PREVALENCE OF MENTAL DISORDERS AMONG OFFENDERS REFERRED FOR PSYCHIATRIC EVALUATION

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ABSTRACT:

The aims of the study are to determine the rate and spectrum of mental disorders among offenders referral to psychiatric evaluation and find out the relation between mental disorder and the nature of the offence. This is cross sectional study that enrolled 120 referrals to the Forensic Psychiatric Committee (FPC) in Al-Rashad Mental Hospital during the period from April 2012 – January 2013. The referrals were interviewed according to a semi-structured interview questionnaire (SSIQ) based on DSM-IV-TR and the diagnosis was compared with that given by the FPC and the cases was included in the study when it was agreed by both the SSIQ and the FPC. This study revealed that illiterate and those with low level of education rated the highest 82.5% were mentally ill. Interfamilial violent assaults were the commonest offences among males while murder, sex crimes and wandering were the commonest among females. Schizophrenia was commonest diagnosis among males and schizophrenia, mental retardation among females. Most of referrals had previous history of referral 83% with intrafamilial violence was the commonest offence and schizophrenia was the commonest

offence and schizophrenia was the commonest diagnosis.Most of the offenders who were referred for psychiatric evaluation were found to bementally ill and the most frequent mental illness was schizophrenia. Most of referral cases were due to violent assaults committed by male schizophrenic and other psychotic.

INTRODUCTION:

The relationship between crime and mental illness forms one of the important aspects of forensic psychiatry. The potential for damage to mental health from crime is now recognized as being as the great risk from actual physical harm, but with repair often taking longer. In turn, mental ill health or disability may predispose or precipitate crime.[20]

Mental disorder resulting in disturbed social behaviour occurring in the community often results in police intervention. Patients reaching treatment facilities via the police are often among the most acutely disturbed who need admission to psychiatric hospitals.[18] Rain et al briefly reviewed the increasing evidence that criminal behavior is in part genetically determined. Their prospective study tested the hypothesis that a psycho-physiological predisposition to criminality partly manifests itself

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through autonomic and CNS underarousal. Result indicated that the adult criminals had significantly

lower electrodermal, cardiovascular and cortical arousal than non-criminals when measured at the

age of 15 years. Almost 75% of subjects could be correctly classified on the basis of arousal variables. Further research is needed to assess the possible relationship of testosterone, 5-hydroxyindole acetic acid &/or insulin secretion to aggressive behaviour.

VIOLENCE:

As one of the main public health problems facing modern society, violence continue to be the focus of a great deal of research. It is both in the community and in institution remains of great interest & concern to clinicians and researchers from the mental health disciplines. Clearly, the phenomenon is the result of many interacting factors, among them genetic predisposition, biochemical anomalies, childhood upbringing, mental disorder & social environment.[15]

Violence is a common phenomenon & not all violence is condemned. All men are potentially violent. Violence is one form that aggression can take.[21]

AGGRESSION:

Aggression is " a form of behaviour which leads to self-assertion. It may arise from innate drives and/or a response to frustration. It may be manifested by destructive and attacking behaviour, by covert attitudes of hostility & obstruction, or by a healthy self-expressive drive to mastery.[20]

Dietz (1992) have distinguished five patterns of relationship between mental disorder on one hand and criminality on other hand among mentally disorder offenders:

Pattern 1 Offenders: are those for whom crime is a response to psychiatric symptoms, most often delusions or hallucinations.

Pattern 2 offenders: commit crimes motivated by

Compulsive desire such as sex offenses by paraphiles & offenses regarded as evidence of disorders of impulsive control.

Pattern 3 Offenders: are those with personality disorder for whom the crime is merely one example of maladaptive pattern of voluntary & knowing behaviour.

Pattern 4 Offenders: that have coincidental mental illness that is unrelated to the crime.

