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Demographic, Clinical and Forensic Profiling of Alleged Offenders Diagnosed with an Intellectual Disability

Nathaniel Lehlohonolo Mosotho ^a, Dipono Bambo^a, Tlangelani Mkhombo^a,
Chuma Mgidlana^a, Neo Motsumi^a, Thabo Matlhabe^a, Gina Joubert^b,
and Helene Engela Le Roux^a

^aDepartment of Psychiatry, University of the Free State, Bloemfontein, South Africa; ^bDepartment of Biostatistics, University of the Free State, Bloemfontein, South Africa

ABSTRACT

Forensic psychiatry and forensic psychology study the link between mental health and the law. These forensic behavioral sciences play a vital role when assessing both a person's competency to stand trial and the degree to which criminal responsibility can be attributed to the perpetrator of alleged offenses by the criminal justice system. Offenders with a suspected intellectual disability are frequently referred for forensic evaluations by courts of law and possible psychosocial rehabilitation thereafter. The aim of this study was to determine the demographic, clinical and forensic characteristics of alleged offenders diagnosed with an intellectual disability who were referred to Forensic Units at a Psychiatric Complex under Sections 77, 78 and 79 of the South African Criminal Procedure Act no. 51 of 1977. A data collection form was used to gather information from the clinical files/records of the 120 participants studied throughout the course of this research project. Participants were mainly black African males (95.8%), the majority of whom had been diagnosed with a mild intellectual disability (70.8%). These offenders were largely accused of sexual offenses. The majority of the subjects were deemed to be neither competent to stand trial nor criminally responsible for their alleged offenses because of intellectual disability. This study provides valuable information on the relationship between intellectual disability and the types of crimes committed by intellectually disabled individuals.

KEYWORDS

Forensic; mental health; law; intellectual disability; competency; criminal responsibility

Background

One of the most common referrals by courts of law to the Forensic Units in South Africa is for an assessment of both the competency to stand trial and the criminal responsibility of people deemed to exhibit an intellectual disability. An “intellectual disability” is described as the incomplete development of the mind and the impairment of necessary skills that are typically acquired during the intellectual development of an individual. These skills play an important role in the individual's level of intelligence (World Health

CONTACT Nathaniel Lehlohonolo Mosotho  mosothol@fshealth.gov.za  Department of Psychiatry,
University of the Free State, P.O. Box 339, Bloemfontein 9300, South Africa

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Organization [WHO], 1992). An intellectual disability is understood as a limitation of the intellectual functioning and adaptive behavior of an individual (American Psychiatric Association [APA], 2013). “Adaptive behaviour” refers to conceptual skills, including an individual’s ability to conceptualize language and time, as well as social and practical skills, such as the ability to solve problems. Such skills include the various activities inherent in daily living, such as getting dressed, eating and using the bathroom (Maulik et al., 2011). Intellectual disability is considered to be one of the most common causes of impairment in children and adults (McConkey et al., 2019). It is also viewed by some authors as a global mental health burden in the developing countries (Molteno et al., 2011).

The levels of severity of intellectual disability are no longer defined by IQ scores only. Intellectual disability has historically been defined as significant intellectual impairment as measured by an IQ of under 70 (Hellenbach et al., 2017) together with impaired adaptive behavior or social functioning (McBrien, 2003). The different degrees of intellectual disability, such as mild, moderate, severe and profound, are defined on the basis of adaptive functioning because it is adaptive functioning that determines the level of support necessitated (APA, 2013). An intellectual disability is a condition that influences the life of an individual and wider society in many complex ways, affecting both the individual subject of the disability and their family as well as various wider social and economic structures; as such, intellectual disabilities should not be taken lightly (Fistikci et al., 2014; Patja et al., 2000). The onset of intellectual and adaptive deficits is during the developmental period. The factors that may interfere with intellectual development may be infection before, during and after birth (Hepner et al., 2015), as well as head injuries/trauma during the developmental period. The DSM-5 also emphasizes the role that may be played by genetic factors for the development of intellectual disability (APA, 2013).

