Board (one of the selection criteria). In fact, at the time the study was conducted, all the 'staff' was waiting for the Special Board.

Participant 27 confirms this observation and finding:

> *"Most of the services I was working with my doctor here. Helping in interviewing people, taking some records, organising which people to see on this day…'*

Next, Participant 28 explained more about the duties of the 'staff':

> *"I am staff of this place ... I am filing their files ... if they* [doctor and nurses] *want their files, they just call XXX* [name deleted], *'Come here, give me somebody's file'. I go there, I put the file, and they* [nurses] *put in their groups, the files. This one's name is wanted, XXX's* [name deleted] *file is wanted, I take* [it] *from the group* [of files].'

The same participant added:

> *"First of all I was cleaning the plates here, to make sure the guards have eaten something, make tea for them. When we are sure they have eaten, take some plates, clean the plates, yes, there* [pointing towards the yard] *I also work there, carrying food for the patients there. We carry their food, give them food is well kept, yes."*

Participant 26 explained that he was "a *dispensary staff, I look after other patients who want to be helped."*

- ***Limited access to rehabilitation services***

The patients were asked about the rehabilitation services that were available to them during admission at the special institution. From their answers, it was apparent that they had limited access to rehabilitation services with regard to the number of patients, the value of the service, and the frequency with which the services were provided.

Participant 26 responded that he was "*a soccer player. I go out and play soccer and we have a garden... A week we go once, once a week yes."*

According to Participant 27, occasional walks and football constituted a large part of the rehabilitation services provided:

> *"… sometimes having some walks ... maybe once after 3 months... We were playing football. Yes, but it was not good as such because it was taking a long time to go to the sports field."*

Participant 28 added:

> *"Other activities I used to grow some vegetables, we have been growing some vegetables here, and keeping some rabbits ... sometimes 10, sometimes 15."*

- ***Lack of effective communication with patients***

Effective communication in the study context referred to dialogue between patients and nurses, doctors or the judiciary that was projected to empower the patients in terms of knowing what to expect from the two systems. It seemed such communication was grossly deficient and this frustrated the patients as shared by some participants. Participant 28 voiced:

> *"I missed two boards* [Special Board]... *Ha-a I was worried manhi* [very much] *but so long, I'm seeing that this other board is...* [gesticulates] *… Can you tell me the date the board is coming?"* [Asks the researcher].

Participant 26 expressed that patients are not informed in any of the system and are simply ignored:

"People from the court, they are not doing justice on the side of the prosecution they are not doing justice exactly. They just ignore, they say is a patient and they ignore you. They ignore you because they take too long to finish your case. They just leave you and when you don't have money you suffer."

Misinformation or no sharing of knowledge regarding how the systems work was supported by participant 28:

"I was expecting that I'm going for board [called to the Special Board] *there at the clinic there. It is done there at the hospital. We were called one by one and only four guys we were six and only four guys were called. I was surprised to see that a-ah, these guys* [Special Board members] *are going out again* [leaving so soon without seeing Participant 28]*.'*

4.5.4 Section D: Central storyline and themes for the relatives of forensic psychiatric patients

TABLE 4.4: Themes, categories and sub-categories of patients' relatives

THEME	CATEGORY	SUB-CATEGORIES
4.4.1 Theme 1: Negative perception of the rehabilitative context	4.4.1.1 Category 1: Physical environment is not conducive to care and rehabilitation	*4.4.1.1.1 Special institution not visitor friendly* *4.4.1.1.2 Special institutions are perceived as serving disciplinary purposes as opposed to having a rehabilitative function*

THEME	CATEGORY	SUB-CATEGORIES
		4.4.1.1.3 Relatives attended to by guards and not nurses *4.4.1.1.4 Disrespectful practices*
	4.4.1.2 Category 2: Psychological deterioration	*4.4.1.2.1 "Patient seems to be frightened"* *4.4.1.2.2 "We want you people to treat them humanely'"*
	4.4.1.3 Category 3: Social deterioration	*4.4.1.3.1 Loss of social interaction* *4.4.1.3.2 Loss of social responsibility*
	4.4.1.4 Category 4: Deterioration of patient due to inadequate care	*4.4.1.4.1 Relatives perceive the patient as getting worse during admission* *4.4.1.4.2 Patients are traumatised by being in an enclosed environment without stimulation*
	4.4.1.5 Category 5: Lack of communication and information elicits anxiety and disempowers relatives	*4.4.1.5.1 Lack of coping mechanism and skills to manage patients leads to fear in the relatives* *4.4.1.5.2 Lack of communication from medical staff*

THEME	CATEGORY	SUB-CATEGORIES
		4.4.1.5.3 Lack of knowledge on transfers and sentencing *4.4.1.5.4 Lack of coping mechanism and skills to manage patients*
	4.4.1.6 Category 6: Negative experience of judiciary staff, services and competencies	*4.4.1.6.1 Delayed processes* *4.4.1.6.2 Financial exploitation by legal practitioners* *4.4.1.6.3 Judiciary perceived as not thoroughly analysing cases*

The central storyline for the relatives was that they experienced the rehabilitative context as largely negative. The physical environment was viewed as not conducive to care and rehabilitation which led to the patient deteriorating physically, psychologically and socially. A lack of communication and information elicited anxiety and disempowered relatives.

4.5.4.1 Theme 1: Negative perception of the rehabilitative context

Relatives of patients perceived the special institution negatively owing to its physical environment which did not enable or promote the recovery of the patients. This was believed to result in the psychological and social deterioration of the patients. Relatives also interpreted the judicial system as exploitative and incompetent. From the data obtained from the relatives of the forensic psychiatric patients, one theme and six categories with sub-categories were identified.

4.5.4.1.1 Category 1: Physical environment is not conducive to care and rehabilitation

The physical environment referred to the set up in the special institution; its physical infrastructure and general administration. Relatives verbalised that the patient care environment was not favourable for rehabilitation because of the prison system administration. The special institution was perceived by caregivers as a place for the purpose of providing care through disciplinary measures. Relatives of patients perceived that the staff did not treat them with respect. Relatives could not access information from nurses because they were attended to by prison guards.

- ***Special institutions are not visitor friendly***

Currently, a special institution is a wing within the prison that caters for patients. In the study it was found that an institution was perceived to be visitor friendly when it was accessible to the general public and the relatives. Being visitor friendly also referred to the reception that relatives would get from the multidisciplinary team once they reached the special institution. Apparently, the special institution was approximately 30 km from the central business district. Most patients' relatives travelled as far as 500 km to visit the patients in the special institutions because of its geographical location. According to relatives, the visits they had sacrificed so much for was expected to be worth their while. As such, they expressed that these special institutions were not visitor friendly because they had to interact with patients through a mesh wired window. Also, due to the distance they had to travel to see the patient for a short while and the money they had to spend to reach the site seemed to imply that it was pointless to do these visits. This was expressed in the following statements:

Participant 22:

> *"E-eh, ya-a, take for instance there is no readily available transport ... it's about a dollar to get there* [to special institution from town] *but the visit, you only see him for fifteen minutes and you have to go back but the place is so*

far away you pay a lot of money to get there and the transport is scarce and so on but the visit itself is a very short, short visit."

Participant 24:

"Isn't I tell the guards that I have visited X. So they call him inside there, he goes round while I also go the window through which I see him. I see him like this [showing half the body]."

Participant 23:

"E-eh because I see him through the window, I don't get to see what is beyond him... I cannot see from where I am standing. But isn't it that's what the law says?"

- ***Special institutions are perceived as serving disciplinary purposes as opposed to having a rehabilitative function***

Special institutions were referred to as such on paper but the average person recognised it as a prison because of their placement and the fact that the billboards at the entrances of these institutions announced them as PRISONS. This then translated to its perception as serving disciplinary purposes as opposed to having a rehabilitative function.

Participant 22 commented on this aspect as follows:

"*Ya-a, to a certain extent it helped because to some sort he needs limitations to his freedom. He needs to know that there are certain things that he should not do. He needs to know the law as well because I am sure they emphasize there the things he should not do and things that he should do... Yaa, for disciplinary purposes, I think it's ok."*

However, Participant 21 asked a critical question with regard to whether a prison environment is suitable to be used as an institution for the treatment of psychiatric patients who had committed a crime.

> *"Isn't XX* [special institution] *is supposed to be for people who have been arrested and have committed a crime? Is someone who is mentally disturbed supposed to go to XX* [prison] *too?"*

- ***Relatives attended to by guards and not nurses***

The special institution, being part of the prison system and being governed by the Zimbabwe Prisons Act of 1996, had guards forming the bulk of its main staff. The emphasis of the special institution's structural setting was on its security mandate. The researcher's observational notes reflected that she noticed the structure of the prison facility (which is functioning as the special institution) was such that the main entrance was locked and controlled by guards. These guards at the entrance were the ones who controlled two more iron gates before you could reach the area where the patients were being taken care of. This translated to a situation where any visitor would not be allowed to go beyond the first entrance.

When a relative visited the special institution, he or she could only have contact with guards and not nurses. It was also possible for the nurses to never know that a patient had had a visitor on any given day. It is also important to understand that the same entrance was also used to access female criminal prison inmates who stayed together with female forensic psychiatric patients. Thus, a guard would be inclined to treat the visitors in the same way whether the person they came to visit was a criminal or a patient. This also translated to relatives depending on guards for any information pertaining to the care that the patients received.

According to the information shared by Participant 23, the guards were the ones who gave relatives information about the patients:

> *"I was told by the guards how I should give him his medication and that I should take him for reviews all the time ... It is the guards who told me this. They told me when I asked them and when my husband also asked them."*

Participant 24 *said:*

> *"The guards ... I tell the guards that I have visited X. So they call him inside there, he goes round while I also go the window through which I see him."*

- ***Disrespectful practices***

The relatives felt that they were disrespected by staff at the special institution. The disrespect was conveyed either verbally or it was implied. This seemed to make them angry because of the effort they would have made to reach the special institution. Participant 22 elaborated on the implied disrespect for both the patient and their relatives by describing a guard's reaction to items brought to the patient:

> *"... you are allowed to bring groceries and things to eat and things like that but then … there is no facility, because, he* [patient] *has got to see what you have brought and there is no special place where you can put the things in the open. You put them on the floor. Even consumable things, you put them on the floor and he looks, he has to peep through the bars to see what is on... It should have a table, a nice table and he can only see them but on the floor he cannot even see them ... then the guards said, 'A-ah you think this is a holiday, bringing all this tobacco with you? We won't allow him to have all this tobacco. This is not a hotel'."*

4.5.4.1.2 Category 2: Psychological deterioration

The relatives of patients expressed that forensic psychiatric patients seemed to deteriorate psychologically while admitted in special institutions. The participants actually specified that patients were in a worse state than they had been when they were arrested and committed to the special institution.

- ***"Patient seems to be frightened"***

Being "frightened" in this study referred to a state or disposition of despair, despondency and fear that a patient would reflect. Relatives believed that the patients were intimidated by the environment in the special institution. They were upset that the patient did not seem to be recovering, but that the patient's condition was, in fact, deteriorating. Participant 24 made the following statement:

> "*The fact that he is incarcerated in there, I think it affects him. He comes across as someone who is scared, you see."*

Participant 23 also shared that the patient's "*being there* [in the special institution] *a-aa... I was not satisfied so I asked him and he said someone had beaten him up ... he was raising his hand saying I want to go with my mother*."

- ***"We want you people to treat them humanely"***

When a patient was admitted for any form of care, relatives expected that the patients would be related to humanely; in other words, be professionally taken care of. However, in their responses the relatives implied that the patients were not being treated as professionally as expected. Participant 23 pointed out this aspect as follows:

> "*We want you people* [professional teams and prison staff] *to treat them humanely, to give them correct medication."*

Participant 22 responded as follows:

> *"E-eh because I know it's a prison but then I thought it was a, it was like a, these people are a different type of a person. Ya-a, they, need e-eh, they need not, as criminal as it is supposed to look. It makes you as though he is incarcerated for a, for a crime of like murder and things like that."*

4.5.4.1.3 Category 3: Social deterioration

The patients were perceived by their relatives as having a right to enhance or retain social skills. They expected this for the patient especially after he had come into contact with the special institution which was expected to have corrected their behavioural problems. On the contrary, participants perceived forensic psychiatric patients as deteriorating socially. This social deterioration was perceived to be related to spiritual deterioration and loss of social responsibility once they came into contact with the prison system where the special institutions are housed.

4.5.4.1.4 Loss of social interaction

Loss of access to spiritual services, which seemed to be perceived as a form of social interaction was a concern for relatives. It would seem that the relatives had a strong conviction that the patients could not psychologically survive in the absence of their religion. The researcher's observational notes reflected that special institutions were devoid of spiritual services to patients. The loss of social interaction was expressed by statements like:

Participant 24:

> *"That boy is a Catholic as from when he was young. I think his being there doesn't make him better because he used to go to church, now there is no church."*

Participant 25:

> *"At XX* [special institution] *there is a woman who goes to church with him. X actually goes to church... I am not satisfied with the way they are being cared for."*

4.5.4.1.5 Loss of social responsibility

The participants who were relatives of patients expressed that when the patients are admitted in special institutions, they are stripped of the social responsibilities they were mandated to do. Patients would have had some responsibilities before they were admitted. These responsibilities seemed to be ignored and therefore not nurtured once the patients were admitted in the special institutions. This loss of social responsibility seemed to have an overall collateral negative effect on the family as well as Participant 24 observed:

> *"… he was fending for himself now he is getting nothing. I had bought him chickens to rear, now he just left them when he was taken away. That upsets me because this was assisting him to get money ... he was responsible for looking after the house."*

Another relative, Participant 22 uttered the following:

> "*I think he feels he needs to, like when there is an issue like there was a death in the family, he felt like he should have come and also participated at the funeral but I don't know maybe it's going too far, but that was one of his requests that he should have been allowed to come."*

4.5.4.2 Category 4: Deterioration of patient due to inadequate care

The participants expressed that patients physically deteriorated during the time they were admitted to the special institution. They believed that this was due to inadequate

care and some of the medications that the patients were taking while in the special institutions.

4.5.4.2.1 Relatives perceive the patient as getting worse during admission

All relatives expressed that the patients they visited while they were admitted to the special institutions had deteriorated physically. This was attributed by all the relatives to the medications the patients were taking for treatment. The observational notes revealed that the medicines given at the special institution consisted of first generation antipsychotics, the commonly used being chlorpromazine and fluphenazine deaconate. These medicines seemed to elicit negative side effects that were noticed by the relatives. Participant 25 was quite adamant that being in the special institution held no positive outcome for a patient:

> *"To be more explicit, why I don't like that place is because he is ill there. When he is here he is not that ill. We know his mental state but he will not be that sick. It seems the treatment he is getting is the one that makes him worse."*

Another relative, coded Participant 23, revealed shock at noticing the physical condition of the patient:

> *"I had observed that his body was no longer healthy; it was not pleasing ... it was different from the way he had left me here. Because he looked emaciated and was dripping green mucus from his nose ... give them correct medication."*

4.5.4.2.2 Patients are traumatised by being in an enclosed environment without stimulation

The researcher's observational notes indicated that the special institution was not a purposefully built structure; it was not a building planned, constructed and built in accordance with specifications that would be taken into consideration if it was to be an institution where psychiatric patients would be cared for and rehabilitated. It was, in fact, a prison facility loaned to care for forensic psychiatric patients. Although named and used as a special institution, the infrastructure remained that of a prison building. The rooms were small with concrete floors and bare, windowless walls. There was no stimulation in the environment; it allowed very little opportunity for a patient to be creative and entertain himself. Relatives interpreted this as traumatic to the patient as Participant 25 revealed:

> *"My son was telling me that when they are inside they wish even to see a mere leaf from a tree ... there is nothing happening there ... I mean to say he will just be sitting there, not happy, seeing no one, being inside there without going out, just doing nothing. All those things traumatise him."*

Participant 24 also linked the cold and dull environment directly to the negativity and fear that the patients experienced:

> *"I think that is unfair... The fact that he is incarcerated in there, I think it affects him. He comes across as someone who is frightened; you see."*

4.5.4.3 Category 5: Lack of communication and information elicits anxiety and disempowers relatives

Frustration was expressed by the relatives because of the lack of comprehensive communication by the judicial system, the medical staff and the prison system. This was

perceived as causing unnecessary anxiety to the relatives and left the latter feeling disempowered.

4.5.4.3.1 Lack of coping mechanism and skills to manage patients leads to fear in the relatives

Relatives verbalised that they were not adequately equipped to deal with the patients after discharge; the patients were apparently either violent or the relatives could not be sure that the patient had been rehabilitated and would not again commit the crime that he had originally committed. Of relevance is that it was observed during the study that the support system of the patients consisted mainly of the patients' widowed mothers. Not having been empowered with coping mechanisms to manage the patient, led relatives to fearing the patient as Participant 21 acknowledged:

> *"I will be afraid that maybe he will pick up something and hit me so I will be afraid that there is nothing I can do because he is a boy child I won't be able to handle him. So he needs a male someone so that when it occurs he will be able to restrain him. But now his father is not there."*

Participant 25 noted that in many cases a family would disown a patient who had committed a crime and had spent time in a special institution:

> *"Those ones* [parents] *won't be willing someone might have done the crime in a way traumatic to the family, and then the family disowns him. But it could be that the patient is violent*."

4.5.4.3.2 Lack of communication from medical staff

Relatives expressed that they had either minimal or no contact with the health staff or the psychiatrist. The little information they got was from the guards. This seemed to upset and frustrate them because voicing their concerns to the guards who, as

discussed before was apparently their only line of communication with the patient, was not an option.

Participant 22 emphasised that relatives did not want to engage in conversation with the medical staff about administrative issues, but they only wished to communicate with medical staff on the aspects of care for the patient:

> *"… if they are failing to get tablets like they are failing, he was telling us because they are only $5.00* [five dollars]. *They need to tell us."*

Participant 24 also referred to the incompetence on the side of the medical staff to communicate accurate information to the relatives and how it negatively affected the patient:

> *"In X's case they have been telling me that he will be released. Even yesterday we went there and they said the same thing. Now it's been 4 months. It's affecting him."*

4.5.4.3.3 Lack of knowledge on transfers and sentencing

Transfers in the context of forensic psychiatry in Zimbabwe and in this study referred to the physical movement of a patient from (i) a remand prison to a special institution; (ii) from the civil psychiatric hospital to the special institution; (iii) from the special institution to the civil psychiatric hospital; (iv) from the special institution to prison to serve a sentence; or (v) from the prison where they were serving a sentence to a special institution. Relatives appeared to be unaware of these transit procedures. In addition, the relatives seemed to be unsure whether the patient was serving a sentence or was being rehabilitated. The next two verbatim quotes verify this finding:

Participant 22:

> *"Ya-a, because we don't know whether they have sentenced him* [becomes emotional] *for years or whatever, we don't know anything about him."*

Participant 21:

> *"It's only that we were in the rural areas, we heard from those in town, his brothers, that he had been sent to XX* [from civil psychiatric hospital to special institution]. *Is someone who is mentally disturbed supposed to go to XX* [prison] *too?"*

4.5.4.3.4 Lack of coping mechanism and skills to manage patients

The relatives shared the vulnerability they felt where violent patients were concerned. They felt inadequate and unable to cope with the realities of caring for a patient because they experienced that the medical system did not prepare them for it. Participant 21 shared their fears as follows:

> "*Aggression only, yes he is so aggressive. Before he got sick he was always someone aggressive so it has been made worse by this sickness. I am now afraid because I live alone; there is no one that I stay with so that means it will be the two of us... I won't be so sure what I should do."*

Participant 21 reiterated the relatives' plight of not being prepared for a patient who has been discharged:

> *"No, they* [medical staff] *haven't talked to us about that* [care of patient]. *There was one mother who was visiting the patient. We always met there* [at special institution]. *Then just one day they just announced to her that 'come*

on Monday and take your son'. So she didn't know the period that the son will be there. She was only surprised that that week they just said 'Come'."

4.5.4.4 Category 6: Negative experience of judiciary staff, services and competencies

The patients' relatives seemed to perceive the contact they had had with the judiciary as negative in the sense that they felt exploited by legal practitioners. The participating relatives also thought that the processes were deliberately delayed because of the financial implications. The relatives verbalised that the judiciary also did not apply their minds to cases because, according to the relatives, the judiciary did not thoroughly analyse the cases.

4.5.4.4.1 Delayed processes

The participating relatives were concerned about the indefinite time taken by the medical and judicial systems to process the patients' papers which resulted in continued detention of the patient in remand prison where they could not access medical treatment or any other rehabilitative interventions. This is confirmed by Participant 22:

"*Ya-a the process was long in the remand, at the time we went there they said there was no doctor to look although we had at the first day we brought all his patient cards and so on that he was a psychiatric patient and so on. But for them, for their side to prove that and bring a doctor, it took quite a long time."*

Participant 24 had the following to share:

"So then we would get to the court. He [the lawyer] *would go up there then come back and tell us that the court has been postponed... I think the*

process is too long. When the doctor makes that decision I think it takes too long."

4.5.4.4.2 Financial exploitation by legal practitioners

When a person who was alleged to have committed a crime came into contact with the judicial system and was presumed to be mentally ill, he was sent to remand prison to await medical examination. This reportedly took a long time. This seemed to force relatives to engage legal practitioners so that the case could be dealt with faster by the judicial system. It is important to note this provision is not covered in the Zimbabwe Mental Health Act of 1996. These legal practitioners were reportedly paid by relatives of patients at every contact. Relatives had a strong conviction that court cases were deliberately postponed because of the financial implications. This was interpreted as financial exploitation by participants as witnessed in the quote from Participant 24:

"That lawyer just wanted money because as from March 2012 we were attending court every time. When we got there, we would be told that the case had been postponed. We paid $500 [five hundred dollars] *every month. That means from what I think he was just making money."*

Participant 23 shared the following:

'It was the lawyer who was talking... I think we went there [court] *how many times, was it thrice? Four times? It's four times I think. Then he* [patient] *was transferred to there* [XX prison]*."*

4.5.4.4.3 Judiciary perceived as not thoroughly analysing cases

Thoroughly analysing a case in this study meant that the legal practitioners, the public prosecutors, and the magistrates were expected to represent the interests of the patient in court. It seemed the judiciary did not make an effort to bring up the most important

issues pertinent to patients. For example, previous psychiatric history or circumstances surrounding the commission of the crime were not taken into consideration. The judiciary was perceived by relatives as not applying their minds to cases. Relatives thought it was unfair to the patients because the patients were either admitted unnecessarily to special institutions or in remand. The personal experience shared by Participant 24 is evident of this finding.

> *"I think in court as parents for cases like that of X who couldn't speak, we should as parents be given a chance to say something in court since we would have been staying with him... At times a lawyer says something that you feel you could explain better as a parent... X was being called to court continuously but we have never met the complainant ... he* [lawyer] *didn't bring those issues up* [that the accused was already a known patient] *and now my son is in a mess about trivial issues."*

Participant 22 stated the following:

> *"Ya-a the process was long in the remand, at the time we went there they said they was no doctor to look ... we brought all his patient cards and so on that he was a psychiatric patient and so on ... because we actually wanted to engage lawyers for him to be brought either to XXX* [civil psychiatric hospital] *or XX* [special institution]."

4.5.5 Section E: Central storyline and themes for the psychiatrists

The central storyline for the psychiatrists centred on the prohibitive processes that negatively affected the overall patient care and recovery. The unconstructive attitudes and beliefs of psychiatrists had a dehumanising effect on the patients.

In Table 4.5 the findings from the analysis of the psychiatrists' data are shown. A discussion of the theme, categories and sub-categories follows.

TABLE 4.5: Psychiatrists' data analysis

Theme	Category	Sub-category
4.5.1 Theme 1: Prohibitive processes negatively affect overall patient care and recovery	4.5.1.1 Category 1: Human resources	*4.5.1.1.1 Lack of human resources to provide care* *4.5.1.1.2 Policy loans only doctors and nurses to special institutions*
	4.5.1.2 Category 2: Practice realities	*4.5.1.2.1 Disjuncture between the psychiatrist and the judiciary* *4.5.1.2.2 Attention given to major crimes* *4.5.1.2.3 "Some patients do not warrant to be in special institution"* *4.5.1.2.4 Large patient numbers* *4.5.1.2.5 Lack of follow-up in remand prison* *4.5.1.2.6 Discharge challenges* *4.5.1.2.7 Use of preliminary report by psychiatrist due to time lapses*
	4.5.1.3 Category 3: Unconstructive attitudes and beliefs	*4.5.1.3.1 Patient sent to special institution to protect the community* *4.5.1.3.2 Lack of interest in psychiatry: "It's just work that needs to be done."*

One theme with three categories and their sub-categories were derived from the psychiatrists' data.

4.5.5.1 Theme 1: Prohibitive processes negatively affect overall patient care and recovery

One theme transpired from the psychiatrists' data, namely that the processes that negatively affected overall patient care and recovery included human resources, practice realities, and unconstructive attitudes and beliefs.

4.5.5.1.1 Category 1: Human resources

The human resource issues covered the actual lack of human resources to provide care and, according to 'policy' (in reality an unwritten understanding between the prison system and the civil psychiatric hospital/unit) doctors and nurses are only loaned to special institutions. This situation seems to have derived from the Zimbabwe Mental Health Act of 1996 and the Zimbabwe National Mental Health Policy of 2004. In its declaration of place in lieu of special institution Part XIV Section 107 of the Zimbabwe Mental Health Act (1996:212) specifies in subsection (1) that: *"If the Minister is of the opinion that there is no hospital or other place that can be conveniently be declared to be a special institution for the purpose of this Act, he may, with the approval of the Minister responsible for Justice, by notice in the Gazette, declare that any institution or other place specified in the notice may be used for detention of patients who should, in terms of this Act, be detained in special institution."*

In the Zimbabwe National Mental Health Policy (2004:9) it is stipulated that: *"Special institutions with over a hundred beds to have a resident psychiatrist or psychiatric nurse practitioner, General Medical Officer, Clinical psychologist, Social worker and an occupational therapist and or rehabilitation technician."*

This then translates to the fact that special institutions are 'lodging' in prison settings that were gazetted as special institutions. The special institutions are administered by the Ministry of Justice, Legal and Parliamentary Affairs but some medical staff is seconded to special institutions by the Ministry of Health and Child Care since it is its prerogative to care for the patients. The medical staff is there to fulfil the specifications of the Zimbabwe National Mental Health Policy as explained above.

The undocumented arrangement then is that of all expected cadres, only nurses and psychiatrists would be loaned. This arrangement was more specifically for the southern region special institution. In the northern region, some nurses and the doctor were loaned from the civil psychiatric unit while some nurses and the medical social workers were employees of the Ministry of Justice, Legal and Parliamentary affairs. The arrangement is such that patients are discharged from special institutions via the civil psychiatric hospital/unit with the hope that they will complete the rehabilitation process by interacting with the remainder of the required staff like the psychologists, occupational therapists and social workers. This particular outlet unit at the civil psychiatric hospital is generally considered to be an extension of the special institution.

4.5.5.1.2 Lack of human resources to provide care

Participating psychiatrists brought up the issue that inadequate staff significantly increased their workload. For them this was a profoundly important issue as evidenced by the fact that they took it up with management at national level. The staff shortages they referred to included psychiatrists, nurses, doctors, social workers, occupational therapists, and psychologists. Participant 20 referred to this issue:

> *"Some of the workload, it's a bit much for the few people who are seeing the patients and currently there is … the last time I checked they were about 245 patients."*

Participant 19 reflected on the psychiatrists' endeavour to involve management at national level:

> *"A-ah rehabilitation course like we had discussion before ...unfortunately, we don't have anyone and when we had meeting in X[*capital city*], we had discussion about this one* [issue] *that there should be one social worker here."*

4.5.5.1.3 'Policy' loans only doctors and nurses to special institutions

The current situation in Zimbabwe is that the Ministry of Health and Child Care made an arrangement with the prison system to provide doctors and nurses only to staff the special institutions. No other professionally trained healthcare providers in the field of psychiatric care, for example, psychiatrists, psychologists and social workers, are included in the agreement. As Participant 19 pointed out, this was an inadequate arrangement that resulted in incomplete, incomprehensive and no quality service provision for the rehabilitation of these patients:

> "*You know exactly but we only have branch here from Ingutsheni Hospital. Branch includes the doctor and nurses according to instruction but not psychologist and not occupational therapist, social worker."*

Participant 20 expanded on this aspect as follows:

> *"There is no full time employed psychiatrist with Zimbabwe Prison Services... things of mental health are multidisciplinary. The patient should have enough occupational therapy and all the activities; they should get psychological help on issues they were dealing with. If they are currently having clinical psychiatric illnesses or symptoms of depression or psychosis, the psychiatrist is part of rehabilitation, medicating, instituting some psychotherapy, the psychologist looking* [looks] *at psychological issues and if there are social*

workers they look into the social context of why this crime has happened... My issue is that there are too many patients then to be able to concentrate and give them the quality service which they [should/need to] *give."*

4.5.5.2 Category 2: Practice realities

Practice realities seemed to be enshrined in the following: disjuncture between the psychiatrist and the judiciary; attention given to major crimes; large patient numbers; lack of follow-up in remand prison; discharge challenges, and the use of preliminary reports by the psychiatrist due to time lapses.

4.5.5.2.1 Disjuncture between the psychiatrist and the judiciary

According to the analysis of the psychiatrists' collected data, it seemed as if the psychiatrists and the judiciary did not have insight into each other's work. The psychiatrists' experience was that the judiciary had unreasonable expectations from them. For example, they expected the psychiatrists to expedite the discharge of patients when they were aware it was within the mandate of the judiciary themselves to discharge patients. But the psychiatrists merely made recommendations. The Attorney General's office and the Mental Health Review Tribunal, both an extension of the judiciary, did the discharging. The psychiatrists also felt that some patients were admitted unnecessarily owing to the misinterpretation of the Zimbabwe Mental Health Act of 1996 by the judiciary. An example would be that of sending a patient to the special institution when there was no criminal charge levelled against that patient as mentioned by Participant 20.

"... lot of patients are brought into the special institution, some who do not have charges, who do not warrant, because there might be difficulties in interpreting the Act from the police... Magistrates, they don't even understand what is happening to that client and also issues of having civil patients being sent for breaking a window to a special institution and spending six months

[there] *when within a week they could have stabilised and gone home and continued with their life."*

Participant 19 made the following statement:

"...but it's [coordination between the judiciary and psychiatrist] *not working in Zimbabwe because they* [judiciary] *are not interested in patients… It* [coordination] *must be very strict like in Europe... but currently now, we are try to do best but from, you see, from* [the] *Ministry of Justice we don't have any help."*

4.5.5.2.2 Attention given to major crimes

Ostensibly the psychiatrists paid attention to those patients who had committed violent crimes like murder and rape or those that were perceived to be dangerous [who exhibited violent behaviour during admission in the special institution]. The observational notes captured this as a common practice in both special institutions. This resulted in patients who had committed minor crimes spending a longer time in the system because of delays in both the assessment and review processes. The words of Participant 19 verified this finding:

"It doesn't matter, you must take attention for [pay attention to] *major crime and for minor crime … 90%* [in 90% of cases] *we give major attention for major crime especially for psychiatric patient who had, before admission at XX* [civil psychiatric hospital], *who* [is] *still dangerous here…"*

Participant 20 added:

"... but truly speaking, there are also some patients who can be dangerous whereby some of the dangerous patients will need to be examined whether

they were patients or not. You understand? [The] *staff might not have enough capacity to handle patients who are dangerous."*

4.5.5.2.3 "Some patients do not warrant being in special institution."

The psychiatrists indicated that at times forensic psychiatric patients were admitted in the special institution when they could have benefitted from treatment in a civil psychiatric hospital. This was based on the gravity of the crimes they had allegedly committed; for example, stealing a loaf of bread in a shop. Processes took extremely long and the patients remained at the special institution when they could have been treated at the civil psychiatric hospital and discharged within a few days.

The question below posed by Participant 20 during the interview directly addresses the issue of a patient being admitted undeservedly to a special institution:

"*...a person with an offense which doesn't warrant* [being admitted to a special institution]*, why are they going to the special institution? For up to a year?"*

Participant 19 voiced the following:

"About minor crime sometimes its' difficult ... if you have somebody who took loaf of bread in shop you know ... if it's minor like assault somebody mentally ill, ya-a, I ask a-ah from … XXX [Attorney General's office] *to organise as soon possible a decision not to proceed* [To indicate that there is no point in sending them to special institution].'

4.5.5.2.4 Large patient numbers

The psychiatrist participants expressed that there were far too many patients; they were not able to accommodate all:

Participant 20:

> *"Some of the workload, it's a bit much for the few people who are seeing the patients and currently there is … the last time I checked they were about 245 patients."*

Participant 19:

> *"Usually it's*[a] *team who is doing hard job of rehabilitation work for many patients here* [implying that because there is no team, caring for the many patients is actually impossible for the current few staff]."

4.5.5.2.5 Lack of follow-up in remand prison

Like all other stakeholders, one psychiatrist identified relapse in remand prison as related to the lack of follow-up. The lack of follow-up was attributed to the administrative process of the prison system. The administration is such that once the patient has been moved from the special institution to remand prison, supervision and monitoring ceased because the patient's status would have changed to that of a criminal. Participant 20 explained:

> *"I don't think from my knowledge that even if those patients are sent to remand prison, they won't have regular check-ups because it's different. When they are in XX* [special institution], *they get their medication from the sisters. They get reviewed by the psychiatrist who was seeing them which might be a problem that if they go to remand, they might not have that follow-up of treatment."*

4.5.5.2.6 Discharge challenges

The participating psychiatrists were confronted with the challenge of discharging patients from special institutions. Participant 20 explained the situation as follows:

> *"So there are challenges that it's easy for a patient to* [be] *brought into a special institution but to get them out its difficult because you will need affidavits from relatives, you need to write a social report, a psychology report before being* [the patient can be] *transferred ..."*

Participant 19 wished for an appropriate rehabilitation centre where the patients' rehabilitation before discharge were up to standard and provided by professional medical teams. This participant was obviously concerned about patients being discharged without having been provided appropriate rehabilitative care:

> *"I had a lot of discussion with* [the] *Ministry of Health and XXX* [Minister of Health and Child Care], *now this new one, I saw him, I met* [him and] *we had several discussion*[s], *we need rehab* [rehabilitation] *centre. We can't discharge patient somewhere... they are suffering, you know."*

4.5.5.2.7 Use of preliminary report by psychiatrist due to time lapses

The psychiatrists confirmed the concern voiced by the nurses as regards the use of the preliminary report to issue a psychiatrist's report. The reality is that following such a request by the judiciary in court, a patient could be admitted and would be assessed by two government medical officers as prescribed by the Zimbabwe Mental Health Act of 1996.The patient would then be admitted in the special institution as a criminal mental patient awaiting a psychiatrist's report. Six or maybe more months could then elapse before this report is made available. In the meantime, over the said period of approximately six months, the patient would be taking medication in the special institution as prescribed by the doctor. When the psychiatrist eventually assesses the

patient, he would by then be probably stable. The psychiatrist would then write a report based on the preliminary findings from the initial reports. Participant 14 explained:

> *"Ya-a, maybe it's because of large numbers and the other thing which I have seen most from GMOs* [Government Medical Officers]*; what I have seen some of the psychiatrists they say maybe the patient was in remand prison … he was seen by those 2 doctors, and then they say the patient is mentally ill so they say maybe since the patient has been there maybe for some months so when he comes here* [special institution], *he might be stable from what? On treatment* [He has been on treatment]. *So now the psychiatrist has to work with the GMOs' preliminary assessment because he thinks that if he sees him as stable, he could have been stabilised by the medication he was given before he was seen by the psychiatrist."*

Participant 20, however, was firm when sharing that the psychiatrists wrote reports which reflected *"retrospective information*" and comprehensive *"history-taking"*:

> "*We see a lot of patients but we work with retrospective information ... by proper history-taking we can tell what was going on."*

4.5.5.3 Category 3: Unconstructive attitudes and beliefs

The psychiatrists expressed that the chaotic nature of forensic psychiatric rehabilitation also revolved around unconstructive attitudes and beliefs that included sending a patient to the special institution to protect society, and the lack of interest in psychiatry.

4.5.5.3.1 Patient sent to special institution to protect the community

In the view of the psychiatrists who participated in this study, the admission of patients to the special institution did not primarily save the interests of the patients, but that of the public. The views of Participant 20 and 19 are reflected in the quotes below.

Participant 20:

> *"We have a scenario where at home he has been violent breaking everything, not sleeping ... so he has to go to a special institution* [to protect the public who were exposed to the violence]."

Participant 19 gave an example of how the public is protected from patients in her native country:

> *"Ya-a, not any prevention specially where strict system in Europe for sexual offender. Sexual offender under very strict control of police and forensic psychiatrist ... you know sexual, you can't change brain. If he wants to rape after discharge, it doesn't matter he can go to rape again. It's* [a] *mind disorder. If he defaulted treatment, he becomes sexually violent, rape everyone, 18 years for 5 years, it doesn't matter for this patient, while usually there is a very strict system to look after sexual offender. Anyone is under police you know* [the point is that such monitoring of the patients as practised in Europe is meant to protect the public. The comparison was meant to emphasise that in Zimbabwe, the system of protecting the public is less prohibitive than that in Russia].