Pattern 5 Offenders: are those who became mentally disordered or feign mental disorder as a result of their crimes such as those who dissociate upon seeing what they have done, those who become depressed in prison,

those who become psychotic on death raw, and those who malinger mental illness.[4]

SCHIZOPHRENIC & DELUSIONAL DISORDERS:

Criminal acts committed by schizophrenics may be closely or distantly related to the phenomenology of the illness. Such phenomenology may be florid in form (e.g. delusional mood, paranoid delusions or misinterpretations of the environment), or it may consist of negative features (e.g. deterioration of personality & social functioning) which characterize residual schizophrenia. In any situation there may be a contribution from the effect of alcohol or drug abuse or a premorbid antisocial personality. The offense itself may vary from trivial to catastrophic. Most violence by schizophrenics, as by others is domestic in nature. The association of violence & schizophrenia remains a matter of controversy.[2]

AFFECTIVE DISORDER:

Major disorders of mood are only rarely associated with the commission of major crimes. Mania and hypomania commonly lead to acts of

public disorder, minor violence & fraudulent dishonestly in association with grandiosity, but rarely results in serious offending. Homicidal acts committed during states of depressive illness are classical of altruistic type. The victim is invariably a family member. There may be more than one victim & such acts are commonly followed by the suicide or attempted suicide of the assailant.[2]

PERSONALITY DISORDER:

It is not surprising that offending is a common feature among those who attract a diagnosis of antisocial personality disorder, for the diagnosis will have made on the basis of the offending.[2]

NEUROSIS:

Some of the offenders commit the same minor offenses again & again. Often the behavior is senseless (e.g. petty shoplifting or indecent exposure) commonly such offenders have fragile personalities & manifest a range of neurotic behaviour patterns e.g. phobic symptoms & panic attacks.[2]

MENTAL HANDICAP:

Mentally retarded people may commit offenses because they do not understand the implications of their behaviour, or because they are susceptible to exploitation by other people. Compared with other offenders, the mentally retarded are more likely to be caught. The most often offenses of mentally retarded are sexual offense, particularly indecent exposure by males and also arson.[7]

ALCOHOL ABUSE:

Although there is a strong association between alcohol abuse and offending, the nature of the relationship is diverse. Drinking may underlies the occurrence of the following types of offenses:

1- Driving offenses. 2-Dishonesty. 3- Violence. 4- Sex offensive. 5-Domestic Violence.

ORGANIC CONDITION:

Disinhibition & and impaired judgment, are characteristic of organic brain disease, may lead to minor crimes of dishonesty & sex offenses. In young men, organic brain damage as a consequence of head injury may lead to disorderly or violent behaviour.[2]

EPILEPSY:

Automatic episodes of aggressive or violent may occur during or after an epileptic fit. A person who commits a crime during the course of a seizure is legally insane & must be committed to a psychiatric hospital.[15] However, automatic behaviour is a rare explanation for the crimes of epileptic patients.[9]

MORBID JEALOUSY:

Jealousy is more than a psychiatric symptom, its language is universal. The conduct & feelings of jealous men & women have repeatedly drawn the attention of the great observers of the human nature.[17] Jealousy is a notoriously dangerous passion and constitute a well-recognized motive for crimes of violence, particularly of gynocidal nature.[17]

OFFENSES AGAINST PROPERTY: which include arson, shoplifting and child stealing (plagium).

FITNESS TO PLEAD:

In determining fitness to plead, it is necessary to determine how the defendant can:

1- Understand the nature of the crime. 2- The difference between pleading guilty and not guilty. 3- Instruct council. 4- Challenge Jurors. 5- Follow the evidence in court.[7]

CRIMINAL RESPONSIBILITY:

To establish guilt it is necessary to demonstrate that the defendant possessed the necessary state of mind or "mensa rea" for the particular crime. The factors of psychiatric relevance that might negative "mens rea" according to the English law are:

1- **Age**: children under age of "10" are not criminally responsible (in our country the age of "7".[23]

2- **Mental disorder**: it is necessary for the defendant to prove that:

A. He was suffering from a disease of mind at the time of crime.

B. This caused a defect of reason.

c. The defect of reason robbed him of the capacity to know what he was doing or know that it was wrong.

3- **The effect of alcohol drugs**: Intoxication by voluntary drinking does not constitute a defense except:

A- If the crime requires proof of a specific intent, for which the intoxicated is unable.

B. If alcohol or drugs have caused a disease of the mind or an abnormality.

C. Conditions like: delirium tremens, Korsakof's syndrome & alcoholic hallucinosis.

4- **Automatism**:Criminal acts performed during episodes of altered consciousness are rare event which may occur in:

A. An epileptic fit. **B.** While asleep**.** **C.** state of hypoglycemia. **D.** when concussed.

Automatism constitute a defense because the mind does not accompany the body's actions.[2]

DIMINISHED RESPONSIBILITY:

According to the English law, to sustain the defense of diminished responsibility, proof of three matters is required:

1- The accused at the time of the crime was suffering from the abnormality of the mind.

