Forensic psychiatry in north Africa

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Purpose of review

This is the first review of literature regarding forensic psychiatry in north Africa that analyzes diversity of practice in this region of the world and its impact on mental health patients dealing with the judicial system.

Recent findings

The present study shows similarities and differences in various countries in north Africa. In fact, there are many more similarities than differences, because of a lack of resources, both in the mental health and in the judicial systems.

Summary

The present study gives an overview of forensic psychiatry in north Africa during the past 40 years. This practice is not well organized, despite the fact that mental health legislation and human rights review bodies exist.

Keywords

expert psychiatric evaluation, forensic psychiatry, mental health legislation

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Introduction

The current definition of forensic psychiatry as provided by the American Board of Forensic Psychiatry and the American Academy of Psychiatry and Law is as follows: 'It is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal context, embracing civil, criminal, correctional or legislative matters'.

Forensic psychiatry is a newly emerging essential subspecialty in psychiatry, but if we look at the different legislations and mental health policies around the world, we will find that 43% of countries worldwide have no mental health policy, 23% have no legislation on mental health, 38% have no community care facilities and in 41% of countries treatment of severe mental health disorders is unavailable in primary healthcare [1].

In a study describing the practice of forensic psychiatry in Africa, Njenga [2] reported that this practice is shrouded in both mystery and confusion, and that most of those who work in the field are likely to be self-taught individuals who have been forced by time or misfortune to remain in the very poorly resourced mental institutions that characterize the African continent.

There are some resemblances in forensic psychiatry between the different north African countries, in that there is no organized forensic psychiatry in these countries. Because of limited human and financial resources, there are no forensic psychiatric institutions and no forensic psychiatrists.

Some beds in the mental hospitals are occupied by mentally ill people who have committed offences or crimes; in particular, homicide or homicide attempt, infanticide, theft and aggression, and have been judged as irresponsible.

For example, in Morocco, the lack of hospital beds in psychiatric institutions (fewer than 2000 beds for 32 million inhabitants), the lack of psychiatrists (1.02 per 100 000 inhabitants), the lack of forensic psychiatry facilities and the slow judicial procedures lead many mentally ill people to be jailed and to remain in prison for a long time without taking into account their mental state. And it is the same situation in all of the north African countries [3–5].

The expert psychiatric evaluations are mainly carried out by general psychiatrists, first and foremost by those employed at the public psychiatric hospital.

The forensic psychiatric report is not very detailed. Its usual length is one or two typewritten A4 pages. The main question to be answered concerns the mental state of the offender and, in particular, his mental state at the moment of the crime. Is he/she responsible or not? The court is not obliged to follow the conclusions reached by the psychiatrist. For example, a woman who killed her husband during an acute psychotic episode, because she saw and heard the Prophet Mohammed asking her to do

so, was condemned to 10 years of prison despite the fact that she had an excellent marital relationship, and that the expert psychiatrist stated that no responsibility could be attached to her homicide.

Currently in north Africa, there are no certifications in the field of forensic psychiatry. However, most psychiatrists working in this field work through their interest and experience in the subject. There are now special courses being held for training psychiatrists in forensic psychiatry that will soon be transformed into special certification in this field in Egypt.

At the moment, all Egyptian convicted mental health patients are admitted to two facilities, either Abassia Hospital in Cairo or El-Khanka Hospital in Kalyobia, to receive treatment, and when they have improved or recovered, they are referred once again to the judicial system. In Morocco, some decades ago, only two institutions received such patients, the Berrechid hospital and the Tit Mellil, one of which was in fact an annex. Now, in all psychiatric institutions in Morocco, convicted mental health patients occupy, usually for a long time, regular psychiatric beds.

In Tunisia, the most important psychiatric hospital, the Manouba, near Tunis, received all patients having been committed by the judicial system for decades before a progressive regionalization of the process. The same thing happened in Algeria from the Frantz Fanon hospital in Blida, south of Algiers, which is still the largest psychiatric institution in that country, before the same process of regionalization took place [6].

Legislation and mental health

All psychiatric locked wards in north Africa are under the theoretical supervision of the judicial system, but the scarce resources in the ministries of justice do not allow frequent inspections. The patients have the right to ask for a judicial inquiry in case they think that they have been wrongly committed to involuntary hospitalization. National review bodies exist, having the authority to inspect mental health facilities, review involuntary admission and discharge procedures, review complaints about investigation processes and impose sanctions on facilities that persistently violate patients' rights [3,5,6].

The mental health law in Morocco is defined by the 1959 *Dahir*, which aims at preventing mental illnesses and protecting mental health patients. Despite its 50 years of age, it is still considered to be a good legislative instrument. This *Dahir* states that the mission of mental institutions is to treat the patients and to protect their rights and their property during their period of illness. This law also achieved the following:

(1) It allowed the creation of the Central Service for Mental Health in the Ministry of Health and the National Mental Health Committee.
(2) It defined the organization of mental health institutions including psychiatric services, with specific manners of patients' admission and discharge.
(3) It outlined the modalities of protection of patients and their personal property [3].

On the contrary, the articles 134–137 of the Moroccan penal code concern the irresponsibility of mentally ill people and the types of hospitalizations into psychiatric units [3].

Egypt was the first country in Africa, Asia and the World Health Organization Eastern Mediterranean Region (WHO-EMRO) to have a mental health act in 1944. This mental health act was recently updated and endorsed by the Egyptian parliament in April 2009 and has been termed the 'Care of Psychiatric Patients Act', which included changes in the penal law, introducing for the first time that there is no responsibility for those with loss of perception and diminished responsibility for those lacking in perception.