4.5.5.3.2 Lack of interest in psychiatry: "It's just work that needs to be done."

The psychiatrists expressed disillusionment with regard to the role they played in the rehabilitation of forensic psychiatric patients. This feeling emanated from an apparently general marginalisation of psychiatry (in the country) and the prevailing cultural beliefs attached to mental ill health. Participant 20 shared the following:

> *"Naturally we know if someone is specialising they want benefits but we know people like in special institutions they don't pay psychiatrists for coming there. They are only paid by their employer at XX* [special institution]*;*

psychiatric patients in Government are seen for free which is unlike other fields where no patients are seen for free. They have to pay if they are having an operation but any public health institution which deals with psychiatry; patients are treated for free by the state providing medication... It's just work which needs to be done."

Participant 19 experienced the same disillusionment:

"...it [the commitment to care for patients] *must move down from Government very strict with everything according, forensic must be under control of Government you know. It must be some injection, financial injection from Government. If you don't have money, you can't do anything else you know in this situation."*

4.6 STAKEHOLDERS RECOMMENDATIONS

After all the stakeholder participants highlighted their experiences about the rehabilitation of forensic patients in special institutions, the made recommendations about what should be done to redress these current realities. The following table shows a summary of recommendations made towards the development of the medico-judicial framework for rehabilitation of forensic psychiatric patients in Zimbabwe (see Chapter 7).

Using these recommendations and findings already discussed above, an initial draft was made and taken back to the stakeholders and experts for validation. During the validation exercise, further suggestions were made as indicated in Table 4.7.

TABLE 4.6: A summary of the recommendations by stakeholders during the situation analysis

Recommendations (Judiciary) • Follow up services from Special institutions • Change of name for the Special institution • Patient friendly unit at point of first contact • In-service training and workshop for the Judiciary • Awareness campaigns • Rehabilitation and recreational facilities beyond the Special institution • More psychiatric trained staff than guards in Special institutions • Special office and separate Clerk of Court • for processing records for patients	**Recommendations (Psychiatrists)** • Revise Mental Health Act and integrate with Prison Act • Integrate police, magistrates and psychiatrists • Halfway homes • Projects for patients • Patients with minor crimes to be treated at civil psychiatric hospital
Recommendations (Nurses) • Revise Mental Health Act • Integrate the Mental Health Act with the Prison Act • Halfway houses near to psychiatric institution • Avail community projects • Awareness campaigns • Involvement of the Ministry of Health and Child Welfare in overall care • Integrated workshops for the medical and judiciary teams • Treat patients with minor crimes at civil psychiatric hospital	**Recommendations (Patients)** • Special institution to be separate from the prison facility • Increase access to multi-disciplinary team • Clinics to have a designated psychiatric area • Programmes to aid occupational rehabilitation • Financial aid • Include family in care • Projects after discharge
Recommendations (Relatives) • Patients to be taught practical skills • Rehabilitation programmes to consider patients level of education • A special vocational facility to be availed after discharge • Structures to be renovated to suit	

patients(therapeutic) • Visit atmosphere to be hindrance free • Patients already known as patients at the time of committing the crime to have their cases expedited and to be treated in civil psychiatric hospitals • Leave of absence for patients who lose Significant others e.g. parent	

The recommendations were incorporated into the development of the medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe (see Chapter 7).

TABLE 4.7: A summary of the recommendations by stakeholders and experts during the validation of the medico-judicial framework

Judiciary	**Medical**
• Have a point of arrest • First screening to be conducted by a public prosecutor who comes into first contact with patient • Criminal Law (Codification and Reform) Act of 2008 to determine proceeding of trial • Remand prison to be user friendly to the patients • Special board and Mental health Review Tribunal mandatory because of nature of crimes committed by patients admitted at the forensic psychiatric hospital	• Medically specific rehabilitation activities to be used at the proposed infrastructure for care of forensic psychiatric patients(psychopharmacological, occupational)

4.7 SUMMARY

In this chapter the findings derived from the qualitative design by following a grounded theory approach were presented in five themes together with each theme's categories and sub-categories. Findings were discussed making use of the 32 participants' quotes. The second objective of the study, namely to explore and describe the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe, were addressed through the analyses of texts using the descriptive open-coding and focused coding for a grounded theory approach.

The analytic memos applied are presented and discussed in Chapter 5. The axial coding and theoretical coding are dealt with in Chapter 6 where the findings are abstracted and conceptualised to discuss the current realities of forensic psychiatric rehabilitation in special institutions in Zimbabwe. This is also done in Chapter 7 to develop the medico-judicial framework.

A succession of memos were written and applied as the research study evolved. This illuminated, refined, compared, connected and abstracted the ideas and categories that emerged.

CHAPTER 5
QUANTITATIVE RESULTS

"We allowed this to happen because we accepted that the tools on offer to us were the tools we should use." Morgan (2004)

5.1 INTRODUCTION

The quantitative aspect of this research study is discussed in this chapter. A retrospective review of 119 documents was done out of a total of 598 documents. This grounded theory based study positioned documents as extant texts to provide required forensic psychiatric rehabilitation data. Documents here referred to the files or notes of male forensic psychiatric patients admitted between 2005 and 2010. The documents for this period were chosen because they would give a wide reflection of current realities in the rehabilitation processes of forensic psychiatric patients. Patients nested within that period were perceived to be likely to have received complete rehabilitative and inherent legal services.

The retrospective review of documents sought to address the last objective of Phase 1of the study. The researcher treated the extant texts in the form of patients' files (or documents) as data to answer the research question albeit as supplementary sources of that data (Charmaz 2014:45). The documents-specific objective was to review the documents of forensic psychiatric patients admitted in special institutions between 2005 and 2010 to identify the rehabilitative mental health services available to forensic psychiatric patients in the two special institutions in Zimbabwe. In this study the documents were considered as representing the discourse of forensic psychiatric rehabilitation practices. This made it possible for the researcher to compare the quantitative results of the documents' contents and their presentation to the larger qualitative discourse and overall forensic psychiatric rehabilitation of which these documents constituted a part (Charmaz 2014:46).

The data were analysed using SPSS version 16.0. Descriptive statistics were used to summarise and present the data. A frequency analysis of categories was also done. An exploratory analysis followed using measures of central tendency and dispersion. In this chapter, an integrated, gestalt interpretation was also done in which analytic memos illuminated the connections between the qualitative findings in Chapter 4 and the quantitative results in Chapter 5. This then became a starting point for gaining insight into the total and comprehensive picture of the rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe (Charmaz 2014:162; Johnson et al 2010:69).

5.2 STUDY SETTING

Table 5.1 shows the frequency distribution according to the study setting which were the only two special institutions in Zimbabwe.

TABLE 5.1: Frequency distribution according to study setting

		Frequency	Percent	Valid percent	Cumulative percent
Valid	1	79	66.4%	66.4%	66.4%
	2	40	33.6%	33.6%	100.0%
Total		**119**	**100.0%**	**100.0%**	

In table 5.1, ‘1’ and ‘2’ refer to special institutions. The majority (66.4%) of the documents reviewed were from the southern region and 33.6% were from the special institution in the northern region of the country. This evolved from the overall sampling procedures that were undertaken to obtain samples from each quota (between the years 2005 to 2010) for the two institutions.

5.3 PERIOD UNDER REVIEW

Table 5.2 shows distribution according to years. The years represent the period under review for the patients' documents and spanned the time from (and including) 2005 to (and including) 2010. Table 5.2 shows that the years which reflected the highest number of admissions were 2008 and 2009 (23.5% each) as compared to 2010 which had the least, namely, 9.2%. The increase in admissions from 2006 and 2007 is 16% respectively. For forensic psychiatric patients cared for within that period their documents were expected to reflect a complete rehabilitation service rendered at the special institutions.

TABLE 5.2: Frequency distribution of admissions according to years

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Year 2005	14	11.0%	11.8%	11.8%
	Year 2006	19	15.0%	16.0%	27.8%
	Year 2007	19	15.0%	16.0%	43.8%
	Year 2008	28	22.0%	23.5%	67.3%
	Year 2009	28	22.0%	23.5%	90.8%
	Year 2010	11	8.7%	9.2%	100.0%
	Total	**119**	**93.7%**	**100%**	
Missing	System	8	6.3%		
Total		**127**	**100.0%**		

5.4 LEGAL BASIS FOR ADMISSION OF FORENSIC PSYCHIATRIC PATIENTS

According to Table 5.3, the provisions of Section 26 of the Zimbabwe Mental Health Act of 1996 were the main guideline (56.3%) for admitting patients in special institutions. Section 26 focuses on the power of the magistrate to order examination and treatment of accused persons (Zimbabwe Mental Health Act 1996:171). The section reads as follows:

(1) In this section – "magistrate" includes the chief magistrate and any regional magistrate.

(2) Without derogation from section twenty-seven or twenty-eight, if a person appears before a magistrate for the purpose of –

(a) remand; or

(b) any other purpose prior to arraignment; on a charge of committing an offence which the magistrate considers will not merit imprisonment without the option of a fine or a fine exceeding level three, and the magistrate has reason to believe that the person is mentally disordered or intellectually handicapped, the magistrate may order that the proceedings against the person be stayed for a definite or an indefinite period, and may –

(i) order the person to submit himself for examination and additionally, or alternatively, treatment in any institution or other place in terms of Part VI; or

(ii) order the person's guardian, spouse or close relative to make an application for the person to be received for examination and additionally, or alternatively, treatment in any institution or place in terms of Part VII or Part VIII; or

(iii) order two medical practitioners to examine the person and inquire into and report on his mental state:

Provided that, if only one medical practitioner is available, the magistrate may order a psychiatric nurse practitioner or a designated psychiatric nurse, social worker or clinical psychologist to examine the person concerned and inquire into and report on his mental state; and may give such directions for the person's release from custody or continued detention or transfer to an institution or other place as he considers necessary to ensure that the person's mental state is examined and additionally, or alternatively, that he receives appropriate treatment.

(3) An order or direction under subsection (2) may be given subject to such conditions as the magistrate think fit.

(4) If the magistrate, after considering medical reports given pursuant to an order under subsection (2) and such other evidence as he thinks fit, finds that the person concerned is mentally disordered or intellectually handicapped and –

(a) is of suicidal tendency or in any way dangerous to himself or to others: or

(b) has committed or attempted to commit any offence or has acted in a manner offensive to public decency; or (c) is excessively dependent on alcohol or illicit drugs; or
(d) in the case of a psychopathic disorder, requires to be detained; or
(e) has no fixed abode; the magistrate may issue a reception order in the prescribed form directing that the person –
(i) be removed to, and received and detained in, an institution to be named in the order; or (ii) subject to section ten, be received, treated and detained in single in a private dwelling-house and not in an institution; and the procedure laid down in Part II shall thereafter be followed.
(5) Notwithstanding any other law, but subject to the terms and conditions of the order concerned, where a magistrate has ordered in terms of subsection (2) that proceedings against a person be stayed, no further proceedings shall be taken against that person in relation to the offence in connection with which he appeared before the magistrate until–
(a) the period, if any, specified in the order has expired; or
(b) any examination or treatment ordered to be undergone by that person has been completed; or
(c) the magistrate, or another magistrate of equivalent jurisdiction, revokes the order; or
(d) the order is set aside by the Mental Health Review Tribunal on an appeal in terms of section thirty-six.

Section 28 (32, 8%) followed Section 26 as guideline. Section 28 covers the procedure followed where a person is found to be mentally disordered or intellectually handicapped during preparatory examination or trial. As illustrated in Table 5.3, “Other “was constituted of the lowest percentage, namely 0.8%. This particular admission was unclassified because the patient was a vagrant who had not committed a crime and could therefore not be accounted for by the Zimbabwe Mental Health Act of 1996. The reason for admission was not clear.

In brief, theresults of the document review of patients admitted between 2005 and 2010 showed that a total of 99.2% were admitted under the Zimbabwe Mental Health Act of

1996. These quantitative results of the study on the use of this Act supported the use of mental health legislation which is widely acknowledged in researches done in Africa. Several authors also highlight the challenges and evolvement of mental health legislation in the care of forensic psychiatric patients in Africa (Hamaoui et al 2009:508; Njenga 2006:97; Ogunlesi et al 2012:3).

It was the expectation that the Zimbabwe Mental Health Act (1996) would drive therapeutic interventions; however, it seemed to be nullified by the parallel Zimbabwe Prison Act of 1996 which was operationalised by the Zimbabwe Prison Service Standing Orders of 1992.The problematic issue here is that these two parallel instruments seemed to invoke conflicting power issues that then negatively affected the management of forensic psychiatric patients. A conclusion can be reached that power issues in the management of patients emanates from the concurrent use of the Zimbabwe Mental Health Act of 1996 and the Zimbabwe Prison Act of 1996.

TABLE 5.3: Frequency distribution according to category of admission under the mental health act of 1996

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Section 26	67	56.3%	56.3%	56.3%
	Section 27	5	4.2%	4.2%	60.5%
	Section 28	39	32.8%	32.8%	93.3%
	Section 29	7	5.9%	5.9%	99.2%
	Other	1	0.8%	0.8%	100%
Total		**119**	**100%**	**100%**	

5.5 PREVIOUS ADMISSIONS IN SPECIAL INSTITUTIONS

Table 5.4 shows the frequency of the number of previous admissions in the period under review. The majority of patients (83.2%) had been admitted only once whereas 4.2% had been admitted more than three times. Considering this data, the conclusion

can therefore be drawn that the majority of patients were being admitted into the system for the first time or, more importantly, they could have been trapped in the system, 'revolving' within the prison system or between the prison system and the civil psychiatric hospital. This conclusion was reached following the qualitative findings from both the judiciary and the forensic psychiatric patients that acknowledged the loss of documents as an issue in forensic psychiatric practice (see 4.5.1.1.4 and 4.5.3.1.1 in Chapter 4).

The dilemma is that if documents got lost the patients could not be discharged by the Mental Health Review Tribunal. The other possibility subsequent to the loss of documents is that if a patient got readmitted, he would be dealt with as if he was admitted for the first time. Over and above these repercussions of losing documents, the prison system was not computerised in terms of records. If records were needed for anything, it had to be done manually. It was unlikely that seven nurses could carefully check more than the six hundred patients' information in the institution during the time under review. Roesch, Ogloff and Eaves (1995:1) posit that forensic psychiatric patients are volleyed between the criminal justice system, mental health system, and community settings.

TABLE 5.4: Frequency distribution according to number of previous admissions

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Once	99	83.2%	83.2%	83.2%
	Twice	14	11.8%	11.8%	95.0%
	Thrice	1	0.8%	0.8%	95.8%
	More than three times	5	4.2%	4.2%	100%
Total		**119**	**100%**	**100%**	

5.6 PATIENT DIAGNOSIS

Table 5.5 reflects the diagnostic labels forensic psychiatric patients had as a basis for admission. The main diagnosis for patients admitted in a special institution was chronic schizophrenia with 38.7%. It is important to note these patients had co-morbidity, meaning that some had more than one diagnosis. The minority was 27.7% who had isolated diagnoses, for example, organic brain disorder, vagrant, organic psychosis, and organic brain damage. It was not clear which instrument was used for diagnosing of the patients because some diagnoses in the patients' documents did not fit into the Diagnostic and Statistical Manual IV Text Revised, for example, vagrant and epilepsy. These quantitative results may put into perspective the effects of inconsistent definitions of rehabilitation.

TABLE 5.5: Frequency distribution according to mental illness

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Acute psychosis	21	16.5%	17.6%	17.6%
	Affective disorder	3	2.4	2.5%	20.2%
	Substance induced mental illness	33	26.0	27.7%	47.9%
	Personality disorder	2	1.6	1.7%	49.6%
	Mental retardation	7	5.5	5.9%	55.5%
	Chronic schizophrenia	46	36.2	38.7%	94.1%
	Epilepsy	3	2.4	2.5%	96.6%
	Other	4	3.1	3.4%	100%
Total		**127**	**100%**	**100%**	

Gustafsson, Holm and Flensner (2012:732) emphasise that correct diagnosis of a patient is the hallmark of comprehensive treatment in forensic psychiatric rehabilitation. In this study, results on mental illness/diagnosis of the patients showed that substance

induced mental illness were the second major reason for admission into the special institutions. However, the results on outcome of service, which specifically sought to evaluate patients who remained addicted to the substance, showed that 4.3% remained addicted. According to the results, 80% of records did not document the outcome specific to substance abuse.

Palijan, Muzinic and Radeljak (2009:429) explain that substance abuse is closely related to forensic psychiatry. These authors view substance abuse as co-morbid with other psychiatric conditions. They advise that rehabilitation should include pharmacotherapy, psychotherapy, and occupational therapy as these therapies are projected to increase social functioning of the patient. The absence of documentation on this aspect may suggest that nurses in the special institution may not have realised what rehabilitation is and that a vital part of rehabilitation was to prioritise and address this issue (see 4.5.2.1.3 in Chapter 4).

5.7 PREVIOUS MENTAL ILLNESS/ILLNESSES IN FORENSIC PSYCHIATRIC PATIENTS

Table 5.6 reflects that the majority of patients had known previous mental illnesses (48.7%) while 16.8% was not accounted for as to whether they had possibly had a previous mental illness.

TABLE 5.6: Frequency distribution according to previous mental illness

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	57	47.9%	48.7%	48.7%
	No	40	33.6%	34.2%	83.9%
	Not known	20	16.8%	17.1%	
	Total	117	98.3%	100%	100%
Missing	System	2	1.7%		
Total		**119**	**100%**		

Hamaoui et al (2009:509), Lamb, Weinberger and Gross (2004:107) and also Flora, Barbaree, Simpson, Noh and McKenzie (2012:415) are in agreement that forensic psychiatric patients in general almost always have a history of previous mental illnesses. In light of these authors' stance, it can be concluded that patients in this study could have had a previous mental illness when they were admitted. It was also possible that the previous mental illness derived from the relapses that had occurred while the patient was still admitted in the special institution because of being trapped in the system of care where they were psychologically vulnerable and did not have the capacity to withstand the symbolic violence inherent in the special institution (prison setting). This conclusion is derived from the fact that in 4.2 of Chapter 4, it was explained that one interview from a patient could not be used because he had relapsed while awaiting the Mental Health Review Tribunal to discharge him. This means that the psychiatrist and the Special Board had agreed that he was mentally stable to warrant a discharge. Those patients who were unaccounted for reflected negatively on the quality of the health assessment procedures (see 4.5.2.1.5 and 4.5.1.1.6 in Chapter 4). It thus seems as if the assessment on patients were incomplete. This factor may impact negatively on the care and rehabilitation of patients. If the information on previous mental illness or illnesses was missing, it would be difficult to assess compliance and adherence issues related to any individual patient.

5.8 AGE DISTRIBUTION OF FORENSIC PSYCHIATRIC PATIENTS

Table 5.7 shows the distribution of the forensic psychiatric patients according to age.

The majority (43.7%) who were admitted during the period under review were between 22 and 30 years old. Those in the oldest age group, between 51 and 60, constituted 9.2%. Of significance is that 9.2% of the forensic psychiatric patients' age groups were not indicated in the patients' notes/documents.

TABLE 5.7: Frequency distribution according to age group

		Frequency	Percent	Valid percent	Cumulative per cent
Valid	18 – 21	5	4.2%	4.2%	4.2%
	22 – 30	52	43.7	43.7%	47.9%
	31 – 40	42	35.3	35.3%	83.2%
	41 – 50	6	5.0	5.0%	88.2%
	51 – 60	3	2.5	2.5%	90.8%
	Not indicated	11	9.2%	9.2%	100.0%
Total		**119**	**100.0%**	**100.0%**	

Coid, Hickey, Kahtan, Zhang and Yang (2007:223) conducted a study to measure the period prevalence and incidence of offences following discharge and identify associated risk factors. They found that offence predictors included a younger age group. But, the younger age range was disputed in a study done by Mezey, Kavuma, Turton, Demetrio and Wright (2010:687) which indicated the patient participants' age range was 37.1 years. This result of the age range for this particular research study showed that the patients were at the peak and most productive period of their lives. The deduction can thus be made that their concerns for being redundant and unproductive while being admitted at the special institutions were justified; the implication being that rehabilitative care should include focusing also on preparing forensic psychiatric patients to be relevant in the marketplace after discharge (see 4.5.3.1.2 in Chapter 4).

5.9 MARITAL STATUS DISTRIBUTION OF FORENSIC PSYCHIATRIC PATIENTS

In Table 5.8 the marital status distribution is presented.

TABLE 5.8: Frequency distribution according to marital status

		Frequency	Per cent	Valid percent	Cumulative percent
Valid	Single	30	25.2%	25.2%	25.2%
	Married	10	8.4%	8.4%	33.6%
	Divorced	1	0.8%	0.8%	34.5%
	Widower	1	0.8%	0.8%	35.3%
	Not indicated	77	64.7%	64.7%	100.0%
Total		**119**	**100.0**	**100.0**	

The majority of patients' documents (64.7%) did not indicate whether the patient was married or not. This is a concern in view of assessing the support system of the patient. Non-documentation could be a reflection of a lack of systematic history taking in the special institutions. Only 8.4% of the patients were known to be married and this is contra-directional to the requirements for compliance to treatment and subsequent recovery. Research on forensic psychiatric patients that included marital status as a variable of interest generally found that most of the patients were not married (Oyffe, Kurs, Gelkopf, Melamed & Bleich 2009:577; Rosca, Bauer, Grinshpoon, Khawaled, Mester & Ponizovsky 2006:60). It was also confirmed in the qualitative phase (see 4.4.1.5.1 in Chapter 4) that all relatives interviewed for the patients currently admitted in special institutions were not spouses but parents of the patients.

5.10 LEVEL OF EDUCATION DISTRIBUTION FOR FORENSIC PSYCHIATRIC PATIENTS

Most (67.2%) of the patients' documents did not indicate the patients' level of education as seen in Table 5.9. Information on their level of education is imperative for the formulation of individualised nursing care plans suitable for each patient. Although by far the minority (2.6%) had no formal education, they were the mentally retarded patients. The qualitative findings indicated there were no individualised care plans. The

reason was apparently that, because the patients were living in overcrowded cells, the emphasis was mainly on custodial care and giving their medicines. This could explain why the medical team did not bother to determine the patients' level of education because they probably did not intend to use such information (see 4.5.2.1.4 and 4.5.2.1.5 in Chapter 4).

TABLE 5.9: Frequency distribution according to level of education

		Frequency	Percent	Valid percent	Cumulative percent
Valid	No formal education	3	2.5%	2.6%	2.6%
	Primary school	9	7.6%	7.8%	10.3%
	Secondary school	23	19.3%	19.8%	30.2%
	Tertiary institution	3	2.5%	2.6%	32.8%
	Not indicated	78	65.5%	67.2%	100.0%
	Total	**116**	**97.5%**	**100.0%**	
Missing	System	3	2.5%		
Total:		**119**	**100.0%**		

5.11 CRIMINAL CHARGES AGAINST FORENSIC PSYCHIATRIC PATIENTS

The majority (22%) of the patients under review had been charged with malicious damage to property (non-violent). This was closely followed by 21.3% assault with grievous (violent) bodily harm charges. This indicated that the crimes committed were normally distributed between violent and non-violent crimes because rape and murder (violent) collectively constituted another 21.2% while the percentage of theft (non-violent) was15%.

TABLE 5.10: Frequency distribution according to criminal charges

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Murder	13	10.2%	10.2%	10.2%
	Rape	14	11.0%	11.0%	21.3%
	Indecent assault	3	2.4%	2.4%	23.6%
	Assault/bodily harm	27	21.3%	21.3%	44.9%
	Robbery	1	0.8%	0.8%	45.7%
	Attempted rape	2	1.6%	1.6%	47.2%
	Theft	19	15.0%	15.0%	62.2%
	House breaking	9	7.1%	7.1%	69.3%
	Shoplifting	1	0.8%	0.8%	70.1%
	Malicious damage to property	28	22.0%	22.0%	92.1%
	Other	10	7.9%	7.9%	100.0%
Total		**127**	**100.0%**	**100.0%**	

5.12 SOURCE OF REFERRAL FOR FORENSIC PSYCHIATRIC PATIENTS

According to Table 5.11, the majority (99.2%) of forensic psychiatric patients had been referred from the courts. This correlates with the results of the major categories of admission as stipulated in Sections 26 and 28 of the Zimbabwe Mental Health Act of 1996. The findings reflected the role of the judiciary in the processes of rehabilitating the forensic psychiatric patients. The results of this study were consistent with that of other similar studies conducted in forensic psychiatry that confirmed the courts as a source of referral for most forensic psychiatric patients (Flora et al 2012:415; Munthe, Radovic & Anckarsater 2010:5; Voren 2006:126). However, the implications of this result is that it was observed and noted in the qualitative phase of this study that when court papers or reception orders were sent to the special institution(s), it was specifically addressed to the officer in charge or superintendent of the prison facility that housed the special

institution. This seemed to give power to the prison management system. This power was the medium through which the voice of the medical team, particularly the nurses, was silenced.

TABLE 5.11: Frequency distribution according to source of referral

		Frequency	Per cent	Valid percent	Cumulative percent
Valid	Court	118	99.2%	100.0%	100.0%
Missing	System	1	0.8%		
Total:		**119**	**100.0%**	**1**	

5.13 REHABILITATIVE INTERVENTIONS FOR FORENSIC PSYCHIATRIC PATIENTS

Table 5.12 below shows the rehabilitative intervention for the psychiatric patients

TABLE 5.12: Frequency distribution according to rehabilitative interventions

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Cognitive therapy	1	0.8%	0.8%	0.8%
	Psychotropic medication	110	86.6%	90.2%	91.0%
	Psychosocial	6	4.7%	4.9%	95.9%
	Not indicated	5	3.9%	4.1%	100.0%
	Total	**122**	**96.1**	**100.0%**	
Missing	System	5	3.9		
Total:		**127**	**100.0%**		

The majority (90.2%) of patients received psychotropic medical interventions during their stay in hospital. The most unpopular intervention of cognitive therapy (0.8%) was

given and signed for by psychology students on attachment from psychology departments of the various universities in the country. This meant that for the special institution per se, the intervention was not offered. This was the same with psychosocial interventions which constituted 4.9% of the service. For 41% of the patients, the records did not indicate the interventions given.

The use of medication (drugs) as a major form of intervention has been confirmed by research studies; this led to the emerging need for an approach that would maximise resources and enhance delivery of evidence-based care in addition to a comprehensive primary care system. Research studies also consistently specify that forensic psychiatric treatment should embrace biological, sociological, and psychological methods that are patient specific and, additionally, that progress assessment is imperative (Linhorst & Turner 1999:19; Palijan et al 2010:65; Stein, Szabo, Moussaoui & Gureje 2010:257). The qualitative findings in the current study revealed that nurses experienced a dichotomy of responsibility. This could have been a result of the disempowering nature of the social field of power, that is, the prison system, to give psychological interventions and other relevant rehabilitative treatment modalities (see 4.5.2.1.2 in Chapter 4).

5.14 SERVICE OUTCOMES FOR FORENSIC PSYCHIATRIC PATIENTS

This variable measured the outcome of all the services and interventions that were availed to the patients. The variables measured were compared to a study that reviewed outcome measures used in forensic mental health research with consensus panel opinion by Fitzpatrick, Chambers, Burns, Doll, Fazel, Jenkinson, Kaur, Knapp, Sutton and Yiend (2010:14). Service outcomes in the current research study were measured in terms of quality of life, self-esteem, recidivism, suicide, substance abuse, mental state, cognitive function, the relationship with the family, compliance, readiness to change, social function, contact with members of the multidisciplinary team and, lastly, that the patient died in custody. These outcomes were expected to be documented whether they were negative or positive as the rehabilitation processes

progressed in the special institutions. Brunt (2008:236) posits that treatment service outcomes in a psychiatric setting should impact positively. This means that services offered to psychiatric patients are expected to facilitate their recovery of function in all aspects of their lives.

5.14.1 Quality of life for forensic psychiatric patients

Quality of life in forensic psychiatry is a concept that is considered to be very significant in the rehabilitation process. Bouman (2012:1) and Bouman, Ruiter and Schene (2008:486) explain that quality of life has a bearing on the general wellbeing of an individual that impacts on criminal recidivism within the forensic psychiatric patient population group. Quality of life in this study was operationalised in terms of patients having future goals. Table 5.13 illustrates that the majority (75.6%) of patients' documents did not reflect the variable representing quality of life for forensic psychiatric patients because there were no entries by the health staff in terms of future goals of patients. It would be expected that as the patient progressed towards recovery, he would develop future goals for himself and that such plans would be documented as part of measuring progress towards recovery of patients in the special institutions.

Only 7.6% of the patients' documents specified that the patients under review had no plans for the future. These quantitative results confirmed the qualitative phase's notion of anxiety and uncertainty (see 4.5.3.1.2 in Chapter 4) when it reviewed distribution of patients according to quality of life. The results revealed that none of the records showed that the patients indicated they had plans for their future. But, it is possible that patients could have failed to make plans because there was no point in looking forward to a future because their future seemed to be unknown due to their endless rotation through the system and, in addition, their continuum of care was blurred.

TABLE 5.13: Frequency distribution according to quality of life

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	20	16.8%	16.8%	16.8%
	Not evident	9	7.6%	7.6%	24.4%
	Not indicated	90	75.6%	75.6%	100.0%
Total:		**119**	**100.0%**	**100.0%**	

5.14.2 Self-esteem of forensic psychiatric patients

The service outcome measuring self-esteem was estimated in terms of whether the patient was committed to a social group, occupation or if he had a reason to live. The majority (76.3%) of the documents did not indicate this variable while 9.3% of the documents reflected that the patients had no evidence of positive self-esteem as presented in Table 5.14. In other words, either there was no positive self-esteem or it was not mentioned at all.

Self-esteem is described in several studies as an indicator of recovery and as inherent in facilitating recovery. Rehabilitation in forensic settings is aimed at fostering optimism, hope, self-care, independence and autonomy. These are reflectors of restructured self-esteem following rehabilitation (Mezey et al 2010:693; 684). Lack of documentation by psychiatric nurses of this very basic tenet in psychiatric nursing practice could be a reflection of their powerlessness or disillusionment as highlighted by the qualitative findings in this study (see 4.5.2.1.2 in Chapter 4). The notion of having very few patients with positive self-esteem could be a result of the dehumanising nature of the prison environment characteristic of the special institutions.

TABLE 5.14: Frequency distribution according to self-esteem

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	17	14.3%	14.4%	14.4%
	Not evident	11	9.2%	9.3%	23.7%
	Not indicated	90	75.6%	76.3%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total		**119**	**100.0%**		

5.14.3 Non-violent recidivism in forensic psychiatric patients

In this study, recidivism was considered as an important concept because it reflects on the impact of rehabilitation services available to patients in forensic psychiatric settings. In fact, the bottom line or the whole point in forensic psychiatric care is to prevent recidivism (Horberg, Sjorgren & Dahlberg 2012:743). Non-violent recidivism was a service outcome variable that was measured by the evidence in the records or document showing that the patient had a reoffending that was not violent or sexual in nature. The results showed that 79.3% of the records did not indicate whether the patient had a non-violent recidivism or not. Only 5.2% of documents indicated non-violent recidivism.

TABLE 5.15: Frequency distribution according to non-violent recidivism

		Frequency	Per cent	Valid per cent	Cumulative per cent
Valid	Evident	6	5.0%	5.2%	5.2%
	Not evident	18	15.1%	15.5%	20.7%
	Not indicated	92	77.3%	79.3%	100.0%
	Total	116	97.5%	100.0%	

		Frequency	Per cent	Valid per cent	Cumulative per cent
Missing	System	3	2.5%		
Total:		**119**	**100.0%**		

5.14.4 Violent recidivism in forensic psychiatric patients

A patient's document that indicated that he had a reoffending that was violent in nature was considered to be having a violent recidivism. The results of the current study revealed that 77.1% of the patients' documents did not reflect whether he had a violent recidivism or not, and only 10.2% of their records revealed this occurrence. In other words, non-violent recidivism and violent recidivism were measured as service outcomes.

TABLE 5.16: Frequency distribution according to violent recidivism

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	12	10.1%	10.2%	10.2%
	Not evident	15	12.6%	12.7%	22.9%
	Not indicated	91	76.5%	77.1%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total:		**119**	**100.0%**		

The combination of results on recidivism subsequently show that the majority (79.3%) of the records did not communicate whether there was or was not non-violent recidivism. On the other hand, 77.1% of records also did not indicate whether violent recidivism occurred.

Oyffe et al (2009:576) describe recidivism as a state in which patients relapse into prior criminal habits. The authors explain that the hallmark of recidivism lie with service

system factors like lack of comprehensive social services and inadequate rehabilitation mechanisms. A conclusion can be made that it was not possible to measure and record recidivism in this study because of the discharge challenges that had patients trapped in the system for so long (see 4.5.5.2.6 in Chapter 4). The consequence was that it was probably difficult to monitor their reoffending or lack thereof.

5.14.5 Suicide among forensic psychiatric patients

A patient who committed suicide or tried to do so was considered to have had a service outcome of suicide or self-harm. Results of the study according to Table 5.17 revealed that the majority (71.8%) of patients showed no indication of harming themselves while in 27.4% of the records it was not indicated whether the patients were suicidal or not. Only one patient (0.8%) committed suicide during the period under review.

TABLE 5.17: Frequency distribution according to suicide/self-harm

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	1	0.8%	0.9%	0.9%
	Not evident	84	70.6%	71.8%	72.6%
	Not indicated	32	26.9%	27.4%	100.0%
	Total	117	98.3%	100.0%	
Missing	System	2	1.7		
Total:		**119**	**100.0%**		

Previous research studies point out patients may perceive seclusion, restraint, and medication as humiliating and punishing (Frost & Hoggett 2008:438). This is explained as psychologically harmful and destructive and could be a motivation for a forensic psychiatric patient to commit suicide. Research studies also show that suicide generally occurs within the first week of admission in a forensic psychiatric setting and is especially common among female patients (Brunt 2008:223; Brunt & Rask 2005:264). A conclusion can be drawn from this discussion that the patient could have successfully

committed suicide because there was no adequate supervision and monitoring in the special institution as evidenced by patients being routinely locked in the cells. It is locked from the outside from 17h00 till 08h00 the next morning (see 4.5.2.1.4; 4.5.2.1.5 and 4.5.3.1.1 in Chapter 4).

5.14.6 Substance abuse among forensic psychiatric patients

Table 5:18 below shows the distribution of substance abuse among the forensic psychiatry patients.

TABLE 5.18: Frequency distribution according to substance abuse

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	5	4.2%	4.3%	4.3%
	Not evident	18	15.1%	15.5%	19.8%
	Not indicated	93	78.2%	80.2%	100.0%
	Total	116	97.5%	100.0%	
Missing	System	3	2.5%		
Total		**119**	**100.0%**		

The substance abuse service outcome evaluated patients who remained addicted to a substance even after they had been rehabilitated. The majority (80.2%) of records did not indicate this variable despite the fact that substance abuse was one of the major diagnostic predicaments for forensic psychiatric patients. The lowest percentage (4.3%) of documents indicated that the patients remained addicted to the substance they had been abusing. The lack of proper documentation remained enigmatic**,** apocryphal and problematic in the care of forensic psychiatric patients. It could be tied to the possibility that nurses might not have had access to patients' records owing to the seemingly irrelevant position they had in the prison system. Naturally, if substance abuse was one of the major reasons for admission, it would be expected of nurses to evaluate the progress of such patients. It is also possible that the nurse versus the guard

phenomenon could have given more emphasis on the classification system deriving from the Zimbabwe Prison Service Standing Orders (1992:56) than on the medical classification of patients that embodied the medical diagnosis resulting in issues of substance abuse being ignored.

The 4.3% of patients that continued to abuse substances could have been patients who were assigned as 'staff' because it is difficult to imagine how else the patients could have accessed the substances. Kita (2011:11) explains that in a situation like a prison setting where patient inmates are present there is a tendency by inmates to "increase their social capital through their ties with staff". These forensic psychiatric patients apparently formed close relationships with guards and nurses; either of the latter two groups could have possibly accessed substances for them. On the other hand, because of the preferential treatment accorded to them; it is possible that substances brought by relatives of these particular patients were not adequately censored.

5.14.7 Mental state of forensic psychiatric patients on discharge

The mental state of the patient at the time of discharge was used as a measure for service outcome. The results, according to Table 5.19, were that 64.4% (constituting the majority) showed that they had no mental illness at the time of discharge or transfer to the civil psychiatric hospital while 25.4% left the special institution while still exhibiting signs of mental illness. The minority (10.2%) of the records, however, did not indicate the mental state of the patient at the time of discharge and also at transfer. The results of the study may then confirm the limitation of the rehabilitation services at the special institutions as indicated by the nurse and forensic psychiatric patient participants in the qualitative phase of the study (see 4.5.2.1.5 in Chapter 4). Brink, Tuinen and Wiersma (2007:1) raise the issue that the prison system is usually concerned about releasing patients who are still psychotic into the community. The authors make the point that, because these patients would have lost contact with the communities outside of their place of care and would additionally have been ignored by the general psychiatric services, these are the patients who eventually get lost in the system.