It is worrying that there is no specific data on the current prevalence of intellectual disabilities in South Africa (Fiegggen et al., 2019). However, Statistics South Africa/Census 2001 conducted a survey on the prevalence of disabilities in the country and found that there were more than 2 million people with various forms of disability. This number constitutes 5% of the total population of South Africa. The provincial prevalence levels showed that the most affected province was Free State (where this study was conducted) with a prevalence rate of 6.8%. The prevalence of sight disability was the highest (32%), followed by physical disability (30%), hearing (20%), emotional disability (16%), intellectual disability (12%) and communication disability (7%; Statistics South Africa, 2005, p. 1). Other studies have been conducted in other countries that focus on the prevalence of intellectual disability in the overall population. For example, in Iran, a predominantly Muslim country, the prevalence rate of intellectual disabilities was reported

to be higher in men than in women with a rate of around 13/1000 of the general population; furthermore, intellectual disabilities were observed to be mostly prevalent in young people rather than adults (Soltan et al., 2015). A similar trend was observed in the Scandinavian region, where Ng et al. (2015) conducted a survey on the prevalence of intellectual disabilities among older people. They found the prevalence of intellectual disability to be 266 per 100,000 population in 2012. The prevalence of such a disability was consistently higher among males, and the gap between genders was widening on an annual basis. These findings are notably different from those reported in Canada by Raina et al. (2013). Although their sample of individuals diagnosed with an intellectual disability was smaller (76 in total), female participants constituted 42% of this sample. A study conducted in India on the prevalence of intellectual disabilities and its association with age in rural and urban samples reported the accumulative prevalence rate of 10.5/1000 (Lakhan et al., 2015). In Ireland, intellectual disability prevalence is estimated to be around 6.13/1000, with mild intellectual disability at a prevalence rate of 1.99/1000 and moderate, severe and/or profound intellectual disability at a rate of 3.6/1000 (Gulati et al., 2018). Delobel-Ayoub et al. (2015) explained that the prevalence of intellectual disabilities is likely to be higher in low- and middle-income nations. Additionally, international literature indicates that the prevalence of intellectual disability varies from country to county with the estimation of 3.31 to 36.75 per 1,000 people, giving an overall prevalence rate of 9.2/1000 in both developing and developed countries (McConkey et al., 2019).

It has been documented that individuals with an intellectual disability are occasionally, depending on where they live, overrepresented in criminal justice systems due to different forensic practices and laws (Riches et al., 2006). A similar observation has been made in Australia, where a noticeable proportion of this demographic are residents in correctional service centers and prisons (Raina et al., 2013; Vanny et al., 2008). Nevertheless, researchers such as Jones (2007) have explained that the majority of people with an intellectual disability are law-abiding citizens, citing the few individuals who display violent and criminal behavioral patterns as the exception. The literature indicates that there is a link between criminality and intellectual disability (Segeren et al., 2018). People with intellectual disabilities may be more susceptible to simultaneously becoming both the perpetrator and the victim of a crime (considering their diminished level of functioning). Research reveals that, compared with the general population, individuals with an intellectual disability are proportionally more susceptible to committing crimes and, consequentially, being incarcerated (Nixon et al., 2017). However, studies determining the relationship between criminality and intellectual disability have been characterized by difficulties and issues regarding definitional and methodological inconsistencies. Similarly, the assessment of

levels of intellectual disability has been plagued by various methods and techniques depending on the environment and region of the study (Jones, 2007; McBrien, 2003).

