

# The Dinosaur of Judicial Disjuncture with Forensic Psychiatric Rehabilitation Processes in Zimbabwe

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**ABSTRACT:** *The study sought to explore the experiences and involvement of the judicial team in the processes for the rehabilitation of forensic psychiatric patients in Zimbabwe. An exploratory qualitative design was used utilizing the Charmaz grounded theory approach. Findings reflected that the engagement of the judiciary is at variance with what will enable patient recovery; instead, its engagement is prohibitive and discrepant. 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. Development of a systematic and jurisprudential framework is projected to realign the judicial system to be in sync with the medical system with regard of forensic psychiatric patients in Zimbabwe.*

**Key words:** *Zimbabwe Mental Health Act, judicial rehabilitation, processes, prohibitive*

## INTRODUCTION

Forensic psychiatric patients are admitted for rehabilitation in what are called Special Institutions in Zimbabwe. These institutions are hospitals located within a prison setting. Patients are discharged from special institutions following the recommendations of the Special Boards and Mental Health Review Tribunal. Their port of exit is to a general psychiatric hospital for rehabilitation and not into the community as expected. They often stay in these institutions for more than five years and some are eventually sent back to Special Institutions creating a revolving door scenario. The researcher observed that there were no guidelines for forensic psychiatric practice and no clear documentation on procedures to be followed in the rehabilitation process in Zimbabwe. An average Zimbabwean should have been able to follow the entry-exit process in the continuum of care for the forensic psychiatric patient. The goal of the study was to understand the experience and involvement of the judicial team in the processes for the rehabilitation of forensic psychiatric patients in Zimbabwe.

## METHODOLOGY

This study embraced an exploratory qualitative design with a constructivist grounded theory approach. Purposive sampling was done for the participants. 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; Polit & Beck 2012). Inclusion criteria for the judicial team included that participants selected shared the characteristics listed below.

1. They had to be directly involved in the processes of care, rehabilitation or legal aspects relating to forensic psychiatric patients.
2. They had to be able to express themselves in Shona, isiNdebele or English

The participants included the magistrates and public prosecutors whose involvement in forensic psychiatric processes is mandated by the Zimbabwe Mental Health Act of 1996. Charmaz (2006; 2014)

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, theoretical sampling for participants who had not been originally purposively sampled became necessary because they needed to clarify some issues or grey areas that were raised by the mainstream participants. Theoretically sampled participants included the regional clerk of the court, an officer in charge of the special institution and a member of the Mental Health Review Tribunal. Data saturation was achieved with a total of nine (9) judicial participants. These will be referred to as participants 1-9 in this paper.

## Ethics of the Study

Permission to carry out the study was granted by the Medical Research of Zimbabwe (MRCZ) and the Judicial service Commission. All participants consented in writing to have audiotaped interviews. The data collection process occurred between May 2013 and October 2013, a period that was in line with the approval specifications of the Medical Research of Zimbabwe. The permission given by MRCZ was for the study to develop a Medico-Judicial Framework for the rehabilitation of forensic psychiatric patients in Zimbabwe. This paper only presents the situational analysis of that study that covered the experiences of the judicial team in the rehabilitation processes of forensic psychiatric patients in Zimbabwe.

## Data Collection

Semi-structured interviews were used to collect data. Field notes and memos augmented and contextualized the data. The average length of each interview was 25 minutes. Contextual challenges influenced the interview time. 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 participant verbalized that it was the first time in his career that he was requested to be interviewed for a research study regarding forensic psychiatric patients.

## Data Analysis

The analysis of interview transcripts and notes were guided by an approach focusing on deriving patterns in the data by means of

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thematic codes. Bowen (2005) and Johnson and Christensen (2008) 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) 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; Saldana, 2009). Line by line coding and analysis, as favoured by Charmaz (2006), made it possible for the researcher to compare new data with that which she had already coded. 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 analyzed 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). The sub-categories developed into major categories. The categories were then integrated into the main theme from which the central storyline evolved. The findings are presented through an analysis of the texts using only descriptive open-coding and focused coding for a grounded theory approach.

## FINDINGS OF THE STUDY

The central storyline that emerged from the judicial team revealed that they are 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 are digressive to the discourse of patient rehabilitation. The role of the family was also generally viewed in a negative light. One theme emerged from the collected data. The theme had four categories and sub-categories are discussed in detail.

### Theme: Discordant Engagement of the Judiciary to the Rehabilitation System

The judiciary has 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). Their engagement, however, seems at variance with that which would enable patient recovery; their engagement came across as prohibitive and discrepant.

### Category 1: Prohibitive Processes to Patient Recovery

Prohibitive processes to recovery were conceptualized 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.