2- The abnormality of the mind may result from immaturity, mental instability, reactive depressed state, mixed emotions of depression & recently "premenstrual tension".

3- The abnormality of mind substantially impaired mental responsibility.

FEMALE OFFENDERS:

One of the cardinal factors about crime that it is overwhelmed a masculine activity. Nine men are convicted of offenses of all types for every woman, and among juvenile about six boys for every girl. In severity of punishment, which reflects the popular view of the seriousness of offenses, the difference is even greater. The sex difference provides a rich quarry for hypothesis about origins of crime & social levels. The incidence of physical & mental illness & other psychological factors are more or less equally distributed between the sexes, so that the tendency has been to regard behavioral differences as social & culturally induced.[8]

GANSER SYNDROME:

This disorder, named after the German psychiatrist "Ganser" who first described it in 1897 among prisoners, is rare and probably not a dissociative or hysterical disorder. The term "Ganser syndrome" is applied to behavior in which dementia or psychosis are simulated or to a similar presentation but restricted to forensic setting. It is characterized by absurd approximate answers to questions (vorbeireden), somatic or mental syndromes of hysterical type, hallucination & apparent clouding of consciousness. It does not excuse the offender from responsibility for the act.

MALINGERING:

is diagnosed by DSM-IV-TR by any combination of the followings:

1- Medico-legal content of presentation.

2- Marked discrepancy between the person's claimed stresses or disability & the objective feeling.

3- Lack of cooperation during the diagnostic evaluation and incomplying with the prescribed treatment regimens.

4-The presence of antisocial personality disorder.[5]

MENTAL HEALTH ACTS

Mental health legislation started in 1774 with the Act for Regulating Madhouses in Britain. The Mental Health Act 1983 is the most recent development in this respect in England.In our country, IRAQ, no mental health act has yet been introduced. The context consist of conventional means for referring to the forensic psychiatric mission for examination and reportation of accused individuals by the courts, police or other government sects, on the ground of suspected mental abnormality. They are often referred to the forensic psychiatric committee (F.P.C.) at Al-Rashad Mental Hospital. The latter is expected to decide whether:

1- The offender is mentally ill or not, at the time of presentation.

2- The offender had had symptoms suggesting a mental abnormality at the time of the act.

3- The offender is responsible for the act or not and, in case he is found responsible, whether he fully or partially responsible.

4- The offender is fit to plead or not.

THE AIM OF THE STUDY

This study was carried out to:

1- Determine the rate & spectrum of mental disorder among offenders referred for psychiatric evaluation.

2- Find out the relation between mental disorder the nature of the offense.

3- Assess the rate of re-referral among mentally ill offenders.

4- Study some socio-demographic aspects of mentally ill offenders.

SUBJECT & METHOD:

The subjects of this study are offenders who were referred from courts, police, security or other government sects to the F.P.C AL-RASHAD Mental Hospital for psychiatric assessment & to decide about criminal responsibility & fitness to plead.All referrals during the period from 1^{15th}of April 2012 to 15th November 2013 were evaluated.The males were kept under observation in Ibn Al-Haytham secure unit & the females in Zainab Ward for females at AL-RASHAD Mental Hospital.The referrals included in this study were 120 referrals aged 11-17 years (mean ± S.D. 34.43 years

±11.57).All were interviewed by the researcher. The interview was made before & after presentation to the F.P.C. The interview consisted of a questionnaire (Appendix 1) containing information about age, sex, address & other socio-demographic information, as well as information about the source of referral, the nature of the offenses, previous history of forensic psychiatric referral, diagnosis given by F.P.C., criminal responsibility, and fitness to plead. The questionnaire was filled by the interviewer.The second step in this study was the use of a semi-structured interview questionnaire (S.S.I.Q) based on the DSM-IV-TR (Appendix 2) to make the clinical diagnosis. The S.S.I.Q. for the purpose of this study is a modification of a previous S.S.I.Q. applied by other researchers in the Iraqi Commission for Medical Specialization in Psychiatry. The interviewer recorded the responses of the offenders to this questionnaire.Eleven cases were discarded from this study because of contradiction with the F.P.C.'s diagnosis & 8 cases were discarded from the study because they were not fit physically for the interview & no information was available.In addition to clinical diagnosis of the S.S.I.Q., diagnosis of malingering was also made, S.S.I.Q. included items to diagnose malingering according to the DSM-IV-TR criteria. (Appendix 3)Epilepsy was diagnosed by direct questioning of the offenders, an informant and EEG.Mental retardation was diagnosed by direct questioning of the offender and/or an formant. The statistics used in this study were simple descriptive statistical measures as rate, mean & S.D.