The role of forensic/clinical psychologists and psychiatrists working in this area is to facilitate the clinical assessment of the competency/fitness of a person to stand trial and to establish the degree to which criminal responsibility can be attributed to alleged offenses. "Competency to stand trial" refers to the ability and/or capacity of the alleged offender to follow legal and/or court proceedings at a given time, understand the criminal charges placed before him/her (Slobogin, 2006), and provide his/her legal team with the instructions necessary to facilitate a competent legal defense (Pillay, 2014). The accused's capacity to stand trial may be evaluated by determining the extent to which the accused understands the various roles and functions of the people working in/for the court. For a trial to adhere to the principles and obligations that dictate the fair administration of justice and the protection of basic human rights, the alleged offender must be of a sound mental capacity and capable of meaningfully participating in all legal proceedings (Freckelton & Karagiannakis, 2014). The South African legal and judicial system is based on Roman Dutch Law. Fitness to stand trial is covered by Section 77 of the Criminal Procedure Act no. 51 of 1977 in South Africa (Janse van Rensburg et al., 2012). In terms of the principal criterion for determining a defendant's competency to stand trial, defendants must be able to assist with the provision of facts and decisions pertinent to the preparation of their legal defense (Piel et al., 2015). The guarantee of an evaluation of competency preserves both the dignity and standards of the courts and is a fundamental means to ensuring the uniform integrity of trial proceedings (Pirelli et al., 2011). The main focus is to determine the current mental status of the accused (Pillay, 2014).

An evaluation of both the defendant's competency to stand trial and the defendant's sanity at the time of the alleged offense is often required in court proceedings. However, determining the mental state of a person at the time of an alleged offense is a complex process (Chauhan et al., 2015). Determining competency to stand trial does not simply involve determining the defendant's guilt or innocence but rather whether he/she can competently follow through with the legal proceedings. The standards of competency vary from country to country, and rationality is not a prerequisite in certain jurisdictions (Reisner et al., 2013). Cognition (language, memory, attention and executive functioning) is an important factor in determining competency as it is a measure of the defendant's level of understanding, comprehension and ability to assist their legal counsel (White et al., 2014). Although the exact role cognition plays in determining a defendant's competency is still not completely understood, it is possible that individuals who possess the general cognition deemed necessary for their able cooperation might still be

unable to represent themselves in a rational manner. There has been a considerable amount of research examining the different aspects constituting a defendant's competency to stand trial. Kois et al. (2013) investigated whether gender, race, ethnicity and cultural diversity are additional factors influencing the evaluation of a defendant's competency to stand trial. One of the critical considerations during the assessment of competency to stand trial is the possibility of a defendant malingering. "Malingering" refers to an individual's faking or exaggerating a mental illness to escape being tried by the courts (Vitacco et al., 2007).

Another key function of both forensic psychiatry and forensic psychology is the evaluation of criminal responsibility among alleged offenders who are suspected of suffering from a mental illness or defect. In South Africa, the legal concept of criminal responsibility and/or defense based on insanity derives from the *McNaughten* rules passed by the House of Lords in 1843 in England. Today's use of the "not criminally responsible" defense is steeped in the legacy of two particular cases, *R v Oxford* (2011) and *R v McNaughten* (1843). *Oxford* was the first recorded case in which "expert medical" witnesses were allowed to provide expert evidence. In statutory law, many jurisdictions today base their definition of criminal responsibility on the *McNaughten* case (Ferguson & Ogloff, 2011). In an attempt to assassinate then-Prime Minister Robert Peel, Daniel McNaughten, a shopkeeper and wood turner from Glasgow, Scotland, mistakenly shot and killed the Prime Minister's secretary, Edward Drummond. From McNaughten's only public statement addressing his motives, it was deduced that he was mentally ill and suffering from paranoid delusions of being persecuted by the Tories. With the help of his legal team, as well as the testimony of nine medical experts, McNaughten was found "not guilty" by a jury of his peers by reason of insanity (Bromber & Cleckley, 1952). His defense team argued that his motives were not politically or morally motivated but rather due to mental illness. The *McNaughten* rules were then passed due to the public's outraged reaction to the verdict so as to prevent such a verdict in the future. The *McNaughten* rules state that a person can be deemed "mentally ill" only if it can be clearly proven that, at the time of the crime, the person suffered from a mental illness or defect and was consequently unable to differentiate between "right" and "wrong". In South Africa, defense on the grounds of insanity is governed by the Criminal Procedure Act of 1977, Section 78 (Department of Justice and Constitutional Development, 1997). This procedure interrogates the mental status of the accused at the time they committed the crime. This task is always difficult to perform in the sense that the criminal offense might have taken place long ago, unlike the assessment of fitness to stand trial in which the focus is on the current mental state of the offender.