TABLE 5.19: Frequency distribution according to mental illness on discharge

		Frequency	Percent	Valid percent	Cumulative per cent
Valid	Evident	30	25.2%	25.4%	25.4%
	Not evident	76	63.9%	64.4%	89.8%
	Not indicated	12	10.1%	10.2%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total:		**119**	**100.0%**		

5.14.8 Cognitive function of forensic psychiatric patients

This was an outcome of rehabilitation which was measured through the assessment of the patients' ability to problem solve, remember, and plan. Table 5.20shows that the majority (77.1%) of the patient's documents showed that his cognitive function was not measured during the patient's admission. Eleven per cent (11%) showed evidence that the patient's cognitive function was functional.

TABLE 5.20: Frequency distribution according to cognitive function

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	13	10.9%	11.0%	11.0%
	Not evident	14	11.8%	11.9%	22.9%
	Not indicated	91	76.5%	77.1%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total:		**119**	**100.0%**		

Rask and Brunt (2006:101) explain that the common denominator for the patient's interaction with the medical team, particularly the nurses, was to develop creativity and thus focused on problem solving skills. This also included re-appraising how creativity

and focused problem solving skills were being affected by childhood experiences in the patient's life and current situation. In this study the cognitive function of patients remained a grey area which was not exactly evaluated in the rehabilitation process.

The findings of the qualitative phase revealed that patients experienced life in the special institutions as that of being "prisoners" and not "patients" (see 4.5.3.1). This could have transcended to a situation where their cognitive function was not of primary importance but their position as incarcerated people was what the focus of the prison system was.

5.14.9 Contact of forensic psychiatric patients with family

After a forensic psychiatric patient was given a service in totality with his family, it was an expected outcome that there would be a functional relationship between the patient and his family. According to Table 5.21, results indicated that 78.4% of the patients' documents did not reveal any contact between the relatives and the patient. Only 14.7% of patients under review were indicated to have had contact with their families.

TABLE 5.21: Frequency distribution according to relationship with family

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	17	14.3%	14.7%	14.7%
	Not evident	8	6.7%	6.9%	21.6%
	Not indicated	91	76.5%	78.4%	100.0%
	Total	116	97.5%	100.0%	
Missing	System	3	2.5%		
Total:		**119**	**100.0%**		

Mezey et al (2010:693) observe that forensic psychiatric patients have a fairly low chance of maintaining healthy relationships with relatives and friends after committing a crime. In terms of contact with the family, the quantitative results showed that 14.7% of

patients under review indicated they had had contact with their families. Mezey et al's explanation can possibly also apply to the researcher's observation notes that some of the relatives who had been traced for interviewing in the current study showed (as also indicated in the patients' notes) that the patients' addresses were non-existent. Providing an address that did not exist could possibly indicate unwillingness on the part of the relatives to be involved in the patient's care.

Families of patients could have also been deterred by disrespectful practices that relatives in the qualitative findings highlighted as an issue with them (see 4.5.1.1 in Chapter 4). It is also possible that relatives might not have known that the patient was at the special institution since they indicated in the qualitative phase that they were not informed of patients' transfers, especially if the patient was being moved from the civil psychiatric hospital to the special institution (see 4.5.4.3.3 in Chapter 4).

5.14.10 Compliance of forensic psychiatric patients to treatment modalities

Compliance referred to the patients' ability to go through with and adhere to therapies availed to them. The results of the research study as shown in Table 5.22 below showed that 79.7% of the patients' files did not indicate whether the patients under review compiled with therapy or not.

TABLE 5.22: Frequency distribution according to compliance

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	11	9.2%	9.3%	9.3%
	Not evident	13	10.9%	11.0%	20.3%
	Not indicated	94	79.0%	79.7%	100.0%
	Total	118	99.2%	100.0%	
Missing:	System	1	0.8%		
Total:		**119**	**100.0%**		

It was in only 9.3% of patient's files where it was evident that the patients under review complied with therapeutic services rendered to them. The qualitative findings indicated that there was a limitation of rehabilitation services given to forensic psychiatric patients partly because of the no guard; no rehabilitation system in the special institutions (see 4.5.2.1.1 and 4.5.2.1.5 in Chapter 4). It would then seem understandable that the patients had nothing to comply with since the services were not made available to them. Thus, as it were the nurses and other medical staff had nothing to record.

5.14.11 Readiness of forensic psychiatric patients to change

The rehabilitation of forensic psychiatric patients in special institutions was expected to elicit a readiness to change in the patient. As illustrated in Table 5.23 below, the results of the study were that in 78.8% of patients' files it was not indicated whether the patients were ready to change or not. In 8.5% of cases there was no evidence that indicated whether patients were motivated to change.

TABLE 5.23: Frequency distribution according to readiness to change

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	15	12.6%	12.7%	12.7%
	Not evident	10	8.4%	8.5%	21.2%
	Not indicated	93	78.2%	78.8%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total:		**119**	**100.0%**		

The qualitative findings revealed that forensic psychiatric patients were in a state of despair because they were not kept informed about their individual situations (see 4.3.1.2.2 in Chapter 4). Kita (2011:13) points out those patients who enter a prison setting are stripped of any capital that they might have had. This includes their identity and freedom to choose what they want their life to be like. Everything about the patients

is controlled by the prison establishment. It would seem then that if a patient really wanted to change, that change would not amount to anything. The lack of documentation could also point to the fact that positive or negative change in a patient was not a priority for the special institution in the prison system.

5.14.12 Social function of forensic psychiatric patients

Social function as a service outcome was attached to the patients' involvement in day to day activities in the unit of admission. Table 5.24 shows that the majority (78%) of the patient files did not indicate anything related to the patient's social function or involvement in day to day activities at the special institutions; however, 10.2% of the files showed evidence of social function in the unit.

TABLE 5.24: Frequency distribution according to social function

		Frequency	Percent	Valid per cent	Cumulative percent
Valid	Evident	12	10.1%	10.2%	10.2%
	Not evident	14	11.8%	11.9%	22.0%
	Not indicated	92	77.3%	78.0%	100.0%
	Total	118	99.2%	100.0%	
Missing	System	1	0.8%		
Total:		**119**	**100.0%**		

The quantitative results on service outcome according to social function explain this phenomenon that was brought up by participants' relatives that patients were being socially incapacitated by having nothing to do all the time (see 4.5.1.3.2 and 4.5.1.4.2 in Chapter 4). Livingston, Nijdam-Jones and Brink (2012:346) elaborate that forensic psychiatric institutions were expected to engage in services that are "inclusive, collaborative and egalitarian". Patient-centred care approach means to empower the service users who, in this case, were the patients. The authors explain that this ideal is impeded by the complexity of forensic psychiatric care which embodies the conflict

between need for security and public safety and creating a therapeutic milieu for the patient. This could also be true for forensic psychiatric patients admitted in special institutions. The patients' social skills deteriorated because they would not have been afforded the opportunity to have a social aptitude that they would need to use and be relevant once outside the special institutions (see 4.5.1.3 in Chapter 4).

5.14.13 Contact of forensic psychiatric patients with members of the multidisciplinary team

This outcome variable was measured by the reflection that the patient had a documented feeling that they had been rehabilitated enough to be reintegrated into society and the employment market following his contact with members of the multidisciplinary team. The current study results showed, however, that 77.8% of the patients' documents or records did not indicate this variable or show the contact between members of the multidisciplinary team and the patient. Only 9.4% had a semblance of contact between the patient and the multidisciplinary team as shown in Table 5.25 below.

TABLE 5.25: Frequency distribution according to contact with members of the multidisciplinary team

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	11	9.2%	9.4%	9.4%
	Not evident	15	12.6%	12.8%	22.2%
	Not indicated	91	76.5%	77.8%	100.0%
	Total	117	98.3%	100.0%	
Missing	System	2	1.7%		
Total:		**119**	**100.0%**		

In a study conducted in a forensic psychiatric hospital, Martin and Street (2003:543) found there was a marked difference between what the services nurses said they

provided were and what was indicated in the patient's progress. The results differed with regard to response to treatment and nursing interventions. There was a tendency to rely on "oral tradition" which seemed to also be the case with the multidisciplinary team in special institutions, especially where the medical staff is concerned. Brunt and Rask (2005:264) note that the promotion of the medical staff's involvement with psychiatric patients resulted in enhancing a generally positive outcome. A conclusion can then be reached that in the current study there was no such documentation because either the interaction was too limited and therefore insignificant for noting or the interaction never happened.

5.14.14 Death of forensic psychiatric patients in custody

The death of patients during admission in special institutions was considered as very significant in this study because it was not expected to happen. Special institutions do not have facilities for physically ill patients. It was therefore imperative to further understand the context of when and why it happened. The quantitative part of the study which sought to quantify deaths during admission in the period under review noted that 13.4% of patients died as shown in Table 5.26 below. The current study revealed, as indicated in Table 5.26, that 31.25% of the deaths occurred in 2007 while 50% occurred in 2008.

TABLE 5.26: Frequency distribution according to patient death in custody

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Evident	16	13.4%	13.4%	13.4%
	Not evident	85	71.4%	71.4%	84.9%
	Not indicated	18	15.1%	15.1%	100.0%
Total:		**119**	**100.0%**	**100.0%**	

In her special report on death and disease in Zimbabwe's prisons, Alexander (2009:995) reported that in late 2008 patients died in custody due to disease and starvation. Forensic psychiatric patients were also counted in this prison population. Food insecurity seems to be associated with the economic state of a country. At the time of writing this report, the country under study was still recovering from an economic meltdown. This could translate to the fact that food insecurity was still a reality not only for the whole population of Zimbabwe, but also for the patients in special institutions (Food Security Network 2008:3). However, Forsyth, Elmslie and Ross (2012:44) expresses that issues of diet and nutrition are basic rights that promote mental health in patients that are admitted in prison settings.

Following Table 5.26 is a cross tabulation (Table 5.27) of year of admission and death in custody. The death of a patient due to medical reasons other than suicide while admitted in a special institution was considered to be a possibility in the current study. The possibility originated from the qualitative finding that there was food insecurity in the prison settings (see 4.5.3.1.2 in Chapter 4). The results showed that 13.4% of patients died in custody during the period under review. Eighteen (15.1%) of the records did not indicate the fate of the patient at the end of their admission period.

It is an unusual occurrence for a psychiatric patient to die while being admitted in a psychiatric institution in Zimbabwe. The magnitude of the significance and rarity of death in a psychiatric setting is reflected by the fact that the death is reported to the Secretary for Ministry of Health and Child Care within 48 hours unlike deaths in the mainstream health delivery system (Zimbabwe Mental Health Act 1996:189). Due to this result, a cross tabulation was done to identify the period in which the patients died in custody. This would give the researcher insight into the context in which these deaths occurred.

TABLE 5.27: Cross tabulation of year of admission and death in custody

		Died in custody			Total
		Evident	Not evident	Not indicated	
Group	Year 2009	1	24	3	28
	Year 2008	8	17	3	28
	Year 2007	5	11	3	19
	Year 2006	1	12	6	19
	Year 2005	1	13	0	14
	Year 2010	0	8	3	11
Total:		**16**	**85**	**18**	**119**

The highest percentages of patients who had died was in 2008 (50%) and in2007 (31.25%). This means that a cumulative total of 81.25% of deaths occurred in 2007 and 2008 – which was during the period under review. Rutherford and Duggan (2007:19) acknowledge that deaths do occur while patients are in the custody of prison settings. In this study the year 2007 and 2008 when most deaths occurred was a time when the nation under study was experiencing an economic crisis (Alexander 2009:995). Forensic psychiatric patients were also counted in this prison population and their deaths could have been caused by starvation.

5.15 ASSOCIATION BETWEEN SEVERITY OF MENTAL ILLNESS AND CRIMINAL CHARGE

An association analysis was also done between mental illness and criminal charge. The results as indicated in Table 5.28 were significant to the fact that there was an association between the diagnosis of a patient and the criminal charge that was laid against him. This means that the more psychotic the patient was, the more likely he was to have committed a heinous criminal offence.

TABLE 5.28: Association between mental illness and criminal charge

	Illness	Criminal charge
Chi-Square	1.320E2[a]	83.906[b]
df	7	10
Asymp. Sig.	.000	.000

The qualitative findings showed that there were no services for forensic psychiatric patients beyond the special institutions (see 4.5.2.1.4 and 4.5.1.1.5 in Chapter 4). This may point to the possibility that patients lacked supervision in the community leading to relapses which, in turn, resulted in the next crime they committed. On the other hand, the quantitative results from the files showed that patients were coming into the system for the first time. This again points to a lack in community services for psychiatric patients because these services would have been able to prevent admissions by identifying at-risk groups in the community and providing them with appropriate counselling and referral.

5.16 RELATIONSHIP BETWEEN CRIMINAL CHARGE AND PREVIOUS ADMISSION

A cross tabulation to link the criminal charge and previous admissions was done. The results revealed that a criminal charge of assault with grievous bodily harm was highly associated with first-time offenders. This was similar to the results pertaining to malicious damage to property. The findings of this association (between criminal charge and previous admission) were significant. It would be expected of the special institutions to have picked up on this trend and to tailor-make treatment modalities that addressed this issue.

TABLE 5.29: Cross tabulation for criminal charge and previous admission

		Once	Twice	Thrice	More than thrice	
Criminal charge	Murder	12	1	0	0	13
	Rape	9	3	1	0	13
	Indecent assault	3	0	0	0	3
	Assault/bodily harm	22	2	0	2	26
	Robbery	1	0	0	0	1
	Attempted rape	1	0	0	0	1
	Theft	13	1	0	1	15
	House breaking	8	1	0	0	9
	Shoplifting	1	0	0	0	1
	Malicious damage to property	20	5	0	2	27
	Other	9	1	0	0	10
Total		**99**	**14**	**1**	**5**	**119**

5.17 ASSOCIATION BETWEEN CRIMINAL CHARGES AND REHABILITATIVE INTERVENTION

Criminal charges determine how patients will be accepted by society. The qualitative findings reflected that some relatives were reluctant to collect the discharged patients from the civil psychiatric hospital after discharge from the special institution owing to the magnitude of the crimes they would have committed (see 4.5.2.1.4 in Chapter 4). Therefore, the relationship between criminal charges and rehabilitative interventions was sought. This was important because the multidisciplinary team was expected to be sensitive to it when rehabilitating the patient. For example, interventions for a patient who had committed murder would need more family therapy because it was the basis on which relatives rejected forensic psychiatric patients.

TABLE 5.30: Correlation between criminal charges and rehabilitative interventions

	Criminal charge	Rehabilitative interventions
Chi-Square	83.906[a]	276.754[b]
df	10	3
Asymp. Sig.	.000	.000

5.18 LINK BETWEEN CRIMINAL CHARGES AND TREATMENT GIVEN

A cross tabulation and correlation analysis was statistically done to identify the link between the criminal charge and the rehabilitation services given. The criminal charges of malicious damage to property and assault to cause grievous bodily harm were highly linked to medical drug therapy. In fact, all criminal charges had rehabilitation linked to medication therapy when compared to other possible treatment modalities that could have been given.

TABLE 5.31: Cross tabulation of criminal charge and rehabilitative interventions

		Cognitive therapy	Psychotropic medication	Psycho-social	Not indicated	
Criminal charge	Murder	0	11	1	1	13
	Rape	0	12	2	0	14
	Indecent assault	0	3	0	0	3
	Assault/ bodily harm	0	25	1	1	27
	Robbery	0	1	0	0	1
	Attempted rape	0	1	1	0	2

		Cognitive therapy	Psychotropic medication	Psychosocial	Not indicated	
	Theft	0	14	0	1	15
	House breaking	1	8	0	0	9
	Shoplifting	0	1	0	0	1
	Malicious damage to property	0	26	1	1	28
	Other	0	8	0	1	9
Total:		**1**	**110**	**6**	**5**	**122**

5.19 RELATIONSHIP BETWEEN REHABILITATIVE INTERVENTIONS AND NUMBER OF PREVIOUS ADMISSIONS

The relationship between rehabilitative interventions and the number of previous admissions was tested and found to be significant. This meant that as rehabilitative services improved, the number of readmissions would reduce. Conversely, as rehabilitative services remained poor or absent either the patient got readmitted or remained trapped in the system, or the documents for the previous admission could have been lost. The focus of the rehabilitation of patients, whose mental health problems are complex such as for forensic psychiatric patients, is to promote recovery and community reintegration. The length of stay by these patients is a major concern for the multidisciplinary rehabilitation team as it is perceived to reflect on the therapeutic modalities offered to patients. The concern comes against a background of instances where some forensic psychiatric patients need repeated and frequent admissions.

TABLE 5.32: Association between rehabilitative interventions and the number of previous admissions

	Previous admissions	Rehabilitative interventions
Chi-Square	217.908[a]	276.754[b]
df	3	3
Asymp. Sig.	.000	.000

5.20 SUMMARY

This chapter sought to identify services that were available to forensic psychiatric patients in special institutions in Zimbabwe. To contextualise these services, the study tried to first understand the study setting, the legislature guiding the admissions and the number of previous admissions. Also, the diagnosis, previous mental illness, age group, and marital status as well as the level of education, criminal charge, and source of referral for the patients.

Rehabilitative interventions and service outcomes were then explored. The overall results showed that the major rehabilitative intervention was psychotropic medication treatment which is actually more of curative than rehabilitative. Service outcomes were not comprehensively documented in the patients' files. In most cases, the file would only hold court papers committing the patient to the special institution and the psychiatrist's reports. Nurses and other medical staff did not document the services they rendered to patients.

The results discussed in this chapter thus put the qualitative findings in perspective. The results from the documents showed the extent to which issues of symbolic power and a common denominator of a system of dominance can nullify subservient systems. In other words, the interests of the prison system that were guided by the Zimbabwe Prison Act of 1996 clashed with the provisions of the Zimbabwe Mental Health Act of 1996 that were supposed to foster comprehensive medical services for patients. The

result of this profound conflict between two powerhouses transcended to these results and findings.

CHAPTER 6
DISCUSSION OF THE CURRENT STATE OF FORENSIC PSYCHIATRIC REHABILITATION IN ZIMBABWE

"*Learn from yesterday, live for today, hope for tomorrow. The important thing is not to stop questioning."*
Albert Einstein (1955)

6.1 INTRODUCTION

This study embraced the constructivist grounded theory tenet urged by Charmaz (2006; 2014) whereby the theoretical analyses rendered interpretive findings of the stakeholders' reality and was not merely an objective reporting thereof. The study sought to co-construct the realities of rehabilitation in forensic psychiatry grounded in the experiences of the judiciary, the nurses, forensic psychiatric patients, the psychiatrists and relatives of the forensic psychiatric patients. The experiences of these stakeholders and results of the quantitative retrospective document review were abstracted to axial and theoretical codes. These codes reflected consistent inherent intricacies of power in the stakeholders' relations as predicted by Charmaz (2014:240): "as the constructivist approach evolves, hidden structures, networks, relationships, and hierarchies of power become obvious". These are what Bourdieu also referred to as "invisible relationships" to someone who cannot see beyond the obvious "because they are obscured by the realities of ordinary sense experience" as described by Swartz (1997:61).

These intricacies seemed to affect the overall outcome of the rehabilitation processes in forensic psychiatry in Zimbabwe. The realities discussed under this chapter were illuminated by Pierre Bourdieu's concepts of the social field, habitus, and capital. The discussion embodies the nexus of the qualitative findings and the quantitative results of this mixed method study.

In Figure 6.1 the current medico-judicial realities existing in Zimbabwe that evolved from the qualitative findings are illustrated as introduction to the discussion.

6.2 THE 'REVOLVING DOOR' PHENOMENON: THE VICIOUS CYCLE

Figure 6.1 basically reflects the 'revolving door' phenomenon or vicious cycle in the current forensic psychiatric rehabilitation practice in Zimbabwe. The vicious cycle was embodied in the recurrent movement of forensic psychiatric patients within the judicial system, the special institution, the civil psychiatric hospital and back to the special institution. The forensic psychiatric patients seemed to be trapped in the system with minimal chances of being discharged either by the Attorney General's office or by the Mental Health Review Tribunal. The minute detail has already been explicated in Chapter 4 and Chapter 5. This 'revolving door' scenario seemed to be based on the relationships between the social fields involved in the rehabilitation of forensic psychiatric patients which include the medical system and the judicial system (See figure 6.2).

The revolving door phenomenon showing current realities of medico-judicial realities highlights the themes that evolved from the participant groups. The themes were building around Pierre Bourdieu's concepts. For example discordant engagement of the judiciary in the system of rehabilitation of forensic psychiatric patients resulted in the judiciary not keeping track of the patient's movement while in the system when it was in their power to do so. This theme overlaps and concurs with that of psychiatrists that viewed processes of rehabilitation as prohibitive and negatively affecting overall patient care and recovery. All this being a result of a system of dominance that keeps swinging a door that traps patients inside the judicial system because this current reality has never been questioned.

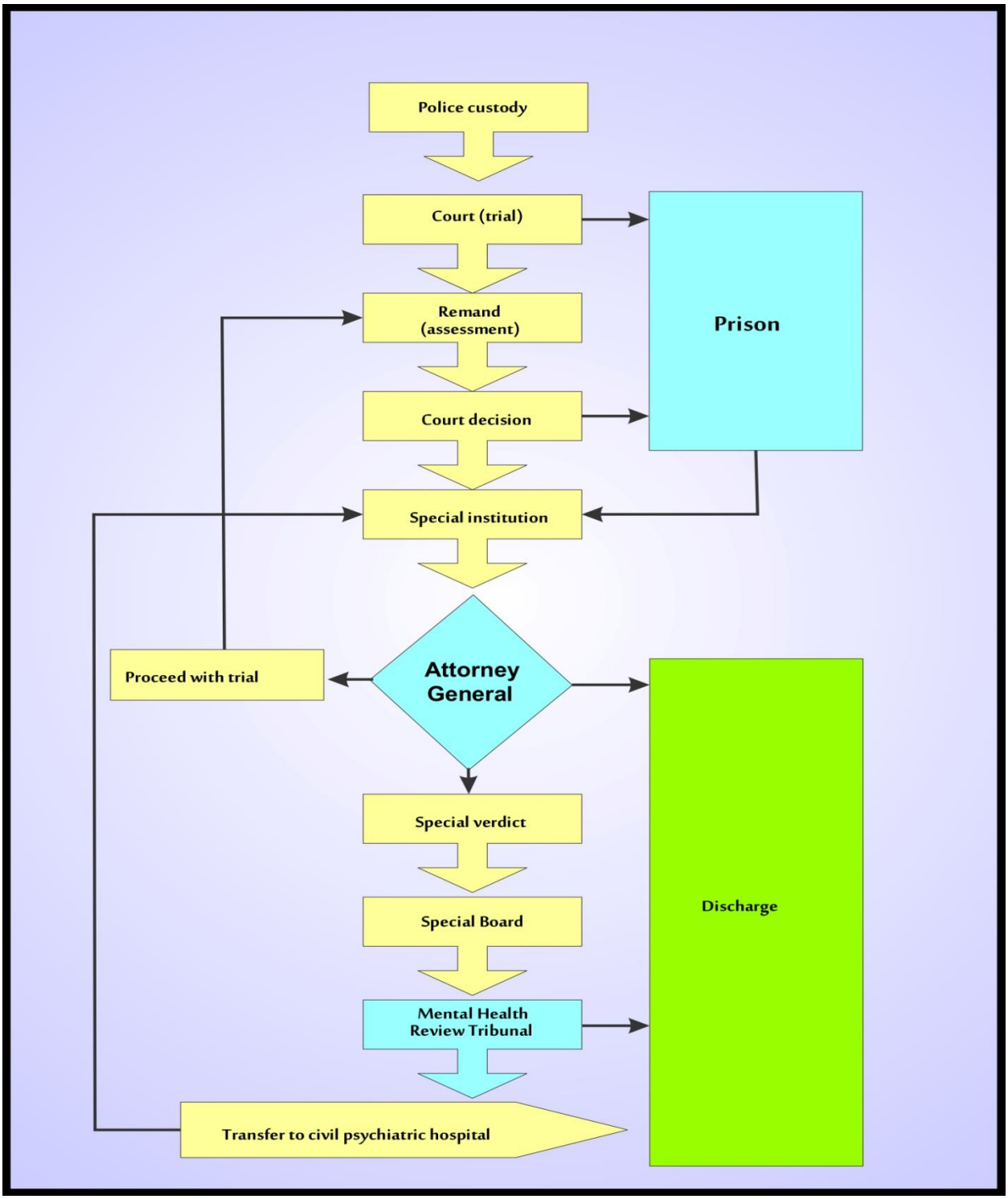

FIGURE 6.1: Current medico-judicial realities

The theme of dichotomous reality in which nurses' responsibility is abdicated led to disempowerment and voicelessness that resulted from nurses' dual loyalty to the

system. As a result of this predicament, nurses could only watch and do nothing as patients kept volleying in the system. The voicelessness and disempowerment of the nurses involved with forensic psychiatric rehabilitation meant that they had no contribution to decisions that were made at the Attorney General's office, Special Board, Mental Health Review Tribunal and special institution outlet unit at the civil psychiatric hospital after the patient had recovered in the special institution. The nurses silently watched as the recovered patient was sent to remand prison to proceed with trial and then relapse there and come back to the special institution. The powerless and silenced nurses kept their peace as the patient was sent to the special institution outlet unit at the civil psychiatric hospital, stay there for years and then got sent back to the special institution, starting the process again.

Patients experienced the life of a "prisoner" and not as a "patient" with ensuing physical, emotional, social and occupational challenges (symbolic suffering) because of a system of power and dominance that objectified them. The power that so disempowered forensic psychiatric patients derived from uncoordinated legal statutes that functioned as hinges of the revolving door. The legal instruments denied patients to fulfil the purpose for which they were admitted at the special institution (rehabilitation) in the first place. Forensic psychiatric patients existed in limbo between irreconcilable exigencies of rendering care while ensuring their custodial tucking 'away' to protect both sanitary and political interests of society as alluded to by psychiatrists.

The negative perception of the rehabilitative environment by patients' relatives is the hallmark of the revolving door phenomenon. The relatives of patients were disempowered and gagged by a system that did not communicate its expectations of them, a system that was both physically and psychologically inaccessible and a system that exploited them when they reached out to the patient who was trapped behind the revolving door of the justice system. In the process, relatives let go and the patient kept volleying...

Figure 6.2 shows the dynamics of the prison system, the judicial system and the medical system and how they affect the overall rehabilitation of forensic psychiatric patients. The figure initially shows the axial codes concocted of ingredients pertaining to the current realities as in power, objectification, and disempowerment; it then abstracts these codes to illustrate how these ingredients blend with each other.

6.3 THE CURRENT RELATIONSHIP BETWEEN THE SOCIAL FIELDS

The judiciary seems to possess the symbolic power ascribed to it by the Zimbabwe Mental Health Act of 1996 in terms of having a patient admitted to or discharged from the special institution. By giving a treatment order, the magistrate is exercising power over other allied systems and by discharging the patient, the Attorney General as an *ex officio curator ad litem* is also exercising power. The Special Boards and the Mental Health Review Tribunal as arms of the judiciary wield the same power.

The judiciary seems to disengage and abdicate its symbolic power to the prison system when it (the judiciary) fails to follow through the treatment order it issues for admission of the patient to a special institution without having knowledge as to what is actually taking place at the special institution. The prison system runs the special institution and therefore takes over symbolic power. This particular symbolic power is what Bourdieu (1989:23) refers to as “performative discourse” in which the dominant group assumes power because of the inherent symbolic capital it possesses. The power then gives that dominant group the ‘right’ to name and manipulate the core business, in this case being that of the rehabilitation of forensic psychiatric patients. This symbolic power dynamic seems to emit symbolic violence through reproducible dominance (Bourdieu & Passeron 1990:4).

The effects of this power dynamic permeate the habitus expressed in the experiences of all stakeholders in one way or another. These effects range from objectification and disempowerment, embodied by the symbolic suffering of patients and relatives, to the voicelessness and disillusionment experienced by nurses in the system.

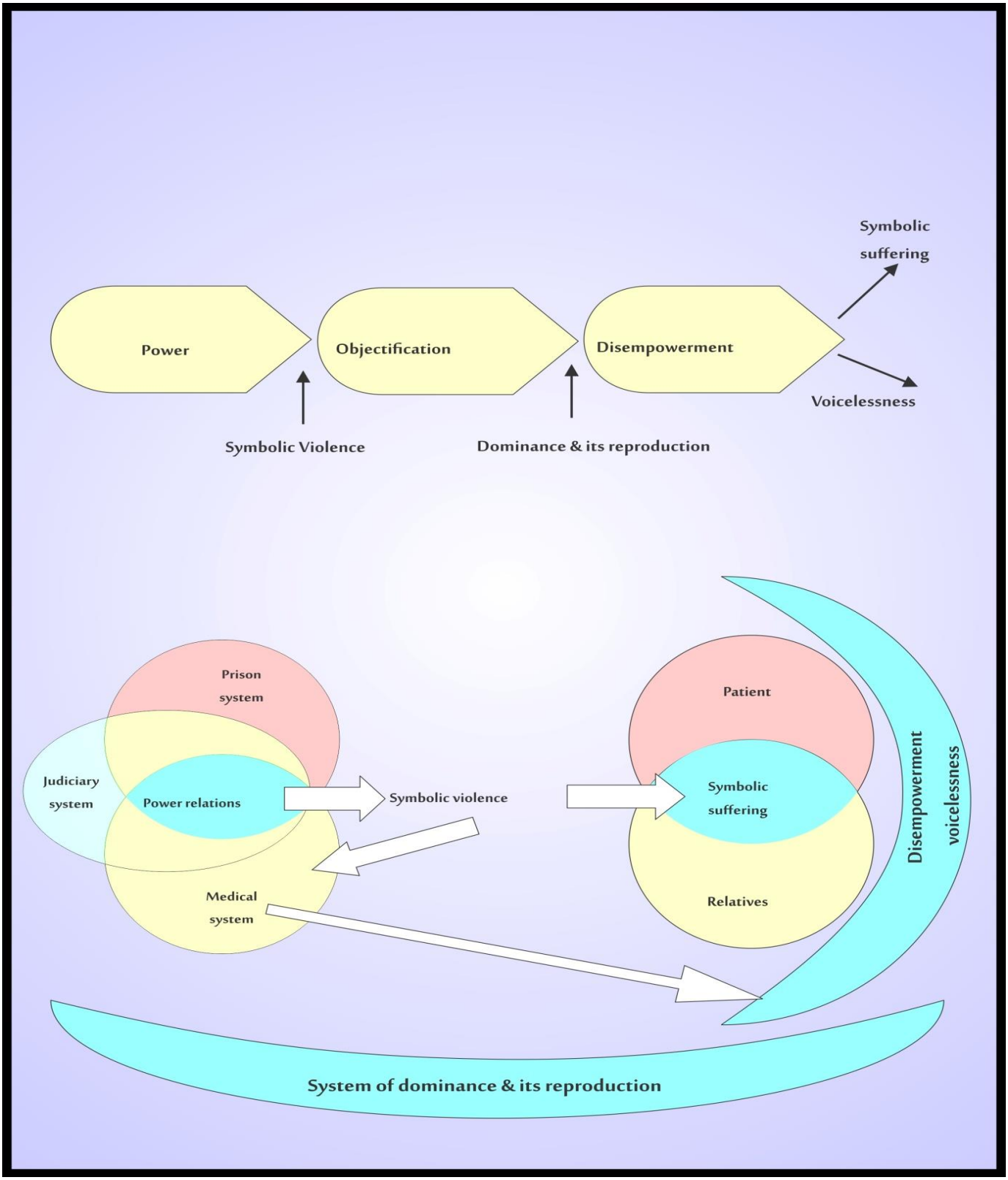

FIGURE 6.2: Power intricacies between the medical system, the prison system, and the judiciary

In other words, the current realities show the outright dehumanisation of forensic psychiatric patients with similar collateral 'damage' to the relatives of the patients. Infra-humanisation is specific to nurses and other health workers in the current context as they are rendered irrelevant to forensic patient care by the dominant prison system.

Although an undercurrent of power struggle is apparently running through the systems, it is undoubtedly the prison system that manages to impose all the dominant capital it possesses. This naturally makes it the most powerful of the three systems. The power held by the prison system is also activated by its recognition as the provider of forensic psychiatric services by the Ministry of Justice and Legal Affairs and the Ministry of Health and Child Care. The prison system further derives its power from the conatus conferred to it– it is presumed to have the knowhow and capacity to care for forensic psychiatric patients. This system also seems to have what Bourdieu (1984b:56) refers to as *illusio* because the prison system manifests its belief that it has power to attach meaning and value to forensic psychiatric practice (Bourdieu 1995:172).The prison system has done this through the objectification of the patients by assigning them prison numbers and classifying them according to the crimes they have committed.

To further explain the dynamics, it must be noted that a lack of homology between the dominant prison system, the judiciary, the medical (health) system and the habitus exists. Treating the forensic psychiatric patient in the context of a prison seems to be unorthodox; thus, a form of heterodoxa (Bourdieu 1984b:65). The bottom line is that the principles and values that govern these three systems are diverse. The values seem to be defined according to the individual mandates and value practices that underlie these systems. This diversity is considered as arbitrary. As such these values are relative and should be understood in this research study as symbolic rather than designating (Grenfell 2004:28). The hegemonic forces within the prison system results in what Bourdieu refers to as "misrecognition" (Bourdieu 1995:169). Misrecognition is specifically directed at the medical system that, by mandate, is supposed to be championing the rehabilitation of the forensic psychiatric care cause. Misrecognition culminates in dominance and the reproduction of the interests of the prison system. This

dominance and its reproduction underline the established order of the current medico-judicial realities in the rehabilitation of forensic psychiatric patients in special institutions.

All these aforementioned relationship aspects were viewed in this study as symbolic violence. Forensic psychiatric patients and their relatives are caught up in a double bind situation in which they have to be aligned with both the contradictory functions– to that of the medical system as well as that of the prison system. The result of this double bind or hysteretic scenario breeds some kind of rehabilitative schizophrenia whereby the context in which patients are cared for and expected to recover is at tangent with the services and milieu availed to them (Grenfell 2004:29). As a result, the patients and relatives experience symbolic suffering. Bourdieu's concepts were therefore expected to enable this study to disengage forensic psychiatric rehabilitation practice from the illusion of accepting without questioning the existing and current realities in the rehabilitation of forensic psychiatric patients.

Developing the medico-judicial framework is projected to transform or transcend what Bourdieu (1995:172) as well as Honneth, Kocyba and Schwibs (1986:48) termed the *libido dominandi* of the present into a *libido sciendi* of the future. This is to say forensic psychiatric rehabilitation practice through developing the medico-judicial framework is extricating itself from an inherited prohibitive and unquestioned system of dominance (*libido dominandi*) by the prison system. The focus is to move towards a system of searching for the truth for and about forensic psychiatric rehabilitation to the extent that practice is hinged on an evidence base (*libido sciendi*) that fosters a therapeutic jurisprudence (Bourdieu 1992b:xi).

6.4 THE JUDICIARY

Apparently, the engagement of the judiciary is at variance with what will enable patient recovery; instead, its engagement is prohibitive and discrepant. Sharma and Sharma (2006:98) suggest that the origin of the discord between the judiciary, the prison system, and the medical field may be as a result of the diversity in these professions'

philosophical views, their value systems, and their governing paradigms. It is possible that the judiciary can therefore be viewing forensic psychiatric rehabilitation from the stance that is in line with their inherent social roles and professional contingencies. In fact, Hardy (cited in Grenfell 2008:131), reflecting on Bourdieu's concepts, observes the probability that it can be a hysteretic manifestation where this is just a glimpse of the dislocation of the judicial habitus from the social field (context) in which it is operating.

The disengagement of the judiciary is reflected in processes that are prohibitive to recovery; negative attitudes impacting on the overall rehabilitation processes; judicial linguistic habitus and its selective reinterpretation that digress the discourse of patient rehabilitation, and the role of family in the recovery process.

6.4.1 Prohibitive processes to patient recovery

Prohibitive processes include procedures for committing and discharging patients from special institutions; the lack of appropriate technology; mixing Detained Mental Patients and Criminal Mental Patients altering assessment procedures; losing documents; relapses in remand prison and the psychiatrist's report that does not inform courts because of linguistic and/or cultural barriers.

6.4.1.1 Prohibitive procedures for committing and discharging patients from the special institutions

The procedures currently followed seem to trap forensic psychiatric patients in the system to the extent that they keep on revolving between the special institutions, the civil hospital, and back to the special institution or to prison. The phenomenon of a similar 'revolving door' in forensic psychiatric practice is acknowledged by Arboleda-Florez (2006:88). Mars, Ramlall and Kaliski (2012:246) also noted similar irregularities in the flow of forensic patients in the system in Africa, specifically because of a shortage of skilled professionals.

Lindqvist and Skipworth (2000b:322) advocate for rehabilitation to begin soon after admission in a special institution to ensure that the forensic psychiatric patient receives as much exposure as possible to rehabilitative care. These authors further explain that rehabilitation should make the patient perceive admission as a way of preventing further admissions and as a strategy to improve their quality of life. Unfortunately, the Zimbabwe Mental Health Act of 1996 is not specific about this aspect because, according to this Act, a magistrate gives a treatment order for a patient to be treated in a special institution, but neither the Act itself nor any other related instrument specifies exactly what should be done at the special institution or what the treatment referred to means.