#### *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. The phenomenon of a similar ‘revolving door’ in forensic psychiatric practice is acknowledged by Arboleda-Florez (2006). Mars, Ramlall and Kaliski (2012) 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 (2000) 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; Greenberg and Shuman, 1997) 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) 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) 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.

### **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 (Aljazeera, Ali & Abdulridha 2011). 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, one has to be taken to Harare.”*

Reeves, Mills, Billick and Brodie (2003) 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) 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) and Sinha (2009) that the lack of budgets specifically for mental health in African countries probably explains why appropriate technological resources are not available. Lynch (2010) agrees with Sinha (2009) 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.

### **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 behavior 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] should be separated.”*

Henderson (2003) 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) 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) 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) summarises this scenario by implying that such occurrences may result from the fact that forensic psychiatry practice is “shrouded in both mystery and confusion”.

### **Loss of documents**

The documents refer to that 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.

This acknowledgement of document loss is not supported by literature. There is a scarcity of information on this issue (Ogunlesi et al. 2012). 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). In fact, Sinha (2009) 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.

### **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; where 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.”*

This scenario could be a result of poor legal and policy frameworks as highlighted by Njenga (2006:97). Ogunlesi et al. (2012) 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) 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) 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.

### **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.”*

Language represents power and is a form of symbolic capital (Bourdieu 1989). Its value is tied to how refined it is or how proper the speech comes across (Hanks 2005). 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), 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) 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) 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.

### **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 unfavorably towards forensic psychiatric patients’ judicial processes. This seemed to affect the rehabilitation process for the forensic psychiatric patients in a negative way.

#### **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..."*

Eastman et al. (2013) confirms that there is inherent discipline incongruence between psychiatry and the law emanating from adversarial values. Nedopil (2009) states that forensic psychiatry is a field without much commercial interest. In support of this view, Sinha (2009) 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.

### ***"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. Judicial 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."*

Sinha (2009) concurs with European Commission Final Report (2005) 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), 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.

### ***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 judicial team and the special institutions. The judicial team 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]."*

Nedopil (2009) 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) and European Commission Final Report (2005) 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) 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.

### ***"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). An unexpected finding emerged from one judicial 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."*

Eastman et al. (2013) 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) 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) propose that the lack of linguistic uniformity

makes it difficult to apply psychiatry to judicial systems.

### ***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...”*

Huxter (2013:) 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) and Sinha (2009) 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) 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.

### **Category 3: The Judicial Linguistic Habitus and its Selective Re-Interpretation were Digressive to the Discourse of 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.

#### ***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) 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).

Eastman et al. (2013) assert that there are always disparities within and between disciplines and, as Wodak (cited in Wodak & Meyer 2009) 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.

#### ***Dehumanization 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).

To illustrate the concept of dehumanisation in this context, Eastman et al. (2013) 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.

#### ***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).

Eastman et al. (2013) 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) 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.

### **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.”*

Coutts (2011) defines incarceration in the context of forensic psychiatry as “confinement or imprisonment in a given area such as a prison”. Eastman et al. (2013) note that the criminal justice system is “highly auto poetic, that is, nonreflexive”. 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.

### **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 prison 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] prison, I don’t know the setup, whether they [forensic psychiatric patients] are going to mix with other detainees or not but simply we just commit [them].”* (I emphasise).

According to Hanks (2005), language use represents reality. This can translate to the possibility of patients living more in the reality of ‘prison’ life. Coutts (2011) quotes Gunn and Maxwell (1978) 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), 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) 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), for example, provides evidence that the placement of forensic institutions has drawn worldwide interest in forensic psychiatry.

### **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.

#### **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.”*

Neil (2012) 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) infers to when they label stigmatization 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.

#### **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). The judicial participants felt that decriminalization 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.”*

Tulloch (2010) and Wilkinson, Mallios and Martinsen (2013) 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) 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) 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) 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.

## RIGOUR OF THE RESEARCH FINDINGS

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; Kvale & Brinkman, 2009).

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; Creswell, 2009; Fielding & Fielding, 1986; Patton, 2002).

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; Charmaz, 2014; Green & Thorogood, 2009; Shenton, 2004).

## CONCLUSION

Findings showed a judicial dislocation and disjuncture relative to other systems involved in processes regarding rehabilitation of forensic psychiatric patients in Zimbabwe.

## PRACTICE IMPLICATIONS

There seems to be an urgent need to develop a systematic therapeutic jurisprudent framework that coordinates judicial and medical efforts in rendering a comprehensive rehabilitative prescript for forensic psychiatric patients in Zimbabwe.

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