Another disputed concept in the field of law and mental health is diminished capacity and/or diminished criminal responsibility (Shiels, 2014). “Diminished capacity” was not a commonly used term in the past. The “diminished responsibility” plea was based on the idea that the accused offender was suffering from a mental illness at the time of the alleged offense, allowing the court to be lenient and convict the accused on a lesser charge. Over the past century, various reforms addressing the areas subject to criticism have indirectly altered the legislative definition of diminished responsibility. The laws also look at the degree of seriousness of the crime committed by the offender (Kennefick, 2011). Nevertheless, some defense attorneys employ diminished capacity as a mitigating factor to support their claim that the accused ought to be considered for a lenient or suspended sentence (Xuan & Weiss, 2014). However, in some cases in the United States of America, it has been argued that a mitigating mental condition may not be accepted as sufficient justification for the reduction or suspension of sentences.

It was against this background that the researchers of this project decided to conduct a study examining the demographic, clinical and forensic profiling of alleged offenders diagnosed with an intellectual disability at a Psychiatric Complex, Bloemfontein, South Africa. The study was also a response to the South African government’s policy that researchers should focus on local geographical areas and communities to meet the needs of the local population. A description and documentation of the defining characteristics (demographic, clinical and forensic) of alleged offenders diagnosed with an intellectual disability, as referred for forensic evaluation and treatment at a Psychiatric Complex, will possibly assist the provincial government in meeting the basic needs of these patients. The results of the study will hopefully influence official policymaking decisions, particularly regarding the provision of adequate and effective mental health services. The aim of this study was to determine the demographic, clinical and forensic characteristics of alleged offenders diagnosed with an intellectual disability at a Psychiatric Complex from 2006–2016.

Methodology

Study design

A retrospective descriptive study was conducted which included the entire population of alleged offenders diagnosed with an intellectual disability admitted to the Forensic Units at a Psychiatric Complex from 2006 to 2016. Participants were referred to as “alleged offenders” because they had not yet been convicted of their alleged crimes. These participants were referred by the South African courts of law (for forensic examination)

under Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977 to determine both their competency to stand trial and their criminal responsibility. Subsequently, they were admitted for psychosocial rehabilitation under Section 42 of the Mental Health Care Act no. 17 of 2002. The assessment of the presence and levels of intellectual disabilities was performed in accordance with globally shared diagnostic criteria such as the DSM-5 (APA, 2013) and ICD-10 (WHO, 1992). The participants in the present study had been evaluated using clinical and psychometric methods and techniques (Di Nuovo & Buono, 2009). These comprehensive assessments were administered by a multi-professional team of psychiatrists, psychologists, professional nurses, occupational therapists and social workers. The different levels of intellectual disability were determined by a clinical assessment, standardized intelligence testing and evaluation of everyday adaptive functioning.

A total of 120 clinical files/records belonging to the members of this population were studied. Consecutive sampling was used to ensure that the sample was representative of the targeted population (Lunsford & Lunsford, 1995). Consecutive sampling is a technique in which every research subject who meets the inclusion criteria is included until the required study sample size is obtained. Patton (2002) explained that consecutive sampling effectively decreases the systematic bias associated with other methods of sampling due to the methodological guarantee that every potential participant has a 100% chance of being selected.

Data collection

A data collection sheet was used to record information from the participants' files. The researchers were trained by the study leader (a principal clinical psychologist/senior lecturer) in terms of how to complete the data collection form whilst ensuring the uniformity of the data collection process. These files, retrieved from the Psychiatric Complex's (hospital) safe storage and archives, were accessed with the assistance of the managers responsible for the safe keeping of the hospital's complete clinical records. Upon being granted access, the researchers screened all the files from the years 2006–2016 to locate the files of those diagnosed with an intellectual disability. The files were divided among the researchers, and the researchers subsequently entered the relevant information into the data sheets. This information included participants' demographic data and diagnoses, clinical notes, types of crimes committed and the outcome of the 30th day of forensic observation/assessment by the forensic multi-professional team. The data sheet information was entered into an Excel spreadsheet. Following the suggested method of sampling, the researchers first conducted a pilot study on 20 patient files to investigate the practical feasibility of the research, as

well as to test the practicality and appropriateness of the data collection sheet. The results were summarized using frequencies and percentages (categorical variables) and means and standard deviations or percentiles (numerical variables). Chi-squared, or Fisher's exact tests in the case of sparse cells, were performed to investigate the associations of competency to stand trial and criminal responsibility with intellectual disability and crimes committed.

