# The profile of mentally ill offenders in Katsina, Northern-Nigeria

The shift towards community care for patients with chronic mental illness has resulted in an increase in the number of forensic patients.[1] This has been associated with other factors such as gender, education, poverty, diagnosis, psychopathology and lack of access to mental health services.[2-4] In Sub-Saharan Africa and other Low and Middle Income Countries(LAMIC) access to mental health facilities is poor and often difficult.[5] A study in Nigeria estimated that 70% of the population had no access to mental health facilities.[6] Moreover, in Nigeria, all the mental health centres are located in urban areas and require out-of pocket payment for access to their services.[6] The situation is further complicated by the tortuous pathway to mental health services in Nigeria leading to delay in presentation, increased morbidity and poor outcome.[7] Schizophrenia, substance use disorders and organic mental disorders are the commonly reported diagnoses among mentally ill offenders.[4,8,9] These disorders can be managed adequately by providing accessible and affordable mental health services in the community. Such services might likely reduce offending behaviours among mentally ill patients.

This retrospective study was conducted at the Katsina State Psychiatric Hospital in Katsina, Northern Nigeria. Materials reviewed were the clinical records and forensic assessment reports of all the patients referred to the hospital by the criminal justice system over a 2 year period. Information retrieved for analysis included socio-demographic characteristics, diagnoses, offending behaviour and other related indices.

A total of 19 patients were referred to the hospital for forensic assessment during the period under review. The mean age of the patients was 28.94 ±9.34 years. The mean age of the female patients was 32.40±14.82 years, while that of male patients was 27.71±6.85 years. There was no significant difference between the mean ages of the male and female patients (t= .68, p=.53). The mean duration of illness among these patients was 8.05±7.78 years. All the patients were either single or divorced as at the time of presentation. None of the patients was gainfully employed at the time of presentation. Other socio-demographic characteristic of the patients are shown in Table I. Homicide was the most common offending behavior committed by these patients, accounting for 68% of all the offences. There was no significant difference in the mean ages and duration of illness between patients that committed homicide and other offending behaviours respectively (t=.016, p= .98; t=.48, p= .71). The act of homicide was significantly associated with living in a rural area ($\chi^2$=7.36, p=.007), not having formal education ($\chi^2$=4.99, p=.046) and having a diagnosis of schizophrenia ($\chi^2$=10.87, p=.003). Relatives of the patients were the most likely victims of offending behavior ($\chi^2$=12.06, p=.001). Gender, substance use and previous contact with mental health services were not significantly associated with homicide.

The socio-demographic characteristics of the patients are similar to those reported by other studies of mentally abnormal offenders.[2-4] The majority of the patients are young, unemployed males, single without formal education. Similar observations were made by Ogunlesi et al in Southern Nigeria and Pal in Papau-NewGuinea.[8,2]

**Table I: Socio-demographic characteristics of the patients**

| *Variable* | *Frequency (N)* | *Percentage (%)* |
|---|---|---|
| 1 Gender | | |
| Male | 14 | 73.7 |
| Female | 5 | 26.3 |
| 2 Place of Residence | | |
| Rural | 14 | 73.7 |
| Urban | 5 | 26.3 |
| 3 Type of crime | | |
| Homicide | 13 | 68.4 |
| Non-Homicidal | 6 | 31.6 |
| 4 Education | | |
| Formal education | 6 | 31.6 |
| No formal education | 13 | 68.4 |
| 5 Diagnosis | | |
| Schizophrenia | 13 | 68.4 |
| Non-Schizophrenic | 6 | 31.6 |
| 6 Victim | | |
| Relative | 11 | 57.9 |
| Non Relative | 8 | 42.1 |
| 7 Cor-morbid substance use | | |
| Present | 11 | 57.9 |
| Absent | 8 | 42.1 |
| Total | | |
| 8 Previous contact with Hospital | | |
| History of contact | 3 | 15.8 |
| No history of contact | 16 | 84.2 |

The most common psychiatric diagnosis among the studied group of patients was schizophrenia with homicide the most common offending behavior . There were significant relationships between place of residence, education, diagnosis and the act of homicide. The patients from rural areas constituted the majority of mentally ill offenders seen in this study and they are more likely to commit homicide compared to those from urban areas. This might be explained either due to lack of access to mental health services or that they are more easily apprehended by the criminal justice system than those from urban areas. Education not only predisposes to poverty but also influences health seeking behavior. In this study not having formal education was significantly associated with offending behaviour and the act of homicide. Patients with out formal education constituted the majority of the mentally abnormal offenders. Similar observations were made by Ogunlesi et al in Southern Nigeria.[8] The diagnosis of schizophrenia was associated with offending behaviour and homicide in this study which might be explained by the nature of the illness with psychopathologies like command auditory hallucinations and delusions. The study further confirmed that relatives of patients with chronic mental illness are often the victims of the offending behaviour. This might be explained by close associations between the relatives and the patient, which might lead to conflict. Similar observations have been made.[4,9] The study did not find a significant relationship between the act of homicide and previous contact with a mental health facility. This might be because the majority of the patients had no contact with a mental health facility prior to presentation for forensic assessment and treatment.

The provision of accessible and affordable mental health services in the community might reduce the incidence of offending behavior among this group of patients. There is a need to improve provision of mental health facilities, as well as to educate the community about the availability of effective treatment for mental disorders, in developing countries- especially in the rural areas where most of the population lives.

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