International Journal of Nursing Science 2019, 9(1): 12-18
DOI: 10.5923/j.nursing.20190901.02

Mental Health and the Justice System in Zimbabwe: An Interpretative Phenomenological Analysis

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Abstract The study explored mental health for female patients within the justice system in Zimbabwe. Purposive sampling of ten justice system participants directly involved with mental health services was done. Data were collected using in-depth interviews. Interpretative Phenomenological Analysis (IPA) was applied to the study. It enabled the justice system participants to make sense of their experiences in working within mental health services. Findings: Analysis of transcripts revealed two master themes: 1) offending, entry and processing of female psychiatric patients in the justice system. 2) Community aftercare issues and future projections. There is need for unity of function between the justice system, the medical arm and the Special institutions for effective rehabilitation of female forensic psychiatric patients in Zimbabwe.

Keywords Forensic, Mental health, Justice system

1. Introduction

Mental health poses a constant challenge for most juridical systems the world over because of the controversy and public interest it generates [5, 3]. In Zimbabwe, mental health and psychiatry are structured as part of the prison mental health care [4]. The entry of patients into mental health and psychiatry are guided by the Mental Health Act of 1996 [6]. Accordingly, Part 3 Sections 26 to 35 of the Act regulates procedures that are followed for mentally disordered persons within the criminal justice system. Section 26 guides on what should be done for a person who is found to be mentally ill while in remand prison. Section 27 caters for individuals who are found to be mentally disordered while under detention. Section 28 directs procedures for persons who appear to be mentally ill during trial. A person who is found to have been mentally ill at the time of committing the crime falls under Section 29. If a convicted prisoner becomes mentally disordered, Section 30 spells out what should be done. In all of these cases, either a magistrate, judge or other judicial officer may order a medical examination for the persons involved. These are then moved to a Special institution gazette by Section 107 of the Act for care and treatment.

The care and treatment order are directed to the Officer in Charge/ Superintendent of the Special institution. Section 31 gives power to the Attorney General's office to discharge patients admitted under Sections 27 and 28. This office also has the power to withdraw criminal charges or decline prosecution. Section 35 mandates the Mental Health Tribunal to discharge patients admitted under other sections of Part 3. The study explored the perspectives and experiences of the justice team responsible for various processes and procedures that involve female psychiatric patients in this continuum of care. Care in this study referred to prosecuting, ordering detention in Special institutions and discharge from such institutions.

2. Ethics

Permission to conduct the study was obtained from the Medical Research council of Zimbabwe (MRCZ). The National Prosecuting Authority (Attorney General's office) gave permission for participation of clerks of the court and public prosecutors, the Judicial Services Commission authorized participation of magistrates and judges. The office of the Commissioner General (Department of Research and Development) approved the involvement of the superintendents of the special institutions. Individual consent was also obtained from participants. Anonymity was ensured through use of code numbers for the participants. Information obtained from participants was kept in a locked drawer in one of the researchers' private office and was not shared with persons that were not involved in the research study.

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Published online at http://journal.sapub.org/nursing

3. Methodology

Purposive sampling of 10 participants was done for the justice team. Participants were identified as 1, 8, 12, and 13, 14, 15, 16, 17, 25, 28. These included magistrates, public prosecutors, clerks of court, and members of the Mental Health Review Tribunal and superintendents of the special institutions. Data were collected using semi-structured interviews. These were meant to initiate and allow the flow of the interviews in the direction of participants while focusing on mental health within the justice system. Interpretative Phenomenological Analysis (IPA) was applied in the study because the research sought to understand the experiences of the justice team within the mental health service. This understanding was based on a double hermeneutic in that the justice team as participants interpreted their experiences of processes and procedures followed in the care and management of female psychiatric patients. Their reflections were then interpreted by the researchers during the analysis stage. IPA was also viewed as idiographic in the study because it allowed examination of each participant experience in detail [8]. In the process, points of convergence and divergence were identified before experiences were analyzed together and themes were grouped.