Permission to conduct the study was obtained from the Research and Ethics Committee of the Psychiatric Complex and the Department of Health. The study was approved by the Health Sciences Research Ethics Committee of the University of the Free State. Informed written consent was deemed unnecessary, as there was no need for direct contact with the participants.

Results

The study sample consisted of 120 participants. The socio-demographic characteristics of the participants are presented in [Table 1](#).

The median age of the participants was 26, and the majority gender (95.8%) was male. Most subjects (85.8%) were Black Africans, single (99.1%) and unemployed (51.7%) at the time they were arrested and criminally charged.

The majority of the participants were diagnosed with a mild intellectual disability (70.8%), with the next largest portion diagnosed with a moderate intellectual disability (22.5%); those with a severe intellectual disability

Table 1. Socio-demographic characteristics of the participants.

Characteristics	% of sample
Gender	
Male	95.8
Female	4.2
Marital Status	
Single	99.1
Divorced	0.9
Race	
Black African	85.8
White	10.8
Mixed Race	3.3
Employment	
Employed	9.2
Unemployment	51.7
Disability grant	35.0
Learners	2.5
Pensioner	1.7
District	
Fezile Dabi	14.2
Lejweleputswa	20.0
Mangaung	30.8
Thabo Mofutsanyane	25.0
Xhariep	10.0

composed only 6.7%. As far as comorbidity of other mental and health conditions is concerned, it was found that 1.7% of the study population was also diagnosed with psychotic disorders not otherwise specified, while 5% of the study sample presented with behavioral disturbances, such as aggression and restlessness. Approximately 8% of those individuals with intellectual disabilities were simultaneously treated for epilepsy. The types of crimes committed by the participants are shown in [Table 2](#).

Rape was the most common crime committed by the alleged offenders, representing 58.3% of the offenses committed, followed by assault at 10.8%. The only significant difference between the levels of intellectual disability regarding types of crime was for burglary: only 1.2% of those with mild intellectual disability committed burglary compared to 11.1% and 12.5%, respectively, of those with moderate or severe intellectual disability ($p = .03$).

The multi-professional team's decisions on competency to stand trial and criminal responsibility are shown in [Table 3](#).

More than 90% of the study subjects diagnosed with an intellectual disability were deemed incompetent to stand trial and not criminally responsible for their alleged crimes. Only 5% of the alleged offenders were declared competent to stand trial and criminally responsible for unlawful acts. There was a strong association between competency to stand trial and criminal responsibility ($p < .01$).

Discussion

The study's median participant age of 26 compares well with the current median age of the South African population, reported by Statistics South Africa as 22 in 1996, 23 in 2001 and 25 in 2011 (Statistics South Africa, 2017). All the research participants were males. This finding is in accordance with

Table 2. Crimes committed by alleged offenders.

Crime	Percentage
Rape	58.3
Assault	10.8
Other	9.2
Sex-related offenses	7.5
Murder	5.8
Theft	5
Burglary	4.2
Malicious damage to property	0.8

Table 3. Multi-professional team decisions.

	Competent to stand trial	Not competent to stand trial	Total
Criminally responsible	5.0	0.8	5.8
Not criminally responsible	4.2	90.0	94.2
Total	9.2	90.8	100

other studies that reported a similar trend among offenders in other parts of the world (Ray et al., 2019).

