WORLD HEALTH ORGANIZATION

Regional Office for the Eastern Mediterranean

ORGANISATION MONDIALE DE LA SANTÉ

Bureau régional pour la Méditerranée orientale

GROUP MEETING ON MENTAL HEALTH AND MENTAL LEGISLATION
Cairo, 12 to 17 June 1976

EM/GR.MTG.MH.ML./5

ENGLISH ONLY

# CARE OF MENTALLY ABNORMAL OFFENDERS

by

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## I INTRODUCTION

This is a preliminary study on the care of mentally abnormal offenders (MAO) in some countries of the Eastern Mediterranean Region (EMR). The paper deals with adult persons who are accused or convicted of an offence or offences, while being mentally ill.

There were several factors which prompted this study. First, while there is a growing awareness in many countries of EMR for the need to develop mental health services in general, the care of the MAO has not been given the attention which it particularly deserves[1]. Second though it has been regarded as a 'fringe' topic with its boundaries extending beyond the medical realm into the legal, penal and social fields, its close relationship to psychiatry has been generally recognised. Yet, how much psychiatry can offer in this respect is one of the challenging issues in mental health work. Again, despite recent advances in mental health care, particularly the advent of the potent psychotropic drugs, the liberalization of in-patient services depicted by the open-door policy and the growing emphasis on rehabilitation programmes, not much progress has been achieved for the differential care of mentally abnormal offenders. On the contrary, the topic still constitutes an area of controversy and confusion in technically advanced as well as in developing countries[2].

Except for an original work on 'Mental Illness and Crime in Iraq'[3], this topic has been but little studied in countries of EMR and hence the paucity of literature.

## II MATERIAL AND METHOD

The material included in this paper is based on two sources : (a) information provided in response to a questionnaire and (b) data collected during the course of field visits during the last four years. With the exception of Cyprus, Oman, Somalia and Yemen Arab Republic, the authors practically

visited all the countries in EMR and became acquainted with existing facilities for the care of mentally abnormal offenders.

Several difficulties were met in collecting accurate information. In the majority of the countries, there was a number of authorities dealing with the mentally abnormal offender, mainly the police, the prosecutor, the jurist, the prison officer and the psychiatrist. In some countries there were no special records kept for these patients. In others the facilities may be shared by various ministries and, in the absence of a central administrative unit, valid information representative of the country under study was often hard to obtain. Other factors which added to the difficulties were that in quite a number of countries the care of mentally abnormal offenders was found to be a rather sensitive national issue and hence any study of this sort was not encouraged. Sometimes the sensitivity could be explained because of the neglected facilities and the deteriotated conditions of the inmates.

On the other hand, when the responsibility for care rested with one institution, such as Taif Psychiatric Hospital, Saudi Arabia, or one ministry, for instance the Ministry of Public Health, Egypt, the information might be readily available. Because of this, more reference will be made to some countries than others.

## III FINDINGS

### 1. Historical perspective

Facilities for the care of mentally abnormal offenders varied from one country to another, due to different historical background, various levels of socio-economic development and availability of psychiatric care services in general. Details on the background of mental health services, in general, in countries of EMR are given elsewhere by one of the authors (T.A. Baasher). It has to be remembered that, though the healing of the mentally ill has a long past, and is still practised in various traditional

forms, modern psychiatric services including the care of MAO were introduced into this Region towards the end of the last century[4]. The model of psychiatric care, especially the large scale mental hospitals and the penal system, are among the vestiges of the past colonial era. Along with this, however, the mentally disturbed are still cared for within the community set-up and the closely-knit tribal system. On the other hand, with accelerated socio-economic development and the increasing growth of urban centres, there has been an increasing erosion of traditional systems. While the traditional family and community support are generally decreasing, the existing psychiatric facilities, which are practically concentrated in the capital or major cities, are far from meeting the needs of mentally ill patients. The outcome of this is that more and more mentally ill patients, especially the vagrant, the homeless and the excited, have found their way into the penal institutions. As a matter of fact in practically most of the countries, the care of mentally disturbed patients was initially provided within the prison system and gradually shifted to the health services.