The process of analysis started with repeated review of transcripts. This was followed by making notes in view of statements that were connected to participants' experiences. Recurring ideas were then sorted to form themes. These themes were collated to the original transcripts. Evolving themes were examined for connections between them to generate superordinate themes.

4. Findings

Findings of the study revealed one superordinate theme and two subthemes. The superordinate theme showed legal and medical processing experiences, aftercare issues and future projections for female psychiatric patients. This superordinate theme was derived from two master themes which included: Offending, entry and processing of female psychiatric patients in the justice system; Community aftercare issues and future projections.

5. Theme 1 – Offending, Entry and Processing of Female Psychiatric Patients in the Justice System

This master theme will be discussed under the following subthemes that were clustered to form it: offences committed by female psychiatric patients, documentation issues, and perception of guiding legal frameworks, initial processing involving the medical examination, processing challenges related to gravity of the criminal offence, entry and exit points for female psychiatric patients.

6. The Offences Committed by Female Psychiatric Patients

Participants were conscious of the fact that accused persons who came before them would have committed crimes because they would be mentally unstable as articulated by Participant 14; '*The cause of crime mostly for female forensic patients I think they are mental; their fitness causes them to commit crimes mostly it's not a willful act to them mostly it's the mental illness which causes them to commit crimes'*. Offences or crimes committed by female psychiatric patients according to participants included malicious damage to property like throwing stones at a moving car or a building. Infanticide through poisoning or drowning was also common which usually took place when the mother (patient) had psychosocial stress. Left undetected and unmanaged, the woman was perceived as developing feelings of hate towards infant, resulting in failure to bond with the baby leading to her murdering the child as expressed by Participant 25: *The people who give birth and are not closely monitored, they end up hating the child to an extent that they end up killing the child because no-one is noticing that this woman has problems.* Participants contended that females were also involved in crimes like stealing due to poverty. Violent crimes were attributed to when the patient had been provoked to the maximum, from domestic violence, or extra marital affairs as expressed by Participant 16: '*…you would see that most female offenders would probably be involved in non-violent crimes maybe out of poverty, like maybe stealing or if there are violent crimes usually, they would be those that emanate from emotions probably a under domestic setup where probably in a fight maybe with other women over a man or such, so that is when probably a female is forced to become violent but generally the trend is women would rarely be in violent crimes'.* Female psychiatric patients were generally considered to be less violent than their male counterparts. This could be due to socialization within the study context.

7. Documentation Issues

Participants from the prosecuting departments indicated that there were delays in sending initial documents from courts to Special institutions due to too much paperwork to be processed as described by Participant 8 who explained this notion more clearly; '*When the transcript sent into the institution the transcribers have got challenges of having too much work so there will be some delays in transcribing the information needed at the psychiatric institutions, we take time before sending the forms to the psychiatric institutions'.* The delays mean that mentally ill individuals took too long before they could be commenced on treatment. If they were already mentally ill when they came into contact with the criminal justice system, it also implied that they would have defaulted treatment during the remand-court- Special instruction processes. Documents also went missing, as they

were either misfiled, misplaced or forgotten as staff was untrained on handling patients' documents. This caused delay in processing patients' documents as voiced by the Participant 15, a clerk of the court: '*Because now we have got too many records, these papers might be misfiled somebody forgets about them because they are not people to us… we are not trained to deal with these psychiatric people we just put the papers in the files take them to the magistrate. If those papers are misfiled or put somewhere somebody forgets he doesn't know what that paper means or what's the use of that paper finally the magistrate saying this person has not been examined. Even the prisons can take the papers to X* [general prison in one province] *instead of Y* [a general prison in another province]*'.*

The statement '*…somebody forgets about them because they are not people to us…*' reflects that female psychiatric patients are viewed as documents or files or cases which may suggest that they may not be priority. It is also important to note that the same staff is responsible for other civil criminal cases. That way documentation was perceived to be a major facet that negatively affected effective processing of female psychiatric patients within the justice system in Zimbabwe.