Regarding marital status, almost 100% of the participants were single. This finding is not surprising because Ray et al. (2019) have reported similar results in Canada. A predominantly single statehood/status among this group of individuals implies that there may be a lack of available adequate supervision and social support systems, especially when considering that they suffer from impaired levels of functioning socially and economically (Fistikci et al., 2014). These individuals may end up being institutionalized at social and health establishments. The racial distribution of the sample was not surprising, reflecting (as reported by Statistics South Africa, 2017) that black Africans are almost 80% of the population distribution in all provinces of South Africa except for the Western Cape and Northern Cape. Racial distribution in the Free State Province is approximately as follows: Black (87.6%), White (8.7%), Mixed race (3.1%) and Asian (0.4%).

The findings that the majority of the alleged offenders were in the mild intellectual disability range concurs with what has been reported elsewhere. For example, Salekin et al. (2010) reported on different levels of intellectual disabilities and explained that there are more individual offenders diagnosed with mild intellectual disability in comparison with moderate or severe ones. In the Free State Province, where this study was conducted, Calitz et al. (2007) reported a 62.5% prevalence of mild intellectual disability among their study group. Intellectual disabilities are developmental and cognitive disorders. The majority of people presenting this type of disorder are born with it. However, there are a few cases in which people developed an intellectual disability after birth due to incidents such as brain damage, poisoning, infection and disease. As far as comorbidity of other mental and health conditions are concerned, such as psychosis, epilepsy and behavioral disturbances, the results are in accordance with the global findings in this field of study. Vanny et al. (2008) rightly noted that individuals with an intellectual disability are more vulnerable to developing other psychotic and psychological conditions than the general population. Männynsalo et al. (2009) expressed that people subject to an intellectual disability may also manifest aggressive behavioral patterns without the presence of any sort of psychosis, affective disorder or personality disorder. Such individuals may also be subject to certain psychiatric conditions without exhibiting any behavioral disturbances or diagnosable symptoms. Moreover, there is the possibility of the coexistence of behavioral patterns and psychiatric disorders among these individuals, as well as the possibility that these factors impact each other.

There was no clear data on the employment status of the research participants in the present study. Nonetheless, a significant number of individuals in the research sample were recipients of social and/or disability grants. Statistics South Africa (2017) reported that the unemployment rate in the

Free State Province was 29.8% in the Last Quarterly Labor Force Survey, Quarter 4, 2016. The data on the distribution of the participants' districts of origin reflects the general provincial population distribution. The area surrounding Mangaung, the only metro in the province, has a larger population than other districts.

Fogden et al. (2016) and Spaan and Kaal (2019) argued that people with an intellectual disability may simultaneously become both the victims and the perpetrators of criminal acts. There is an erroneous perception among the public that this most vulnerable group of individuals are to be associated with crimes (Mercier & Crocker, 2010). This attitude or misconception promotes the stigmatization of intellectual disabilities. The finding that rape was the most common crime is consistent with the findings of Sakdalan and Egan (2014) that research individuals diagnosed with an intellectual disability were more likely to be accused of sex-related offenses. Finally, the majority of the participants with intellectual disability were neither competent to stand trial nor criminally responsible for their alleged crimes. Wall and Lee (2019) explain that intellectual disability is the second most cause of incompetency to stand trial throughout the globe.

Conclusion

Almost all the participants were males presenting with a mild intellectual disability. This study concluded that alleged criminal offenders with an intellectual disability are generally not fit to stand trial and largely not responsible for their criminal acts. There is a need for additional empirical studies on the epidemiology of intellectual disability in developing nations such as South Africa. The findings of this study provide valuable information on the relationship between intellectual disability and the types of crimes committed by individuals with an intellectual disability. Although there have been many studies on the link between mental illness and criminality, there is still a dearth of information regarding the link between intellectual disabilities and criminal behavior. This study has confirmed the link between intellectual disability and the constructs of competency to stand trial and criminal responsibility, respectively. Nevertheless, due to the relatively small size of the sample and the restricted area of research, the results of this study may not be generalizable and should thus be interpreted with caution.

Disclosure statement

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ORCID

Nathaniel Lehlohonolo Mosotho  <http://orcid.org/0000-0002-6069-6957>

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