RESULTS:

During the period from 15/4/2012-15/1/2013 there were 120 referrals to the F.P.C. in AL-RASHAD Mental Hospital all of them were included in our study. The frequency of referral according to age & sex is presented in Table (1). Their age range was 11-71 years (mean ± S.D. 34.43 years ± 11.57). The males were 102 and the females 18. 18.63.3% of the sample (64.7% of the males & 55.6% of the females) were between the age of 20-39 years. The males were 5.7 times of the females.Single patients formed 65% of the sample (66.7% of males & 55.6% of females) (Table 2).

Table (3) demonstrates the rate of offenders who had been diagnosed by the FPC & the SSIQ as mentally ill or as "malingerers". The malingerers included those who had antisocial personality disorder & simulated mental illness. 99 of the total referrals were diagnosed as mentally ill (82.5%) & 21 (17.5%) as malingerers.The distribution of the types of offences according to the sex (Table 4) revealed that intrafamilial violence was the commonest among the male offenders while murder, sex crime & wandering were the commonest among female offenders.However, the other types of offences were commoner in age group 20-29 years The type of mental illness that was found that was found among offenders, according to sex, is illustrated in Table(5).Schizophrenia was commonest among males while mental retardation and schizophrenia were more prevalent among female. Table (6) shows the distribution of mental disorders according to age group, it was found that schizophrenia was more prevalent in the age range 30-39 years (33.3%).Studying the relationship of the type of mental illness to the type of offence (Table 7) revealed that schizophrenia was the most predominant in those who committed murder & manslaughter, intrafamilial violence, extrafamiliar violence & wandering while cases with antisocial personality disorder tended to commit robbery more than other offenders. Psyhosis other than schizophrenia committed intrafamilial violence more than other offences.

Tables (8) concern the matter of previous referral to the PFC amongst the mentally ill according to sex, age , type of mental disorder and types of offence successively.

Table (9) show that 83 offenders had committed previous offences (78 males & 8 females). The Frequency of previous offending was significantly higher among the males.

Table (1): Ages of the Sample

Age (years)	Male		Female		Total	
	NO.	%	NO.	%	NO.	%
=<19	4	3.9	4	22.2	8	6.7
20.29	35	34.3	5	27.8	40	33.3
39-39	31	30.4	5	27.8	36	30
40-49	21	20.6	3	16.7	24	20
50-59	7	6.9	1	5.5	8	6.7
>=60	4	3.9	0	0	4	3.3
Total	102	100	18	100	120	100

x2=57.29 df=5 p.v=0.001

Table (2): Marital Status of the Sample

Marital Status	Male		Female		Total		statistic value		
	NO.	%	NO.	%	NO.	%	x2	Df	p.v
Single	68	66.7	10	55.6	NO.	65	43.12	1	0.001
Married	27	26.5	4	22.2	31	25.8	17.06	1	0.0003
Divorced	5	4.9	2	11.1	7	5.8	1.286	1	0.256
Widow	2	1.9	2	11.1	4	3.3	0	1	1
Total	102	100	18	100	120	99.9			

Table (3): Psychiatric Morbidity Of The Sample

Psychiatric Morbidity	Male		Female		Total	
	NO.	%	NO.	%	NO.	%
Mentally ill	86	84.3	13	72.2	99	82.5
Malingerer	16	15.7	5	15.7	21	17.5
Total	102	100	18	100	120	100

x2=53.82 df=1 p.v=0.0001

Table (4): Types of Offences According To Sex

Offence	Male		Female		Total		statistic value		
	NO.	%	NO.	%	NO.	%	x2	d.f	p.v
Murder	7	6.9	4	22.2	11	9.2	0.81	1	0.36
Manslaughter	3	2.9	0	0	3	2.5	3	1	0.08
Robbery	16	15.6	1	5.55	17	14.2	13.2	1	0.0004
Intrafamilial Violence	47	46.1	2	11.1	49	40.8	41.32	1	0.0001
Violence Outside Family	10	9.8	1	5.55	11	9.2	7.36	1	0.0006
Shoplifting	2	1.9	0	0	2	1.6	2	1	0.15
Arson	0	0	1	5.55	1	0.8	1	1	0.31
Sex Crimes	2	1.9	4	22.2	6	5	0.66	1	0.4
Wandering	10	9.8	4	22.2	14	11.7	2.37	1	0.108
Others	5	4.9	1	5.55	6	5	2.66	1	0.102
Total	102	99.9	18	99.9	120	100			