Despite the fact that the (Zimbabwe Mental Health Act 1996:173,175,178,179; Greenberg and Shuman 1997:52) highlights the importance of the time frame to forensic psychiatric processes and care, the findings of the current study indicated that these were handled as negligible issues during the process resulting in delays at all the levels of the judicial processes. Njenga (2006:97) expounds on this issue in an African setting by pronouncing that these settings are driven by poor legal and policy frameworks. This could explain the 'revolving door' scenario in Zimbabwe. Velinov and Marinov (2006:98) support Njenga's view by pointing out that worldwide there is no uniformity in judicial practice as the general world development stifles the possibility of developing forensic psychiatry unified standards that are related to judicial practice in particular.

6.4.1.2 Lack of appropriate technology

Technology is a form of symbolic capital that the judiciary as players in the social field of the rehabilitation of forensic psychiatric patients consider mandatory. The judiciary indicates that technology is a form of objectified capital and they (the judiciary) need to execute their duties if they are to be effective. Reeves, Mills, Billick and Brodie (2003:89-95) explain that brain imaging can be used in a court of law to explain a variety of central nervous system disorders. A psychiatric expert can use it in court

when, for example, a patient is suspected to be mentally ill and is projected to deserve a disposition that he was not criminally responsible for the criminal act. The same authors, however, point out that that technology can be manipulated and distorted by the court system.

The issue of the lack of resources and appropriate technology in an African context is also observed by Ogunlesi et al (2012:3) who state the dire lack of facilities in countries on the African continent hampers forensic psychiatry processes. It is the interpretation of both Njenga (2006:97) and Sinha (2009:22) that the lack of budgets specifically for mental health in African countries probably explains why appropriate technological resources are not available. Lynch (2010:2) agrees with Sinha (2009:56) that as crime becomes more sophisticated, it is imperative to update and better the technological standards of data collection so that the rehabilitative system remains relevant to society.

6.4.1.3 Mixing Detained Mental Patients' and Criminal Mental Patients' altering assessment procedures

The judiciary commits patients to special institutions to receive treatment. At the same time, patients awaiting the psychiatrist's report are in the same social space. This seems to increase the social and special institution-specific cultural capital of the Criminal Mental Patients as they copy the behaviour of those already certified as mentally ill (Moore cited in Grenfell 2008:105). This alters the assessment procedures as Criminal Mental Patients transcend to being Detained Mental Patients when they should be going to prison to serve their sentences.

Henderson (2003:16) explains that assessments are ordered by the court when it is apparent that the patient may be mentally ill which may affect his or her ability to testify in a court of law. The mandate for doing forensic psychiatric assessments is given to the forensic psychiatric services commission at the forensic psychiatric hospital. The assessments involve both subjective and objective data about the patient. In the author's explanation, the movement of the patients is also clear and does not reflect a

possibility of mixing those awaiting a psychiatric report and those who have already been confirmed as mentally ill.

Sinha (2009:29) states that stakeholders have always been concerned about the mentally ill's placement while they await diagnostic assessments. The Central Institute of Mental Health (2007:285-287) explains that pre-trial placement for the mentally ill is diverse; however, the bottom line is that wherever they are placed has a bearing on the quality of care and the overall outcome of the processes involved. Njenga (2006:97) summarises this scenario by implying that such occurrences may result from the fact that forensic psychiatry practice is "shrouded in both mystery and confusion".

6.4.1.4 Loss of documents

The loss of documents by the judiciary is a reality that represents a form of symbolic violence because if a patient is due for discharge but his documents are missing, the Mental Health Review Tribunal sends him back to the special institution and the process is started again. Meanwhile, the patient experiences symbolic suffering as he remains in the system and does not know his fate.

This acknowledgement of document loss is not supported by literature. There is a scarcity of information on this issue (Ogunlesi et al 2012:3). However, it is prohibitive to patient recovery since the documents are needed for continued care and also to be used as the basis for decisions used by both the judicial and medical teams. This predicament may probably be significantly related to the "mystery and confusion shrouding" forensic psychiatric practice as alluded to by Njenga (2006:97). In fact, Sinha (2009:10) proposes that in forensic psychiatry there should be a mechanism of capturing mental health information that relates to fitness hearings; data pertaining to whether the patient is fit or not fit to stand trial should be stored to be retrieved when needed.

6.4.1.5 Relapses in remand prison

The relapses of patients in remand prison are the direct consequences of the beliefs and a standard (doxa) of the judicial social field. The rule is that the person goes to remand prison pending trial. Whether this person is a patient or whether it is known that he is a patient has no relevance; his status is not questioned– it is simply the standard that anyone awaiting trial goes to remand. As the results of this study show, the indisputable truth is that the patient will stay in remand until he relapses. It also includes patients who have been treated successfully and have been moved from the special institution to remand prison. The patient simply relapses and has to start the whole process again right from the beginning.

This scenario could be a result of poor legal and policy frameworks as highlighted by Njenga (2006:97). Ogunlesi et al (2012:5) specifically state there is an urgent need to update Zimbabwe's Mental Health Act of 1996. This may imply that the Act's current frame is inadequate and out-dated because it does not address the remand prison issues that result in patients' relapses. Forensic psychiatric practice is in general underdeveloped. Ogunlesi et al (2012:3) further point out that "pervasive neglect" occurs in these institutions which seem to be the hallmark of what the participants were saying during the study. Sinha (2009:54) asserts that the general supervision of patients and their treatment within the correctional system and beyond facilitates the continuity of their care. Unfortunately, this is not happening in remand prison in Zimbabwe.

6.4.1.6 The psychiatrist's report does not inform the courts because of language and cultural barriers

Language represents power and is a form of symbolic capital (Bourdieu 1989:23). Its value is tied to how refined it is or how proper the speech comes across (Hanks 2005:76). Apparently, the foreign psychiatrist from the medical team has the power to name the disease and issues of criminal responsibility. However, in this study it became obvious that this symbolic power seems to decrease as the judiciary social field

questioned the psychiatrist's symbolic capital of language and culture relative to the dominant native languages, namely, Shona and isiNdebele.

According to Kalmbach and Lyons (2006:262), it is crucial for the person giving a forensic testimony to have knowledge of the legal standards that are required as well as the standards on which the testimony is based. On this issue, Kalmbach and Lyons (2006:275) report as follows:

> *… many different cultures have prescribed ways of behaving and interacting with others that can be quite different from mainstream culture, but nonetheless equally valid. In forensic practice, examinees will behave, think and feel in ways that are influenced by the cultural context of their lives. The astute and multi-culturally competent evaluator will be able to consider factors outside of clinical training to arrive at a more accurate and representative picture of the examinee.*

Ogunlesi et al (2012:5) remark that issues of cultural diversity and their implications have largely been ignored in forensic psychiatry practice in Africa. For this reason, they argue that it should be made mandatory for those who practice forensic psychiatry to be fully informed of the language needs as well as the culture and beliefs of the people receiving rehabilitative services. These authors project that by addressing these critical issues, services facilitating the recovery of patients will ultimately become more credible, comprehensive, and overall effective.

6.4.2 Negative attitudes of the judiciary impact on overall rehabilitation process

Concerning the negative attitudes of the judiciary, it was experienced that the judiciary apparently focused more on "*political"* than "*mental*" cases; that "*the system has always been like this*"; there was limited interaction with the special institution; the belief was that "*mental patients cannot be treated*"; and, finally, that "*patients deteriorate in special*

institutions". (These quotes are written in italics since they were quoted by participants as reflected in Chapter 4).

6.4.2.1 Judiciary focus more on "political" than "mental" cases

The suffering of persons or groups is experienced when there is a failure of recognition of their plight as a result of exigencies of domination by another group (Frost & Hoggett 2008:440). In this study the "plight" being the vicious cycle the patients was trapped in and that kept on repeating itself: being moved from the court room to a special institution to the civil psychiatric hospital and back to the special institution and the court with no apparent nor foreseeable or immediate outcome or solution for the patients.

The forensic psychiatric patients seemed to be trapped in the system with minimal chances of being discharged either by the Attorney General's office or by the Mental Health Review Tribunal. The minute detail has already been explicated in Chapter 4. This 'revolving door' scenario seemed to be based on the relationships between the social fields involved in the rehabilitation of forensic psychiatric patients which include the medical system and the judicial system. Figure 6.2 shows the dynamics of the prison system, the judiciary, and the medical system and how they affect the overall rehabilitation of forensic psychiatric patients. It symbolises that at present there is differing access to services by 'political cases' and 'mental cases'. This inequality fosters a sense of "relative deprivation" and "relative powerlessness" resulting in the mental and physical deterioration of forensic psychiatric patients (Frost & Hoggett 2008:453). This deterioration can be elicited by the consequent delays in processes as a result of inequality.

Eastman et al (2013:8-9) confirms that there is inherent discipline incongruence between psychiatry and the law emanating from adversarial values. Nedopil (2009:232) states forensic psychiatry is a field without much commercial interest. In support of this view, Sinha (2009:20) confirms that Canadian studies have shown that criminal courts do not focus on offenders who are exhibiting mental illness. Instead, such patients are

sent to remand prison because they cannot afford legal representation or pay bail. This may then suggest that political cases are more financially lucrative, further suggesting that the preferred political cases have more monetary gain than humanitarian-based mental cases.

6.4.2.2 "The system has always been like this." (Dominance and its reproduction)

This statement reflects a form of doxa; a type of 'taken for granted' way of doing things (Deer cited in Grenfell 2008:120; Grenfell 2004:28). Deer (cited in Grenfell 2008:122) notes that allodoxa (which is a "learned form of ignorance") then becomes a misrecognition that is set to represent and perpetuate the prevailing relational predispositions of the dominant group(s). In this study, the dominating groups whose discursive ideologies are being reinforced were the prison system and the judicial system.

Sinha (2009:12) concurs with European Commission Final Report (2005:15) that there is really nothing new as far as the involvement of mentally ill people with the criminal justice system is concerned. However, according to Eastman et al (2013:11), this status quo has resulted in the judiciary being pre-occupied by procedures and processes that involve prosecution and defendants. As these authors bask in the sacredness of this antiquity, Lynch (2010:2) challenges the status quo by highlighting the need for a wider role in the clinical investigation of crime and the legal process.

6.4.2.3 Limited interaction between the judiciary and the special institution

This is the exact point at which the judiciary relinquishes its power to the prison system which houses and runs the special institution. By deferring to follow up on the treatment order, the judiciary increases all forms of capital for the prison system as they interpret the treatment order in the way that suits the social field of their system.

Nedopil (2009:225) explains that generally major influence groups are ambivalent towards forensic psychiatry; this is manifested by a reluctance of these groups to associate with it. It is the stance of both Sinha (2009:22) and European Commission Final Report (2005:12) that stigma and discrimination is the major culprit in alienating forensic psychiatric patients. These authors all maintain that forensic psychiatric patients are ignored or warehoused or avoided by the criminal justice system because they are perceived as "mad and bad" clients. Coutts (2011:13) concludes and suggests that members of the judiciary or legal profession lack training in integrating their work with professions that are traditionally biased towards humanism.

6.4.2.4 "Mental patients cannot be rehabilitated."

This *in vivo* code provides a picture of the extent of the hysteretic dislocation within the judiciary itself. The judiciary sends the patients to the special institution but does not believe that they can be treated or, indeed, successfully treated. This is a very interesting and important outlier of how the judiciary perceive the rehabilitation of forensic psychiatric patients in special institutions. Eastman et al (2013:10) reason that there are very real concerns that psychiatry and the law need to address. These include the differences in values, language and ethics found in the interface between the two professions. Sinha (2009:53) suggests that these challenges emanate from a mutual lack of knowledge from both sides of the judiciary and the medical systems which affect the assessment and treatment of forensic psychiatric patients. Ogunlesi et al (2012:5) propose that the lack of linguistic uniformity makes it difficult to apply psychiatry to judicial systems.

6.4.2.5 Patients deteriorate in special institutions

The judiciary acknowledges the forensic psychiatric patients' symbolic suffering without making the connection that it results from the symbolic violence emanating from the dominating social field of the prison system (Schubert cited in Grenfell 2008:183). The blame is placed on the medical team by alleging they are overmedicating the patients.

Yet, as Huxter (2013:737) points out, the conditions of a prison setting are contra-directional to recovery because of it being non-therapeutic and non-conducive to the extent that it exacerbates the patient's mental illness. Kita (2011:9) and Sinha (2009:13) expound on the outcome of an investigation done in early 2000 into the criminal justice system and the sentencing of mentally ill offenders in Washington DC in the USA by adding that a prison setting is fashioned to dehumanise and deter the patient from incurring further societal infractions. Njenga (2006:97) warns that in the process of punishing a person, what is seen at the end is "dispossessed and confused mental patients who walk about in a daze talking to themselves".

6.4.3 The discourse of patient rehabilitation digresses because of the judicial linguistic habitus and its selective interpretation

The judiciary use certain language terms not universal in the medical and prison systems. This is their unique cultural capital that they 'exchange' with the systems already mentioned (Thomson cited in Grenfell 2008:69). The social field of the prison system that is expected to operationalise these terms has its own beliefs and unique "logic of practice" (Thomson cited in Grenfell 2008:90). It is only natural that the prison system interprets these terms according to its own practices or doxa. Consequently, it has been found that the patients' rehabilitation digresses due to the prison system's punitive approach to care.

An accused person is a person who is alleged to have committed a crime (Sinha 2009:15; Baumann 2007:563). If a patient gets a medical report that is positive to the effect that he is mentally ill, he ceases to be "an accused person" because he is not guilty by reason of insanity (Zimbabwe Mental Health Act 1996:178). Eastman et al (2013:10) assert that there are always disparities within and between disciplines and, as Wodak (cited in Wodak & Meyer 2009:10; Bourdieu 1984a:2) point out, in a given situation the use of a certain language wields social power. In other words, the used language indexes and reflects the power of the people using it thus influencing the predicament of those against whom the language is used.

6.4.3.1 Dehumanisation of the patient

Dehumanisation in the context of forensic psychiatry is an act of degrading forensic psychiatric patients (Haslam 2006:252). This degrading is a form of symbolic violence. Dehumanisation in the processing of forensic psychiatric patients is represented by referring to patients as 'case files'. Yet, this form of dehumanisation seems to be natural and procedural in the world of the judiciary in relation to forensic psychiatry.

To illustrate the concept of dehumanisation in this context, Eastman et al (2013:11) uses an interesting comparison. They compare psychiatry and law to two neighbouring countries. Each of these countries uses its own language and each has its own structures and sub-structures just as psychiatry is expressed in different diagnoses and diagnostic categories. If these two countries wish to interact, there is need for translating the language of the one country into the other's own language. Unfortunately, the negative repercussions of translating include exposure to distortion and confusion. Hence, in the case of correctional services if they were to translate their language it could disadvantage the patient because he will not be treated as a human being but as a sheaf of papers.

Kita's (2011:10) and Sinha's (2009:13) views of dehumanisation in the current context is similar: it is a way of stigmatising a human being as a piece of paper that reinforces the correctional staff's 'right' to maintain the position of the patient as their prisoner. However, Bourdieu (1989:17), Swartz (1997:123) and Vandenberghe (1999:44) share an abstract viewpoint on this issue. They propose that individuals or groups are positioned in a social field in line with the power to which they have "differential access". Each of these individuals or groups borrows that power from the degree of closeness with other groups or individuals. This means that the judiciary can be using words or approaches because of its relationship with the inherent source of power which, in this case, would supposedly be the prison system.

6.4.3.2 Rehabilitation referred to as an "investigation" or "examination"

In this study patients being treated were referred to as being "investigated" or "examined" by the judiciary. According to the Dictionary of Contemporary English for Advanced Learners (2009:927), 'investigation' refers to the process of finding out the facts about something while 'examination' refers to the process of finding information about something through asking specific questions (2009:582).

Eastman et al (2013:10) express that the constructs of the domain of the criminal justice system are dissonant from those of biological or psychological origins such as psychiatry and medicine. This diversity is projected to breed a lack of understanding of these constructs. Overly, this affects the care of the patients involved in the negative mode. Sinha (2009:14) refers to this observation when he writes about "notable variations" that exist between systems and agencies which, he states, is especially true for the criminal justice system. Borrowing from Kita's (2011:11) and Peillon's (1998:216) observations from their investigations on psychodynamic psychotherapy and social change with incarcerated patients and the sociology of welfare, this may be the legitimisation of symbolic capital by the judiciary in terms of language. The judiciary is thus expressing the power to name and to make valid. The envisaged result is that treatment programmes in prison settings are an expression of these dynamics of power that are at play among the systems involved in the social field of forensic psychiatric rehabilitation.

6.4.3.3 Admission referred to as "committing"' or "incarceration"

The judiciary refer to admitting a patient to special institutions as "committing" or "incarceration". Coutts (2011:11) defines incarceration in the context of forensic psychiatry as "confinement or imprisonment in a given area such as a prison". Eastman et al (2013:11) note that the criminal justice system is "highly auto poetic, that is, non-reflexive". This is to say that the criminal justice system's discourse has its inherent concepts that it adheres to and which are prohibitive to the reception of ideologies from

other disciplines; it can distort the meaning if applied to the other different disciplines. Kita (2011:13) reasons that this is why inmates are assigned numbers instead of using their names and why the clothing they put on is state property.

The use of the word 'incarcerated' can also relate to the idea of conflict over the power to define the clinical situation in a forensic psychiatric setting. Deer (cited in Grenfell 2008:122) tackles this issue by explaining that the reproduction of symbolic power and the legitimisation of the doxa are the results of the categorisations and classifications that are arbitrarily misrecognised by language and linguistic exchanges.

6.4.3.4 Special institution referred to as "prison"

The social field of the judiciary conceived the special institution to be a 'prison'. According to Hanks (2005:76), language use represents reality. This can translate to the possibility of patients living more in the reality of 'prison' life. Coutts (2011:11) quotes Gunn and Maxwell (1978:9) who define prison as a "system intentionally organized for the purpose of inflicting deterrent punishment". This may be the reason why, according to Njenga (2006:97), units that represent forensic psychiatry are placed in "ghettos" within maximum security structures where they functionally resemble the parent institution, namely, the prison. Njenga (2006:97) continues to say they exist as "orphan units" as neither the prison system nor the medical system is committed to run them. However, there seems to be hope for a better outcome with regard to this dilemma. Arboleda-Florez (2006:89), for example, provides evidence that the placement of forensic institutions has drawn worldwide interest in forensic psychiatry.

6.4.3.5 The role of family in the recovery process

The judiciary acknowledges relatives as key to patient recovery in that the latter seems to wield the social capital that the judiciary needs to effectively execute its functions. Neil (2012:2) explains that forensic psychiatric institutions are situated in an area far away from residential sites or patients' homes. This may be the reason why relatives

are not accessible when needed by the criminal justice system. It can also be what the European Commission Final Report (2005:12) infers to when they label stigmatisation as the culprit attached to mental illness. Many families apparently perceive forensic psychiatric patients as dangerous; hence, their probable reluctance to associate with the patients.

It has been further indicated that families are prohibited by statutes when they seek treatment when a family member is not willing to be admitted as a patient to a forensic psychiatric care facility (The Sentencing Project 2002:5). It is possible that the mentioned logistical and societal difficulties exacerbate the relatives' reluctance to cooperate.

6.4.3.6 Manipulation of the system to evade justice

The judiciary perceive forensic psychiatric patients as manipulative in a bid to evade justice. Frost and Hoggett (2008:449) paint a clear picture of what happens when people are symbolically violated. The symbolic suffering may manifest as maladaptive defence mechanisms. Manipulative behaviour can be one of these defences.

Tulloch (2010:2) and Wilkinson, Mallios and Martinsen (2013:1) concede that manipulation is a mechanism used by a person to cause another person to behave and respond in a certain way. The response will be such that it is not in the responder's best interest. Manipulation manifests in forms of lying, deception and intimidation of others; in the context of this study 'others' pertained to those who witnessed the crimes and the judiciary who dealt with crimes in court. Tulloch (2010:4) adds that people manipulate those they perceive to be in power, in other words, those that are likely to influence the outcome of her or his predicament. Baumann (2007:272) posits that manipulation can also be a manipulator's self-preservation mechanism that is directed at achieving a different agenda that is, in fact, also different from that which is intended by the one being manipulated. In a criminal case, manipulation can therefore be viewed as a tool used by the manipulator to tip the investigation and prosecution in the manipulator's

favour. Porter, Doucette, Woodworth, Earle and MacNeil (2008:28) emphasise that legal decision makers need to be vigilant to ensure that the assessment procedures are credible and not influenced by any kind of manipulation.

6.5 THE NURSES

At present, issues pertaining to the role of the nurses in special institutions are that their role and responsibility to take care of the forensic psychiatric patients on a medical (health) level is subordinate to the position of the guards who are representatives of the prison system.

6.5.1 Nurse versus guard

Nurses seem to experience infra-humanisation, a subtler form of dehumanisation. Infra-humanisation is basically minimising the importance of a certain group of people as evidenced by disregarding their feelings or mandate (Delgado, Rodriguez-Perez, Vaes, Leyens & Betancor 2009:699). This infra-humanisation is embodied in the unpleasant context in which nurses are expected to perform their duties. It compromises the nurses' functional compass in the rehabilitation of forensic psychiatric patients. The guards seem to possess all forms of capital in the prison system: its cultural, social and economic capital. This capital represents symbolic power over the disillusioned and voiceless nurses.

Huxter (2013:741) comments that it is unfortunate that in a forensic psychiatric setting, the responsibility of patient care is "diffused". Kita (2011:10) expresses that the presence of staff members who focus on therapeutic interventions for mentally ill patients breeds anxiety among the staff of the correctional system because they regard them as 'common prisoners' who should be without the luxury of having medical care. Faulkner and Morris (2003:15) suggest that emphasis on security militates against the forensic psychiatric patients' involvement with activities that promote their recovery.

6.5.2 Perceived power issues

Conflict of power is evident in the management of forensic psychiatric patients. The dominant social field controls the movements of patients in the special institution and this seems to interfere with the nurses who are purported to operationalise the rehabilitation process. Wodak (cited in Wodak & Meyer 2009:8) explain that power is a key factor if one wants to understand dynamics and issues of control. The authors highlight that power is invisible and that organisations wielding power influence the values and ideologies of the context in which they are operating in such a way that all other subordinate systems behave in the way that the dominant organisation wants them to behave.

6.5.2.1 Nurses voiceless and disillusioned in the system

The nurses, being the minority in the special institutions, are voiceless and disillusioned. Both Kita (2011:9) and Saunders (2001:xxiii) elaborate on the "antithesis of a prison regime" where the role of a possible therapeutic intervention to a patient can be compared to that of a child who is encouraged to explore the world, but at the same time he or she has his or hands tied behind the chair. Swartz (1997:73) explains that a possible explanation for this finding of voicelessness and disillusionment of the nurses emanates from the cultural, social and symbolic resources in the prison system's social order which they (the nurses) are not empowered to tap from. Due to a lack of connectivity, nurses are often silenced by the system.

The confirmatory quantitative results showed that there is no comprehensive documentation of services rendered to patients or the service outcomes for the care of forensic psychiatric patients. Research studies have repeatedly asserted that the treatment of forensic psychiatric patients has been found to be historically deficient in quality (Wettstein 2005:158; Schroder & Lundqvist 2013:334). The lack of making entries may be one result of the decrease in work output owing to frustration, powerlessness, a high workload, the lack of rewards, and the disillusionment of medical

(nurses) staff which is characteristic of forensic psychiatric settings (Linhorst & Turner 1999:19; Zonana 2010:501). The conclusion can therefore be drawn that nurses could fail to document either because they are disillusioned or burnt out or they do not have access to the records or documents of patients.

6.5.3 Expectations for rehabilitation

The expectations for rehabilitation are reflected in the definition of the concept itself which seems to be inconsistent among the nurses.

6.5.3.1 Definition of rehabilitation inconsistent among nurses

Nurses are not rooted within the field of the prison system. They are found operating in the chasm between medical professional expectations and the mandate of the prison system. Moreover, nurses that staff the male side of the special institution (the setting on which the current study focused) are 'loaned' from the civil psychiatric hospital. This is especially true for the special institution situated in the southern region of the country. This violates the doxa that is specific to the nurses resulting in a hysteretic phenomenon where their definitions are dislocated from what is expected of them (Deer cited in Grenfell 2008:123). They may thus be unsure of what is expected of them in a forensic setting.

Kita (2011:9) comments on the irony of prisons having become the de facto service providers for forensic mental health; in such a context it can be difficult for nurses to define rehabilitation. Arboleda-Florez (2006:87) challenges the definition of forensic psychiatry as being "restrictive". This restrictiveness may be the reason why nurses in the present study could not articulate rehabilitation. Ogunlesi et al (2012:3) advocate for an organised forensic psychiatric service in Africa. The authors expressed that Africa needs to be more orderly, systematic and structured in its approach to forensic psychiatric practice. The fact that forensic psychiatry is not organised in Zimbabwe

could be the reason why the nurse participants' definition of rehabilitation was also not organised.

6.5.4 Giving hope versus a 'brick wall' of hopelessness

The notion of giving hope where only a 'brick wall' of hopelessness exists was conceptualised through two avenues. The first being that the patients' emotional condition and, subsequently, physical conditions become worse after admission because of despair. The second relates to the fact that the patients never get home after transfer to a civil hospital.

6.5.4.1 Patients get worse after admission because of despair

Pierre Bourdieu's principle that forms of symbolic violence induce feelings of humiliation, anger, despair, and resentment accosts this predicament of forensic psychiatric patients who experience domination and repression (Frost & Hoggett 2008:439). Such deep emotional experiences are bound to worsen the overall health condition of any patient in forensic psychiatric rehabilitation.

When a patient is admitted for care, treatment, and rehabilitation it is the expected outcome that he will be able to recuperate and lead a normal life again (The Redress Trust 2009:8). It is Huxter's (2013:737) view that when mentally ill patients are in a prison setting they are undertreated and not managed properly and this worsens their mental illness. Supporting Huxter's statement, Kita (2011:9) confirms that a prison setting is designed to be "chronically distressing" with the goal of deterring the person from criminogenic tendencies. Obviously then these two authors' viewpoints concur with the findings of The Sentencing Project (2002:9) that patients lack privacy, there is significant overcrowding, and they are exposed to violence in a prison setting. All of these factors are undoubtedly detrimental to patient recovery.

6.5.4.2 Patients never get home after transfer to a civil hospital

When a forensic psychiatric patient is trapped in the system of the judiciary, the prison, and the civil hospital there is a disjunction of his habitus and a hysteretic effect. This effect comes as a result of not being sure of what will become of him and the constant shift of the habitus: from the special institution, the civil hospital, and back to special institution. Huxter (2013:735) confirms this when he highlights that prisons and jails are functioning the way they did in the 18thcentury where they operated as “mental warehouses”. The Sentencing Project (2002:9) observes that the lack of continuity and coordination between the systems involved with forensic mental healthcare can be the reason why patients do not get home beyond being admitted in a special institution. Henderson (2003:4) suggests that if forensic psychiatric services were to be comprehensive, they would include safety nets in the community that would link discharged patients to welfare services, expert practitioners, rehabilitation and other clinical services. Based on this perspective by Henderson, it can be posited that relatives would perhaps feel less vulnerable and more willing to take the patients back into their homes.

6.5.5 Perceived responsibility versus actual reality

Perceived role versus actual reality was conceptualised with greater emphasis on physical care, the lack of financial and human resources, the lack of understanding on the part of the multidisciplinary team, issues around family systems, and limited or no rehabilitation resulting in a ‘revolving door’ scenario.

6.5.5.1 Greater emphasis on physical care

The forensic psychiatric patients are basically admitted for psychological problems but the nurses seem to concentrate on physical care. Huxter (2013:737) explains that mental patients in prison settings receive care in custodial contexts that deny them comprehensive psychiatric treatment. Instead, the emphasis is placed on drug regimen

only. Greenberg and Neilsen (2002:158) as well as Henderson (2003:23) explored the challenges encountered by service practitioners in prisons. These authors not only agree but they highlight that whatever these practitioners do eventually translates to custodial care. Bettridge and Barbaree (2008:9) ascertain that nurses are supposed to be part of the multidisciplinary team that focus on assisting with activities of daily living, supervising patients, and offering emergency care.

6.5.5.2 Lack of financial and human resources

The nurses lack the social, cultural and financial capital which renders them powerless to operationalise the rehabilitation of forensic psychiatric patients. This exposes the nurses to hierarchies of discrimination which is a form of symbolic violence (Moore cited in Grenfell 2008:104). It places the nurses in a disadvantageous position and this intensifies the reproduction of care of patients from a punitive realm by the prison system. Ogunlesi et al (2012:3) confirm this by mentioning the fact that there is a critical shortage of staff trained specifically in psychiatry or forensic mental health services.

Arboleda-Florez (2006:87) advises that there should be an integration of the systems involved in forensic mental healthcare and it needs to include harmonising of the budgets. This is then meant to facilitate comprehensive interdependency within these systems. The Sentencing Project (2002:8) found that psychiatric patients in prison settings have been denied access to treatment because of the overload in the system and inadequate resources for treatment

6.5.5.3 Lack of knowledge and understanding on the part of the multidisciplinary team

Knowledge is a form of cultural capital that the multidisciplinary team is lacking. This then gives leverage to the prison system to alienate the medical multidisciplinary team. According to The Sentencing Project (2002:8), the public generally has misinformed perceptions about the mentally ill patients who are caught up in the realm of the criminal

justice system. Because of this, policies that are formed blur the demarcation between treatment and punishment. As Ogunlesi et al (2012:3) point out, in Africa there is no formal forensic psychiatry training for staff who should be giving this type of care. Instead, forensic mental healthcare is offered by general psychiatric trained personnel. This may account for the lack of knowledge and understanding. Henderson (2003:22) concludes that the emphasis of care should be directed at correcting the misconceptions that revolve around the relationship between mental illness and criminogenic tendencies.

6.5.5.4 Issues around family systems

The involvement of the family was viewed by nurses as increasing all forms of capital to the patient; without the family's involvement efforts at the rehabilitation of the patient will be most probably unsuccessful. As Huxter (2013:736) explains, society has alienated and shifted the responsibility of the mental illness onto the mentally ill. This has resulted in them being treated unfairly. These societal values maybe the ones influencing the perceptions of the patients' relatives. Arboleda-Florez (2006:87) challenges society to change its attitudes and perceptions towards forensic mental health issues so that the human rights of the mentally ill people in the criminal justice system can be upheld. However, this challenge may be more problematic than it seems because, as Draine Wolff, Jacoby, Hartwell and Duclos (2002:570) explain, the forensic psychiatric patients generally originate from poor social backgrounds. Henderson (2003:11) adds that forensic psychiatric patients can also be homeless and unemployed. Considering this factor can perhaps explain the reluctance of relatives to take care of the now unproductive patient.

6.5.5.5 Limited or no rehabilitation resulting in a 'revolving door' scenario

The disempowerment of nurses results in limited rehabilitation of forensic psychiatric patients. Symbolic violence experienced in a prison setting leads to the suffering of

forensic psychiatric patients as evidenced by the patients being sent unceremoniously from one place to another in the system.

Arboleda-Florez (2006:87) acknowledges the 'revolving door' phenomenon for forensic psychiatric patients. The author specifies that there needs to be expectations for a forensic psychiatric patient who is leaving the system. For example, his readiness for discharge and prediction of the likelihood of reoffending need to be considered. Henderson (2003:12) attributes the lack of the continuum of care to the bureaucracy that dichotomises forensic psychiatric care and general psychiatric care. Accordingly, this lack of continuity of care results in the revolving door phenomenon. Draine et al (2002:571) project a broader view of the phenomenon by explaining that mental illness represents only the smaller picture of the problem; the bigger picture lies with the treatment given for the mental illness. These authors note that treatment is too limited in extent to address the effects for positive social outcomes.

6.6 THE FORENSIC PSYCHIATRIC PATIENTS

Patients experience life in the institution as a "prisoner" and not as a "patient" with ensuing physical, emotional, social, and occupational challenges. This experience was conceptualised under the following two categories: the judiciary system fails patients resulting in prolonged stays, and the failure of the health system resulting in relapse. The patient who is experiencing the life of a "prisoner" is stripped of his agency, autonomy, independence and inability to act in his own best interests (Frost & Hoggett 2008:439).

6.6.1 Judicial system fails patients resulting in prolonged stays

The issue of the judicial system failing patients was attributed to the loss of documents and a lack of monitoring and supervision.

6.6.1.1 Lost documents

Documents literally represent patients because it serves as the basis of decision making by the relevant stakeholders. Its loss therefore embodies a violation of the progress of the patient in the system. Losing documents symbolises suffering as a result of the inconveniences that ensue, for instance, one patient case in the current study could not be concluded by the Special Board and the Mental Health Review Tribunal because of missing documents. The patient eventually relapsed. Coid et al (2007:228) confirm the issue of lost documents. When they conducted a study on patients discharged from medium secure forensic psychiatric services, they found some hospital case files were not available. Davis (2012:12) draws attention to the fact that the legal and mental health systems have a record system that is extremely deficient. It can therefore be accepted, as Njenga (2006:97) states, that the "confusion" in Zimbabwe's medico-judicial systems is seemingly replicated in the general disorder of forensic psychiatric care.

6.6.1.2 Lack of human resources resulting in process delays

The human resources referred to are the multidisciplinary medical team. The diminished medical social space increases symbolic domination by the prison system because the 'voice' of the medical team (nurses and psychiatrists) is drowned by the prison system staff members who constitute the majority. The resultant process delays from this human resource scarcity then represent suffering which Bourdieu refers to as *"la petite misère"* (Bourdieu 1999:viii). This is to say the patients experience all forms of suffering in the processes explained above. Gunn (2000:334) and Hamaoui et al (2009:507) share the view that the issues that need to be addressed urgently are the resource constraints, its resultant delays, and the lack of a therapeutic milieu.

However, Nedopil (2009:225) has a different but important stance on the aforementioned view. This author found there were general ambivalence and reluctance from major influence groups to associate with forensic psychiatry. This may be due to

the aspect raised by Davis (2012:6), namely, that most countries are not adequately equipped to deal with forensic psychiatric patients because of a resource allocation system that is skewed towards giving resources to areas concerned with preventing recidivism. In this study, it was observed that the resources are simply not there.

6.6.1.3 Lack of monitoring and supervision

Lack of monitoring and supervision in the special institution (prison) setting could come from the inherent conflicting relations between the medical and prison systems. In this regard, Bourdieu (1989:17) is quoted as stating "objective relations are the relations between positions occupied within the distributions of the resources which are or may become active, effective, like aces in the game of cards, in the competition for the appropriation of scarce goods of which this social universe is the site". This applies to the intricacies observed and noted in the current study. The prison officers and medical workers (nurses) seem to compete for discursive power (who gives medication, what should be done after patient transfer from special institution to remand prison, who gets transferred to hospital after a physical ailment and who does not).

The tragedy of forensic psychiatric practice has been documented in research studies as being legally controlled when ideally it should be under the auspice of the medical professionals. As many authors suggest, such adverse control negatively affects the monitoring, supervision and continuity of care for forensic psychiatric patients (Davis 2012:7; Farkas, Gagne, Anthony & Chamberlin 2005:154; Lindqvist & Skipworth 2000a:372).

6.6.2 Health system failure resulting in relapse

Health system failure resulting in relapse was conceptualised under physical challenges, emotional challenges, social challenges, occupational challenges and challenges during admission. The health system's failure is basically a result of the fact

that it has no control over both the *modus operandi* (practice processes) and *opus operatum* (service outcomes) (Bourdieu 1989:18).

6.6.2.1 Physical challenges

Physical challenges included food insecurity and rehabilitation which largely focused on chemical therapy.

6.6.2.1.1 Food insecurity

Food in a prison setting (special institution and remand prison) seems to be scarce. The shortage of food translates it to a form of prison-specific economic capital in which it can be transformed and exchanged (Moore cited in Grenfell 2008:102). Food was traded by patients in remand prison for antipsychotic drugs. For example, a patient who would have been transferred to remand prison would be given his medication, chlorpromazine. The responsibility of managing and complying with the medication was also shifted onto the patient who abused this independence by trading this much-needed drug for food with criminals awaiting trial. The ordinary criminals needed the drugs for their sedative properties so that they could sleep and mask the emotional pain associated with incarceration. In the process, the patient would relapse because he would have technically defaulted treatment.

Hamaoui et al (2009:509) point out that most parts of Africa are poorly resourced. Ogunlesi et al (2012:3) add that because of the lack of resources and delayed revision of guiding legislature, prisons have had to provide “rudimentary”’ services to forensic psychiatric patients. Moreover, Njenga (2006:87) paints a chaotic picture of Africa’s forensic psychiatric care where patients were said to belong to neither the prison system nor the medical fraternity. It is then possible that this dichotomy can spill into food security issues. It can be in the sense that food is not given priority by neither the prison system nor the Ministry of Health and Child Care involved in the care of the forensic psychiatric patients.