2. Existing facilities

Broadly speaking, the physical resources for the care of MAO can be grouped under two main divisions : facilities established within the existing psychiatric services and those within the penal system.

(a) Facilities within psychiatric services

As will be noted from Table 1, the survey showed that there was a variety of facilities for the care of MAO within the established psychiatric services, ranging from single locked rooms in a psychiatric institution, such as in El Salam Clinic, People's Democratic Republic of Yemen, to a separate psychiatric hospital as seen in Khanka Hospital, Egypt. The majority of countries (13) provided some form of care within the facilities

of general psychiatric hospitals. These were either in the form of initial observation and psychiatric assessment prior to disposal, as applied in Abbassia Hospital, Egypt and Razi Hospital, Teheran, or of further continuation of care, as seen in Bahrain, Cyprus, Kuwait, etc.

For security reasons, more than one third (9) of the countries had locked wards within psychiatric hospitals. The security measures may be relaxed or unduly tightened[5,6]. There were single closed wards as well as several open wards within locked, high-walled courtyards. The patients' community may be divided into sections and the MAO confined to a special area behind iron bars.

Where there were no locked wards in a general psychiatric hospital, the mentally accused was often kept under a security guard with formal dress. Occasionally, there was the exception, as in Bahrain, where MAO were treated similarly to other patients. Another example was also seen in Saudi Arabia, where mentally-disordered female patients were admitted into the general psychiatric wards, and the males (MAO) were confined in a special locked ward.

(b) Facilities within penal system

Apart from general detention of MAO in prisons, various facilities were developed within the penal system. These included : separate units in prisons, detention centres, special institutions and asylums. The countries where such facilities existed and their number are given in Table 1. This table shows that there are special units in prisons for the care of MAO in approximately one country out of three. Exceptionally, the Sudan established during the last quarter century five separate, special institutions for forensic psychiatric care. In Afghanistan, the asylum, known as Majhol-ul-Ahwalan, catered for "mentally ill adult offenders who have no relatives or are wanderers....."

Table 1

Types of Facilities for the Care of Mentally Abnormal Offenders in Countries of EMR

| Name of Country | Facilities within psychiatric services | | | | Facilities within penal system | | | |
|---|---|---|---|---|---|---|---|---|
| | Locked Room | Closed Section or Locked Ward | Separate Hospital | General Psychiatric Hospital | Unit in prison | Detention Centre | Special Institution | Asylum |
| Afghanistan | | | | x | | | | x |
| Bahrain | | | | x | | | | |
| Cyprus | | | | x | | | | |
| Egypt | | | x | x | | | | |
| Ethiopia | | x | | x | x | | | |
| Iran | | | | x | x | | | |
| Iraq | | x | | x | | | | |
| Jordan | | | | x | x | | | |
| Kuwait | | x | | x | | | | |
| Lebanon | | x | | | | | | |
| Libya | | x | | x | x | | | |
| Oman | | - | | - | - | - | - | - |
| Pakistan | | | | x | | | | |
| PDRY | x | x | | x | | | | |
| Qatar | | | | | | x | | |
| S. Arabia | | x | | x | | | | |
| Sudan | | | | x | | | x | |
| Syria | | x | | | | | | |
| Tunisia | | x | | x | | | | |
| UAE | | | | | x | | | |
| Yemen | | | | | x | | | |

(c) Number of beds for MAO

One of the criteria for a comparative study of health facilities is obtained by counting the number of beds for a certain community at a certain point in time. In assessing mental health services, it has been found, however, that defining what is meant by a psychiatric bed involved some difficulties[7]. These difficulties became even greater when examining the total number of beds for the care of MAO. It is true to say that when a country is small and there is one psychiatric/penal establishment, such as the Detention Centre, United Arab Emirates (UAE), no difficulty may arise. However in countries where MAO patients were admitted both in psychiatric and penal institutions and where no beds were specifically designated for this special group of patients, it would be rather difficult to assess the accurate number. Again, in a country like PDRY where there was one psychiatric institution with a bed occupancy of more than 200 per cent and where the MAO were accommodated in the limited psychiatric facilities as well as within the penal system, it was not possible to specify the number of available beds.