Table (5): Type Of Psychiatric Morbidity According To Sex

Diagnosis	Male		Female		Total		statistic value		
	NO.	%	NO.	%	NO.	%	x2	d.f	p.v
Schizophrenia	65	63.7	4	22.2	69	57.5	53.92	1	0.0001
Morbid Jealousy	1	1	0	0	1	0.8	1	1	0.317
Psychosis	10	9.8	2	11.1	12	10	5.33	1	0.209
Depression	1	1	1	5.6	2	1.7	0	1	1
Alcoholism	2	2	0	0	2	1.7	2	1	0.15
Mental Retardation	6	5.8	6	33.3	12	10	0	1	1
Epilepsy	1	1	0	0	1	0.8	1	1	0.3
Malingerer With Antisocial Personality Disorder	8	7.85	3	16.7	11	9.2	2.27	1	0.131
Malingerer Without Antisocial Personality Disorder	8	7.85	2	11.1	10	8.3	3.6	1	0.057
Total	102	100	18	100	120	100			

Table (6): Psychiatric Morbidity According To The Age

Age (years)	Schizophrenia		Morbid Jealousy		Psychosis		Depression		Alcoholism		Mental Retardation		Epilepsy		Malingers With P.D.(1)		Malingers Without P.D.	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
<=19	2	2.9	0	0	2	16.7	0	0	0	0	2	16.7	0	0	1	9.1	1	10
20-29	17	24.6	0	0	6	50	0	0	0	0	7	58.3	0	0	8	72.7	2	20
30-39	23	33.3	0	0	3	25	2	100	2	100	2	16.7	0	0	0	0	4	40
40-49	16	23.2	1	100	1	8.3	0	0	0	0	1	8.3	1	100	1	9.1	3	30
50-59	7	10.1	0	0	0	0	0	0	0	0	0	0	0	0	1	9.1	0	0
=>60	4	5.8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	69	100	1	100	12	100	2	100	2	100	12	100	1	100	11	100	10	100

1: personality disorders. X2= 59.4 d.f=8 p.v=0.0001

Table (7) Types of Psychiatric Disorders Found in Each Type of Offence

A. Murder

Disorder	NO.	%
Schizophrenia	6	42.8
Morbid Jealousy	1[(1)]	7.15
Psychosis	1	7.15
Mental Retardation	2	14.3
Epilepsy	1	7.15
Malingerer with P.D.[(2)]	1	7.15
Malingerer without P.D.	2	14.3
Total	14	100

1: Manslaughter of the wife by offender. 2: Antisocial personality disorders. X2=10 d.f=6 p.v=0.124

B. Robbery

Disorder	NO.	%
Schizophrenia	1	5.9
Psychosis	2	11.7
Malingerer with P.D.	8	47.1
Malingerer without P.D.	6	35.3
Total	17	100

X2=7.706 d.f=3 p.v=0.05

C. Intrafamiliar violence

Disorder	NO.	%
Schizophrenia	38	77.8
Psychosis	7	14.3
Mental retardation	3	6.1
Alcoholism	1	2
Total	49	100

X2=73.69 d.f=3 p.v=0.0001

D. Violence Outside The Family

Disorder	NO.	%
Schizophrenia	10	90.9
Mental Retardation	1	9.1
Total	11	100

X2=7.34 d.f=1 p.v=0.124

E. Shoplifting

Disorder	NO.	%
Schizophrenia	1	50
Mental Retardation	1	50
Total	2	100

X2=0 d.f=1 p.v=1

F. Arson: Only one female offender and the diagnosis was depression

G .Sex Crime

Disorder	NO.	%
Psychosis	1	16.7
Mental Retardation	3	50
Malingerer With P.D.	2	33.3
Total	6	100

X2=1 d.f=2 p.v=0.6

H .Wandering

Disorder	NO.	%
Schizophrenia	11	78.6
Psychosis	1	7.1
Mental Retardation	2	14.3
Total	14	100

X2=13 d.f=2 p.v=0.001

Table (8): Frequency of Previous Referral Of Mentally Ill Offenders To The FPC According To Sex.