Rehabilitation largely focused on chemical therapy

This finding on the use of chemical therapy was also confirmed by the results of the quantitative phase of the study which showed that 90.2% patients had received medical treatment only. The prison system has more symbolic capital and therefore controls the processes of rehabilitation of forensic psychiatric patients. The prison system determines patients' access to psychosocial intervention. However, the patients cannot access the psychosocial interventions because of the prison classification and operational systems. This boils down to patients accessing chemical therapy only.

Anthony et al (2002:2) specify that rehabilitation for psychiatric patients should focus on maximising the function of these patients so that they fit into the environments of their respective societies. Lindqvist and Skipworth (2000a:372) found that the rehabilitation for forensic psychiatric patients was biased towards drugs instead of having a general rehabilitative approach that is specific to patients. Neil (2012:119) asserts that forensic psychiatric patients have healthcare needs that are specific to them in view of the complexity of the setting in which they are cared for and the inherent challenges related to their psychiatric, medical, and social circumstances.

6.6.2.2 Emotional challenges

Emotional challenges were addressed under anxiety, uncertainty and under the concept of how patients perceive power issues in the process of their management.

6.6.2.2.1 Anxiety and uncertainty

The anxiety and uncertainty experienced by forensic psychiatric patients seem to be a consequence of their precarious social position (habitus) in the prison system. Patients experience what Bourdieu (1989:19) calls "a sense of the place of others" instead of having "a sense of one's place". Forensic psychiatric patients are treated neither as ordinary criminals nor as patients and they have no ready answers to their predicament.

This makes them suffer from anxiety and uncertainty. Palijan et al (2010:65) state the hallmark of treating forensic psychiatric patients is to develop awareness within the patients. According to Neil's (2012:120), observation, anxiety about the future and frustration was inherent in forensic psychiatric patients and this negatively affected their psychological atmosphere. This may relate to the fact that in Africa forensic psychiatric services are not organised (Hamaoui et al 2009:507).

6.6.2.2.2 Patients perceive power issues in the process of their management

Patients are aware of the conflict between the prison system's need for security and the health workers' desire for the establishment of a therapeutic environment for the forensic psychiatric patients. This power dynamic is a form of symbolic violence that culminates in the symbolic suffering of the forensic psychiatric patients. In Silva's (2009:499) view, the relationship between law and psychiatry has always been complex with ensuing dynamics of both collaboration and competition which have irreversibly affected both the law and psychiatry.

Mullen (2000:309) states services for forensic psychiatry in prison settings have always been problematic owing to the perpetual correctional intrusions which emphasise authority and control while health staff endeavour to sustain a therapeutic milieu of care to the same patients. Hamaoui et al (2009:508) confirm that in Africa, forensic psychiatric services are supervised by the judicial systems albeit with minimal resources. Ultimately then, this scenario is likely to breed conflict in the systems involved with the care of forensic psychiatric patients as Wettstein (2002:624) and Bailey (2011:55) both suggest.

6.6.2.3 Social challenges

Social challenges were understood in the context of support systems' limitations resulting in loss of social functioning.

6.6.2.3.1 Support systems' limitations results in loss of social functioning

Forensic psychiatric patients expressed that their support systems were very limited. The family represents the patient's habitus or the patient's "sense of place" (Bourdieu 1989:19). It is within this habitus that the patient can regain his agency, autonomy and where he can act towards his own best interest. At this point in time, however, this support structure seems to be limited with regard to patients admitted in special institutions and it translates to the disempowerment of the patient.

It is a concern for Barlett (cited in McSherry & Weller 2010:407) that the relatives of forensic psychiatric patients are unavailable because of economic difficulties. To this author, the financial aspect that prevents relatives of patients to be readily available is extremely "problematic". It supports Mullen's (2000:308) observation that forensic mental health services are geographically removed from the mainstream health services. In the current study, Participant 22 specifically referred to the fact that the geographical isolation of the special institution made it less visitor friendly. Hamaoui et al (2009:508) mention the issue that forensic psychiatric patients remain in the system for a long time and this can probably result in the caregivers experiencing burnout because they are expected to continuously visit the patients in the interim.

6.6.2.4 Occupational challenges

Occupational challenges referred to the patients' uncertainty related to social functioning after discharge.

6.6.2.4.1 Uncertainty related to social functioning after discharge

An occupation was viewed by the patients in this study as a form of economic capital that would emancipate them beyond the special institution. This concern reflects that the state of the *modus operandi* of the prison system does not capacitate the patients to be functional after discharge. Anthony et al (2002:4) expound on the notion that

forensic psychiatric patients may be limited in their social functioning and ability to perform by the psychiatric illness. Neil (2012:122) adds that social inclusion in the form of stable social relationships and employment are vital to the mental and physical wellbeing of a patient. It is the stance of Davis (2012:6) that all the stakeholders should develop a unified approach to effect treatment that would capacitate the patients and facilitate continuity of care and life in general.

6.6.2.5 Challenges during admission

Challenges during admission included the concept of some patients assuming the role of 'staff' as a form of rehabilitation, limited access to rehabilitation services, and a lack of effective communication with patients.

6.6.2.5.1 The concept of a patient being 'staff' as a form of rehabilitation

Becoming mentally stable seems to increase the patient's symbolic capital. The patient becomes a 'staff' member and has access to activities that other patients are not privileged to. The patient 'staff' works closely together with both the guards and health workers. They control other patients during the doctor's round by marshalling them into and out of the consultation room and are allowed to be in the room during these sessions. Other privileges include helping during meal times, being given the responsibility of identifying and retrieving the files of other patients who are due for review. It was also observed in this study that the 'staff' even has right to give the doctor information about the progress of the patient being interviewed. While in the queue to see the doctor the 'staff' was observed to be coaching other patients and structuring answers in anticipation of the questions that would be asked by the doctor. In other words, the patients due for review engage in a pre-interview session with the 'staff'. Even more disturbing was that the 'staff' also assisted in giving other patients their medication.

Promoting a patient to a ‘staff’ member is considered in the special institution as a form of a higher level of rehabilitation. The unsettling part of this finding is that this form of rehabilitation occurs against the background of other patients’ documents being lost apparently somewhere in the system. The conclusion can be made that the loss of documents could be linked to this form of rehabilitation. Unfortunately, there is a scarcity of information in literature with regard to the phenomenon of forensic psychiatric patients being ‘staff’.

6.6.2.5.2 Limited access to rehabilitation services

Successful rehabilitation of the forensic psychiatric patient is the only way in which the patient can get his agency (power to control his life) back. Apparently rehabilitation services are limited. Martin and Street (2003:542) found that the care given to forensic psychiatric patients was biased towards custodial care. The implication is that the patient is disempowered.

To this effect, related findings from the quantitative results of the retrospective document review indicated that there were no entries in the patients’ notes on the rehabilitation given to patients. Nursing interventions were invisible in the patients’ notes. If the activities were not documented, it was then difficult to prove them as having been done.

Reid (2004:390) brings up a very interesting angle to the issue of rehabilitation. The author points out that the medical system has an obligation to effectively rehabilitate the patients because it promises to do so. The same promise is implied when the medical system accepts the prison as suitable for the care and safety of forensic psychiatric patients. However, Davis (2012:18) concurs with Coutts (2011:1) that insufficient care, the stakeholders’ lack of coordination and the prison service’s inclination towards a punitive stance against forensic psychiatric patients generally thwart any meaningful rehabilitation of these patients.

6.6.2.5.3 Lack of effective communication with patients

Availing information about his care is a form of cultural capital to the forensic psychiatric patient (Swartz 1997:75). In a setting like the special institution, the forensic psychiatric patient needs this form of capital so that he can plan his life and future. At present this symbolic capital is denied and the patient settles into a mode of resigned despair. Farkas et al (2005:142) refer to effective communication as communication that empowers patients with knowledge which helps him to recover from severe mental illness.

To Palijan et al (2010:65) the thrust of rehabilitating forensic psychiatric patients is to make them aware of what is happening, what the next step in their rehabilitation will involve and providing them with more insight of their current and future situation because having more knowledge helps them to recover. The reality, as explained by Gunn (2000:335), is that prison systems are meant to be deterrent and punitive. As such, not giving information and keeping forensic psychiatric patients in suspense and in an unpredictable psychological environment may therefore be seen as simply another form of punishment.

6.7 RELATIVES OF FORENSIC PSYCHIATRIC PATIENTS

The negative perception of the rehabilitative context by the patients' relatives was based on the following: the physical environment is not conducive to care and rehabilitation; psychological deterioration; social deterioration; deterioration due to inadequate care; the lack of communication and information elicits anxiety and disempowers relatives; and negative experiences of the judiciary staff, services, and competencies.

6.7.1 Physical environment is not conducive to care and rehabilitation

The description of the physical environment as being not conducive to care and rehabilitation was based on the special institutions' unfriendliness towards visitors, the

special institutions perceived as serving disciplinary purposes as opposed to having a rehabilitative function, relatives attended to by guards and not nurses, and disrespectful practices.

6.7.1.1 Special institutions are not visitor friendly

The doxa or known practice of visiting in a prison setting is that the relative is treated as an extension of the 'prisoner'. A dislocation is formed between this doxa and the circumstances of the visit by the patient's relative. The relative's visit is supposed to contribute to the rehabilitative service outcome and beyond. The reality at the moment is that patients' relatives are treated the same as visitors for ordinary criminals.

Canning, O'Reilly, Wressell, Cannon and Walker (2009:869) expand on the issue of visits by highlighting that when patients are admitted in institutions that are far away from home, it is difficult for relatives to visit and this usually leads to family disintegration. Tsang, Pearson and Yuen (2006:23) explain that relatives who are likely to visit are usually those closely related to the patient like siblings, children or parents of the patient. Wolfson et al (2009:320) state when relatives visit, there should be a room where they can meet with the patient that is neither the bedroom nor the communal area. At the special institutions in this study it was the lack of this aspect that incensed the relatives. Some felt that the sacrifices they had made to visit as parents of the patients were being spited by the special institution. This finding supports Tsang, Pearson and Yuen's (2006:23) similar finding because all except one relative interviewed were mothers of the admitted patients. Only one was the paternal uncle of the patient.

6.7.1.2 Special institutions are perceived as serving disciplinary purposes as opposed to having a rehabilitative function

Because of the double bind function of the special institution, relatives experience a 'hysteresis effect' to the extent that some are not aware that their relatives are

undergoing rehabilitation. This is a troublesome finding considering that it plainly stresses that an incompatibility does exist between the environment and its purpose, namely punishment versus therapeutic rehabilitation.

The sentiments of participants about the special institution serving disciplinary purposes is confirmed by Kita (2011:13) who indicates that in prison or correctional systems, the prevailing officer adage is: “If you can’t do the time, don’t do the crime.”. Coffey and Byrt (2010:xii) posit that this may emanate from the public’s relentless demand for safety and that prohibitive measures be taken against all offenders regardless of what might have triggered their behaviour. To curb the public’s obvious outcry against all people in prison, Wolfson et al (2009:28) suggest that rehabilitation services in psychiatric settings impart life skills to patients so that they are empowered with self-esteem, confidence and hope for the future. In this study relatives of forensic psychiatric patients were seemingly not aware that the special institution served as a ‘hospital’ in its own right.

6.7.1.3 Relatives attended to by guards and not nurses

Guards have more symbolic capital in the prison system than nurses. As a result of this they have more control over patients’ affairs than nurses. They attend to the relatives and discuss patients’ issues with them instead of with the nurses. Coffey and Byrt’s (2010:2) interpretation of the issue that nurses do not actually interact with the relatives is that it should be borne in mind that nurses who work in forensic psychiatric settings engage with a diverse crop of professionals who may even be non-medical whereas their counterparts in general psychiatry are specifically part of a multidisciplinary medical team.

Other authors confirm that relatives, even those who are regular visitors, have minimal contact with hospital staff in forensic psychiatric settings and that this is a problematic issue because successful rehabilitation is dependent on an informed caregiver (Gustafsson et al 2012:732; Tsang et al 2006:23). In the case of patients in a prison

setting, a guard (an uninformed individual) connects with the relatives and not the informed caregiver (the nurse). Livingston, Rossiter and Verdun-Jones (2011:115) conclude that societal attitudes are embodied and enshrined in policies that govern service delivery models. The service delivery affected by such policies then become contra-directional to the cause of rehabilitating forensic psychiatric patients.

6.7.1.4 Disrespectful practices

Relatives are dehumanised when they visit special institutions. This observation is embodied in the lack of respectful practices, of touch and humane warmth which induces emotional trauma to the very support system of the patient. Canning et al (2009:880) explain that relatives of forensic psychiatric patients may be discouraged from giving support because of the negative encounters that they may have had with the health services from which they received no support. According to MacInnes and Watson (2002:375), it is not unusual or strange for family caregivers to be annoyed by the lack of services they receive in forensic psychiatric settings because it adds to their frustration, uncertainty and anxiety on the behalf of both the patient as well as their own. Collins, Johnston, Tang, Fung, Kwan and Lo (2006:39) confirm that families of forensic psychiatric patients experience trauma and are being underserved. The authors propose that administrative procedures, professional dispositions and the media should be modified to reduce this trauma.

6.7.2 Psychological deterioration

Psychological deterioration was measured by the relatives' plea for staff to treat them humanely and the fact that the relatives perceived patients as frightened by the system.

6.7.2.1 "Patient seems to be frightened"

Patients could be frightened by the realities of the prison culture for which they have no capital with which to exchange and cope. The neglect of their individual needs, for

example, privacy, and the coercive treatment can be the reason why the patients seem frightened. Research into forensic psychiatry practice has shown that the way a relative of a patient conceives the quality of care can be combined with how professionals and patients perceive it; these three groups' combined perceptions paint an overall picture that can be referred to as a 'standard'. The issue of being in a prison setting, the fact that it comprises of strict routines and is a highly controlled setting with more emphasis on safety and security than caretaking, is perceived by relatives to be frightening to the patient (Kita 2011:9; Schroder 2006:13). Wolfson et al (2009:22) calls for the rehabilitation units to strive to provide a therapeutic milieu that reflects safety so that stability for forensic psychiatric patients is fostered and non-abusive relationships are created.

6.7.2.2 "We want you people to treat them humanely"

This *in vivo* code in the participants' view meant that forensic psychiatric patients were being dehumanised. 'Humanness' was a quality that the forensic psychiatric patients were perceived to be denied. Dehumanisation in this study occurred, according to relatives of forensic psychiatric patients, in the form of over-medicating the patients and by the multidisciplinary team interacting with these patients as if they were criminals.

Haslam (2006:252), Barnard (2001:98) and Szasz (1973:200) question the inclination of forensic psychiatry practice to adopt an inhumane style and relate to patients that is "mechanomorphic" thereby "thingifying" these patients so that they are eventually treated as "defective machines". Pouncey and Lukens (2010:102) approach the issue of treating patients humanely by asking how can "we advocate for treating persons with mental illness as full moral agents for the purpose of providing social goods, while simultaneously treating them as compromised moral agents when the same illness earns them social sanction?" Research studies repeatedly call for policies and institutional practices to address social problems that influence the perpetuation of stigmatisation of patients. On the other hand, patients also need to collaborate in their

care because their needs do not always revolve only around their mental illness but sometimes even beyond it (Fluttert 2010:101; Livingston et al 2012:346).

6.7.3 Social deterioration

Patients deteriorate socially as evidenced by their loss of social interaction, of social responsibility and their lack of productivity once they come into contact with a special institution.

6.7.3.1 Loss of social interaction

Religion is a social symbolic capital that the forensic psychiatric patient is denied the moment he is admitted in the special institution. Symbolic suffering ensues as a result of this violation and deprivation.

Over time research reports has continuously emphasised the positive influence that an individual's belief system or spirituality can have on her or his mental health. Study findings further reflect that inner harmony is driven by integrative energy that is derived from spirituality. Where there is spiritual distress, the mental health outcomes are more likely to be poor (Fortinash & Holoday-Worret 2008:138; Stuart 2009:51). It is concluded by Kita (2011:13) that when an individual becomes an inmate, he is stripped of all previous symbolic capital (in this case religion is included) that he could have possessed before he was put in prison. This is because the new reality for this inmate is totally constructed by the prison system and not by the inmate; thus, religious deprivation may further destabilise the patient.

6.7.3.2 Loss of social responsibility

Patients experience social hurt because their social responsibilities are obliterated by the stigma associated with their predicament. The patient seems to be perceived as incapable of meeting the required social standards because of the mental illness.

Livingston et al (2011:116) as well as Tsang et al (2006:24) emphasise that the forensic label has a pernicious effect of creating a major prohibitive barrier to social reintegration of the patient. These authors point out even socialisation with family members as part of forensic psychiatric patients' productivity decreases during the time of the illness. This loss of positive social behaviour can be attributed to the inherent discrimination and social stigmatisation experienced by these patients. The same authors continue it is therefore imperative for the families to receive maximum support from forensic psychiatric services. Coffey and Byrt (2010:11) recommend that future care should be holistic in nature; thus encompassing the individual's psychological, cultural and social mandates

6.7.4 Deterioration of patient due to inadequate care

The category of deterioration due to inadequate care covered the following areas: relatives perceive the patients as getting worse during admission, and the patient is traumatised by being in an enclosed environment

6.7.4.1 Relatives perceive the patient as getting worse during admission

The scenario of patients' conditions getting worse after admission was universal among all stakeholders. According to Frost and Hoggett (2008:453), this worsening of a patient's condition can be attributed to the feeling of powerlessness he experiences. The findings of research studies on this phenomenon consistently reflect that in rehabilitation settings for psychiatric patients, distressing drug side effects are observed. It is also noted that in a forensic psychiatric setting there is no use of any new generation of atypical antipsychotics because governments apparently cannot afford it (Pearson 2008:4; Wolfson et al 2009:21). Contrary to the finding of this study, Tsang et al (2006:23) found in the study they conducted that relatives of forensic psychiatric patients were generally satisfied with the care received and were only concerned about the system's lack of involving the relatives in the care of the patient.

6.7.4.2 Patients are traumatised by being in an enclosed environment without stimulation

An enclosed environment is an environment that has been constructed by the prison system as the dominant group. Such an environment symbolises symbolic violence with its bare walls and nothing to occupy the patient with. Previous research into prison environments discovered that conditions are not conducive to patient recovery; instead, their mental conditions further deteriorate. Propositions have therefore been made that a rehabilitation setting for forensic psychiatric patients should foster a culture that empowers the patients in terms of respect for others, confidence, courtesy, emotional literacy, and the ability to adjust to the circumstances they find themselves in (Huxter 2013:737; Wolfson et al 2009:28). The notion of trauma to patients who are in an enclosed setting is, however, contradicted by the results of a study conducted by Tsang et al (2006:23) which showed that relatives were satisfied that the patients remained in the hospital where conditions were controlled and patients were therefore presumably safe.

6.7.5 Lack of communication and information elicits anxiety and disempowers relatives

The above concept was embodied in the lack of coping mechanisms and skills to manage patients that led to fear in relatives, a lack of communication from the medical staff, and a lack of knowledge on transfers and sentencing.

6.7.5.1 Lack of coping mechanism and skills to manage patients leads to fear in the relatives

Relatives seem to lack cultural capital (skills and knowledge) which is an important factor where caring for the patients at home is concerned. This disempowered mentor ignites from all the stakeholders who are involved in the power struggle for patient control. For example, the prison system does not make allowance for the medical team

to reach out to relatives and the medical staff members resign themselves to this predicament because of their feelings of despair and disillusionment**.**

It has been found in earlier studies that families of the forensic psychiatric patients are exposed to both physical and verbal aggression from the patients; family members at times again become victims of the crime that the patient has committed and which led to his incarceration (Canning et al 2009:868; Kumpula & Ekstrand 2009:538). Such evidence undoubtedly suggests that caregivers need to be capacitated in order to deal with the discharged patient on a day-to-day basis. Knowledgeable and supportive caregivers can influence the outcome of patients with major mental disorders positively (Pearson 2008:4). But, as Collins et al (2006:38) acknowledge, a heavy burden is shouldered by relatives of forensic psychiatric patients. If they have no ventilation outlet, it can result in burnout. Tsang et al (2006:22) point out that caregivers are vulnerable because they are often not able to control the violence expressed by forensic psychiatric patients at home and they perceive this as stressful. Pearson (2008:4) states relatives need to be capacitated to reduce their stress and increase their ability to solve problems. This can be done through the use of treatment modalities like cognitive behavioural therapy.

6.7.5.2 Lack of communication from medical staff

The medical staff cannot access and communicate with the relatives because of the domination by the prison system. Bourdieu (cited in Richardson 1986:23) expresses this when he pronounces that “symbolic capital is a credit; it is the power granted to those who have obtained sufficient recognition...” The current state of affairs in special institutions in prison settings is that the medical team has yet to be granted this power. At the moment they are disempowered.

Canning et al (2009:884) note that relatives of patients consider the healthcare staff as valuable sources of information. According to Collins et al (2006:39), family members of forensic psychiatric patients report that healthcare workers do not avail either formal or

informal support to them. This perceived lack of communication is further confirmed by Schroder (2006:13) who states research studies have shown that there is minimal communication between staff and relatives of patients.

6.7.5.3 Lack of knowledge on transfers and sentencing

Relatives are disempowered because of the lack of information pertaining to the movements and fate of their relatives. Their objectified relatives are parcelled around the system without them being informed. The findings of Tsang et al (2006:23) in their study on forensic psychiatry indicate that the relative respondents were not knowledgeable about the services made available to them. The Centre for Mental Health (CMH) (2011:51) is very specific on the issue of transfers. It expresses that processes involving transfers are not clear and their appropriateness is questionable; in fact, these aspects are termed as "Byzantine and convoluted" by the CMH. The conclusion drawn by Canning et al (2009:869) is that relatives' anxiety is worsened by misinformation and having minimal knowledge (if not no knowledge at all of mental health issues and the services that are in place for them).

6.7.6 Negative experience of judiciary staff, services, and competencies

The notion of negative experiences with the judiciary staff, services, and competencies was enshrined in delayed processes, financial exploitation by legal practitioners, and the perception of the judiciary as not thoroughly analysing cases.

6.7.6.1 Delayed processes

"*Justice delayed is justice denied."* These words of one of the judicial participants in this study relate how devastating delays in the processes can be for forensic psychiatric patients. Such delays violate the individual's right to self-determination and represent the loss of opportunities because one cannot structure future activities basing on an unknown admission outcome (CMH 2011:51). Unfortunately, delays in the processes

involving forensic psychiatric patients within the criminal justice system and the consequent continued holding up of patients in remand prison are a reality. It is of great concern that research studies consistently identify system failures in the processes of both the medical and criminal justice systems where the handling of forensic psychiatric patients is involved (Fanelli, Fouhy & Wu 2013:7; HM Inspectorate of Prisons 2007:23). This seems to still be the case despite the fact that in 2006 already it was determined that there was a profound need to establish more effective processes – especially for health staff who are responsible for preparing assessment reports (Queensland Health 2006:16).

6.7.6.2 Financial exploitation by legal practitioners

Relatives traded their economic capital for the speeding up of the patients' case processing. In the process the relatives' sentiments on the issue reflected symbolic violence in the form of financial exploitation. Very little information about the exploitation of relatives of forensic psychiatric patients by legal practitioners is found in literature.

6.7.6.3 Judiciary perceived as not thoroughly analysing cases

The judiciary not thoroughly analysing cases can be dehumanisation that possibly originates from the stigma associated with mental disorders (Haslam 2006:254). In this regard, Bar-Tal (2000:122) dissects dehumanisation as it could be applicable to this finding by pointing out that it involves "labelling a group as inhuman, either by reference as subhuman categories...". This supports the finding in the judiciary participant group where the judiciary were more interested in "political" cases than "mental" cases.

Several forensic psychiatry authorships express that there may be legislative barriers related to information processing within stakeholders. This is believed to result in a lack of providing adequate and relevant information related to the patient's criminal history and witness statements. Specifications have been proposed that there should be judicial standards of practice in forensic psychiatry and that breaching of such standards of practice should result in the judicial practitioner being penalised (Fanelli et al 2013:8;

Heilbrun, DeMatteo, Marczyk & Goldstein 2008:1). Errors in the analysis of cases in court can derive from what is known as “hindsight bias” where “exposure to known outcomes (like those of patients who are already known even before psychiatric assessment) causes people to update their beliefs without realising that their decision making has been affected” (Knoll & Gerbasi 2006:221).

6.8 THE PSYCHIATRISTS

The psychiatrists encountered challenges almost similar to that of the nurses but they presented differently as they had a different scope of practice. Psychiatrists have a different access to all forms of capital in the system by virtue of their cultural capital (qualifications). The following theme was central to the experiences of the psychiatrists.

6.8.1 Prohibitive processes negatively affect overall patient care and recovery

The prohibitive processes that negatively affect overall patient care and recovery are shrouded in human resource issues, practice realities, and unconstructive attitudes and beliefs. The human resource issues in forensic psychiatric rehabilitation include the actual lack of staff to provide care, the disjuncture between the psychiatrist and the judiciary as well as the ‘policy’ pertaining to the loan of only doctors and nurses.

6.8.1.1 Lack of human resources

Psychiatrists working in special institutions bemoan the lack of both human and material resources. This is a serious issue because the scarcity of human resources, particularly psychiatrists, is consistently acknowledged in literature (Arboleda-Florez 2006:88; Njenga 2006:97; Ogunlesi, et al 2012:3). It is projected to result in the lack of follow-up and poor communication between patients and the multidisciplinary team. The lack of human resources is a result of brain drain in some countries or the unavailability of trained psychiatrists (Carroll, Lyall & Forrester 2004:409; Cox 2008:27; Kauye 2008:29; Sinha 2009:8; Skuse 2008:28; Taylor 2002:S61).

6.8.1.2 'Policy' only loans doctors and nurses to special institutions

Loaning doctors and nurses to special institutions is the current practice but there are no specific guidelines or policy to this effect. They are loaned from the civil psychiatric hospital. In literature there is a dearth of information about the concept of loaning doctors and nurses to special institutions.

However, it is important to note that the Zimbabwe National Mental Health Policy of 2004 (2004:9) is very specific about the staffing of special institutions. It stipulates that in a special institution with over a hundred beds there should be a resident psychiatrist, psychiatric nurse, general medical officer, clinical psychologist, social worker and occupational therapist. It seems that these cadres do indeed staff prison settings, except for the psychiatrist. On the other hand, the special institutions are staffed by the nurses and psychiatrists 'loaned' from the civil psychiatric hospital establishment – especially in the southern region. These are nurses from whom guards cannot take orders. This may then allude to the assertion by Njenga (2006:97) that forensic psychiatric practice in Africa is "mysterious" and "underdeveloped".

6.8.2 Practice realities

Practice realities encompass the disjuncture between the psychiatrist and the judiciary, attention being given to major crimes, large numbers of patients, a lack of follow-up in remand prison, discharge challenges, and the use of the preliminary report by the psychiatrist due to time lapse.

6.8.2.1 Disjuncture between the psychiatrist and the judiciary

A lack of coordination between the psychiatrists and the judiciary is an issue in forensic psychiatric practice in Zimbabwe. For example, the psychiatrists highlighted in this study that sending a patient to the special institution when he has no charges are laid against him, is common practice. When the psychiatrist then comes into contact with this person

(who is now a “patient”), he or she does not know why the person has to be assessed or what he should be treated for.

The lack of comprehensive communication between magistrates and forensic psychiatrists is also acknowledged by Njenga (2006:97).Disjuncture was acknowledged in literature as a reality that needed to be addressed, especially for the benefit of vulnerable people like the mentally ill (Hughes, Williams, Chitsabesan, Davies & Mounce 2012:15; Richardson 2009:4). This disjuncture violates the thrust of the special institutions which is therapeutic jurisprudence (Alexander-Guera 2009:467; Glaser 2003:149; Sharma & Sharma 2006:98; Verdun-Jones 2000:77).

6.8.2.2 Attention given to major cases

Major crimes like murder and rape get first priority when patients are reviewed by the psychiatrist in the special institution. Stein et al (2010:157) assert that it is a known fact that psychiatrists focus on certain areas when practising in the field. According to Njenga (2006:97), if a patient is admitted in forensic psychiatric care and does not have major problems, he is not reviewed; in fact, the author states only the most psychotic patients are the ones that are reviewed.

6.8.2.3 “Some patients do not warrant being in a special institution”

The psychiatrists highlighted that that some patients are unnecessarily admitted in already overcrowded special institutions. This may be due to the fact that forensic mental health services in the area where this study was conducted are still rudimentary and therefore not clearly organised. The other factor to be considered is that the untrained and disillusioned staff could be producing these faulty assessment procedures (Hamaoui et al 2009:507; Njenga 2006:97; Skuse 2008:27).

6.8.2.4 Lack of follow-up in remand prison

Psychiatrists reported patients as relapsing in remand prison because of the lack of follow-up logistics. This notion was also implicated by Hamaoui et al (2009:507) when they reported on forensic psychiatric practice in Africa. It can also derive from the practice of “passing around” the patients between departments that lack clarity on what they are supposed to do with the patients (Gustaffson et al 2012:734; Sestoft 2006:95).

6.8.2.5 Discharge challenges

Once patients are admitted in the special institutions it is not easy for the psychiatrists to discharge them. According to Carroll et al (2004:407) and the NWS Ministry of Health Policy Directive (2012:1), this is because decisions either to transfer or discharge the patient lies with the courts or tribunals. This is true for Zimbabwe where the actual discharging is done either by the Attorney General’s office or the Mental Health Tribunal. Skuse (2008:28) suggests that such scenarios can be a result of forensic psychiatric services that are still evolving.

6.8.2.6 Use of preliminary report by psychiatrist due to time lapse

The psychiatrist may be obliged to write a psychiatrist’s report based on the general medical report of the first two doctors who consulted the patient. This occurs because of the lapse of time between the preliminary assessment and the time of the psychiatrist’s report which could be as long as six months. The psychiatrist is forced to use the findings of the initial report because the patient could be stabilised by the time he reviews the patient. This is an issue because technically one report is functional and that flouts the specifications of the Zimbabwe Mental Health Act of 1996.In literature, this factor is neither acknowledged nor refuted. There is a scarcity of information about this aspect.

6.8.3 Unconstructive attitudes and beliefs

Unconstructive attitudes and beliefs were conceptualised under sending patients to special institutions to protect the community and lack of interest in psychiatry.

6.8.3.1 Patient sent to special institution to protect community

Psychiatrists expressed that patients are sent to special institution to protect the community. Literature has consistently supported this finding, highlighting that the multidisciplinary team's imperative is to ensure the safety of the public from the patient. Forensic psychiatry is then used as a "quasi-medical cloak" from behind which society hides the fact (Adshead & Sarkar 2005:1012; Carroll et al 2004:408; Glaser 2003:147; Verdun-Jones 2000:81).

6.8.3.2 Lack of interest in psychiatry: "It's just work that needs to be done."

Psychiatrists indicated that generally doctors are not interested in psychiatry because of the stigma attached to it and the lack of financial incentives associated with the practice. Psychiatrists have no obligation to visit special institutions; they do it out of their own accord. This finding is supported by Alexander-Guerra (2009:466), Skuse (2008:28), Cox (2008:27) and Olugbile (2008:34) who all agree that a therapeutic impasse results in the absence of secondary gain and internal motivation.

6.9 SUMMARY

This chapter focused on describing the current state of forensic psychiatric rehabilitation in Zimbabwe. The reality at present is that there is discordant engagement of the judiciary and the rehabilitation system. The nurses are experiencing a dichotomous reality in which responsibility is abdicated.Patients, on the other hand, experience life in the institution as a "prisoner" and not as a "patient" with ensuing physical, emotional, social, and occupational challenges. The relatives of forensic psychiatric patients

currently have a negative perception of the rehabilitative context. The psychiatrists profess that prohibitive processes negatively affect overall patient care and recovery; conversely, the unconstructive attitudes and beliefs of psychiatrists have a dehumanising effect on the patients.

CHAPTER 7
A MEDICO-JUDICIAL FRAMEWORK FOR THE REHABILITATION OF FORENSIC PSYCHIATRIC PATIENTS IN ZIMBABWE

"Forensic medicine is like an illegitimate child of health and home departments. We belong to both, but none belong to us. We offer our services to both, we are answerable to both, but we receive nothing from either. I feel that it is high time that our paternity is ascertained and we be adopted by our rightful parentage."

Prof. L Fimate (2001)

7.1 INTRODUCTION

Chapter 4 discussed the study findings using open codes. Chapter 5 integrated the quantitative results to give perspective to the qualitative findings in Chapter 4 while Chapter 6 discussed the current realities of rehabilitation of forensic psychiatric patients in Zimbabwe by abstracting the study findings to axial and theoretical codes. The key concept deduced from the study findings was an operational system of power and dominance, the disempowerment and voicelessness of nurses, relatives and patients including symbolic suffering which was exclusive to relatives and forensic psychiatric patients.

This chapter sought to integrate the study findings and the results with participants' recommendations to develop a medico-judicial framework purported to break away from the current system that embrace the tenets of *libido dominandi* and sublimate it into a *libido sciendi*. The breakaway inherently symbolises a change in symbolic capital, for example, cultural capital and linguistic capital, to the advantage of the forensic psychiatric patients. The development of the medico-judicial framework was also a fulfilment of the challenge Bourdieu (1989:24) posed to academia to say "science has never progressed except by questioning" the status quo. The framework was subjected to the scrutiny and validation of experts and stakeholders in forensic psychiatry practice

in Zimbabwe. Guidelines for implementing the framework are also discussed in this chapter.

The final draft of the medico-judicial framework was divided into pro-judiciary with less emphasis and pronounced pro-medical reconstruction which gave it more enablement. The medico-judicial framework advocates for a new field of forensic psychiatric rehabilitation of which the practice is foreseen to be autonomous. In the process, forensic psychiatric rehabilitation will be disengaging from the prison system which has become so taken for granted that the subordinate fields like the medical have become oblivious of the functional arbitrariness of the prison system's rules and regularities (Deer cited in Grenfell 2008:125). In a way, according to Bourdieu's (2000:185) thinking, the medico-judicial framework becomes some form of "symbolic hijacking" by challenging the orthodoxy present at the time of the framework inception.

7.2 JUDICIARY PROCEDURES

Figure 7.1 shows the final graphic presentation of the preferred future medico-judicial framework for rehabilitation of forensic psychiatric patients in Zimbabwe. The structuring of the framework followed specific steps at the levels of both the judiciary and medical continuum of care or service.

7.2.1 Step 1 – Point of arrest

The framework has a **point of arrest** where the person is apprehended by police officers. These police officers would be from the Ministry of Home Affairs. A person who is apprehended by police is initially attended to at what is called 'a base station'. At this point, personal details are collected and recorded. The person is then transferred to a police station in the local community where a docket is opened and investigations are done within 48hours.

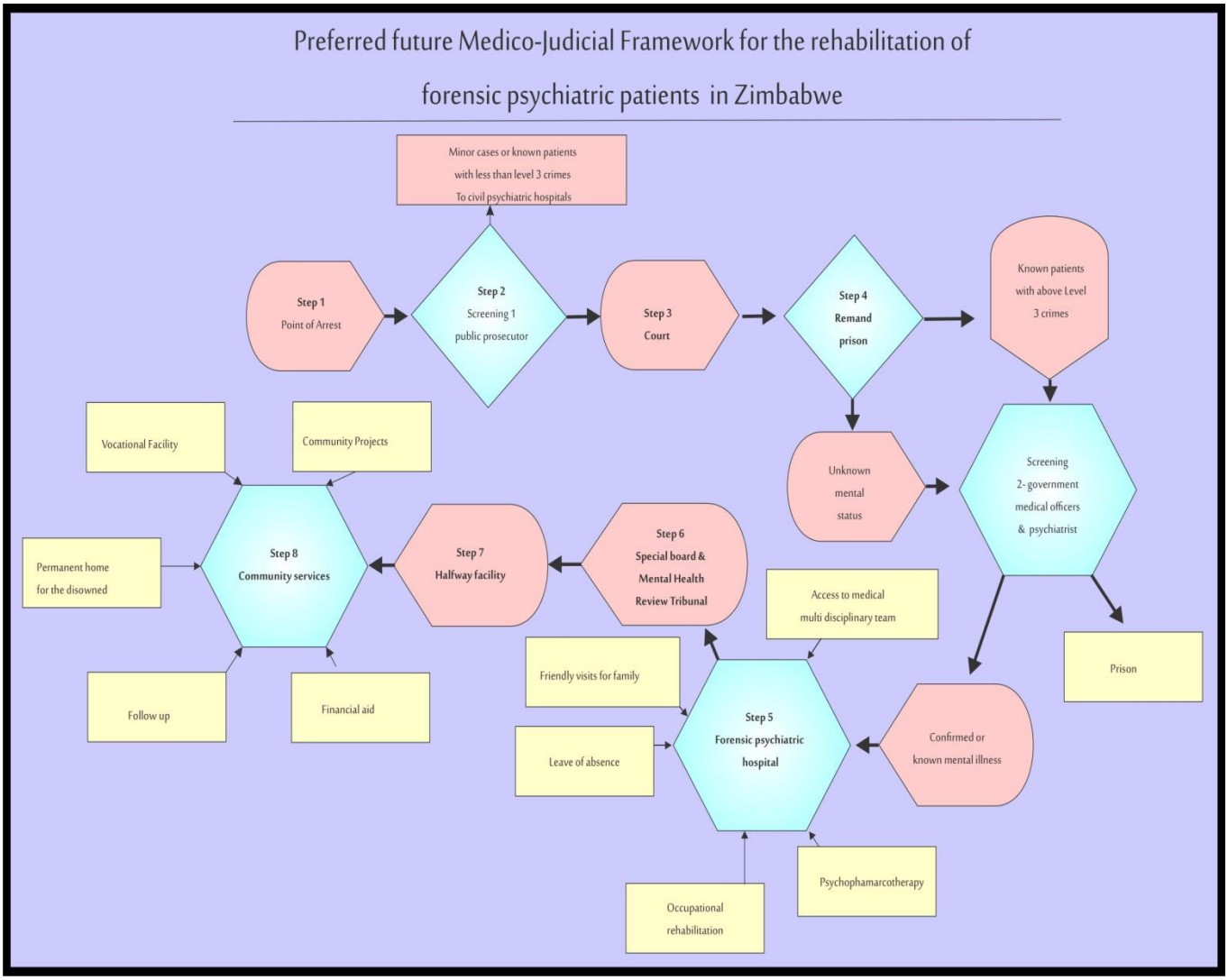

FIGURE 7.1: A Medico-judicial framework for rehabilitation of forensic psychiatric patients in Zimbabwe

7.2.2 Step 2 – Screening 1 – Public prosecutor

When a patient is moved from the police station the next step would be **Screening 1** by a **Public prosecutor** (see **Screening 1 – Public prosecutor** in Figure 7.1). In the criminal justice system in Zimbabwe, public prosecutors interact with the accused persons before they proceed to court. It is at this point, during this interaction, that the public prosecutor would be expected by participants, stakeholders and experts to verify if the accused person is already a psychiatric patient and determine the gravity of the

crime he has committed. If the crime is minor or less than level three and there is evidence that the person is already a confirmed psychiatric patient, the patient should be sent to a civil psychiatric hospital.