On the other hand, in some countries where facilities have been especially established for the care of MAO, information may be readily available. Examples are given in Table 2.

3. System of admission

The system of admission of MAO into the existing facilities greatly varies from country to country and even in the same country, depending on the nature of the offence, the type of available facilities, the locality, means of transportation, penal procedures and legal provisions.

The patient may be admitted before or after being prosecuted. He may or may not be psychiatrically examined. However, the circumstances which were commonly found to warrant admission can be summarized as follows :

Table 2

Number of beds available in some countries for the care of Mentally Abnormal Offenders

| Country | Name of Institution | Type of facilities | No. of beds |
|---|---|---|---|
| Afghanistan | Majhol-ul-Ahwalan | Asylum | 50 |
| Egypt | Abbassia Hospital | Section in the mental hospital | 120 |
| | Khanka Hospital | Mental Hospital | 800 |
| Iraq | Shammaeyia | Ward for the accused in the mental hospital | 300 |
| Lebanon | Asfouriyeh | Special section in the mental hospital | 140 |
| Libya | Gargarish | Special ward in the mental hospital | 40 |
| Qatar | Mental Centre | - | 10 |
| Saudi Arabia | Taif | Special ward in the mental hospital | 100 |
| Sudan | Kober | Special institution | 200 |
| | Ban Gadeed | Special institution | 180 |
| | Kassala | Special institution | 120 |
| | Salalat | Special institution | 40 |
| | Maringan | Special institution | 20 |
| Syria | Ibn Sena (Avicenna) | Closed section in the mental hospital | 55 |
| | Doweirena | locked ward | 40 |
| UAE | Detention Centre | - | 10 |

- vagrant and homeless mentally ill patients;
- personal or public safety in cases of excited patients;
- mental assessment of an accused person before or during trial;
- management of a patient legally convicted but recommended to stay under psychiatric treatment;
- management of patients found mentally disturbed while in prison.

Though most of the countries seemed to have special regulations regarding the admission of MAO into psychiatric or penal facilities, some of these patients were just admitted and kept in confinement. It is not intended to elaborate here on the availability or lack of mental health legislation, for this has been well-documented elsewhere.[8,9]

The main sources of referral of MAO to the penal system or psychiatric care were : the Ministry of Justice(the Prosecutor-General or the different Courts), the Ministry of the Interior (police investigators, police officers, prison physicians) and the Commissioner or Governor of a province.

4. Co-ordination

It was clear that the care of the MAO was shared by several ministries. Yet there was practically no one official body in any one country entrusted with such responsibility. There were ad hoc committees however, in a number of countries for decision-making regarding the confinement or discharge of patients. In Bahrain, for instance, a Medical Board, comprised of two or more of the psychiatric hospital physicians, decide on such issues . A different example was found in Ethiopia, where "psychiatric forensic patients are committed and discharged by Orders of Courts after prosecution through a Medico-Legal Committee. The Medico-Legal Committee is a legally established group of medical and social experts, whose chairman reports to the Courts of Law the decision of the Committee". Again, in Libya, a special committee comprised of two consultant psychiatrists and a representative of the Ministry of Justice was charged with the responsibility for weekly examinations and taking of decisions in all admitted and discharged cases including the medico-legal.

5. Manpower Resources and Treatment Programmes

The deficiencies in the care of MAO in the majority of the countries is generally reflected by the lack of qualified workers in this complex field. Rarely is any formal forensic psychiatric teaching included in the undergraduate medical education. In a response to the question: "To what extent is clinical

instruction given in forensic psychiatry?" the great majority of the countries replied: "none". Two stated "brief" and one indicated "one hour". Similarly, in post-graduate teaching, except in one country, forensic psychiatry did not feature in the recognized curricula. Administratively and academically, though there were full-time psychiatric consultants dealing with forensic psychiatry, there was no recognized speciality as such.