Sex	Mentally ill offenders with past history of referral		Mentally ill offenders with no past history of referral	
	NO.	%	NO.	%
Male	78	94	8	50
Female	5	6	8	50
Total	83	100	16	100

x^2=22.74 df=1 p.v=0.001

Table (9): Type of Mental Disorder in Previous Referral to FPC.

Disorder	Mentally ill offenders with past history of referral		Mentally ill offenders without past history of referral		statistic value		
	NO.	%	NO.	%	x2	d.f	p.v
Schizophrenia	64	75.3	5	20	50.4	1	0.001
Morbid Jealousy	0	0	1	4	1	1	0.31
Psychosis	7	8.2	5	20	0.33	1	0.5
Depression	0	0	2	8	2	1	0.15
Alcoholism	2	2.35	0	0	0.33	1	0.5
Mental Retardation	9	10.6	3	12	3	1	0.08
Epilepsy	1	1.2	0	0	1	1	0.3
Antisocial P.D.	2	2.35	9	36	4.45	1	0.034
Total	85	100	25	100			

DISCUSSION:

The relation between crime and mental illness has increasingly drawn the attention of psychiatrists in the last few decades. Bearcroft and Donovan (1965) stated that the incidence of criminal behaviour in the mentally ill seemed to depend, to some extent, upon social factors[1] and in another study Bearcroft (1966) reported differences between patients admitted to hospital from prison and from other sources include both medical and social factors[1] Cooke et al (1973) dealt with factors affecting referral to determine competency to stand trial and gave importance to proximity to evaluation facilities and knowledge concerning use of competency evaluation laws among other identified factors.[3] Psychiatric referral from police were investigated by Sims and Symonds (1975) and they found that most of the referrals were suffering from psychosis[18]

A survey of records of 1241 males remained in prison by Taylor and Gunn (1984) yielded a high prevalence of psychiatric disorders and high risk of violence among men with schizophrenia[19]. In Egypt, Okasha et al (1975) noticed high incidence of EEG abnormalities among the prisoners whose crime was apparently motiveless or with slight motivation[19]. In our country Al-Ta'an and Jameel (1975) studied 100 mentally ill patients who committed murder[14] . Mentally ill murders were again studied by Olaiwi in a thesis work in 1992[14]. Khammas (1989) studied in an unpublished work the psychiatric morbidity among police referrals to the FPC in Al-Rashad Mental Hospital[14]. The present work concerns the socio-demographic and clinical psychiatric aspects of 120 subjects referred from different governmental sects to the F.P.C in Al-Rashad Mental Hospital during the period from 1-Feb.2011 to 1-10-2012 Intrafamilial violence was the offense in 46.5% of the male offenders in the study which is similar of Khammas[14] and that of Sims and Symonds[18]. Dell and Robertson reported serious violence in the majority of their male sample[19]. Homicide and other types of assault formed the majority of total referrals[3]. In our study murder, sex crimes and wandering were the commonest offenses among the female referrals. Sims and Symonds reported wandering to form the majority among female, referrals[18]. The reason for predominance of violence in males who are mentally ill may be attributed to the fact that there are no legal facilities for compulsory admission of violent patients without police intervention. In our society, people are reluctant to report such events to the police unless when a serious event had already been committed or the threat of violence was quite alarming. Taylor and Gunn attributed that to the greater risk of schizophrenia for committing violence[19]. This is supported by the study of Dell and Robertson[19] and Cooke et al[3] who showed that violent offenses were more common among psychotics. Among all the psychotic offenders in this study were considered not responsible for their act and unfit to plead. Apparently attention was not paid to the fact that some of psychotics have not committed the offense within the disease context and this excuse has been used by the offender to repeatedly commit such offences and to have the opportunity of referral more than other offenders. Among the other offences committed by schizophrenics was wandering and begging which is related to the deterioration in personality and poor family circumstances. Similarly the F.P.C rendered