In 1989, the Egyptian parliament also passed a law for addiction (substance abuse) that enabled the judge to admit a patient with repeated offences and treatment trials for substance abuse or if accused of possession of drugs involuntarily for treatment in special hospitals rather than sending them to prison [7].

In Tunisia, mental health legislation was enacted in 1992 and reviewed in 2004, focusing on the 'conditions of hospitalization of individuals with mental disorders' and the mechanisms to oversee the involuntary treatment practices [5].

In Algeria, the law 85-05 of 16 December 1985 related to protection and promotion of health explains the mode of admission of mentally ill patients and how to protect their rights [6].

Practice of forensic psychiatry in north Africa

A systematic review of all studies published during the past 30 years concerning forensic psychiatry in north Africa was done using *Medline, Embase, Psychlit* and *Google Scholar*. We found only seven relevant articles: three from Egypt, two from Algeria, one from Morocco and one from Tunisia.

Touari *et al.* [6,8] reported their experience in forensic psychiatry especially on 3984 expert psychiatric evaluations in the eastern Algeria over a period of 23 years. They found a significant association between psychosis

and homicide or homicide attempt committed by male participants. These psychotic participants were older, more likely to have a previous psychiatric history and less likely to have been raised by their parents than other groups.

Concerning the Moroccan experience, Rammouz *et al.* [9] discussed a clinical case of infanticide committed during the postpartum period, and its psychopathological and forensic backgrounds. It is indeed an important topic, knowing that there are a number of female patients who committed infanticide and who are currently hospitalized in various mental hospitals in Morocco.

Otherwise, we have analyzed the archives of the mental hospital of Berrechid (40 km south of Casablanca), the largest mental hospital in Morocco, screening for all forensic psychiatric patients admitted between 2001 and 2007. Over 7 years, 219 participants were admitted, 74 for expert psychiatric evaluations and the others judged and committed in the mental hospital by the judicial authority. Only one female participant was admitted during the same period, and she was hospitalized after an infanticide.

The mean age of the sample was 44 years and the mean duration of hospitalization was 363 days; 69.4% were single and 59.4% were jobless. Homicide represented 25.8% all cases and homicide attempt 8.6%. Assault represented 10% and pyromania 9.4%. The diagnosis of schizophrenia was made in 70% of the sample.

The Tunisian experience was reported by Maalej *et al.* [10]. The authors reported on the assessment of a 6-year activity of expert psychiatric evaluations related to forensic psychiatry in Sfax south of Tunisia. The study concerned 125 cases with 91.2% men. All these participants presented mental health disorders at the beginning of their hospitalization. Fifty-six percent had medico-legal antecedents. At the time of evaluation, 58.4% were in detention. The delay before evaluation was longer than 1 month for 68.8% and longer than 12 months for 28%. Homicide and attempted homicide represented 13.6%, aggravated assault 22.4%, theft 31.2% and issuance of cheques without funds 10.4%. Participants with schizophrenia represented 12.8% and dementia was diagnosed in 44.8%.

In a report assessing the mental health system, the Tunisian ministry of health reported that 77% of forensic patients spent less than 1 year in the psychiatric institution, 17% 1–4 years, 4% 5–10 years and 2% more than 10 years. The majority of these patients had mental retardation, dementia or schizophrenia [5].

In Egypt, in a study conducted by El-Kholi [11] in 1969 on 2076 convicted patients including 123 women admitted to mental hospitals over a 12-year-period from 1941 to 1963, it was found that 462, including seven women, were not mentally ill. Of the remainder, 0.5% were diagnosed with dementia, 9.3% with general paralysis of the insane (GPI), 1.18% with dementia secondary to Parkinson disease, 18.14% with mental symptoms secondary to pellagra, 26.75% with schizophrenia, 3.65% with psychosis secondary to epilepsy, 0.05% with hysteria, 0.93% with a personality disorder and 18.39% with mental retardation.

Okasha *et al.* [12] carried out a psychosocial study of 90 Egyptian murderers, 60 from prison and 30 from the state mental hospital, and electroencephalography (EEG) was carried out on 76 of them. The incidence of EEG abnormalities was 43.48% in the prison group and 57% in the mental hospital group. The most important observation was the high incidence (over 70%) of abnormal EEGs among the prisoners whose crime was apparently motiveless or with a slight motive. In this study, the finding that psychotic patients showed a higher proportion of EEG abnormalities (60%) than psychopaths (33%) was different from other studies.

In a more recent study, Okasha *et al.* [13] studied psychiatric morbidity among prisoners in which 776 prisoners (311 men and 465 women) were evaluated. The results showed that 119 of them had different psychiatric morbidity, giving an incidence of psychiatric disorders in prison of 15.33%, which is similar to a study carried out in Australia by Herrman *et al.* [14], which showed an incidence of 15%.

The study showed that 36.9% were suffering from depression, 33.6% from anxiety disorder, 12.6% from somatoform disorder, 7.6% from substance abuse disorder, 2.5% from schizophrenia, 1.7% from bipolar disorder, 1.7% from delusional disorder and 0.8% from dissociative disorders.

Conclusion

This brief study on forensic psychiatry in north African countries may clarify how difficult the practice of forensic psychiatry is in these countries, and that it is a constant challenge to protect the rights of mental health patients in a health institution with scarce resources, working in partnership with the judges and other justice workers, who also suffer from all kinds of shortages. With the increase in psychiatrists and other mental health workers in all these countries, there is hope that the future will be better than the present, which is already better than the past.

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