The number, background education and qualification of workers caring for the MAO varied greatly. In general, those admitted into psychiatric facilities were rountinely attended to, by the same staff looking after the general mentally ill inmates. Difficulties arise when the psychiatric services are understaffed, and here there is the possibility, as was observed in several countries, that the MAO get the least attention. Under such circumstances, there was the tendency to resort to more restrictive measures rather than therapeutic care.

The care within the penal system also depended on the national policy, the philosophy of approach to the mental health problems of MAO and the available manpower resources. Two consultant psychiatrists, for instance, supervised the thirty-bed unit in the prison of Teheran. In the locked section of the prison in Jordan, there were five inmates who were looked after by one attendant and one aid under the supervision of the prison general physician. Every now and then they were seen by a general psychiatrist. Similarily, in the Sudan there was no full-time psychiatrist in the penal services. However, the consultant psychiatrist of the Ministry of Health visited weekly the special institutions where the MAO were kept. As regards the general workers, attempts were made to build up the staff on a similar basis to the general health services, where there was one nurse for every four patients. In certain institutions, such as the fifty-bed asylum in Kabul, Afghanistan, no psychiatric care was provided because of the lack of qualified personnel.

On the whole, the treatment programmes were generally deficient due to the scarcity of qualified personnel and the limitation of therapeutic facilities. Not surprisingly, in the absence of proper therapeutic care and effective rehabilitation programmes and because of the inherent socio-legal problems, the MAO inmates commonly suffer from social breakdown, chronicity and personality deterioration.

6. The Patients

(a) Social profile

The characteristic social profile of MAO generally found was that of a young population between the age of 20 to 50, with overwhelming predominance of male over female ratio, and greater representation of the lower socio-economic group.

As a case study, analysis of the 126 accused patients admitted in 1975 into Abbassia Mental Health for psychiatric assessment revealed the following:

(i) Age group: The findings are summarized as below:
0 - 10 none; 11 - 20 nine per cent; 21 - 30 fifty-two per cent; 31 - 40 twenty-one per cent; 41 - 50 fifteen per cent; 51 - 60 three per cent. None was above the age of sixty.

(ii) Sex and marital status: of 126 patients 123 were males and three were females. Of these forty-five per cent were married, thirty-three per cent were unmarried, seventeen per cent were widows and the remaining three per cent were divorced.

(iii) Religion: 93 per cent were Moslems and seven per cent were Christians.

(iv) Nationality: With the exception of two Syrians, the remaining 124 patients were all Egyptians.

(v) Educational background: The percentage of illiteracy was thirty-three. Forty-five per cent could just read and write; seventeen per cent were of elementary level; four per cent were of high education.

(b) Psychiatric profile

(i) Psychiatric profile at early stage of admission

Of the 126 patients examined in Abbassia Mental Hospital (AMH) during 1975, thirty-three per cent had been previously admitted and of these five per cent were referred as mentally abnormal offenders.

Of the same sample, one out of ten had a history of drug dependence and the pattern commonly found was: hashish-smoking (40 per cent), opium-eating (10 per cent) and alcohol drinking (10 per cent).

Psychiatric assessment of those admitted as accused patients during the first year revealed that seventy per cent were suffering from mental disturbances and thirty per cent were diagnosed as normal. The great majority of those diagnosed as mentally ill showed psychotic reactions, and the diagnostic details are given in Table 3.

Table 3

| Diagnostic category | Number | Percentage |
|---|---|---|
| Manic depressive disorders | 29 | 40 |
| Schizophrenic reactions | 28 | 38 |
| Reactive depression | 5 | 8 |
| Acute confusional psychosis | 2 | 4 |
| Epilepsy | 4 | 6 |
| Mental subnormality | 2 | 4 |
| Total: | 70 | 100 |

(ii) Psychiatric profile at later stages

As accused patients, after being psychiatrically assessed at (AMH) were referred to Khanka Mental Hospital (KMH), a general analysis of the statistical data of the MAO kept in this institution was carried out. It is to be noted that KMH is considered the main forensic psychiatric hospital in Egypt, where all the long-stay MAO were accommodated. The analysis covered all the patients admitted (789) during the last fifty years. Table 4 gives details of the diagnostic categories, the number of patients and their percentage in each.