The levels of crime are determined by the Zimbabwe Criminal Law (Codification and Reform) Act of 2008.This Act defines the offences and provides punishment for each crime. As shown in the framework public prosecutors would have to acquiesce being guided by the prescribed fines to determine the level of crime the patient has committed.

The admission of forensic psychiatric patients to the civil psychiatric hospital is strongly advocated for, especially if they have committed minor crimes. At the time this study was undertaken to birth this medico-judicial framework, it seemed like a non-psychiatric patient who committed a similar crime had a better deal than the forensic psychiatric patient because the former was sentenced for a definite period after which he was discharged. Alternatively, he could be given a community service sentence. By comparison, the forensic psychiatric patient stayed for an indefinite period of time because of the attendant discharge challenges in the special institution. The aforementioned discrepancy in the sentencing process was considered in this study as a form of symbolic violence (an inherent concern in Bourdieu's oeuvre) that culminated in the symbolic suffering of forensic psychiatric patients. The act of sending a patient with a minor offence to the special institution instead of to the civil psychiatric hospital represented an imposition of the cultural arbitrary by the judicial system. **Screening 1** by public prosecutors is also supported in literature. Dabbs and Isherwood (2000:199) as well as Parsons, Walker and Grubin (2001:201) advocate for the screening of individuals on reception as a way of reducing psychiatric morbidity and unnecessary detention in high security hospitals.

7.2.3 Step 3 – Court

If, according to the Zimbabwe Criminal Law (Codification and Reform) Act of 2008, the public prosecutor determines that the crime exceeds a level 3 fine and believes that the person is mentally disordered, she or he facilitates the proceeding to court for the magistrate to handle the patient's case. The decision of the magistrate is determined by the behaviour of the person during the court proceedings. If the person behaves inappropriately in court, or has incoherent thought processes or does not understand the charges that are levelled against him, the magistrate should send this person to remand prison according to the Zimbabwe Mental Health Act of 1996. Whether this behaviour in court is normal or abnormal, in a case where the person is already known as a psychiatric patient the magistrate would send the patient to remand prison as well (see **Step 3 – Court** in Figure 7.1).

During court procedures, the need for a special office and separate clerk of court for processing patients' records evolved from the study findings relating to the occurrence of the loss of documents in the system. This reconstructed recommendation came from the stakeholders, participants and experts. The hope is to achieve effective processing of patients cases because, as determined in the study, the loss of documents or documentation that was not in order caused significant delays. If documents are lost anywhere in the system, unnecessary delays are imminent and unavoidable. Having a separate clerk of court would also assist with the processing of papers for forensic psychiatric patient because this person would be focusing on just one area of the judiciary prerogative.

7.2.4 Step 4 – Remand prison

In accordance with this medico-judicial framework, the magistrate will be expected to send the psychiatric patient to a remand prison which is already staffed by psychiatric trained personnel (see **Step 4 – Remand Prison** in Figure 7.1). It is essential that health staff trained in mental health be there and available when the magistrate sends

patients to remand prison because it would prevent the relapsing of patients who are already on treatment. At remand prison, both of these categories of patients (those whose mental status was unknown before and those who are already a psychiatric patient) would undergo a **second screening** by two government medical officers.

After the preliminary examination by the two doctors, a psychiatrist's report would be made available while the person is still in remand prison. After the preliminary examination by the two doctors and the psychiatrist, the psychiatrist will use their diagnosis to prepare a report that must be made available to the magistrate who ordered the mental status examination while the person is still in remand prison. This step would prevent the altering of assessment outcomes due to mixing of patients/persons at different levels of assessment where persons who are not mentally ill end up being admitted as mentally ill patients when they are not.

At the time of this study, the mixing of Criminal Mental Patients and Detained Mental Patients was viewed as obliterating the actual needs that the special institution has in relation to care of bona fide forensic psychiatric patients. Separating the two groups of patients in the forensic psychiatric hospital is vital for protecting patients from other dangerous criminals. For example, in this study it was found that in the special institution in the northern region the mixing of the two groups of patients was complicated by the fact that both the Criminal Mental Patients and the Detained Mental Patients were kept together with approximately 50 ordinary convicts (criminals) because of the shortage of space in the overall prison facility. The presence of convicts in the special institution was viewed negatively because some participants shared that the former influenced forensic psychiatric patients towards acquiring maladaptive behavioural patterns and tendencies. If either of the patients with a known mental status or those with an unknown mental status is found to be mentally stable, they would be sent to prison to serve their sentence.

The prisons would make provision for psychiatric trained staff (nurses) to identify and refer patients to the forensic psychiatric hospital. These nurses will supervise the

treatment and care to known psychiatric patients who were found to be mentally stable during **Screening 2** so that they do not relapse. It was found in the study that an erroneous sentencing was oftentimes made which led to patients losing their identity as psychiatric patients in remand prison because no one in the system knew about their condition. Being 'lost in the system' implies that nobody knew they were already psychiatric patients; they were identified and sentenced as ordinary convicts and, subsequently, they received no medication or care resulting in relapse which equates to symbolic suffering. In the developed medico-judicial framework the symbolic suffering of forensic psychiatric patients would be reduced and they would be empowered through their interaction with the trained psychiatric staff members.

If, at the second screening, the patient is found or confirmed to be mentally disordered, he is sent to what would, as shown in Figure 7.1, be referred to as a **forensic psychiatric hospital** instead of a special institution. If a patient is found to be mentally disordered, the diagnosis has to be clear and be compliant with the Diagnostic and Statistical Manual of the time. At this point, such a patient becomes a forensic psychiatric patient. The uniformity of a label for these patients is expected to harmonise their rehabilitation and care. At the time of the study they could either be known as *forensic psychiatric patients* or *mentally disordered* or *intellectually handicapped persons* in custody by the Zimbabwe Ministry of Health and Child Care statutes while the judicial statutes currently determine them either as *Criminal Mental Patients* or *Detained Mental Patients*. This interdisciplinary linguistic discord or disharmony seemed to be the origin of the rehabilitative mayhem that characterised forensic psychiatry at the time of this study.

The prevalence of mental disorders in remand prison is acknowledged as a reality by Parsons et al (2001:196).The authors conducted a study on the prevalence of mental disorders in remand prison and found that 19% of persons had psychotic disorders; 43% had mood disorders; 42% had anxiety disorders while 4% had a history of mental disorder but no current symptoms. These findings emphasise the necessity to conduct psychiatric evaluations while the persons/patients are in remand custody.

7.3 STEP 5 – THE FORENSIC PSYCHIATRIC HOSPITAL

The study findings and results indicated the need to separate forensic psychiatric rehabilitation services from the prison facility. The state of affairs at the time of the study was such that the special institutions within the prison facility were congested. When they attempted to decongest, they merely overcrowded the civil psychiatric hospital from which the patients did not get discharged. Moreover, forensic psychiatric patients were cared for in the presence of other prisoners and convicts because of the lack of space. All these factors did not facilitate patient recovery. Schubert (cited in Grenfell 2008:184) argues that "categorisation make up and order the world and hence constitute and order people within it". Therefore, when in accordance with the developed medico-judicial framework, the categorisation of forensic psychiatric patients outside the prison system would eventually prevent the perpetuation of the arbitrariness and misrecognition in the realm of forensic psychiatric rehabilitation that characterised special institutions at the time of the study.

As far as rehabilitative treatment for forensic psychiatric patients is concerned, the developed medico-judicial framework as shown in Figure 7.1 highlights that the pro-medical interventions would be the main impetus to drive the rehabilitative treatment process in the forensic psychiatric hospital (Step 5). Pro-medical interventions are regarded as the major role players likely to be beneficial in rehabilitative treatment for forensic psychiatric patients (American Psychological Association 1992:1600; Greenberg & Shuman 1997:54). The forensic psychiatric hospital would have more psychiatric trained staff than guards to facilitate supervision of the patients as well as monitoring their medication; thus, the guards would be expected to focus on security only. This system would open up forensic psychiatric rehabilitation to new possibilities and new ways of giving specific care to forensic psychiatric patients in a new social field and new habitus (Grenfell 2008:220).

The forensic psychiatric hospital is projected to repossess all forms of capital that would empower it to function as autonomously from the prison system as possible. The

Zimbabwe Mental Health Act of 1996 does not specify what exactly is meant by “treatment and care”. The results and findings of this study indicated that because there is no uniformed understanding of its intended meaning, misinterpretations thereof resulted in leaving psychiatric rehabilitation liable to various interpretations by the prison system. In this medico-judicial framework the stakeholders and experts co-constructed what they expected of the forensic psychiatric hospital. This included availing comprehensive psychopharmacological interventions, patient specific occupational rehabilitation, increasing patient access to the multidisciplinary team, facilitating friendly visits for the family who are the core support system of the patients, and affording patients leave of absence in the advent of pressing issues like death in the family(for example, that of a parent or child).

The forensic psychiatric hospital would be managed by the Zimbabwe Ministry of Health and Child Care. The Zimbabwe Ministry of Health and Child Care was perceived as distancing itself from or abdicating its responsibility on the overall care of forensic psychiatric patients. The Zimbabwe Ministry of Health and Child Care seemed to abdicate its mandate to the Zimbabwe Ministry of Justice, Legal and Parliamentary affairs. It would be expected of the Zimbabwe Ministry of Health and Child Care to facilitate holistic care to forensic psychiatric patients in terms of coming up with comprehensive discharge plans and community services. The lack of continuity in the care of forensic psychiatric patients at the time of the study was attributed to the perceived disengagement of the Zimbabwe Ministry of Health and Child Care in the overall care of forensic psychiatric patients.

It further seemed as if the Zimbabwe Ministry of Health and Child Care perceived the prison system conatus as legitimate and sufficient constituting a dialectic through which irregularities in forensic psychiatric rehabilitation processes were perpetuated. This is to say the prison system seemed to be perceived as having the capacity to rehabilitate patients and in the process maintaining the status quo of ineffectiveness. Skipworth and Humberstone (2002:48) state outright that the health system has the responsibility of care for forensic psychiatric patients and not the justice system. Chaimowitz (2011:1),

Skipworth (2005:70) and Taylor (2008:24) all highlight the need to find an alternative in forensic psychiatry rehabilitation of which the principles will ensure effective therapeutic interventions in even the most restrictive environment.

7.3.1 Psychopharmacotherapy

The forensic psychiatric hospital would be instituted consistently by medical staff that is trained to do so. Prescriptions would be done by medical staff members who have prescription authority. It will be further expected that the medicines given would be those that have minimal side effects so that patients do not “get worse”. The participants perceived negative side effects from the neuroleptic medicines. Prescriptions and the medicines given to each patient would be documented for continuity of rehabilitative care.

The psychopharmacological issues discussed above are put into perspective in the findings of a transcultural study on psychopharmacotherapy for schizophrenia by neuroleptic treatment. The study was conducted by Kurihara, Yagi, Reverger, Kawai and Inada (1998:S189) between Tokyo and Bali. The findings suggest that the way in which neuroleptic treatment is administered determines the readmission rate. In three further consecutive studies conducted in which low doses of neuroleptic drugs were given, these authors discovered that tardive dyskinesia was less likely to occur. The relation of these findings to the structuring of the medico-judicial framework in the current study is that, if psychopharmacotherapy is instituted professionally, forensic psychiatric patients would be less likely to “get worse” as symbolised by tardive dyskinesia in the Tokyo and Bali study.

7.3.2 Occupational rehabilitation

The basis of sending the forensic psychiatric patient to a forensic psychiatric hospital is to facilitate their rehabilitation and, ultimately, their reintegration back into society. At the time of this study, it seemed that the comprehensive rehabilitation of forensic psychiatric

patients was affected by the objectification of patients which disempowered them. It was apparently as a result of their classification under the Zimbabwe Prison Act of 1996. As told by the patient participants in this study, it meant that the patients could not engage with activities outside the physical walls of the special institutions situated within the prison.

Conversely, the findings and results pointed out there was a need from patients to be taught practical skills during their time of admission in the forensic psychiatric hospital. The practical skills proposed were co-constructed around ordinary activities of daily living (like patients being able to wash their own clothes) to more skilful activities like gardening, carpentry, and poultry farming projects. These activities would be tailor made to suit the individual patient's educational level. The acquired skills would then keep the patients busy, therefore facilitating recovery and self-sustenance.

Occupational therapy is the hallmark of this projection. It would then be expected of the forensic psychiatric hospital to have comprehensive rehabilitation programmes that prepare patients to live productively in society. This would be realised by staffing the forensic psychiatric hospital with appropriately trained personnel who are able to run programmes without the interference of parallel statutes– unlike what the reality was at the time this study was done. Occupational rehabilitation programmes are perceived as instrumental in aiding the recovery of patients (Occupational therapy in mental health services 2000:13). These need to include creative workshops, music, sport and fitness, drama and art therapy as well as social activities. Occupational services would be expected to provide support for forensic psychiatric patients to engage in spiritual, religious, and cultural activities suitable to each patient.

Capacitating patients is projected to increase the forensic psychiatric patients' economic capital and empowering them in the process. Moore (2004:S40) and Tregoweth, Walton and Reed (2012:50) support this notion by specifying that occupational therapy should be involved in the daily activities of forensic psychiatric patients. Such activities should include self-care and work as well as leisure so that these patients move from previous

maladaptive behaviours to a functional disposition. In addition to this, placing emphasis on occupational rehabilitation would enable forensic psychiatric patients to reprogramme their social role performance, make plans for the future which should include the potential of being employed.

Taylor (2008:24) reports on a study in which stakeholders from both medicine and the judiciary shared their experiences on transfer and discharge of patients from high security hospitals. The findings revealed that the stakeholders' main concern was that patients had a "pathological dependence "which they worked out to foster a situation; "facilitating independent living" is still an issue that the medico-judicial framework is poised to address through occupational therapy in the realm of the forensic psychiatric hospital.

7.3.3 Access to the multidisciplinary team

The study findings highlighted the need to have a pro-medical team that is accessible to forensic psychiatric patients. This is the team that would transact rehabilitation. It is obvious that the more limited the access patients have to the team, the less likely they are to recover. This accessibility would be covered both at forensic psychiatric hospital level, halfway facility level, and at community level. The increase of access to the multidisciplinary team would lead to an increase in the forensic psychiatric patients' specific capital for rehabilitation.

The composition of the medical team is supported by Moore (2004:S40) who posits that in forensic psychiatric settings, psychologists' contribution in the assessment of patients are used to craft patient-specific interventions that are in line with the patients' functional ability and competence. Psychiatric nurses would be able to monitor the bio-psychosocial and spiritual needs of patients by virtue of being the cadre that spends the most time with the patients. The identified needs would give the medical team more insight as to what interventions are suitable for the patients. Social workers would be expected to trace and untangle the complex pathways that relate to the forensic

psychiatric patient's social landscape. This function of the social worker would be expected to define particularly the position and dynamic of the family in the patient's predicament, especially as a potential support system.

The family as a support system, as Skipworth and Humberstone (2002:51) explain, would be in a position to identify signs of relapse after the patient has been discharged from the forensic psychiatric hospital. It would also be a reference point for the forensic psychiatric patient with which to identify. When the social worker is in an alliance with the family, the family may be open to express their fears. Social work as a department can address or refer the relative(s) to other members of the multidisciplinary team depending on the complexity of the issues the family brings up.

Access to the multidisciplinary team would be more comprehensive and effective if the medical and judiciary teams have a unity of function in terms of processing and care of forensic psychiatric patients from the courtroom right down to the community after discharge. This unification of function would hinge on the modified specifications of the Zimbabwe Mental Health Act of 1996 and the integrated training of both the medical team and judiciary team which will facilitate insight into each other's professions. The integration of functioning would then reduce the disjuncture and dichotomy of functions that negate the outcome of rehabilitation processes for forensic psychiatric patients. This may be similar to Bourdieu's claim about the nobility and advantage of a cohesive e*spirit de corps* that achieves more within groups. Briefly thus, there would be a need for a seamless or a continuum of service that embraces the medical team, the judiciary team, and security and the community per se (Simpson 2006:835; Skipworth & Humberstone 2002:49).

7.3.4 Friendly visits

A removal of all forms of barriers was called for by the participants. This included both physical and psychological barriers. The physical barriers at the time of the study were very much family-specific and pertained to relatives not having physical access to the

forensic psychiatric patients. Psychological barriers included not having opportunities in an environment that was private and friendly to discuss important family issues which affected the patient and his recovery. This was found as symbolic suffering on the part of the relatives and seemed to be the result of 'border' disputes between the prison system and the medical system. While the Zimbabwe Mental Health Act of 1996 advocates for an enabling environment in the special institution, there seemed to be failure of convergence between the two disciplinary interests.

The prison system came from a punitive ideal; hence, this observation by the participants. In other words, according to Schubert (cited in Grenfell 2008:184), the participants were calling for a destruction and reconstruction of the forensic psychiatric rehabilitation ethos and actions that would enable the availing of social capital pivotal to the recovery of forensic psychiatric patients. The concept of a forensic psychiatric hospital is envisaged to achieve the reconstruction of the ethos directed at therapeutic jurisprudence in the form of comprehensive family involvement. Family involvement could be facilitated by adequately funding social workers who would then maintain contact with the families of the patients. Contact with family members drives movement and the management of patients. Family represents symbolic social capital to forensic psychiatric patients; family involvement is an aspect that is central to their recovery.

Simpson (2006:835) underscores the issue of family involvement in forensic psychiatric rehabilitation by highlighting that of all the clinical relationships there can be, the patient and his family is the most important because it is the common denominator to all clinical services that can be rendered.

7.3.5 Leave of absence for forensic psychiatric patients

On humanitarian grounds, patients whose significant others have passed away would be expected to be afforded the opportunity to attend the funeral or burial service. Participants felt that forensic psychiatric patients were not serving a custodial sentence and therefore it was humane to give them leave of absence in the advent of a significant

other's death. An example was that of parents of the forensic psychiatric patients who had passed away and the patients involved were not allowed to leave the special institution and attend the funerals despite the effort that was made by relatives to appraise the prison management of the deaths.

In this study it was perceived that patients got worse when the issues of parents' ill health were ignored. Aho (2008:251) explains that psychiatric patients are dehumanised when they are denied the opportunity to express their process of emotional suffering. In this study dehumanisation of the patients seemed to emanate from the objectification of patients derived from the Zimbabwe Prison Act of 1996 as operationalised by the Zimbabwe Prison Service Standing Orders of 1992 which, to a certain extent, is perceived as symbolic violence. The symbolic violence is embodied in viewing the patients as "prisoners". This makes them just a number or a file and that strips them of the capacity to feel or 'be'. Granting leave of absence needs to be considered as therapeutic in its own right. Skipworth (2005:73) believes that granting leave to the forensic psychiatric patient during admission is a proxy measure of progress. Although, as the author acknowledges, its granting is dependent on myriad of other clinical variables, the fact that leave of absence is indeed considered and given in certain circumstances is in itself indicative of the some progress towards upholding a patient's humaneness.

7.4 STEP 6 – SPECIAL BOARD AND MENTAL HEALTH REVIEW TRIBUNAL

The stakeholders and experts insisted that since the forensic psychiatric patients had committed crimes exceeding level 3 fines, they needed to be discharged by the **Mental Health Review Tribunal** following the recommendations of the **Special Board**. This means that after the forensic psychiatric patients have recovered, the multidisciplinary team led by the psychiatrist should compile a report to the effect that the patient has recovered and is ready to be reintegrated into society.

In the context of the developed medico-judicial framework, the Special Board would pay regular visits to the special institution and assess the forensic psychiatric patient based on the report of the multidisciplinary team. The Special Board would then transmit its report to the Mental Health Review Tribunal. The Mental Health Tribunal would subsequently discharge the patient to a **halfway facility** (Steps 6 and 7 – **Special Board and Mental Health Review Tribunal and Halfway facility** in Figure 7.1) to start preparing the forensic psychiatric patient for community placement. While the forensic psychiatric patients are still admitted in the forensic psychiatric hospital, the Mental Health Review Tribunal would be expected to familiarise itself and interact with the hospital so that it executes its primary mandate of upholding the rights of patients. While developing this medico-judicial framework in the study, the members of the Mental Health Review Tribunal had not had professional interaction with the special institutions that were rehabilitating forensic psychiatric patients.

7.5 STEP 7 – HALFWAY FACILITY

The **halfway facility** is projected to prepare psychiatric patients for community placement. Halfway facilities would be within a reasonable radius of a psychiatric unit so that supervision is easy. This would be a place where patients are in a controlled environment in which they would learn a variety of skills that they would need once they have been discharged and again join the community. Patients in the halfway home which, in fact, would serve as a community-based safety net, would be supervised primarily by the occupational therapy team. This will be a gradual progress towards patients' autonomy as opposed to the heteronomy fostered by an indefinite stay in special institutions evident at the time of this study.

Recommendations were made that halfway facilities should also be staffed by psychiatric prepared staff. The expectation for implementing this step is that the patient would be in possession of symbolic capital, for example, social and cultural capital that would prepare him for the real world in the community. The concept of a halfway facility is acknowledged by Dabbs and Isherwood (2000:200) as a place where patients can

live a semi-independent life and practise activities of daily living pending their community placement. The authors Alcock and White (2009:108) and Skipworth and Humberstone (2002:48) emphasise that the gradual introduction of forensic psychiatric patients into the community makes the transition progress into society easier for them. It allows them to practice and enhance the skills and coping mechanisms they have learned in the forensic psychiatric hospital in a semi-protective environment before entering the world outside of forensic psychiatric hospital. The authors recommend that a halfway facility be staffed by a composition of a wider psychiatric multidisciplinary team. Alcock and White (2009:118) specifically note that facilities that are functionally similar to a halfway facility have been associated with allow conviction rate and successful reintegration of forensic psychiatric patients into the community.

7.6 STEP 8 – COMMUNITY SERVICES

Skipworth and Humberstone (2002:50) reflect on the discrimination of communities against forensic psychiatric patients who have been discharged. According to these authors, such discrimination forms the basis of the typical neglect these patients experience in their communities after discharge. When community services neglect helping or advocating for the discharged forensic psychiatric patients, the message communicated to the people is that these persons are dangerous. Community services were therefore viewed as central in the recovery and reintegration into communities (and society at large) of forensic psychiatric patients.

Viable community projects, sustained by financial aid from the government and non-governmental organisations (NGOs), to include follow-up and follow-through activities were advocated for by all stakeholders and experts in this study. Vocational facilities where patients would interact and have peer support while learning various skills were strongly advocated for. The issue that elicited a spirited argument among the stakeholders was the provision of a permanent home for discharged persons who are disowned by their relatives following the commitment of a heinous crime. The

stakeholders insisted that disowning of patients was a reality which no amount of community awareness and education can contain.

7.6.1 Community projects

To curb recidivism, the participants recommended that there should be community projects. Projects in the community were also projected to reduce the likelihood of maladaptive behaviours like substance abuse that often results from idleness. Other projects included making job opportunities available and eliciting community support in this instance. For the community projects to suffice and be sustainable, a recommendation was made that there should be financial injection either from the government or other sources like non-governmental organisations (NGOs). This would empower the forensic psychiatric patients and reduce symbolic suffering to both them and their relatives. Without skills that empower them, it is likely that forensic psychiatric patients will not be in possession of the configurations of capital (habitus predispositions or propensity) that they will need to be recognised by members of society to be worthy human beings in their own right.

7.6.2 Vocational facility

Beyond the special institution, participants advocated for a special vocational facility that patients could utilise or identify with. The facility should be funded by the Ministry of Health and Child Care or its arms and continue to provide the practical skills initiated at the special institution. The production at the vocational facility for patients would be sold so that the programme remains sustainable and patients can be independent. Therefore, the **vocational facility** included in the medico-judicial framework would be expected to avail all forms of capital to the forensic psychiatric patients. The social capital would be enabled by networks that would be formed in the process of interaction; cultural capital would evolve as they learn the skills at the facility, while economic capital would be inherently tied to materials that would be sold from the proceeds of products or articles made.

Previous research study findings show that rehabilitation in special institutions was belied by the administration of psychotropic and other related medicines. Tregoweth et al (2012:49) call for a strategic rehabilitation that embraces vocational intervention so that symptoms are abated by interaction and integration but at the same time the forensic psychiatric patient is prepared for the employment market. According to the same authors, being employed is considered as a significant indicator for successful community reintegration for forensic psychiatric patients.

7.6.3 Follow-up

Follow-up of patients was viewed as imperative by the participants. They suggested that it could be best done by medical staff working at the forensic psychiatric hospital. But, as the participants emphasised, the medical staff members must be psychiatric trained. The follow-up was to be focused on three areas: patients/persons facing trial, patients who have been transferred from the special institution to remand prison, and persons who have been discharged into the community. Relating to patients/persons facing trial, these would be those who have been denied a special verdict and would be proceeding to prison after recovery in the special institution.

The judiciary consistently highlighted the need to engage the relatives of the patients in the follow-up process. Follow-up was furthermore projected to increase the social and cultural capital for facilitating patients' recovery. In the medico-judicial framework, follow-up would maintain the focus of the rehabilitative team so that patients would not get lost in the system. The concept of follow-up of forensic psychiatric patients beyond the special institutions has been acknowledged as vital in literature (Dabbs & Isherwood 2000:200). Research studies confirm that the follow-up of forensic psychiatric patients can catalyse rehabilitation started in hospital into a successful community reintegration endeavour (Anzai, Yoneda, Kumagai, Nakamura, Ikebuchi & Liberman 2002:546; Coid et al 2007:226). This means that patients who have been afforded follow-up can successfully reintegrate into society as evidenced by employability and autonomous interactions with their families.

7.6.4 Financial aid

The participants advocated for funding to **financially aid** programmes that facilitate the rehabilitation of forensic psychiatric patients. Such funds would assist patients to pursue their areas of interest both occupationally and vocationally. The bottom line is that the economic capital which referred to real money and possessions was not available to forensic psychiatric patients; specifically, the male patients. The researcher observation notes and Participant 11 indicated that humanitarian agencies focused on female forensic psychiatric patients. At the time of the study there seemed to be an economic laissez faire with regard to support for male forensic psychiatric patients. In other words, there seemed to be a presence of alienation or anomie evident in financial support to forensic psychiatric patients from the government or their social support system. In the projected future, the medico-judicial framework would take cognisance of the warning by both Dabbs and Isherwood (2000:202) and Skipworth and Humberstone (2002:48) that for services to be viable in forensic psychiatric practice and to avail a therapeutic environment, there should be central funding. Without funding, it is likely that patients' behaviour could be criminalised to the extent that they would then filter back into the prison system.

7.6.5 Permanent home for the disowned

Regarding the family attitudes of not wanting to take responsibility for forensic psychiatric patients, the study findings revealed participants felt it would only be practical to have a **permanent home** for the disowned. This would be a facility in the community which would not be a halfway facility or halfway home. Although it might become a potentially controversial arm of community services, the necessity and desire for a permanent home was voiced and recommended by stakeholders and experts. The permanent home concepts was also reinforced by the observation that there were relatives who never visited forensic psychiatric patients while in custody of the special institutions or who deliberately gave wrong addresses. When this structure (a permanent home) is in place, it is hoped that with time continuous de-stigmatisation and

awareness campaigns would make the facility less and less necessary. Unfortunately, information in literature on the concept of a permanent home for disowned forensic psychiatric patients is limited.

7.7 GUIDELINES FOR IMPLEMENTING THE FRAMEWORK: THE VISION OF A NEW MEDICO-JUDICIAL COSMOS

While the medico-judicial framework was an attempt empower and redefine the rehabilitation of forensic psychiatric patients in a forensic psychiatric hospital, the study could not ignore primordial, discursive values and precarious exigencies (prohibitive factors) related to forensic psychiatric rehabilitation at the time the study was conducted. In view of these prevailing arbitrary rehabilitation processes, a need emerged to move towards context dependent rehabilitation; thus, towards enablement.

It was vital to look at where the medico-judicial rehabilitation system in Zimbabwe *was* before it could be enabled to ride the wave *of change to somewhere*. Analogically, it would have been pointless to look for a $10 note in Harare when one had lost it in Bulawayo. This is what this study did – it located where the system *was*. It then became natural to trudge towards the land of possibilities and potential for effective rehabilitation through the developed medico-judicial framework. This journey was powered by a wide array of enabling factors that were fundamentally guidelines for implementing the framework. The enabling factors were those parts of the integrated study findings and stakeholders' recommendations that were perceived as having the potential to catalyse or activate the proposed medico-judicial framework for the rehabilitation of forensic psychiatric patients in a forensic psychiatric hospital in Zimbabwe.

7.7.1 Exposing the dinosaur of obsolescence: revision of the Zimbabwe Mental Health Act of 1996

The stakeholders' frustration regarding the datedness of the Zimbabwe Mental Health Act of 1996 and its general misinterpretation was obvious in their criticism thereof. The

medico-judicial framework could therefore be activated by the Act's collective revision. This means that the experts from the judiciary team and the medical team would need to congregate and deliberate on what needs to be changed to empower both teams and emancipate the forensic psychiatric patient. Areas already mentioned would include what a treatment order entails when a magistrate issues it for admission of a patient at the forensic psychiatric hospital. Also, differentiation of a minor and major crime needs to be explicated in the Act to prevent unnecessary admissions in a forensic psychiatric hospital. Referral of patients from the civil psychiatric hospital under Chapter 37 needs to be revisited as well since it also adds to the overcrowding and gives rise to confusion to patients' relatives.

The revised Zimbabwe Mental Health Act would be expected to define and be the basis on which the habitus of the medical system field is anchored. This means that up to now forensic psychiatric rehabilitation should have revolved around the medical field's system of training and expertise. In this regard, Bourdieu's (1994:14) statement where he conceptualises the habitus as "cognitive structures inscribed in bodies by both collective history (phylogenesis) and individual history (ontogenesis) and on the other, the objective structures of the world to which these cognitive structures are applied" would be correctly understood.

Unfortunately, in the past and still at the time of this study the Act that is supposed to empower and focus the efforts of the medical field system is deemed to be obsolete, inconsistent and open to misinterpretation by any power that is exposed to use it. Therefore, if the Zimbabwe Mental Health Act of 1996 could be revised, it would expose the medical field system to possibilities and potential for empowerment and autonomy. In other words, empowerment would also mean that the revised Act restores symbolic capital to the medical system field and that would spell effective practice (Habitus) (Capital + Field = Practice) as mathematically expressed by (Maton cited in Grenfell 2008:51).

7.7.2 Change of names and location for the special institutions: renaming and finding a new home for forensic psychiatry, 'the bastard child'

At the time this study was conducted, the special institutions were known as Mlondolozi Prison and Chikurubi Maximum Prison respectively. It was the words 'Prison' and 'Maximum Prison' that disempowered both the medical health workers and the forensic psychiatric patients because the former's role and the latter's status were compromised and overshadowed by the security aspect of a prison system. Changing the words from 'Prison' / 'Maximum Prison' to 'Forensic Psychiatric Hospital' would remedy any misconception of the role and status of the aforementioned persons and contribute positively to comprehensive forensic psychiatric rehabilitation. It would also most likely promote the use of comprehensive and effective therapeutic interventions.

Moreover, renaming the special institution from 'Prison' / 'Maximum Prison' to 'Forensic Psychiatric Hospital' would realign the habitus of the medical system field of rehabilitation which seemed to be out of sync with the punitive imperative of the prison system. In other words, language is a form of cultural capital that wields power and can direct the course of rehabilitation depending on the value of those interpreting it. So, if the medical system field is using its 'hospital' language, it empowers them and the forensic psychiatric patients as it reduces the inherent hysteresis that can occur if two conflicting systems define the same concept. Deer's (cited in Grenfell 2008:122) perspective on the language issue with regard to Bourdieu's idea of the complexity of language is that "language and linguistic exchanges and the misrecognised arbitrary classifications, categorisation and differentiation they operate and reproduce are the key elements of the symbolic power that contribute the legitimation of doxa". Substituting the word 'prison' with 'hospital' in the name of the special institution is therefore an effort to counter Deer's perspective.

7.7.3 Realigning the lopsided rehabilitative wheel: medical staffing of the remand prison

The framework would be activated by the presence of medical staff in remand prison so that the entire medical and judicial systems are correctly advised about the mental state of the patients before they are lost in the system. Staffing the remand prison would be an endeavour by the forensic psychiatric rehabilitation practice, which aims to preserve and affirm itself as the custodian of knowledge on forensic psychiatric care. It would also be an expression of a yearning to understand the predicament of forensic psychiatric patients in remand custody. This would also be a form of repossessing symbolic power by the medical system field so that it has the legitimate power to control the fate of forensic psychiatric patients along the continuum of care. The ultimate winner would be the forensic psychiatric patients. They would be safeguarded against relapses while in the system; relapses trap them behind the hinges of the 'revolving door' phenomenon that dehumanises and takes life away from them.

7.7.4 Realigning the engine and the anchor: in-service training workshops for the judiciary

The training of public prosecutors and magistrates would equip them with the requisite knowledge that would transport them from a hypothetical approach to the handling of forensic psychiatric patients–or what they term mentally ill 'accused' persons. In-service training would also include basic psychiatric concepts so that they can follow the reasoning of the expert witness (doctor or psychiatrist). Being informed would prevent the judiciary from making errors of judgement whereby they either sentence a patient or let him filter through the cracks of the system or not sentence a person when they are supposed to sentence him. This then means that the errors would be representing the anchor which holds back recovery while the knowledge would represent the engine that spurs forensic psychiatric rehabilitation forward.

The training of the judiciary would also reduce their system's habitus from responding in disharmony or discord to the medical system field which is born out of lack of insight into each other's work. This collision has resulted in unproductive mudslinging with the forensic psychiatric patient receiving the actual 'dirt' as they stand in the middle. The 'dirt' is embodied in reduced quality of life and being sentenced to *"life in the vacuum*"' as expressed by Participant 9.

7.7.5 Locating the missing pieces: awareness campaigns

Awareness campaigns would include aggressive education programmes targeted at the public through the public media machinery and outreach programmes. Awareness would be expected to capacitate the public with regard to knowledge on what to do with forensic psychiatric patients as well being aware of the availability and accessibility of forensic psychiatric services.

In raising awareness the goal would be analogous to Bourdieu and Wacquant's (1992a:251) notion that the point is not to produce a "new person" but a "new gaze "or 'new eyes' which, in this case, would pertain to a psychiatric rehabilitation cosmos eye. According to these authors, this "new gaze"' can only be realised if there is what they call "conversion of one's gaze"; a *metanoia* or a mental revolution; meaning a transformation of the public's total vision of the realm of forensic psychiatric patients and their rehabilitation. With this new pair of eyes, it would be expected of the public domain to understand that sending forensic psychiatric patients away for rehabilitation is not to 'put them away' for public safety, but that their rehabilitation cannot be polarised as it is an integral part of what makes up the fabric of society.