8. Follow-Through Issues

The justice system participants indicated that they had no mechanisms of checking the flow of patients in the system. If, for instance, the prosecuting department finished its task, another department took over and accountability became blurred. Participant 13, a public prosecutor expressed this opinion: '*…areas I feel our systems are still lacking in terms of real follow ups and even in terms of management we should have structures that are very clear even within every department … so that they know that anything can happen if we are found with a patient who is unaccounted for… but now the system is, it's just like another docket I throw it in and I move on. The most important thing is team work and then the referral system should be clear and I should know what is next, if you are passing the button to the next person, what exactly do they do, and what do they expect me to do? Have I done that? So that the gap is understood'.*

Participants indicated that they did not have a clear referral and communication system. For instance, police could just arrest a patient and bring her for prosecution without ascertaining through investigations whether the person was on treatment or where their relatives were. Participants also indicated that pressure of work and the need to meet their own key result areas as the system had an overriding impact on processing of files of patients. In the process, participants failed to engage with the mentally disordered clients who needed their priority attention.

9. Perception of the Guiding Legal Frameworks

The Mental health Act of 1996 was perceived as outdated, not user friendly and in need of review so that it could accommodate the welfare of patients as articulated by Participant 25: '*It's one of the gaps where we are saying the law is there but the implementation* [Showing that it's not effective]. *I don't think the Act* [Mental Health Act] *is really getting enough coverage in terms of being used. We find most of the challenges especially in the prosecution of these cases. I think the evidence part of it is required to be standard, considering the persons we are dealing with* [female forensic psychiatric patients]. *For instance, at law we are saying, 'X' should come in and testify … without any other evidence at times you can tell that although this is a patient, we are not really doing justice. The Mental Health Act itself it's supposed to be reviewed it's overdue'.* This means that the Mental Health Act (1996) was understood to be no longer meeting the demands of the patients at the time of the study, which had a negative impact on patients' processing and subsequent rehabilitation.

The concurrent use of the Mental Health Act and the Prison Act both of 1996 was understood by the justice team participants as noble, suitable and beneficial. The basis of this understanding was that since the patients were cared for in prison settings and were cared for together with civil female prisoners, some rights like movement needed to be removed to maintain security as expressed by Participant 8: *'... yes we can say there is little freedom when they come to prison, we can say that but I think these people are brought into prison not as the mental patients alone* [but together with civil female prisoners]. *I can safely say any patient sent to prison automatically some of the rights are being removed like the freedom of movement, if we can allow all of them to move freely at the end of the day, we will have nobody here and we will be charged for that so we have to ascertain they are here at all times they get their food, bathing'.* Female psychiatric patients were viewed as prisoners, just like the ordinary female prisoners in the same custodial space. This then suggests that they were treated like 'prisoners' not 'patients' which could be detrimental to effective rehabilitation. The participants, particularly those that were directly involved with court processes indicated that they were not conversant with the Prison Act of 1996 since they were mandated to use the Mental Health Act of 1996 in court proceedings. Participants, however, perceived that the two Acts complement each other. Participant 12, a magistrate articulated this issue: '*usually the two Acts* [Mental Health Act and Prison Act], *they more like assist each other on how to manage that particular person* [the female psychiatric patient] *… as the judiciary officer I use the Mental Health Act mainly. As to what then happens to the patient when he goes to prison it's a different department altogether'.* The justice system participants were not aware of the possible implications of the concurrent use of the Prison Act of 1996 after they would have given the treatment order according to Section 34 of the Mental Health Act of 1996. Essentially the provisions of the Prison Act nullified the rehabilitative mantra of the Mental Health Act beyond the courtroom.