Table 4

Psychiatric diagnosis, number and percentage of patients in KMH

| Diagnostic category | No. of patients | Percentage |
|---|---|---|
| Schizophrenic reactions | 458 | 59 |
| Manic depressive disorders | 138 | 17 |
| Organic reactions | 23 | 3 |
| Mental Subnormality | 142 | 18 |
| Epilepsy | 19 | 2 |
| Drug dependence | 9 | 1 |
| Total | 789 | 100 |

Under schizophrenic reactions (458), three were specifically labelled as paranoia. The organic reactions (23) included a heterogenous group of : pellagra, syphilitic condition, dementia and psycho-geriatric state. As will be noted from the diagnostic analysis, there was a high percentage of mental subnormality (18) which comes , in numerical order, next to the schizophrenic reactions (59). On the other hand, if the percentage of manic depressive disorders were added to the schizophrenic reactions, the functional psychosis

would constitute 76 per cent of the MAO in KMH.

When these results were compared with the study of Maghazaji et al.[10] in Iraq, significant differences in psychiatric categories of MAO were found. The latter study was carried out on accused mentally ill patients (120) admitted into Shammaeya Mental Hospital (SMH) during the last five years. While the Khanka sample was exclusively for male inmates, in the Shammaeya there were 108 males and twelve females; both are included in Table 5.

Table 5

Type of psychiatric disorders, their number and percentage in Shammaeya and Khanka Mental Hospital

| Diagnostic Category | Shammaeya Mental Hospital | | Khanka Mental Hospital | |
|---|---|---|---|---|
| | No. of patients | Percentage | No. of patients | Percentage |
| Schizophrenic reactions | 92 | 77 | 458 | 59 |
| Manic depressive disorders | 5 | 4 | 138 | 17 |
| Organic mental reactions | 8 | 7 | 23 | 3 |
| Mental subnormality | - | - | 142 | 18 |
| Epilepsy | - | - | 19 | 2 |
| Drug dependence | 13 | 11 | 9 | 1 |
| Personality disorder | 3 | 1 | - | - |
| Total | 120 | 100 | | |

While schizophrenic reactions top the list in both studies, the differences in the percentage of manic-depressive disorders and mental subnormality was quite apparent. As the Shammaeya study was limited to 120 patients, it will be interesting to find out how this striking difference will be affected, if the total MAO in Shammaeya (300) were surveyed, similar to the Khanka one. Again, the number of paranoid reactions in SMH sample was significantly higher than that of KMH, and further more systematic studies may yield interesting results.

(c) Nature of offences

Statistical analysis of the nature of offences committed by the 789 patients in KMH showed also an appreciable difference between the group as a whole and between patients with various psychiatric-entities. Tables 5, 6 and 7 give the nature of offences committed by the whole group, the schizophrenic and the mentally subnormal patients.

Table 5

Nature of offences

(All inmates - Khanka Mental Hospital)

| Nature of Offence | Number | Percentage |
|---|---|---|
| Murder and Attempted murder | 327 | 42 |
| Against person or property | 263 | 33 |
| Sexual assault | 37 | 5 |
| Against public order | 94 | 12 |
| Vagrancy | 50 | 6 |
| Possession/trafficking in narcotic drugs | 15 | 2 |
| Others | 3 | - |
| Total | 789 | 100 |

The analysis indicated that while the percentage of murder and attempted murder was the highest offence (42) among the MAO inmates as a whole, it was even relatively higher among the schizophrenic patients (47). Conversely, it sharply dropped down among the mentally subnormal (16). On the other hand, this picture was reversed in the case of offences against person or property. The percentages were respectively 33 among the whole group, 31 among the schizophrenic and 39 among the mentally subnormal.