7.7.6 Repairing the cracked mirror: more psychiatric trained staff than guards in forensic psychiatric hospital

The cracked mirror here relates to the duality of forensic psychiatric rehabilitation which distorts the image to being comical, sinister or bizarre. At the time of the study the

image was bizarre because its double bind inclination produced nothing more than some kind of rehabilitative schizophrenia in the system. This was embodied in lack of supervision of patients resulting in them selling medicines to criminals in exchange for food and therefore defaulting treatment. More medical staff in a specific forensic psychiatric setting would be in a position to determine the depth, width and direction of forensic psychiatric rehabilitation without their prerogative being violated by deficiency of all forms of capital that characterised the trend at the time of the study. The violation of the medical team's mandate equalled a non-functional rehabilitation for patients in special institutions.

Having more medical staff within the field of the remand prison would better position medical staff's trajectory insofar as the future of forensic psychiatric rehabilitation would be concerned. This new habitus would also direct and position the medical staff in view of possession of symbolic capital configurations that would then spill into the principles of logic in the field of the remand prison. It would put the forensic psychiatric patients in a position of rehabilitative advantage (Grenfell 2008:223).

7.7.7 Exposing the antithesis of pluralism: special office and separate clerk of the court

This is a service that specifically relates to court procedures. The clerk of the court's pluralistic function resulted in symbolic violence and symbolic suffering for forensic psychiatric patients. Removing this pluralism would enable thorough expediting of cases for persons and patients who go through the criminal justice system and need forensic psychiatric services. The clerk of the court would also be expected to prevent the loss of documents. The loss of documents trapped patients in the system either judicially or medically.

The pluralistic function of the clerk of the court in this study seemed to put him in a position where he did not have "a sense of place". He was not sure whether he should have a *les gens modestes* or common ground with the judiciary system covering the

criminals or the judiciary system covering the mentally ill persons as they came into the system that led them to their rehabilitation (Bourdieu 1989:17). In the process of all this confusion emanating from the double bind exposure, it showed that the clerk of the court did not apply his mind to 'mental cases'. Removing this pluralistic function and having a specific clerk of the court to process records of forensic psychiatric patients would foster the clerk's identification with the cause of rehabilitation of forensic psychiatric patients.

7.7.8 Embracing a world without clones: separating Criminal Mental Patients and forensic psychiatric patients

Criminal Mental Patients and forensic psychiatric patients share the same socio-historical ancestor in Zimbabwe but their unnoticed 'genetic' differences seemed to cause discord in forensic psychiatric rehabilitation. To facilitate clear pro-patient rehabilitation procedures, there would be need to not allow convicts, Criminal Mental Patients and forensic psychiatric patients in the forensic psychiatric hospital. Bunching these three groups seemed to be retrogressive because of the tendency to emphasise on the security part of management. This separation, like stakeholders said, would make it possible for the managers of the forensic psychiatric hospital to identify the actual needs of the forensic psychiatric patients.

Bourdieu (1989:20) expresses that a combination set-up like the one described above, this symbolic *collectiopersonariumplurium,* made the combined groups to have unbalanced opportunities. Using an analogy, Bourdieu explains that "just as feathered animals are more likely to have wings than furry animals", so are those patients who have already been assessed by a psychiatrist more likely to benefit from forensic psychiatric rehabilitation than those who have not (Bourdieu 1989:20). Hence, the idea is that patients who have been examined by the two government medical doctors should remain at the remand prison until a psychiatrist has assessed them and then only can they be sent to the forensic psychiatric hospital. Not mixing the Criminal Mental Patients and forensic psychiatric patients in this new reality of the medico-judicial

framework would most likely discard the language and politics of the old order of the special institution and in the process undo the de facto unorthodox vision present at the time of this study.

7.7.9 Navigating the *libido dominandi*: integrating the Zimbabwe Mental Health Act of 1996 with the Zimbabwe Prison Act of 1996

The two instruments' concurrent utilisation fosters a struggle for legitimating and asserting power between the prison system and the medical system (*libido dominandi*). Experts and stakeholders would be expected to navigate, that is to plan, control and direct the course of forensic psychiatric rehabilitation practice which at the time of the study was boxed into an ill-fitting identity. The framework would be implementable if the Zimbabwe Mental Health Act of 1996 and the Zimbabwe Prison Act of 1996 are harmonised in their function.

The bone of contention on the issue of using both the Zimbabwe Prison Act and the Zimbabwe Mental Health Act revolve around the diversity of the inherent languages used. Considering Bourdieu's (1991b:2) principles, the aspect of the linguistic habitus embodied in the Zimbabwe Prison Act of 1996 being seen as having the "primordial form of consensus that is in agreement" to the prison system is inclined to be functionally biased towards the interests of the prison system. In practice, this becomes a strategy of condescension to and therefore negating the Zimbabwe Mental Health Act of 1996. Harmonising this power play between the two instruments would then add symbolic efficacy and value to the rehabilitation of forensic psychiatric patients in the forensic psychiatric hospital.

7.8 SUMMARY

This chapter discussed the medico-judicial framework for rehabilitation of forensic psychiatric patients in Zimbabwe. The thrust of this study was to develop a medico-judicial framework reflecting a systematic and comprehensive guide adopting a

therapeutic jurisprudence approach in Zimbabwe. The goal was to reframe to a forensic psychiatry specific doxa of rehabilitation in the habitus of forensic psychiatric hospitals in Zimbabwe that is articulated around therapeutic social, economic and cultural capitals. At the present moment, the misrecognition of the prison system has fostered heteronomy and symbolic legitimating in the rehabilitation processes in special institutions rendering the processes ineffective and bastardised as implied by Bourdieu (1984c:7).

The framework was focused to drive forensic psychiatric practice in Zimbabwe into a new habitus and doxa for forensic psychiatric rehabilitation within a scientific and locally relevant realm. Validation of the framework was also done by the stakeholders and experts who modified the original version or draft of the framework to what it eventually evolved to become.

CHAPTER 8
SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

"We are so made, that we can only derive intense enjoyment from a contrast and only very little from a state of things."
Sigmund Freud (1909)

8.1 INTRODUCTION

In Chapters 4, 5, 6 and 7 the build-up towards the medico-judicial framework for rehabilitation of forensic psychiatric patients in special institutions in Zimbabwe was presented. This was based on open codes, focused codes, axial codes, theoretical codes and quantitative results enmeshed in the constructivist grounded theory on which this study was rooted.

The study was driven by the research question: ***"What should a medico-judicial framework consist of for the rehabilitation of forensic psychiatric patients in Zimbabwe?"*** The challenge with this research study was to develop a medico-judicial framework which was non-existent in Zimbabwe at the time it was conducted.

This is the first study to be conducted in the field of forensic psychiatric rehabilitation in Zimbabwe. In view of this assertion, this work is an original contribution to both general and forensic psychiatry and therefore to world knowledge. The focus in this chapter is to bring to a close the endeavour of this study. This chapter takes us through the summary of how study objectives were achieved, points out the limitations of the study and makes recommendations in view of the findings and results.

8.2 SUMMARY

The study developed and availed the medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe as envisaged by the overall aim of the study.

The focus and context of the study was at the only two special institutions responsible for forensic psychiatric rehabilitation in Zimbabwe. The study participants included stakeholders and experts in the medical system, the judicial system, the prison system, forensic psychiatric patients and relatives of forensic psychiatric patients. The study was founded on the mixed method approach. It utilised grounded theory as a paradigmatic perspective, social constructivism as its meta-theoretical grounding and Pierre Bourdieu's concepts of capital, field and habitus as its theoretical framework.

The study was conducted in two phases. Initially qualitative data was collected and analysed. Bracketing, debriefing, intuiting, inductive and deductive reasoning facilitated synthesising the data on the rehabilitation of forensic psychiatric patients in special institutions. Qualitative data was analysed using open codes, focused codes, axial codes and selective codes. These codes were later abstracted into concepts that represented and described the current realities of forensic psychiatric rehabilitation in special institutions in Zimbabwe.

The findings showed dislocation and dissonance between and within the habitus of the social fields of medical, the judicial and the prison systems with an ensuing hysteretic effect that negatively affected the outcome of forensic psychiatric rehabilitation in special institutions in Zimbabwe. An instrument was then developed from the qualitative findings to be used in the quantitative phase. The instrument was developed after open and axial coding because data already showed the patterns of how the special institutions operated and functioned.

The quantitative phase involved the retrospective collection of secondary data from documents of forensic psychiatric patients admitted between 2005 and 2010. The results of this phase indicated that rehabilitation was biased towards psycho-pharmacotherapy therapy or psychotropic medical treatment. Service outcomes were generally not documented in the patients' documents. Conclusions on the lack of documentation were wide and varied, ranging from possible disillusionment of medical staff to possible lack of access to the forensic psychiatric patients' records. The medico-

judicial framework then evolved from the integrated themes and concepts of the qualitative research findings and the quantitative results of document review.

8.2.1 Flow of the study

The study had objectives that were categorised into 3 phases and the study set out to achieve these objectives. Phase 1 of the study constituted objectives that sought to analyse the situation of current trends and realities. The objectives included:

1. to conduct a literature review of the rehabilitation of forensic psychiatric patients in developed and developing countries
2. to explore and describe the stakeholders' experiences of the medico-judicial procedures related to rehabilitation followed during the detention of forensic psychiatric patients in Zimbabwe
3. to explore and describe stakeholders' recommendations for the development of a medico-judicial framework
4. to review the documents of forensic psychiatric patients admitted in special institutions between 2005 and 2010 in order to identify the rehabilitative mental health services available to forensic psychiatric patients in two special institutions in Zimbabwe.

Phase 2 sought to develop a medico-judicial framework based on the findings of the situation analysis while Phase 3 validated the medico-judicial framework by a group of experts and stakeholders. All these objectives were achieved and were part of Chapter 1 of the study.

8.2.2 Literature control of research findings and themes

A literature control of the findings from the stakeholders' experiences was done. Extant literature on forensic psychiatric practice globally and regionally guided the control of

the findings. The main themes that evolved from the study were grounded on each stakeholder group. The themes are presented below.

- Discordant engagement of the judiciary to the system of rehabilitation of forensic psychiatric patients.
- Dichotomous reality in which nurses' responsibility is abdicated.
- Patients experience life in the institution as a "prisoner" and not as a "patient" with ensuing physical, emotional, social and occupational challenges.
- Negative perception of the rehabilitative context by patients' relatives.
- Prohibitive processes negatively affect overall patient care and recovery for psychiatrists.

Themes were further abstracted to axial and theoretical coding hinging on Pierre Bourdieu's conceptual canon of field, habitus and capital. A literature control in view of the themes revealed a generally chaotic picture of forensic psychiatric rehabilitation, especially in the region (Africa). In other cases there was scant information to support or refute the findings or other sub-themes. Literature related to the first theme revealed that there was shortage of resources and skilled professionals. It also highlighted that forensic psychiatric settings were driven by poor legal and policy frameworks including a lack of unified standards for forensic psychiatric practice. Double stigma (psychiatric patient plus prisoner) of forensic psychiatric patients was also a factor in literature.

Literature related to the second theme indicated that the care of forensic psychiatric patients was diffused within a wide array of stakeholders. There is general disorganisation of forensic psychiatric practice in nursing which is skewed towards rudimentary custodial care.

As regards the third theme, a literature control suggested that there were deficient legal and mental health services for patients resulting in a lack of comprehensive, coordinated care and services. In the region, literature showed that the predicament of forensic psychiatric patients was generally a result of a lack of resources, absence of

guiding legislature and the use of prisons as service providers for forensic psychiatric care and treatment. Literature also pointed out the conflict of interest regarding the patient between the judiciary and other stakeholders.

The fourth theme literature generally pointed out how forensic psychiatric practice should integrate with relatives. However, the findings were not in line with what this literature was modelling. The findings remained in deficit of what was expected by the global perspective.

The last theme's literature review confirmed the issues of lack of resources and disjuncture between the psychiatrist and the judiciary. Literature also consistently supported the findings that made up the theme in the light of the fact that patients are sent to special institutions to protect society. Ideally, protecting society is not the primary interest in the rehabilitation of forensic psychiatric patients. The point is to make the patients functional members of society. Literature control formed the bulk of Chapter 6 while general historical literature to identify gaps in forensic psychiatric rehabilitation was covered in Chapter 2.

8.2.3 Process of developing the medico-judicial framework

The development of the medico-judicial framework was based on the findings, results and recommendations of the stakeholders. After the initial draft of the medico-judicial framework had been crafted, a validation exercise was done on forensic psychiatry practice's major stakeholders and experts. Suggestions for the alterations and realignments were done by the stakeholders and experts from the medical and judiciary teams as explicated in Chapter 7. The factors that would activate the framework were explained in Chapter 7 as well. Generally, the medico-judicial framework for the rehabilitation of forensic psychiatric patients was positively accepted by the experts and stakeholders who are its possible future users.

Peer review of the study findings and results was also done through three research conferences, two international and one national, in which four presentations based on this thesis were done. The international ones included the Tenth International Congress for Qualitative Inquiry held at the University of Illinois in Urbana-Champaign (21–24 May 2014) in the United States of America. The second international presentation was done at the 3rd International Conference and exhibition on Neurology and Therapeutics at Hilton Philadelphia Airport (8–10 September 2014) in the United States of America. In this particular presentation, the paper, 'A Medico-judicial Framework for Rehabilitation of Forensic Psychiatric Patients in Zimbabwe' was presented. Two presentations (national) were done at the Annual Nursing Education Conference held at Emperors Palace in Gauteng, Republic of South Africa (25–27 June 2014). The following are two documented peer review statements by two of delegates and one acknowledgement:

Peer review 1:

"*Your presentation took this idea of the 'revolving door' to another level of despair, describing how individuals in forensic psychiatric rehabilitation were often completely lost in the system, as if no longer alive, let alone no longer important to life. The fact that you are illuminating this with your research, carefully navigating the bureaucratic context in which the rehabilitation practices and system are enmeshed, is both hopeful from a humanitarian point of view and impressively comprehensive from a scholarly point of view. Even that you care to do this is a great humanitarian statement and I hope that many of the individuals in the forensic psychiatric rehabilitation system feel empowered by your example."* (Munly, 2014).

Peer review 2:

"It (the research study) *also reflected focus and depth regarding the response to the challenges that faced the researcher in the study. The study covered a broad base of players involved in the realities of forensic psychiatric patients–this is evident in the section on sampling and data collection. The methodology used in the study* (grounded

theory) *matched the nature of the study and assisted greatly in answering the research question. The findings highlighted the lack of communication and functionality among the different organs that form part of the realities of the patients*: *'There was a lack of homology between the dominant prison system, the judiciary and the medical/health system and the habitus'*. *A broad study with depth and great relevance."* (Modipane 2014).

When the medico-judicial framework for rehabilitation of forensic psychiatric patients in Zimbabwe was presented, a certificate of recognition was presented to the researcher by the OMICS Publishing Group and the editors of Journal of Neurology & Neurophysiology, Brain Disorders & Therapy and the Journal of Neurological Disorders and Autism. The certificate describes the oral presentation as phenomenal and worthy and the presentation abstract was published in the Journal of Neurology & Neurophysiology 2014, Volume 5, Issue 5, page 107.

8.3 CONCLUSION

In view of the current realities and trajectory embodied in and underlined by a system of dominance, it seemed that symbolic suffering, disempowerment and voicelessness were emitted by the disjunction between the fields and habitus of the prison system, the judicial system and the medical system (Schubert cited in Grenfell 2008:87). Along similar predicaments, hope about resolving this predicament is revived when considering Bourdieu's (cited in Bourdieu & Wacquant 1992a:136) proclamation that: "Although it is difficult to control the first inclination of the habitus,...reflexive analysis, which teaches us that we endow the situation with part of the potency it has over us, allows us to alter our perception of the situation and thereby our reaction to it". With this statement, the author validated that structural transformation in any field and any habitus is possible. This assertion is even consolidated when Bourdieu (cited in Hillier & Rooksby 2002:29) points out that "the habitus may be changed...by new experiences, education and training" as specified in the framework implementation guidelines in

Chapter 7 to be part of the transformation process towards the new rehabilitative cosmos.

Developing the medico-judicial framework was not exactly a journey that was reached as alluded to in Chapter 1; it was definitely not an arrival but a long voyage through a world which was projected to find its destination in comprehensive rehabilitation services for forensic psychiatric patients. In the process of the journey, ghostly voices from the socio-historical past of forensic psychiatry and a cocktail of expectation from the generality of Zimbabwean psychiatric practice were expected to stalk the implementation of the medico-judicial framework. The wheels propelling the journey of the medico-judicial framework implementation would be expected to be lopsided initially but would also be expected to spin evenly on its axis with time since it was powered by evidence-based research and moving in cycles around the cooperation of medical and judiciary systems that validated the framework. This predictive assertion emanated from debriefing interviews with both medical and judicial teams who consistently implied that it would be an uphill task to change the status quo and to transcend the libido dominandi of the judicial system.

8.4 LIMITATIONS OF THE STUDY

The study was conducted on male forensic psychiatric patients and not on female forensic psychiatric patients because there were important variables in the two groups that were not homogenous as explained in the inclusion and exclusion criteria in Chapters 1 and 3. However, it is possible that including females in the study could have added perspective to the study. This also limits the generalisation of findings beyond the male forensic psychiatric participants.

One other very important limitation was that relatives of forensic psychiatric patients who were interviewed were available and willing to participate in the research study. They were generally supportive to forensic psychiatric patients admitted in the special institutions and they were all (except one) parents of the patients. However, the limitation refers to the fact that a comprehensive and true picture of actual family

support systems could have been availed if the relatives who never visited or deliberately gave wrong addresses had participated. Relatives who never visited seemed to have had contact with the patient as far back as the during the court proceedings. When trying to trace them, they had migrated many times to the extent that it was impossible to locate them. In other instances, relatives would have come from rural areas then give an address of an urban dwelling acquaintance. When traced, that acquaintance would have moved elsewhere, again making follow-up very difficult. If such relatives were accessed, a different picture would have possibly been painted in this study with regard to the position of relatives in the rehabilitation of forensic psychiatric patients.

With regards to retrospective review of documents in the quantitative phase, the lack of documentation did not give a comprehensive picture of what actually happened to patients while they were admitted at the special institutions. With the little documentation that was done, there was also a tendency by psychiatrists and nurses to document negative rather than positive events and trends. For example, a psychiatrist could write ‘hallucinations have resurfaced’ without giving reference to the preceding mental state of the patient. An example from a nurse would be ‘patient refused to go to the garden today’ without indicating the previous positive cooperation of the patient in rehabilitative activities. The documents/files of patients had therefore a negative bias which was a major limitation to this study.

8.5 RECOMMENDATIONS

Recommendations were made with regard to possible future avenues related to the rehabilitation of forensic psychiatric patients. These include research, policy makers, nursing education and forensic psychiatric practice.

8.5.1 Research

Future research should include female forensic psychiatric patients so that their experiences are integrated with that of their male counterparts. This could give a total

comprehensive picture of the rehabilitation of forensic psychiatric patients in Zimbabwe. The area of child forensic psychiatric patients also remains invisible in Zimbabwe. In future research studies it may be valuable to explore what happens to specifically children who commit heinous crimes.

Research should also heed the admonition of Anthony et al (2002:111) who comment on research related to mental health rehabilitation in prison settings. They advise that "qualitative and non-traditional measures of studying important processes and outcomes related to recovery must be used and the influence of nonrandomised trials for the development of evidence based practice must be acknowledged. Programme principles and practices rather than program models, should be our next focus for research and the underlying values of our field should be operationalised and tested."

When the ethics segment of the research study was presented to peers at the 2014 Annual Nursing Education Conference (25–27 June 2014) at Emperors Palace in Gauteng, Republic of South Africa, peer delegates confirmed that there was indeed need for collaboration among academia, practice, professional organisations and regulatory bodies to untangle the intricate prohibitive ethical web that characterises research in forensic psychiatry in Zimbabwe. The ethical issues related to this study were presented at the conference entitled: 'Navigating the libido dominandi: intricate realities of forensic psychiatry research ethics in Zimbabwe'.

8.5.2 Policy makers

There is need for policy makers to re-enfranchise or rebrand forensic psychiatric rehabilitation services in Zimbabwe. This could positively involve the marketing or selling of forensic psychiatric rehabilitation to the stakeholders and to the public. This is projected to counter the stigma, disinterest and disillusionment that run through both professional and public domains alike. The unique skills inherent in forensic psychiatric rehabilitation practice should be embraced with gloves of comprehensive research, therapeutic jurisprudence and upholding of the dignity and rights of forensic psychiatric patients.

A similar school of thought was also brought up during a peer review of the study at the Tenth International Congress of Qualitative Inquiry (21–24 May 2014) at the University of Illinois in Urbana-Champaign when peer delegates brought up the issue of how this study could be used to inform policy to become in line with correcting the forensic psychiatric patients' predicament. This was addressed by referring to the activating factors of the medico-judicial framework discussed in Chapter 7 hinging on the fact that the government of Zimbabwe, through the relevant arms involved in policy making, had already invested in the current study and as such the hope was kindled that it was therefore likely to follow through the persuasions of this study with regard to policy readjustments.

The first port of call for policy makers would be to integrate all instruments used in the care of forensic psychiatric patients. An example would be the Zimbabwe Prison Act of 1996 with related operationalising instruments and the Zimbabwe Mental Health Act of 1996. Policymakers would also benefit from adopting the medico-judicial framework as a legal document that represents the will of experts and stakeholders in view of the comprehensive rehabilitation of forensic psychiatric patients. Future policy is recommended to facilitate the removal of the special institution from a prison setting to a different place to empower both recipients and givers of forensic psychiatric rehabilitation services. The policy makers should also revisit the dichotomous function of forensic psychiatric practice in Zimbabwe.

8.5.3 Nurse education

The Psychiatric Nurses (Training) Regulations of 1991(Statutory Instrument 370 of 1991) which guided the training of post-basic psychiatric nurses at diploma level (18-month programme) at the time of this study did not have a provision for theoretical input related to forensic psychiatry. However, it is a precondition in the curriculum that the same students be attached to a forensic psychiatric setting for four weeks. After graduation, these nurses staff the special institutions.

The researcher therefore recommends that it will be necessary to give pre-service forensic psychiatric nursing input based on some of the findings and results of this study. This could facilitate comprehensive training and resultant excellence in service provision. It should be borne in mind that during the quantitative phase of this study, the results showed that nurses did not make important entries in the forensic psychiatric patients' documents. In the qualitative phase the nurses emphasised custodial care of patients (feeding, grooming, giving medication). This could have resulted from the lack of theoretical knowledge input about forensic psychiatric nursing. In other words, the researcher recommends revision of the aforementioned training instrument.

8.5.4 Forensic psychiatric rehabilitation practice

The study did not focus on nursing per se but to the entirety of forensic psychiatric rehabilitation. It is therefore recommended that nurses, psychiatrists, doctors, occupational therapists, social workers as well as judicial and special institution (prison) stakeholders should align their activities to this research-based medico-judicial framework. This is projected to foster a widened scope of a therapeutic jurisprudence. It would seem like forensic psychiatric practice has all along been, and is still, drinking forensic psychiatric rehabilitation water from a cracked cistern of prison system supremacy which does not slacken the thirst of comprehensive rehabilitation. Forensic psychiatric rehabilitation practice in the region can also borrow from this medico-judicial framework so that the "mystery and confusion" (Njenga 2006:97) that define forensic psychiatric rehabilitation in Africa is stabilised.

The medico-judicial framework is offering to take forensic psychiatric rehabilitation beyond the boundaries of the known. It is opening a door into a forensic psychiatric rehabilitation new world order. The medico-judicial framework is forwarding the forensic psychiatric practitioner to a new address since it has changed its residence from the special institution to the forensic psychiatric hospital. It is inviting the person involved with forensic psychiatric rehabilitation to begin again, inciting him or her to be open to the possibilities of mapping the path through the tangled growth of current realities into

an increased width and depth of comprehensive forensic psychiatric practice that follows an empowering legislative prescript.

8.8 CONCLUDING REMARKS

"Forensic medicine is like an illegitimate child of health and home departments. We belong to both, but none belong to us. We offer our services to both, we are answerable to both, but we receive nothing from either. I feel that it is high time that our paternity is ascertained and we be adopted by our rightful parentage." (Fimate, 2001).

Developing a medico-judicial framework is a way of sticking a pin on the shining walls of the bubble of the current health delivery system. The bubble has all along fenced out forensic psychiatry practice and enclosed mainstream psychiatric services. The pin is projected to release forensic psychiatry practice from perpetually being a stepchild of health programmes in Zimbabwe: unwanted, ignored and condemned to eternal confusion. The release will foster this stepchild to belong and be in sync with the whole health delivery system discourse.

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ANNEXURE 1
ADDITIONAL VERBATIM QUOTES

CHAPTER 4
QUALITATIVE FINDINGS OF THE STUDY

4.3.1.1 Prohibitive processes to patient recovery

Prohibitive processes to recovery were conceptualised to include: procedures of committing and discharging patients from special institutions; lack of appropriate technology; mixing criminal mental patients with detained mental patients altering assessment procedures; loss of documents; relapses in remand prison; psychiatrist report not informing courts because of language and cultural barriers.

4.3.1.1.1 Procedures of committing and discharging patients from special institutions

'It's possible...because nowadays the quality of our judicial officers ... the prosecution must distinguish that the person when they committed the crime had the intention, separate from any effect of mental illness. If the judicial officer does not separate the two, is bound to convict without taking into account whether or not the mental illness had an effect. So you realise that even the prosecutors, they don't put, they don't apply their mind to the fact that the person could have been a mentally ill patient' (Participant 3).

4.3.1.3 Mixing criminal mental patients and detained mental patients altering assessment procedures

'...Yes, they start the system again but unfortunately one thing that I have noticed is that for serious offenses, we have mental patients that ... who then pretend that they have relapsed on the basis that they talk that you are bound to get this type of

punishment...and who is now aware, the nature of the sentence that he may get, either he relapses as a result of stress again or as a result of getting away from that punishment which is usually for patients who commit serious offenses' (Participant 3)

'…These people come in and they stay in prison and they assess their chances, it may be robberies or whatever and then the person will check and see how the case is going to go. So they watch others who are coming from the courts with 15 years, 30 years what, what, there see its bad... then based on their recommendations then goes to XX [special institution]*. We had two gentleman who did that last time, is it 2 or 3 and they ended up escaping from XXbecause it's the --- where they were it's a maximum security setup for armed robbers. So now when they were at XX, the security was a bit lax. So they made sure they were moved from that other place to XX and then they escaped...*' (Participant 4).

4.3.1.4 Loss of documents

"*The docket can get lost because it gets shuffled between the police and the court and if there is a mental patient for the decision, it goes to the attorney general and the attorney general is based in Harare and here. But with the court criminal record, it is stationery at the court… And sometimes we hear that the dockets have been lost there somewhere and this one is fit to stand trial'* (Participant 3).

4.3.1.6 Psychiatrist report does not inform the courts because of language and cultural barriers

'...Yes like for instances like this one where people lie and also the other thing I noticed is that we have a language barrier... I don't know whether the differences in culture, you know... So when you have a Tonga person coming in, they will be dealing with a Ndebele person, they will be dealing with someone who is British or Swedish and then they start doing their Tonga dance and they are trying to be mad you know. You won't know that' (Participant 4).

'*...you see now because well the psychiatrist maybe qualified if it someone who is able to communicate, with the particular patients, then the assessment would be much better for the doctor to come up with a proper, otherwise better opinion. Rather than someone who requires an interpreter you know to interpret, to translate'* (Participant 6).

4.3.2.2 "The system has always been like this" (dominance and its reproduction)

'...all along, this is my first time in my career about mental patients. We only see copies of forms of Reception Order this then this. No one has actually come up to say look, let's come up with a way of taking care of these people. We only know procedure' (Participant 3).

'...No, we don't have a problem. What normally happens is that as soon as the accused person is committed, we file the record, awaiting for the what? The psychiatric report, that affidavit from prison, then we just write a letter to say can this person ---- to remand, that is if the attorney general wants to prosecute' (Participant 7).

4.3.2.3 Limited interaction between the judiciary and the Special Institution

'That much we don't know (about the special institution). What we simply do is we commit. There are certain forms that we fill then we commit them but after some time, or period of treatment they will then give us a feedback whether the person has recovered or not' (Participant 3).

'…because of lack of resources we at one time proposed that we want to have a tour of all the institutions where we are discharging our patients or recommending that these patients should be discharged through… but a-ah the visits had to be cut short because of lack of resources' (Participant 9).

4.3.2.4 "Mental patients cannot be rehabilitated''

'...XX [special institution] *is not for rehabilitation, it's a mental institution. Is not for rehabilitation there are just, they are being treated…* b*ecause there are, there are, people who are at XX (phone rings). People who are in XX they are unlike people who are Down Syndromes, with Down Syndrome, you can't treat it. It's not, not an illness. Its (phone rings) harnessed, its harnessed growth. You can't treat it but psychiatric problems, they can get treated. You can treat them so there are treated given medication whether its diazepam, what have you. For them to be normal. Before that stage of e-eh, what do you call it? E-eh, a period of normality. There is a term that they use for that. Yes. There is a medical term for that. Yes. That person, we have got people like that in our community even who are holding positions of authority who are on medications. Yes. So those people they are treated giving treatment to be normal. When they are normal, then they get a report that no, those people are now normal. They are now fit to what? To stand trial'* (Participant 5).

4.3.2.5 Patients deteriorate in Special institutions

'I expect that the, you, the accused to get better but I realise that it's on the contrary… and I have assumed that perhaps it's a result of drugs aah maybe overdose or something amongst others because he will be in a more subdued state than when he appeared before me' (Participant 3).

'You wonder whether these people you are going to direct a discharge on will feed back into society or are they just going back into society and still commit another crime and come back into the system...With the types of crimes that these patients have committed, some of them are grievous crimes murder, at times multiple counts of murder and outcomes or prognosis for such people is quite poor....' (Participant 9).

'As much as I would like to so that I have a detailed in-depth knowledge of the place… I, would have wanted to see more e-eh medical staff and, because I think that as it is

there is more of the prison officers than the psychiatrist department there. That is what I believe so I think we should have more of the psychiatrist department in there and of course the, the, the prison officers coming for the security' (Participant 4).

4.3.3 The judicial linguistic habitus and its selective interpretation digress patient rehabilitation

4.3.3.1 Patient referred to as 'accused person'

*'Generally we receive cases from the police and if one, if an **accused person** is mentally unstable, we get that information from the police, they tell us that they have received information either from the relatives or just by his appearance you can tell that this person is unstable'* (Participant 1).

4.3.3.2 Dehumanisation of the patient

*'...otherwise **if on the face of the docket** it looks like an ordinary crime, and there is no one who tells us that this person has a history of mental illness, and with some people, their mental illness is not out there and the person officers don't pick it up, these unfortunately are the ones that could get lost'* (Participant 4).

*'So it is only **the form** from the psychiatrist tells us whether the person is mentally ill or not. ... Normally, there is a form that they send to us to indicate that the person has recovered and is now fit to stand trial then we proceed'* (Participant 2).

'...*Once that happens, after that has happened,* those two documents *are brought back to the clerk of court. Now for example, you know, those documents are placed in the court record. Then referred again to court'* (Participant 6).

4.3.3.3 Rehabilitation referred to as an 'investigation' or 'examination'

'*...If they are of the opinion that that particular accused person is mentally ill, sick then the next stage will be that the prosecutor will then make another application that the accused person be examined by a psychiatrist now.... Then the psychiatrist now will examine that particular patient. After that, that record is supposed also to come back to us, now when we receive that report. We are supposed to be taken to the, we are in the Attorney General's department but there is, we have a senior public prosecutor, that report is taken to the senior public prosecutor together with the docket. Now the opinion by the psychiatrist now is the one that is going to be used to determine whether that person is supposed to be prosecuted or not'* (Participant 6).

'*Yes it is our job to actually make sure the mental illness is investigated... Ya-a it's us in terms of the Mental Health Act who ask for the investigation to be done… She will then tell us that this person is suffering from what, what, what, you know and then after telling us, what this person is suffering from, she then writes her recommendations'* (Participant 4).

4.3.3.4 Admission referred to as 'committing' or 'incarceration'

'... So simply the magistrate having seen that report, if he feels the accused person needs to be committed to XX [special institution] *then we facilitate the committal papers, that is the charge sheet, the state outline, the record or evidence'* (Participant 7).

4.3.3.5 Special institution referred to as 'prison'

'No, it is the court which says after the two reports have been brought, you know, for the 2 doctors that person won't be at XX [special institution] *Prison...'* (Participant 6).

4.3.4.1 Uncooperative relatives

'*Well, I don't know. It's like the problem is relatives, whether these people have relatives or not. It is not clear to us...It is now the prison public relations department, they are supposed to verify whether this person has relatives or not so that at the time of release, they actually advise the relatives that this person is on medication, must continue taking medications but normally it's difficult for us to monitor after court processes. It is now the prison department'* (Participant 2).

4.3.4.2 Manipulation of the system to evade justice

'There are some who are just pretending. Pretends to be mentally ill because they know once they say something that is incoherent in court they will be referred to an institution for examination and once they are at the institution they will take that opportunity to then escape, so most of these people mostly the results are they are stable, they are actually not mentally ill' (Participant 2).

'...No, what I'm saying in the other case, they were in remand normally our regional courts are not remand courts, they are trial courts, they are remanded in court 2 there was no history of illness. He was given a trial date he came into the court and when he got into court, he started, the witnesses were there, put in the charge, then he started saying, the road to Harare, talking about the President, started all sorts of funny things. Owning airplanes and some things like that. Then you say ha-a, what's going on. Then you say maybe this person is mentally ill because we don't have the means of really checking then we say ok, postpone trial but go for an examination then they will go for an examination' (Participant 2).

'E-*eh in the psychiatry of course, e-eh, you know um-mh (silence), like I said, the psychiatry reports that we get, they are not binding. They are merely persuasive, you know. Either party may challenge whether the defence or the State, you see, so you*

might say we don't agree with this report because this person never interviewed the what? Maybe some relatives' (Participant 5).

'We have people that came in and because, I don't know whether it's because we don't have this first point of contact, I am not too sure. These people come in and they stay in prison and they assess their chances, it may be robberies or whatever and then the person will check and see how the case is going to go. So they watch others who are coming from the courts with 15 years, 30 years what, what, there see it's bad. The person who comes next and it's his turn to be tried starts singing in the dock, taking off his clothes, staff like that, pretending that he is ill and when he pretends that he is ill, he has to be examined by 2 doctors and some do it so well. The 2 doctors then based on their recommendations then goes to XX [special institution]*. We had 2 gentleman who did that last time, is it 2 or 3 and they ended up escaping from XX* [special institution] *because it's the … where they were it's a maximum security setup for armed robbers. So now when they were at XX* [special institution]*, the security was a bit lax'* (Participant 4).

The nurses

4.4.1.1 Nurse versus guard

'…when you are noticing that this special institute is inside a prison setup. You find the prison officers are not going to take; I wouldn't call it an order because I wouldn't order them around. I am not their senior but they will not take a suggestion from me, from a nurse…this is their place… o-oh, o-oh power thing, definitely. Power thing definitely, definitely. Power struggle most' (Participant 11).

'Prison officers are there to, because in medical terms we say they are not prisoners but on the prison side, they are prisoners because they have a prison number' (Participant 12).

4.4.2.1 Nurse voiceless and disillusioned in the system

'I feel psychiatric patients are not being treated fairly…there is no community awareness of how to take care of patients. Community doesn't know because they were not taught. If the government can allow some campaigns, maybe, it will help… Yes, but we don't have facilities. We don't have a utility car so it's difficult for a nurse to make a follow up without a vehicle or any means of transport because some patients are from far away' (Participant 12).

'Maybe it's just because we said we are admitting patients from all over the country. It becomes very difficult…at the moment we have got only 5 psychiatric nurses in the institution catering for around 205 patients… there is no transport available to make follow ups on discharged patients' (Participant 10).

'I am trying actually through management to engage our own professionals. Unfortunately, as you know the government incentives aside and the conditions of service, a lot of people have moved out…some of our challenges e-eh is when these patients are in special institutions is yes, it's true we as professionals we treat these as patients and our officers, some of the officers we have treat them as inmates, criminals and ya-a, it is one of our challenges that we need keep on actually educating these officers' (Participant 14).

4.4.3.1 Definition of rehabilitation inconsistent among nurses

'We have got a programme that is in place. We take them for a weekly walks within the complex' (Participant 10).

'…the rehabilitation of these patients, it involves 2 ministries, they have been treated but judiciary, they also want to put place a situation whereby maybe the patient is being handed over to the other ministry' (Participant 13).

'We take care of the welfare of patients that they have fed in the morning, evening and night. Make sure they have bathed and also monitoring when they are feeding and we are also responsible for giving them medication, we give them in the morning and a few of them get some medication in the afternoon and some at night and we are also involved in rehabilitation of patients such as gardening' (Participant 15).

'…rehabilitation wise, there isn't much but mostly they are involved in activities of daily living like generally cleaning their department but because of their unpredictable behavior they cannot be sent to occupational therapy department outside ward ' (Participant 16).

4.4.4.1 Patients get worse after admission because of despair

'Ya-a, it's really a challenge considering our forensic institutions e-eh the two forensic institutions that is XX [special institution] *and XX Psychiatric Unit are sort of e-eh, confined places where, rehabilitation of these patients is a little bit difficult but we are trying… as you are going to see when we get to our institution here, there are so many patients over 250 patients where e-eh, we have also realized that a lot of patients are relapsing'* (Participant 14).