10. Initial Processes Involving the Medical Examination

At any given point, Part 3 of the Mental Health Act (1996) may mandate a mental assessment of a person suspected to be mentally disordered. The justice system participants experienced instances where patients were not medically examined within the timelines stipulated in the Act. Clients/patients were initially not assessed within the stipulated 7-day period by the psychiatrist because there was no resident psychiatrist. The psychiatrist visited the patients on specific days at the time of the study. This in turn delayed the client/ patient to be brought before the court at the initial appearance. The process took longer for the justice team involved to receive final results as narrated by Participant 8: '*We had challenges of psychiatric doctors, for instance the patient can be seen by one doctor and left with the second opinion. So there was much time spent on that period to facilitate the second psychiatric doctor. We don't have a specific institution doctor; the doctor maybe comes on a certain day'*. This was further explained by Participant 12, a senior magistrate: '*Patients are not examined within the stipulated period of time which we want that seven days. And usually the main challenge is that they say we don't have a specific doctor institution; the doctor maybe comes on a certain day…. so it will take a bit longer to get that particular person to be brought before the court and then that will be more than seven days. We're required to assess whether that particular person is challenged not challenged* [mentally ill] *at the initial appearance'.* The understanding was also that when a person/patient was put into an institution again the process took too long for feedback to the magistrates as to whether that particular person was mentally challenged or could be brought to court to face her trial or whether she still needed further management whilst in prison. This reality translated to female psychiatric patient failing to timeously access rehabilitation services.

11. Processing Challenges Related to Gravity of the Criminal Offence

The patient could be medically examined and found to be mentally disordered. The common practice for petty crimes was that if there was family support the patient was released into the custody and care of the family, and dealt with as a civil patient. This applied to patients under Sections 26, 27 and 28 of Part 3 of the Mental Health Act of 1996. Determination of whether the crime was petty or not was understood to be guided by the Zimbabwe Criminal Law (Codification and Reform) Act of 2008. This particular Act defined the offences and availed how each criminal offence was punished. Participants indicated that most of the patients lacked family support. In such cases, the justice system was left with no option but to send patients with petty crimes to Special institutions. Participant 25 narrated such a scenario: '*Well, we have tried to keep petty offenders out of the institution* [Special institution] *at the point of inception at the lower courts. The prosecutors there assess the gravity of the offense, if the offense is not so serious and if there is family support the patient is supposed to be released into the custody and care of the family and given instructions to take the patient to the psychiatrist for treatment and assessment. The situation becomes difficult where there is no family support, there is no-one to release this person to and there is no-one to so they end up in the institution* [special institution]. This scenario played out this way because some female psychiatric patients were mobile and when they committed crimes they would be very far from their families. Sometimes they were not able to give the justice team specific details of where they came from, where their relatives were because of the mental problem they were experiencing. It then became impossible to locate relatives of patients concerned. Participants' experience with lack of family support systems caused ethical and practice dilemmas for the justice team.

12. Reports at Entry and Exit Points for Female Psychiatric Patients

After a member of the justice team requests for a medical report, such a report is availed. The challenge for the justice team at the time of the study was that the medical jargon used was usually not clearly defined and the mental state of the patient not adequately explained by medical reports which hindered appropriate interaction between the justice system and the patient. Participant 16 articulated this notion: *'…the medical personnel, at times you find that they will just say mild or severe* [mental retardation] *but mild is subjective severe is subjective what is mild to you might be severe to the next person. At times when we are dealing with the mental mind, it would be better if we specify the estimated mental age. She is 40 years but mentally she is five then I know what questions to put, how to lead her. I've been called by people to assist on a case of 4-year-old we know what to do but for a patient to use a blanket statement? So, this is how sometimes we lose our cases it's a challenge on the part of nature of medical affidavits. There is that gap in the information that we get from the medical reports, it's not giving us enough to assist us* [to make decisions]. The medical affidavits are less explicit and deficient in information to construct enough evidence needed for use in the court thus causing a challenge for the courts and the justice team dealing with female psychiatric patients.

After a patient has been treated at the special institution, the Special Board writes a report to the Mental Health Tribunal to the effect that the patient is mentally stable and ready for discharge. The Special Board is advised by the psychiatrist and other medical team members to reach such a decision. Such medical reports were also perceived as monotonous, relying mostly on subjective data than objective data, and not comprehensive enough to prove the mental state of the patient, leaving an element of doubting

the evidence given as articulated by Participant 25, a member of the Mental Health Review Tribunal: *We get psychiatric reports from institutions but what I have observed is these reports become more like uniform what you read for a report for you and me you find that it's just the names that are different but everything else might be the same*[duplicated for all patients]. *Secondly, I think our forensic psychiatric health needs to be more advanced. You find our reports depend a lot on what the patient tells the psychiatrist. They*[patient(s)] *say they started using Cannabis 5 years ago, they drink alcohol and this is what the patient is telling the psychiatrist and the report is mainly on that and the conclusion is mainly arrived at on that. So, I thought mental health is supposed to be a science other than the patient telling their history… You* [Mental Health Review Tribunal] *end up even seeking a second opinion because legally you are at limbo you don't understand if this person, was this person mentally incapacitated at the time of committing the offense or did they become mentally ill after?'*