every offender with antisocial personality disorder as responsible for his act and fit to plead unless there was an associated mental disorder. This did not give them the opportunity of referral when they committed any offense afterward. The findings of this study justified the referral for psychiatric assessment as particularly in the case of those who committed serious acts such as murder, manslaughter, assaults and wandering. Antisocial personality disorder was the diagnosis in the other types of offenses such as robbery. Such offenses need planning and sufficient skill which is rarely found in individual with severe mental disturbance. In our study 83 of mentally ill offenders (83.8%) had previously been referral for forensic psychiatric assessment. This is near to the result reached by Khammas[14] and Bearcroft[1]. This may be due to the chronicity of the illness, tendency of the referring bodies to refer those already "labeled" as mentally ill or had a previous admission, abuse of the offender himself for the sick label that he or she had received in the past and failure of treatment and rehabilitation program. Intrafamilial violence was the most frequent in those who were referred frequently for psychiatric evaluation, this may be due to the early discharge by their own families, the presence of the same stress factors at home and this continuation of treatment. Murderers were the least among those who were re-referred probably because of the seriousness of the offense which make them stay longer in hospital and receive more psychiatric attention from their relatives after their release from hospital. Of the mentally ill offenders, schizophrenics were more often re-referred then others for the reason mentions above.

CONCLUSION:

1- Most of the offenders who were referred for psychiatric evaluation were found to be mentally ill & the most frequent mental illness was schizophrenia.

2- Sociodemographic factors like age, sex, marital status, level of education & occupation appeared to have some effect on the type of mental illness.

3- Most of referred cases were due to violent assaults committed by male schizophrenic & other psychotics while most robbery cases were either not mentally ill or individuals with antisocial personality disorder simulating mental illness.

4- Most of the referrals had previously been referred to the FPC & they were mainly males & schizophrenics who committed intrafamilial assaults.

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الخلاصة

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معدل و نطاق الأمراض النفسية بين المتهمين المحالين لأغراض التقييم النفسي

خلفية الموضوع: تكون العلاقة بين الجريمة و المرض النفسي أو العقلي أحد أهم جوانب الطب النفسي العدلي. فالمرض العقلي الذي يؤدي إلى خلل في السلوك الاجتماعي غالباً ما يتسبب في تدخل الشرطة أو الأجهزة الأمنية تتبعها إحالة المتهم لغرض التقييم النفسي العدلي من ناحية تحمله لمسؤولية الفعل الذي قام به و قدرته على الدفاع عن نفسه أمام المحكمة.

الأهداف: صممت هذه الدراسة لتبيان معدل و نطاق الأمراض النفسية بين المتهمين المحالين لأغراض التقييم النفسي.

الطرق: هذه الدراسة المقطعية شملت العينة المأخوذة في ١٢٠ متهماً محالاً(١٠٢ ذكراً و ١٨ أنثى) إلى اللجنة النفسية العدلية في مستشفى الرشاد للأمراض النفسية و العقلية ضمن الفترة من شهر نيسان٢٠١٢- إلى شهر كانون الأول٢٠١٣..

أجري الفحص النفسي للمحالين بواسطة المقابلة شبه الأصولية و المعتمدة على الجدول الإحصائي و التشخيص الرابع المنقح (DSM-IV-TR) ثم تم مقارنة التشخيص مع تشخيص اللجنة الطبية النفسية العدلية. و قد تم أخذ الحالات التي يتفق فيها التشخيصان.

النتائج: كان التشخيص (٨٢,٥%) من الحالات بأنهم يعانون من أمراض نفسية. كان أكثر التهم الموجهة للمحالين الذكور هي الاعتداء على أفراد العائلة. أما الإناث فقد كان التسكع و القتل و الجرائم الجنسية.

كان أكثر مرض نفسي تم تشخيصه في الذكور هو الفصام، أمام الإناث فقد كان الفصام بالإضافة إلى التخلف العقلي.

أكثر الأشخاص المحالين كان لديهم تأريخ سابق بالإحالة إلى اللجنة (٨٣%منهم)

كانت الجرائم المتضمنة على العنف هي أكثر أنواع الجرائم المرتكبة من قبل المرضى الذين يعانون من الفصام، أما الذين لديهم الشخصية المضادة للمجتمع فقد كان أكثر جريمة هي السرقة.

الاستنتاجات: قد توصلنا إلى استنتاج أن العوامل الاجتماعية و الإحصائية كالعمر و الجنس و الحالة الاجتماعية و نوع العمل و مستوى التعليم أثرت على معدل الإحالة بصورة عامة و لكنها لم تؤثر على نوع المرض المشخص و كذلك إن معظم الحالات المحالة خاصة الذكور و المصابين بالفصام هي بسبب الاعتداءات التي تنطوي على العنف كان المتهمين بجرائم القتل أكبر عمراً بصورة عامة من المتهمين بجرائم أخرى.