4.4.5.1 Greater emphasis on physical care

'…we try to let the medication do its work and counselling services here and there where needed… you try to counsel them but pressure' (Participant 11).

'Ya-a because there won't be any staff in prison station no medication. Right now we are lacking medication MSF is bringing in its own medication. The government can not provide antipsychotic drugs for these patients to avoid these relapses' (Participant 14).

'It's us psychiatric nurses who commence that patient on what? On treatment, then from there that patient will be seen by a Psychiatrist who either change that medication

or maybe will continue with that medication which we would have commenced the patient on. And also we take care of the welfare of patients that they have fed in the morning, evening and night. Make sure they have bathed and also monitoring when they are feeding and we are also responsible for giving them medication, we give them in the morning and a few of them get some medication in the afternoon and some at night' (Participant 15).

4.4.5.2 Lack of financial and human resources

'At the moment there is no social worker who is attached to this institution… we have very little resources. Most of the resources here soccer, football, they are donated by church organisations' (Participant 10).

4.4.5.3 Lack of knowledge and understanding on the part of the multidisciplinary team

'It's not every mental patient who has committed a crime who should come to prison. There should be a … if you have done a crime like maybe someone has taken maybe a drink from shop, which is almost R5 but they come here at XX Special institution and will stay in here maybe for more than 6 months or so. I e-eh as for myself, I think those patients with lighter crimes should go maybe to be admitted at Hospitals like XXX [civil psychiatric hospital]*, XXX there or XX Hospital psychiatric unit or they stabilize and be discharged back home. I think that's the other thing also causing overcrowding because most of the patients will be in there with petty crimes. But they are here for (gesticulating long time)* (Participant 15).

'Our legal procedure is that after the psychiatrist e-eh has written the report and after this patient has stabilized, the psychiatrist has to write a report, informing the magistrate that the patient you referred to this special institution has recovered and is fit to stand trial. He has to go back to the magistrate who actually committed him. Through that, they relapse there as I have said due to challenges there on the medication. There

won't be continuity of the management of this patient from a special institution to that prison institution because there are no psychiatric nurses at the prison station where this patient will be' (Participant 14).

'Yes it's a challenge that we may end up in conflict with the prison authorities on the general side because they will say where are you taking this? He is not supposed to go out because he is a D-class according to them. But according to us, to rehabilitate this patient it is always a challenge. It depends on the Officer in charge. If the Officer in charge understands, we are trying to say we can't… we realized, we have been discussing to say how come we use two Acts at one time and that's the confusion' (Participant 14).

'XX [special institution] *I think a-ah once they have shown some improvement, I think social workers from that side should also trace their relatives and send those patients to where, the areas where they came from. But as it is XX it looks like a-ah they don't trace relatives. They send patients to Ingutsheni, in the end we are stuck with these patients because of crimes that they committed, relatives are no longer interested in their welfare so they are ours for keeps'* (Participant 16).

4.4.5.4 Issues around family systems

'Relatives, some don't have relatives that come. Imagine you spend the whole year here nobody comes to visit you or any one of you don't see when you are going home anytime soon'. (Participant 11).

'I think also e-eh, what can I say e –eh, the relatives also. A- ah some of them according to other state case outline, you really see that a – ah the patient would have done the crime but maybe the community or maybe the family members might not want that person at home' (Participant 15).

'…there are a lot of information which we require, collected from relatives from the community about the illness or about an offence which this patient would have committed and all this information is collected together by health professionals' (Participant 14).

4.4.5.5 Limited or no rehabilitation resulting in 'revolving door' scenario

'…because if they stay idle, they will end up committing some crimes or smoking dagga or drinking alcohol because that is the only thing which is available but if they are occupied, they won't do such dirty things… mostly we only want facilities and I was saying the setup, the prison setup. It doesn't allow much' (Participant 12).

'Considering the number of nurses which are here or staff which is here, e –eh, I can just say it's too much workload for us to monitor all those patients in terms of rehabilitation, we can't rehabilitate all of them considering the number of patients we have but maybe if they were just a few patients. Even things like let's say they should sweep in their room imagine that overcrowding it is very difficult there is not enough space where they can really sweep because there will be someone's blankets there just next and there will be someone there also and so forth' (Participant 15).

'The difficulties are that in most cases what we were expecting is to see various rehabilitative activities in these institutions but due to lack of resources e-eh that is material resources for the rehabilitation activities--- actually if planning activities for them to be rehabilitated on discharge. It's a challenge' (Participant 14).

4.5 Forensic psychiatric patients

4.5.2.1.2 Rehabilitation largely focused on chemical therapy

'I was taking medication'. (Participant 27)

4.5.2.2.1 Anxiety and uncertainty

She (psychiatrist) is not around for a month. So no-one is seeing the patients as it is the duty of a psychiatrist. We are just waiting for her to come maybe'. (Participant 27)

4.5.2.2.2 Patients perceive power issues in the process of their management

Prosecutors are just angry with the case and say it's just a rape ok let me give you what? a sentence...they(prosecutors) know, there is a patient, they know that he is a patient but they take the Doctor's affidavit and remove it and give the magistrate just a docket, prosecuting but the doctor's affidavit has been removed... (Emotionally) they remove! The magistrate knows the law, when the affidavit is there, they do exactly what they are supposed to do but they don't do that'. (Participant 26)

4.5.2.3.1 Support systems

'*They phoned my relatives and my relatives are supportive but some of the relatives are not supportive*' (Participant 27)

4.5.2.4.1 Uncertainty related to social functioning after discharge

'Ha-a I am planning to have a butchery. That is the plan, I want butchery... Ha-a so I will just go and talk to my young brother. He is growing some tobacco outside there'. (Participant 28)

4.5.2.5.3 Lack of effective communication with patients

'E –eh, according to me I don't know but according to the nurses, a –ah I don't know what are they thinking about if they see me'. (Participant 29)

4.6 Relatives of forensic psychiatric patients

4.6.1.1.1 Special institutions are not visitor friendly

'...yes, like a prisoner for the two years he has been there, we would see him through the window' (Participant 21).

4.6.1.1.4 Disrespectful practices

'At XX [special institution] *we only saw him through the window; there was no place to sit with him'* (Participant 21).

4.6.6.2 Judiciary perceived as not thoroughly analysing cases

'I don't know what the issue is with the magistrates there, it's because his case was still pending in the courts. A certain Mrs XXX was the one presiding over the case. Then she went to Harare. So that's why it took so long for the case to be handled (Participant 25).

ANNEXURE 2

LIST OF PARTICIPANTS FOR THE RESEARCH STUDY: A MEDICO-JUDICIAL FRAMEWORK FOR THE REHABILITATION OF FORENSIC PSYCHIATRIC PATIENTS IN ZIMBABWE

Text participant reference	**Actual participant identifier**
Participant 1	Senior judicial member/ Attorney General
Participant 2	Magistrate 1
Participant 3	Magistrate 2
Participant 4	Public prosecutor 1
Participant 5	Public prosecutor 2
Participant 6	Public prosecutor 3
Participant 7	Regional clerk of the court
Participant 8	Officer in charge of special institution
Participant 9	Mental Health Review Tribunal member
Participant 10	Psychiatric nurse 1
Participant 11	Psychiatric nurse 2
Participant 12	Psychiatric nurse 3 – Sister in charge
Participant 13	Psychiatric nurse 4
Participant 14	Psychiatric Nurse 5
Participant 15	Psychiatric nurse 6
Participant 16	Psychiatric nurse 7
Participant 17	Medical social worker 1
Participant 18	Medical social worker 2
Participant 19	Psychiatrist 1
Participant 20	Psychiatrist 2
Participant 21	Relative 1
Participant 22	Relative 2
Participant 23	Relative 3

Participant 24	Relative 4
Participant 25	Relative 5
Participant 26	Forensic psychiatric patient 1
Participant 27	Forensic psychiatric patient 2
Participant 28	Forensic psychiatric patient 3
Participant 29	Forensic psychiatric patient 4
Participant 30	Expert 1 – Universityof Zimbabwe Lecturer
Participant 31	Expert 2 – Chief occupational therapist
Participant 32	Expert 3 – Principal nursing officer

Categories of participants

Participants 1 - 9 constituted the judicial team

Participants 10 - 20 constituted the medical team

Participants 21 - 25 constituted relatives of the forensic psychiatric patients

Participants 26 - 29 constituted forensic psychiatric patients

Participants 30 - 32 constituted experts in forensic psychiatric rehabilitation in Zimbabwe

ANNEXURE 3
ETHICAL CLEARANCE CIVIL PSYCHIATRIC HOSPITAL

Telephone: 466463 – 5/ 472420
463411-3

Telegraphic Address
"MEDICUS", Bulawayo
Fax: 473966
Telex:

REFERENCE:

Ingutsheni Central Hospital
P.O. Box 8363
Belmont
BULAWAYO
Zimbabwe

ZIMBABWE

18 June 2013

Virgininia Dube
University of South Africa
SOUTH AFRICA

RE: PERMISSION TO CARRY OUT A STUDY IN WARD (SPECIAL INSTITUTION OUTLET UNIT)

The above subject matter refers.

Permission is hereby granted to you to carry out a study in ward entitled: A Medico-Judicial Framework for the rehabilitation of Forensic psychiatric patients in Special institutions in Zimbabwe.

Wish you the best in your learning endeavours.

Thank you.

DR N T CHAIBVA
ACTING CHIEF EXECUTIVE OFFICER

INGUTSHENI CENTRAL HOSPITAL
18 JUN 2013
P.O. BOX 8363, BELMONT
BULAWAYO

ANNEXURE 4

ETHICAL CLEARANCE COMMISSIONER OF PRISONS

ZIMBABWE PRISON SERVICE

Reference:

Telephone : 706501/2/3/4, 777384/5
754197,710095

OFFICE OF THE COMMISSIONER

08 May 2013.

Ms. Virgininia Dube
Ingutsheni Central Hospital
P.O.Box 8363
Belmont
BULAWAYO

RE: REQUEST FOR PERMISSION TO CONDUCT DATA COLLECTION AT [redacted] PRISON SERVICE YARD.

1. The above subject refers

2. You are hereby informed that your request to conduct preliminary data collection on the topic: **MEDICO-JUDICIAL FRAMEWORK FOR THE REHABILITATION OF FORENSIC PSYCHIATRIC PATIENTS IN ZIMBABWE** at [redacted] Prison and [redacted]: Maximum Prison – Service Yards, was approved. Authority is therefore granted for you and your supervisor – 63 02070093087- Professor Jeannette Maritz of University of South Africa, to embark on data collection exercise at [redacted] Prison on 27 and 28 May 2013.

3. You are therefore required to make your arrangements to travel to Mlondolozi Prison on the said dates. Please note that you and your supervisor will be required to produce identity documents together with a copy of this letter.

4. By copy of this letter, the Officer Commanding, Matabeleland and OIC-[redacted] are advised of this approval.

D. Garaúzive (SUPERINTENDENT)

STAFF OFFICER PERSONNEL
PRISONS NATIONAL
HEADQUARTERS
07 MAY 2013

RESEARCH AND DEVELOPMENT

Internal

Action

ANNEXURE 5

ETHICAL CLEARANCE COMMISSIONER OF PRISONS

ZIMBABWE PRISON SERVICE

Telephone : 706501/2/3/4, 777384/5
754197,710095

Telegrams : "PENAL", HARARE
Fax : 754157

Reference:

OFFICE OF THE COMMISSIONER
Private Bag 7718, Causeway
Harare: zps@gta.gov.zw

11 September 2012.

Ms. Virgininia Dube

Ingutsheni Central Hospital

P.O.Box 8363

Belmont

BULAWAYO

RE: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY AT [redacted] PRISON AND [redacted] MAXIMUM PRISON(SERVICE YARD).

1. The above subject refers

2. You are hereby informed that your request to conduct research on the topic: **MEDICO-JUDICIAL FRAMEWORK FOR THE REHABILITATION OF FORENSIC PSYCHIATRIC PATIENTS IN ZIMBABWE** at [redacted] Prison and [redacted] Maximum Prison – Service Yard, has been approved.

3. You are therefore required to make your arrangements to travel to [redacted] and [redacted] Maximum Prisons. On completion of the research study, you are required to submit a hard and soft copies of your findings to the **Commissioner of Prisons**

4. By copy of this letter, the Officers Commanding, Matabeleland and Mashonaland Regions and OICs- [redacted] and [redacted] Maximum Prisons are advised of this approval.

11 SEP 2012

D. Garauzive (CHIEF PRISON OFFICER)
RESEARCH AND DEVELOPMENT

ANNEXURE 6

ETHICAL CLEARANCE JUDICIAL SERVICE COMMISSION

Our Ref.: CM/CORRESPONDENCE GENERAL/13

Your Ref.:

Telephone: 772995/6
Telegrams: "YULELOGS"

ZIMBABWE

JUDICIAL SERVICE COMMISSION
CHIEF MAGISTRATE'S OFFICE
Private Bag 7704
Causeway, Harare
Zimbabwe

9 May 2013

Ms V Dube
Ingutsheni Central Hospital
P.O. Box 8363
Belmont
Bulawayo

APPLICATION FOR PERMISSION TO CARRY OUT A STUDY ON JUDICIAL STAFF INVOLVED WITH PATIENTS ADMITTED IN SPECIAL INSTITUTIONS

Reference is made to your application dated 6th May 2013 in relation to the above.

Please be advised that authority for you to carry out your study has been granted on condition that the information you will collect will be used solely for purposes of your study and that it will remain strictly confidential. No name identifying the institutions involved or participants' background shall be disclosed.

M. Mutevedzi
ACTING CHIEF MAGISTRATE

ANNEXURE 7

ETHICAL CLEARANCE MEDICAL RESEARCH COUNCIL OF ZIMBABWE

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL LETTER

REF: MRCZ/B/410

08 January 2013

Ms V Dube
University of South Africa
P.O Box 392 UNISA 003
South Africa

RE: Medical – Judicial Framework for the Rehabilitation of Forensic Psychiatric Patients in Zimbabwe.

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

a) Completed MRCZ form 101
b) Study protocol
c) Informed Consent Form for staff (English)

- **APPROVAL NUMBER** : **MRCZ/B/410**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **Expedited**
- **EFFECTIVE APPROVAL DATE** : **08 January 2013**
- **EXPIRATION DATE** : **07 January 2014**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
08 JAN 2013
APPROVED
P. O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

ANNEXURE 8

ETHICAL CLEARANCE UNIVERSITY OF SOUTH AFRICA

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/93/2012

Date: 31 October 2012 Student No: 4741-297-6

Project Title: Medico-Judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.

Researcher: Ms V Dube

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Prof JM Maritz
Qualification: Phd
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE 9

CONSENT FORM FOR MEDICAL AND JUDICIARY PARTICIPANTS

Informed Consent Form (medical and judicial staff) - English
Medico-Judicial Framework for the rehabilitation of forensic psychiatric patients in Zimbabwe, 2013

Principal Investigator: Ms Virgininia Dube
Phone number: +263712923112

Dear Participant

My name is Virgininia Dube, a doctoral student studying with the University of South Africa. As part of my study, I am required to conduct a research. You are invited to participate in that research study called *Medico-Judicial Framework for the rehabilitation of forensic psychiatric patients in Zimbabwe.* The purpose of this research is to develop a medico-judicial framework for the rehabilitation of forensic psychiatric patients in Zimbabwe. You were selected as a possible participant in this study because you are part of the team that is involved in the rehabilitation of forensic patients. All members of the multidisciplinary team including other stakeholders will be selected for the study.

PROCEDURES AND DURATION

If you decide to participate, you will undergo individual interviews about your demographic, personal/behavioural, opinions and other aspects in relation to rehabilitation of forensic psychiatric patients. The study will end on 30 October 2013.

RISKS AND DISCOMFORTS

There are no risks associated with participation in this study. It is extremely unlikely, but possible, that you may find answering some questions uncomfortable. Should this

happen, you may refuse to answer or you may be referred for support in the form of debriefing that will be provided free of charge by the researcher. I assure you that your identity and the information you share will be kept confidential.

BENEFITS AND/OR COMPENSATION

We cannot guarantee that there will be any direct benefits to you for participating in this study. However, the study may benefit the Ministry of Justice and Ministry of Health and Child Welfare by providing a better understanding of the rehabilitation process of forensic psychiatric patients. It may also inform policy makers on how best to organise forensic psychiatric services.

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, we plan to disclose the results of the study (not personal information) to peers and academic staff in the Ministry of Health and Child Welfare and Ministry of Justice, Legal and Parliamentary Affairs. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Data and all information from this study will be made available to my academic supervisors. Under some circumstances, the Medical Research Council of Zimbabwe may need to review the data collected and the results of the study.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Ministry of Health and Child Welfare or the University of South Africa, their personnel, and associated hospitals**.** If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

The date you sign this document to enrol in this study, that is, today's date, MUST fall between the dates indicated on the approval stamp affixed to each page. These dates indicate that this form is valid when you enrol in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form's validity as approved by the MRCZ.

Name of Research Participant (please print)	Date
Signature of Participant or legally authorized representative	Time
Signature of Witness (*Optional*)	Signature of Staff Obtaining Consent

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research subject or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe on telephone 791792 or 791193.

ANNEXURE 10

CONSENT FORM FOR FORENSIC PSYCHIATRIC PATIENTS

Informed Consent Form (patient) - English

Medico-Judicial Framework for the rehabilitation of forensic psychiatric patients in Zimbabwe, 2013

Principal Investigator: Ms Virgininia Dube
Phone number: +263712923112

Dear Participant

My name is Virgininia Dube. I am a student at the University of South Africa where I am studying for a doctoral degree specialising in mental health. In order to complete these studies, it is mandatory that I conduct a research study in line with mental health issues. The research I am carrying out is aimed at formulating the basis which can be used by health and judiciary services responsible for rehabilitation of patients in Special institutions. If you choose to participate in this research exercise, I will be asking you questions pertaining to your stay in this institution. This research exercise will end on 30 October 2013.

Your participation is not expected to cause you harm in any way whatsoever. You are free to express any feelings of discomfort throughout this research exercise. Information that you give will be kept confidential. I cannot guarantee that you will directly benefit from this research exercise. However, the findings of this research will provide the health and judicial services with a new approach to the rehabilitation of patients in Special institutions.

You are not forced to participate in this research exercise. If you wish to withdraw your participations, you can do so and this will not affect your relationship with the health or judicial authorities.

Before you sign this form, you are free to ask for any clarification. If you choose to participate in this research exercise, your signature on this form becomes evidence that you have agreed to participate in this research. The date that you will sign the consent form (today's date) should be after the date on the stamp that appears on the approval letter from the Medical Research Council of Zimbabwe. This shows that the form is a legal document.

Full name of researcher ----------

Signature----------

Full name of participant ----------

Signature----------

Full name of Witness (if necessary) ----------

Date----------

You will be given a copy of this document. If you have any questions about this consent form, this research exercise or your personal rights, contact me on the following numbers: 09-471932, 0712923112 or email addressvirgydube@gmail.com. If you want to direct your inquiries to someone other than myself, you can contact The Medical Research Council of Zimbabwe on the following numbers 04-791193 or email address mrcz@mrczimsahred.co.zw

ANNEXURE 11
CONSENT FORM FOR RELATIVES OF FORENSIC PSYCHIATRIC PATIENTS

Informed Consent Form (patient relative) - English
Medico-Judicial Framework for the rehabilitation of forensic psychiatric patients in Zimbabwe, 2013

Principal Investigator: Ms Virgininia Dube
Phone number: +263712923112

Dear Participant

My name is Virgininia Dube. I am a student at the University of South Africa where I am studying for a doctoral degree specialising in mental health. In order to complete these studies, it is mandatory that I conduct a research study in line with mental health issues. The research I am carrying out is aimed at formulating the basis which can be used by health and judiciary services responsible for rehabilitation of patients in Special institutions. If you choose to participate in this research exercise, I will be asking you questions pertaining to your relative's stay at a special institution. This research exercise will end on 30 October 2013.

Your participation is not expected to cause you harm in any way whatsoever. You are free to express any feelings of discomfort throughout this research exercise. Information that you give will be kept confidential. I cannot guarantee that you will directly benefit from this research exercise. However, the findings of this research will provide the health and judicial services with a new approach to the rehabilitation of patients in Special institutions.

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Full name of researcher ----------

Signature----------

Full name of participant ----------

Signature----------

Date----------

You will be given a copy of this document. If you have any questions about this consent form, this research exercise or your personal rights, contact me on the following numbers: 09-471932, 0712923112 or email address virgydube@gmail.com. If you want to direct your inquiries to someone other than myself, you can contact The Medical Research Council of Zimbabwe on the following numbers 04-791193 or email address mrcz@mrczimsahred.co.zw

ANNEXURE 12

DATA SHEET FOR COLLECTING DATA FROM PATIENTS' DOCUMENTS

Data Sheet: Documents of forensic psychiatric patients

1. Study setting

1. Mlondolozi Prison	
2. Chikurubi Maximum Prison (Service yard)	

2. File number and date of admission for rehabilitation

File number	
Date of admission	

Demographic profile at the time of admission

3. Category of admission under the Mental Health Act of 1996

1. Section 26	
2. Section 27	
3. Section 28	
4. Section 29	
5. Section 30	
6. Section 37	
7. Other (Specify)	

4. Number of previous admissions

1. Once	
2. Twice	
3. Thrice	
4. More than three times	

5. Mental illness

1. Acute psychotic disorder	
2. Affective disorder	
3. Substance induced mental illness	
4. Anxiety disorder	
5. Personality disorder	
6. Mental retardation	
7. No mental disorder	
8. Chronic schizophrenia	
9. Epilepsy	
10. Other (Specify)	

Previous mental illness

1. Yes	
2. No	
3. Not known	

7. Age group

1. 18-21 years	
2. 22-30 years	
3. 31-40 years	
4. 41-50 years	
5. 51-60 years	
6. >60 years	
7. Not indicated	

8. Marital status

1. Single	
2. Married	
3. Divorced	
4. Widowed	
5. Separated	
6. Not indicated	

9. Level of education

1. No formal education	
2. Primary education	
3. Secondary education	
4. Tertiary education	
5. Not indicated	

10. Criminal charge

Violent crime		**Non violent crime**	
1. Murder		8. Theft	
2. Attempted murder		9. Housebreaking	
3. Rape		10. Shoplifting	
4. Indecent assault		11. Fraud	
5. Assault with grievous bodily harm		12. Malicious damage to property	
6. Robbery		13. Other(specify)	
7. Attempted rape			

11. Source of referral

1.Court	
2.Civil Hospital	
3.Criminal prison	
4.Family	
5.Other(specify)	

12. Rehabilitative interventions

1.Cognitive therapy(specify)	
2.Therapeutic community(specify)	
3.Family therapy(specify)	
4. Psychotropic medication(specify)	
5.Psychosocial interventions(specify)	
6. Other	

13. Service outcome

Domain	Description	Evident	Not evident	Not indicated in patient's file
1.Quality of life	Individual had future goals			
2.Self esteem	Patient committed to a social group, occupation or had reason to live			
3.Recidivism-non violent	Patient had a reoffending that was not violent or sexual in nature			
4.Recidivism-violent	Patient had reoffending that was violent in nature			
5.Suicide or self harm	Patient killed self or tried to do so			
6.Substance abuse	Patient remained addicted to a substance			
7. Mental state	Mental illness			
8.Cognitive function	Problem solving, remembering, planning			
9.Relationship	With family			
10.Compliance	Adherence or concordance to therapy			
11. Readiness to change	Motivation of patient to change situation			
12.Social function	Involvement in day to day activities			
13.Contact with members of the	Patient feeling that they have been rehabilitated			

multidisciplinary team	enough to reintegrate into society and employment market			
14.Patient died in custody	Patient died due to other medical reasons other than suicide			

ANNEXURE 13

INTERVIEW GUIDE FOR THE MEDICAL AND JUDICIAL TEAM

Interview guide for the multidisciplinary health and judicial team

1. What rehabilitation services do you offer to the forensic psychiatric patients during admission at this institution?
2. Which medical procedures are involved in the rehabilitation of forensic psychiatric patients to this institution? [For health team]
3. Which judicial procedures are involved in the rehabilitation of forensic psychiatric patients to this institution?
4. Which resources help to rehabilitate forensic psychiatric patients at this institution?
5. Which resources make it difficult to rehabilitate forensic psychiatric patients at this institution?
6. What community services do you utilise for forensic psychiatric patients beyond the special institution?
7. How do you think the medical and judicial teams can work together to improve the rehabilitation of forensic psychiatric patients?

ANNEXURE 14

INTERVIEW GUIDE FOR FORENSIC PSYCHIATRIC PATIENTS

Interview guide for forensic psychiatric patients

1. What helped you to recover during your admission at this institution?
2. What made it difficult for you to recover during your admission at this institution?
3. What activities are helping you to live a healthy, useful or active life again since you were admitted at this institution?
4. What community services are available to you after your discharge?
5. What can be done to improve the system for your rehabilitation and care?

ANNEXURE 15

SEMI STRUCTURED INTERVIEW

TIME: 24:48minutes

I = Interviewer

P = Participant 14

	TRANSCRIPTION
I	I understand you are the coordinator for Chikurubi Maximum prison for the forensic psychiatric patients
P	Yes, actually I am the Acting National Coordinator for Mental health in the Zimbabwe Prison Services
I	O.K, when these patients are committed to you from the courts, what service are you providing to these patients in this institution?
P	OK, what we do is, e-eh we admit mentally defective offenders using documents from the courts that is those committal papers for admission. A-ah after admission we assess them e-eh through our psychiatrist, the doctors we have who come regularly to assess those patients, after the assessment, the psychiatric nurse assist the psychiatrists including the social workers to the general welfare that is from medical treatment e-eh, the general welfare that is grooming, bathing and grooming, their feeds and also most importantly their rehabilitation for their total reintegration into society.
I	O.K, you have brought up a very important issue here where you are saying that they are rehabilitated
P	Yes

I	So that they become functional members of society. What exactly do you do in this institution?
P	Ya-a, it's really a challenge considering our forensic institutions e-eh the two forensic institutions that is Mlondolozi and Chikurubi Psychiatric Unit are sort of e-eh, confined places where, rehabilitation of these patients is a little bit difficult but we are trying – upon admission we have to initiate what we term psychosocial support system and also family support system whereby our social workers e-eh are supposed to engage the relatives of these patients and to also assess through our occupational therapists and psychologists, they do assess the rehabilitation needs of these patients so that they can be rehabilitated.
I	What are the difficulties then?
P	The difficulties are that in most cases what we were expecting is to see various rehabilitative activities in these institutions but due to lack of resources e-eh that is material resources for the rehabilitation activities--- actually if planning activities for them to be rehabilitated on discharge. it's a challenge.
I	Maybe let me understand this, as a national coordinator, what is rehabilitation to you? What does it look like to you?
P	***(Silence).*** O.K I don't understand.
I	When you are saying rehabilitation. What do you mean? What is rehabilitation to you? What is your definition of rehabilitation?
P	Ok, it is where, a process whereby we involve these patients in activities, which will help them we are trying to sort of rejuvenate the, what can I say, how can I explain it? Only to define rehabilitation but maybe I'm
I	What is it that you can offer to a patient which makes them functional?

P	Ok, ok
I	Yes
P	We do offer the projects we can do like e-eh gardening, they do a lot of activities, various activities including gardening or involving them in recreational activities like just playing soccer, playing whereby they will be socializing. We will be able to assess whether these patients are functional back into normal because of their mental problems enough to be accepted into society. So we try and assess. It helps us also to assess whether the patient is recovering or has recovered after we would have initiated the medical treatment, the drugs the psychiatrist would have prescribed. We need to involve these patients in activities. Rehabilitation helps us to assess whether the patient have recovered.
I	How long does it take for a patient to be rehabilitated on average?
P	Ok, they, they the average time mostly depends on the patient's condition but averagely, the psychiatrist would want to rehabilitate this patient at least for 24 months. That's the average, 18 to 24 months. That's the period which we agreed actually with the psychiatrist that we would wait.
I	Is that happening?
P	***(Silence)***
I	Is this happening, are you functioning within that time frame?

P	Ya-a we are trying but as I have said that there are challenges that at times we won't be having enough human resources to do the activities and enough material resources which may be needed for these patients to be doing activities.
I	You have mentioned social workers, psychologists, occupational therapists, are these from government or they are from a non-governmental organization for Chikurubi?
P	Currently the ones we have are from a non-governmental organization Medicine San Frontier, Holland. O.k., it has come to our rescue, it has actually provided the human resources which we need, the psychologist. They brought in two psychologists and about two occupational therapists, they are assisting us. Unfortunately, they are only assisting us on one institution, here at Chikurubi and Mlondolozi is facing the same challenges which Chikurubi is facing so, ya-a they are trying. Most of these professionals which I mentioned are being provided by the non-governmental organization
I	But they can pull out any time
P	Yes, yes
I	Now that they have introduced some programmes, are you going to be able to sustain them after their leaving?
P	We are trying. I am trying actually through management to engage our own professionals. Unfortunately, as you know the government incentives aside and the conditions of service, a lot of people have moved out. We used to have an occupational therapist, we used to have so many social workers but most of them have left, as I said its one of our challenges – the human resources, which is affecting us to a-ah – fully implement rehabilitative activities.

I	As a coordinator, there is something that has been noted, I don't know what you think about it. It has been discovered that isn't it a patient is admitted here at Chikurubi, they get well, a psychiatrist writes a report to the effect that the person is mentally stable to the judicial offices. Then as the patient is waiting to go to court, they are removed from Chikurubi…
P	Sorry, may you come again.
I	The patient has recovered, then the psychiatrist writes a report to the effect that they are fit to stand trial?
P	Yes
I	Now when they are said to be fit to stand trial they are removed from a special institution to the remand then patients are found to be relapsing from there. What is your comment on that?
P	***(Silence)*** Ya-ah, I think it's true, it happens and it is due to a lot of factors whilst they will be …. Our legal procedure is that after the psychiatrist e-eh has written the report and after this patient has stabilized, the psychiatrist has to write a report, informing the magistrate that the patient you referred to this special institution has recovered and is fit to stand trial. He has to go back to the magistrate who actually committed him. Through that, they relapse there as I have said due to challenges there on the medication. There won't be continuity of the management of this patient from a special institution to that prison institution because (1) there are no psychiatric nurses at the prison station where this patient will be. (2) there won't be medication for this patient to take so, it means there will be no monitoring of this patient for continuity of care as a result.
I	So then when the patient relapses, he goes back to court and is found to be mentally ill and starts the system again?

P	Ya-a as you are going to see when we get to our institution here, there are so many patients over 250 patients where e-eh, we have also realized that a lot of patients are relapsing because….
I	In custody?
P	Some of them out of custody. A-ah when we discharge them there is no proper discharge plan for community of care in the community and you might be seeing that a lot of them, about ¾ of these patients will be readmissions, why because there is no continuity of care when they get back home and these ones who would have relapsed whilst in custody before their legal procedure, it's unfortunate that…. As I have said that it might be incontinuity of care whilst in custody. Ya-a because there won't be any staff in prison station no medication. Right now we are lacking medication MSF is bringing in its own medication. The government cannot provide antipsychotic drugs for these patients to avoid these relapses so, it becomes a vicious cycle whereby the patient remain in the system because of those problems I have mentioned.
I	As a national coordinator what do you think is the way forward on this?
P	Alright, that one ya-a it's a challenge***…(hesitates)***
I	Your personal opinion…
P	My opinion is that as the acting national coordinator for the Zimbabwe Prison Service, I understand the Ministry of Health, these patients, my opinion was , patients were supposed to be under the care and welfare and management of the Ministry of Health. If we can work together with the, our mother Ministry of Health to say we should have

	structures in the community whereby we try and make sure that there is continuity of care and there are proper discharge plans as like even right now, we were discussing issues of the rehabilitation centres which we have for drug abusers because most of them you find that they are drug abusers and we can try our level best to manage these patients well here. They recover, they are discharged back home but at the end they will relapse and home back here because why? There won't be continuity of care after discharge. So my own opinion is if we can work together with the Ministry of Health to say Ok, let us put in place these structures within the mental health delivery system, to say, to ensure, to say, the ministry of Health takes over from there and they try and maintain the management of this patient. Keep these patients occupied in the community and try and remove all the stressors which might have caused this. In most cases in my opinion which I have realized that most of them its maybe due to drug abuse
I	When I talked to the magistrates and the prosecutors, they consistently bring up the issue of pretense. They believe that when patients are in remand and they are due to come and stand trial, they pretend to be mentally ill so that they are sent back to the special institution, that it could be possible that they are relapsing but they are also bringing up the issue that there is a possibility that like murder or rape, the person is likely to fake mental illness because they want to evade justice. That's the opinion of the magistrate. Do you think that's possible?
P	A-ah, I'm not sure but I think that ya-a if they suspect that there is malingering, the patient is faking mental illness to avoid legal a-ah, I think the way forward --- the magistrates here work to --- that's why we say if patients are admitted in the special institution, we need experienced, qualified people to deal with these patients so that --- e-eh, because there is – there are a lot of information which we require, collected from relatives from the community about the illness or about an offence which this patient would have committed and all this information is collected together by health professionals. We can tell that this patient is faking mental illness or is a problem.
I	But then the problem is where this patient is faking the illness there is no nurse. The patient in remand, there is no nurse placed there. Is coming from remand right to court

	and the magistrate makes a decision to send the patient back to the special institution
P	A-ah I don't know within the system when the magistrate suspects that there is malingering. The magistrate needs to follow our Mental Health Act and actually order the patient to be assessed by two doctors and those two doctors from there that's where we start. Whenever there is any manipulation, any malingering I think it can be to --- until the patient comes into the institution. And when the psychiatrist attends to this patient , there are a lot of investigations which are done for the psychiatrist to make a proper diagnosis for these patients.
I	Ok, I also understand that when the patient is admitted, in this institution, they are admitted under the Mental Health Act of 1996 but I'm also meant to, I was also meant to, I stand to be corrected, that there is also another parallel act used by the prison system on the same patient which justifies the presence of guards.
P	Ya-a as I said earlier on, some of our challenges e-eh is when these patients are in special institutions is yes, its true we as professionals we treat these as patients and our officers, some of the officers we have treat them as inmates, criminals and ya-a, it is one of our challenges that we need keep on actually educating these officers.
I	Yes. These two definitions, the fact that you see them as a patient and they see them as a criminal, what implications does that have on rehabilitation of these patients?
P	Ya-a, it's a challenge professionally to approach it in our own professional way, try to rehabilitate the patient. There will be some conflict actually whereby these people, they will be sort of restrict e-eh the , as you have asked saying you said its running a parallel, the Mental Health act and the Prison Act, according to their Prison Act, there are some restrictions let me give you an example to say at times, thee patients, they are when they are admitted, they are classified according to their offenses. If one has committed murder, they will classify him as DMP – D – Class, a D – class inmate is not supposed to go out of prison or our for any rehabilitative activity we may want to indulge on this patient. Yes it's a challenge that we may end up in conflict with the prison authorities on the general side because they will say where are you taking this? He is not supposed to

	go out because he is a D-class according to them. But according to us, to rehabilitate this patient it is always a challenge. It depends on the Officer in charge. If the Officer in charge understands, we are trying to say we can't… we realized, we have been discussing to say how come we use two Acts at one time and that's the confusion which…
I	Actually the Acts are nullifying the function of the other…..
P	Yes
I	Yes because, it's to rehabilitate the patient and this one is trying to restrain the patient.
P	Yes, so it's a challenge but some of the Officer in charge they are quite cooperative after we have explained to them, they understand and they allow us to do the rehabilitation on this patient but other officer in charge may be very, what can I say e-eh
I	Vindictive?
P	Rigid and whatever
I	The Officer in charge
P	Yes, because normally us as health professionals when we work, when we are doing our duties, we are doing those duties for the Officer in charge. We are supposed …. We report to the Officer in charge actually because he is the administrative overall in charge of every activity

I	But then he is not trained in what you are doing?
P	Most of them yes, but others understand and after we have explained they agree
I	Are there other things that I could have left out that you think are important about this issue?
P	Ya-a, yes of course e-eh maybe just to add you said we are using the Mental Health Act of 1996. Ya-a it's a long time back now and according to us, most of the challenges we are experiencing would relate them to the lack of sensitivity on the need to review the Act so that it suits the stakeholders or us the implementers of that Act because most of the problems would be, we are sort of bound by that Act and we feel that it needs to be reviewed so that maybe some of these sections can be clarified to suit the ……
I	For example?
P	For example e-eh these mentally defective offenders some of them, most of them are sort of chronic cases and when they commit an offense, be it a minor offense, according to my own opinion, I don't see it necessary to convict that somebody to say ….. if he is a known case of mental illness, rather for this patient to benefit, should go to the psychiatric institution for management yes, so some of the sections you would see that the procedure sort of delays the process of managing these patients or discharging these patients.
I	Thank you very much, how did you feel about this interview?
P	a-ah, it was ok and I think from this interview you have observed areas of concern for us how we can improve mental health delivery system in this country. Maybe it can also help us to, to , to make some corrections to actually try and address challenges we are

	facing on the ground in the welfare of these mentally defective offenders
I	O.k, thank you very much.