The issue of the medical reports and other related logistical issues were put into perspective by participants to the effect that as the members of the Mental Health Tribunal, they faced challenges in terms of the management of patients especially the medications and the issue of affidavits where relatives were not visiting the female psychiatric patients in prison and patients then overstayed in the prison setting when they were supposed be discharged. The other issue was that when the Mental Health Review Tribunal checked the affidavits, it found that affidavits would have been done three years before for example. It then became very difficult for the Mental Health Review Tribunal to concede and say the patient could be discharged. The Mental Health Review Tribunal would want recent affidavits that would have been done at least three months before, showing the interests of the relatives to take care of the patients.

The Tribunal did not want to discharge patients into the 'wildernesses. The bottom line was the issue of family support. What then happened was that whenever the Tribunal convened, it deferred a lot of cases that would have been recommended for discharge because it really wanted to confirm whether there was family support for the female forensic psychiatric patient. This concern hinged on the foreseen potential for recidivism and the subsequent revolving door phenomenon.

The most important issue also was that the Mental Health Review Tribunal, if perceived to be discharging patients into the community who then commit crimes, it remained accountable. Its mandate was to be very careful and thorough. As a result, the Tribunal did not discharge patients if it was not satisfied. Another example where the Mental Health Review Tribunal chose not to discharge patients was when an affidavit was availed for a person who is young and was being discharged into the custody of a care giver who is 86 years old or vice versa. The 86-year-old would have written an affidavit indicating she/ he would look after this patient who murdered a close relative or any other person. In such a case, the patient could not be discharged because the potential care giver herself/ himself needed to be cared for as well, having no capacity to look after this particular patient.

Justice team participants also indicated that at times deferments made by the Mental Health Review Tribunal emanated from conflicting reports of the Special Board and that of the psychiatrist. The Special Board recommended discharge of a patient whom the psychiatrist would have noted as not fully recovered. The experiences peculiar to the Mental Health Review Tribunal were the most challenging because they translated to the female psychiatric patient being retained in the criminal justice system. This was due to the fact that where the Mental Health Review Tribunal was not satisfied, the process had to start again and it could take a long period for the special institution to trace relatives, convene a Special Board meeting and transmit the communication to the Mental Health Review Tribunal. At times the patient would have even relapsed by then, needing more treatment and rehabilitation. Participant 28 highlighted these Tribunal challenges that the justice team were very concerned about: '*…so yes there have been instances that there have been recommendations for discharge and then we said no, we order that person be detained and may be reviewed again and then the Special Boards should meet again and report comes back to us* [Mental Health Tribunal]. *I do understand that problem because yes, they are delays, there have been delays and there have been various reasons for the delays, most of those have been structural in terms of firstly the special institutions themselves, their capacity to do the lag work and prepare the files and folders.* The justice system was therefore perceived to be having bottlenecks that needed redress with regards to the functionality of the Special Boards and the Mental Health Review Tribunal.

13. Theme 2: Community Aftercare Issues and Future Projections

Participants acknowledged that female sections of Special institutions occasionally got aid from humanitarian and church organizations who assisted with medication and infrastructural renovations. This however did not extend beyond the institution. Female psychiatric patients tend to reoffend (recidivism) and then be re-admitted in Special institutions owing to poor family support, defaulting treatment and community rejection as alluded by Participant 8: '*It creates a lot of challenges there, if one has been rejected by the community and the family the last option will be to embark in committing an offense and the end result is being placed in prison again'*.