Table 6

Nature of Offences
among Schizophrenic patients, KMH

| Nature of offence | Number | Percentage |
|---|---|---|
| Murder and Attempted murder | 217 | 47 |
| Against persons or property | 142 | 31 |
| Sexual assault | 11 | 2 |
| Against public order | 62 | 14 |
| Vagrancy | 19 | 4 |
| Possession/trafficking in narcotic drugs | 7 | 2 |
| Total | 458 | 100 |

Table 7

Nature of Offences
among Mentally Subnormal persons, KMH

| Nature of Offence | Number | Percentage |
|---|---|---|
| Murder and Attempted murder | 23 | 16 |
| Against person or property | 56 | 39 |
| Sexual assault | 19 | 13 |
| Against public order | 12 | 9 |
| Vagrancy | 25 | 18 |
| Possession/trafficking in narcotic drugs | 5 | 4 |
| Others | 2 | 1 |
| Total | 142 | 100 |

However, if the nature of the offences was further examined, it would soon be revealed that a considerable number of the offences by the mentally subnormal was not only trivial but obviously reflected defective judgment, low intelligence, inability to cope with stressful or new situations and a tendency towards being easily influenced. Offences such as house-trespass, taking away a donkey, walking away with a child, stoning the traffic-police and various other minor offences against public order, can easily be explained in the light of the low mentality of this group.

DISCUSSION

When discussing the care of MAO, one has to take into consideration the size of the problem, the basic philosophy of approach to the problem, the difficulties standing in the way of progress, the merits and demerits of existing systems and institutions in this field and future strategy.

Based on the findings of this preliminary study, it seems possible to come to some practical points in discussing this complex topic.

First : evidence shows that the care of MAO, though it varies from country to country, is increasingly emerging as a major mental health problem. Available data indicated that within the existing psychiatric facilities 7 per cent of all psychiatric beds in Lebanon, 15 per cent in Iraq and 17 per cent in Egypt, for example, were allotted to the care of MAO. When the facilities in both the psychiatric services and the penal system were taken into consideration, it was found that in the Sudan exceptionally, approximately 75 per cent of all available psychiatric beds were assigned for the care of MAO.

It was clear that there was a general shortage of resources, in terms of proper physical facilities and manpower. Moreover, the lack of training

and qualified personnel, devoted full-time to this intriguing problem, jeopardises future progress. Again, under the rapid socio-economic changes, the continuous breakdown of the closely-knit family system, the erosion of cultural values and the psycho-social stresses of the growing urban centres, mental health needs, including the care of the MAO, have been increasingly felt.

Second : An overriding issue in the care of MAO has been the dilemma of the basic philosophical approach to the problem. In brief, the issues involved can be posed as follows : Is the problem of the care of MAO a matter of health, or safety? or of both? Should he be punished and placed in penal institutions or treated more humanely and looked after in medical establishments?

In practice, the care of MAO in the majority of the countries fell within the domain of three Ministries, namely Health, Judiciary and Interior. It is true to say that there was a growing tendency to provide psychiatric care for the MAO within the mental health services. However, the legal implications and security measures were often found to run contrary to the universally-accepted concept of the therapeutic community, the importance of social interactions and the involvement in an effective rehabilitation programme. A recurring issue is:how to strike a balance between an open-door policy and the establishment of security units within psychiatric institutions? The existing models which have been shown in Table 1 were varied,there were certain merits and demerits of the special units in general psychiatric institutions, of the separate mental hospital (Khanka type) and the special institution within the penal system (Sudan type). In countries of EMR, where the resources are still scarce, the logical question to be raised is:how can a country pool its resources to deal more effectively with a multi-sided problem such as the care of the MAO? The first obstacle in this respect

is that, despite the close inter-relationship between the various ministries concerned, there was a general lack of co-ordination. Hence, the organization and administration of the services of MAO were often disjointed, isolated and sometimes confusing.

Whichever model a country adopts, three criteria seem to be essential, namely : (a) availability of an adequate number of trained staff, similar to other health services, (b) a humane approach with up-dated mental health legislation (c) a central co-ordinating body entrusted with the responsibility for the organization and administration of the care of MAO.