Participants voiced recidivism as also being caused by treatment noncompliance. The experiences for all participants about recidivism was that women who had been to institutions re-offended because they would have defaulted treatment. Medication was reported to be in-accessible to most patients depending on where would be staying after discharge from the Special institution. Some clinics and primary health care centers were understood by

participants as having inadequate supplies of antipsychotic medication or medication was only in stock at hospitals that were inaccessible to the patients. This was viewed as disturbing the continuity of care and causing re-offending among patients. According to participants, female psychiatric patients needed community programs like halfway homes for rehabilitation to be effective. However, they reported that as far as they knew, there was lack of or minimal or unknown community programs to discharge to, for reintegration. Strategic discharge planning was also perceived as lacking, and there were no structures or safety nets to prepare patients for community reintegration.

Social services in the community were viewed by participants as non-functional and this was an issue of concern for them. Participants put forward suggestions on the way forward for the aftercare of female psychiatric patients. They indicated the need for efforts to be made by both governmental and non-governmental organizations to facilitate comprehensive rehabilitation at community level. Participants also recommended that clear referral should be made to the patient's nearest clinic after the patient is discharged from the Special institution and for those clinics to have adequate supply of medications. The justice team also suggested efforts towards availing community based psychosocial approaches to prevent readmissions. The female psychiatric patients were perceived as being short changed and ignored. Fighting stigma through awareness was also highlighted by participants as mandatory.

According to participants, patients' reintegration into the community was seen as difficult due to nature of the crimes they would have committed. When the female psychiatric patients were admitted at the Special institution for a crime like murder, it seemed very difficult for the community to accept them. As a way forward, participants suggested utilization of non-custodial versus custodial sentences for female psychiatric patients. The custodial sentencing could then become an option for patients who would have committed a violent offence like murder.

Participants also emphasized that at the lower courts, the prosecutors needed to be more vigilant in assessing the gravity of the offence. This would then mean that patients with minor offences with adequate family support systems could then be discharged into the custody and care of the family right away instead of letting them enter and unnecessarily clog the system.

Participants believed that things specifically needed by female psychiatric patients on a daily basis were not adequate in the special institution. The institutions were partially able to supply sanitary ware, clothes and soap but food with protein sources like meat were in short supply due to the economic situation of the country at the time of the study.

Participants suggested a future in which the environment of care would be reviewed and made conducive for the female psychiatric patients. Need for privacy for the female psychiatric patients was expressed as a basic human right by participants. Other gender specific issues that participants felt needed future redress included the fact that the female psychiatric patients were admitted in the same space as that of civil criminal women who brought children of either sex with them. At times female psychiatric patients themselves came into the institution pregnant. It would be appropriate for the children to be removed from such environments as the environment was viewed as psychologically unhealthy for these children.

14. Discussion of the Findings

The judicial team participants experienced offences of female psychiatric patients as revolving around infanticide, theft and malicious damage to property. Previous studies have shown that women who come into contact with the criminal justice system are more likely to be convicted of arson and self-harm and are usually diagnosed with intellectual disability, personality disorder and psychopathic behavior [2, 1]. The contrast in the findings could be due to economic and socialization factors differentiating the study contexts. Documentation and follow-through issues reflected lack of coordination within departments of the justice system. Participants viewed guiding legal frameworks as obsolete and irrelevant to trends and realities in forensic mental health at the time of the study. Challenges with medical reports of patients and decisions regarding gravity of offences showed significant repercussions in the care and management of female psychiatric patients. Medical reports at the exit point (Attorney General's office and Mental Health Tribunal) were perceived as inadequate. Participants made a call for redress of community aftercare to curb the revolving door phenomenon. Similar issues were identified elsewhere that included fragmented care and gaps within forensic mental health care systems and inadequate and unclear community-based aftercare processes[3]. Fragmented care in Zimbabwe is symbolized by poor communication of mental health information between services like police, medical personnel, prosecution, courts and Special institutions. This points towards need to create cross-ministerial consorting in order to promote knowledge transfer and information sharing that would result in consistency and comprehensive legal and medical rehabilitation processes for female psychiatric patients.

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