Third : In one of the psychiatric institutions (AMH) it was shown that one out of three accused persons referred for mental assessment had been previously admitted for psychiatric treatment and of these only 5 per cent as MAO. This raises the issue of prevention and whether there are any valid diagnostic criteria which can be used as a reliable tool to detect those mentally ill patients who are more prone to commit offences. While this can be a useful aid, the main aim should obviously be the provision of appropriate treatment on internationally accepted lines [11].

Another issue is how to reduce the relatively higher hospitalization/ detention rate compared to other psychiatrically-ill patients. Primarily, this depends on several factors, particularly the availability of services, legal provisions, community attitude and the system of follow-up. It seemed possible that with the intensification of therapeutic and rehabilitative programmes, it would be possible to reduce chronicity among MAO. Indeed, in some of the institutions, the mere diagnostic review and the paying of more general attention resulted in the reduction of the undue prolonged custodial stay of MAO.

Fourth : An important question to be asked is : Are there any social determinants, which influence mentally ill people to such a degree that they eventually become offenders? The only two positive factors generally found were that 70 to 80 per cent of mentally ill offenders were in the age group of 20 to 50 and that there was a significantly high preponderance of male over female.

The finding regarding the age period seems to be comparable to what has been found in other, different, cultures.[12] The specificity of age can be explained on the basis of the high prevalence of schizophrenic reactions during the age span 20 to 50, as well as among the MAO.

Again , in more technically advanced countries, the ratio of male to female MAO was equally high[13]. The difference was that, while in countries of EMR the ratio, though to a lesser extent, continues the same in the non-offender population of general psychiatric patients, conversely, the female ratio was higher in the general population in technically advanced countries. In the countries of EMR, the sex difference is generally explained on the basis that the female population is generally more protected and less exposed to stressful life situations. Though this may seem to be a plausible explanation, further investigations are indicated to establish conclusive evidence on the underlying factors of cultural differences and social determinants.

Available information in general seems to be inconclusive regarding marital status and the influence of married life, as an index of social stability , on the frequency of MAO. The same can be said of the educational and economic background of this group.

Fifth : The overwhelming majority of the MAO in countries of EMR were found to be suffering from functional psychotic reactions. Though this, as a whole, was estimated at 70 to 80 per cent, there was an appreciable difference between the ratio of schizophrenic reactions and manic depressive disorders.

In the Shammaeya sample, for example, they constituted 77 and 4 per cent respectively, while in the two samples from Egypt they were 59 and 17 per cent in Khanka and 40 and 38 in Abbassia. This obviously calls for further study. None the less, it indicates that the major toll of MAO is attributed to functional psychosis and that concerted efforts have to be made in this important area.

Importantly, it is not uncommon to find a number of mentally subnormal persons among the MAO in a number of countries. However, their number was found to be exceptionally high, 18 per cent, in the inmates of KMH. On the basis of the special needs of the mentally subnormal, and for the better organization of mental health services, it seems reasonable to suggest that mentally subnormal offenders should receive special care and their management should be conceived differently. From the nature of the offences committed by them, it was generally clear that many of them would be better served, if special provisions or alternative facilities were more readily available.

Though psychopathic behaviour was not 'considered a sign of mental illness' in some countries such as Iran [14] and Afghanistan, a relatively small number was found among the MAO.

The incidence of other psychiatric categories associated with the problems of MAO, such as epilepsy, drug dependence, organic mental reactions etc., seemed generally low and constituted no special problems.

In all the countries neurotic persons were considered legally responsible for offences they may commit and hence there were not found among MAO.

Finally, the relationship between criminality and psychiatric disorders is generally suffering from lack of definition. Hence, the variation in the categorization of patients and the difficulty of comparative studies.

On the whole, the field of MAO is riddled with anomalous areas which call for further study, clearer policy, more realistic approach and better programming. The discussion of this topic at a Regional level is an important step in this direction.

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