Not Guilty by Reason of Insanity (NGRI): Adjudication, Clinical Outcomes, and Rehabilitation

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Abstract:

In this chapter, we examine how the criminal justice system in Africa processes mentally disordered offenders. The insanity defence plea and its associated disposition has not received much scholarly attention in Africa. Although there are legal provisions in several countries in Africa in relation to mentally disordered offenders, these provisions are largely inherited from colonial rule. There has been little effort to interrogate these legal provisions and safeguards for offenders with mental disorder and the varied ways these insanity clauses operate in Africa. This chapter provides an overview of the insanity defence law and its origins, and how the insanity defence law has been applied in selected African countries. We examined the criminal adjudication process involving the insanity defence plea and the varied disposal options available to the courts in different juridictions on the continent. The chapter also reviewed the clinical characteristics of insanity acquittees and effectiveness of rehabilitation regimes across jurisdictions in Africa. We then evaluate clinical outcomes of defendants invoking the insanity defence and rehabilitation of insanity acquittees. The chapter concludes by offering some recommendations for future research into the insanity defence in Africa.

Introduction

In several jurisdictions across the globe, criminal liability generally is a function of two essential factors. There is a requirement that a person actually committed or attempted to commit a crime (*actus reus*) and that the person had and/or had acted on the requisite rational intent, knowledge and free will (*mens rea*). The general presumption is that any individual charged with any offence is deemed to have the necessary *mens rea*. At the same time, an argument can be advanced that *mens rea* was impaired or that a defendant lacked the necessary *mens rea* at the time the offence was committed. The two major considerations in this regard are whether mental disorder contributed to the defective or irrational *mens rea* and consequently whether the insanity defence is appropriate. Invoking the insanity defence law essentially means that there is no contention about the commission of the offence. Instead, the adjudication and disposition processes would be centered on the mental element or *mens rea* of the defendent at the time the offence was committed. The disposition associated with a successful insanity defence plea is Not Guilty by Reason of Insanity (NGRI). The insanity defence plea and its associated disposition has received the attention of researchers, criminal justice practitioners and sometimes the public over the years (Adjorlolo, Chan, & Agboli, 2016; Allnutt, Samuels, & O'driscoll, 2007). However, there is a dearth of literature on these constructs from Africa. This chapter examines NGRI in Africa with a particular focus on the adjudication process, clinical outcomes and rehabilitation of individuals who have raised the insanity defence or were acquitted based on the defence.

The first section provides a brief overview of the insanity defence law and its origins, and how the insanity defence law has been applied in selected African countries. The second section

examines the criminal adjudication process involving the insanity defence plea and dispositions associated with a successful insanity defence plea. We then evaluate clinical outcomes of defendants invoking the insanity defence and rehabilitation of insanity acquittees. The chapter concludes by offering some recommendations for future research into the insanity defence in Africa.

Insanity Defence Legislation in Africa

Contemporary insanity defence legislation and practices are linked to the historical case of Daniel M'Naughton who mistakenly shot and killed the private secretary of the Prime Minister of England, Edward Drummond in 1843 (Syed, 2019). M'Naughton was acquitted of the murder charges brought against him by prosecutors because the court, based on a psychiatric assessment report, reasoned that M'Naughton was mentally incapacitated at the time the offence was committed (Allnutt et al., 2007). To quell public tension and controversy surrounding the acquittal, the judges of the Queen's Bench made two seemingly important proclamations (Yeo, 2008). First, they noted that the insanity plea can be raised if it is proven that, a) the party accused was laboring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act being committed or, b) that he or she did not know that the act was wrong. The judges also stated that a person under insane delusion who commits an offence could be exculpated (Yeo, 2008).

These proclamations, termed as the M'Naughton Rules, have influenced the insanity defence legislations of commonwealth African countries and former colonies of Britain. As the first country to have gained independence from the British in Africa, Ghana’s insanity defence legislation retains essential elements of the M'Naughton Rules. Section 27 of the Criminal

Offences Act, 1960 (Act 29; henceforth Act 29), which is termed "special verdict in respect of an insane person", states that insanity plea can be claimed (a) "if that person was prevented, by reason of idiocy, imbecility, or a mental derangement or disease affecting the mind, from knowing the nature or consequences of the act in respect of which that person is accused or", (b) "if that person did the act in respect of which that person is accused under the influence of an insane delusion of a nature that renders that person, in the opinion of the jury or of the court, an unfit subject for punishment in respect of that act" at the time of the crime (Adjorlolo et al., 2016, p.4).

The insanity legislation in Commonwealth countries in Eastern and Central Africa, namely Botswana, Kenya, Tanzania, and Uganda have similar wordings; "A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is, through any disease affecting his mind, incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission…" (Yeo, 2008, p. 243). In South Africa, the insanity defence legislation is contained in the Criminal Procedure Act 51 of 1977 ("the Act"). Section 78(1) of the Act states "A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable— (a) of appreciating the wrongfulness of his or her act or omission; or (b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such act or omission."(Stevens, 2015, p.31). Section 28 of the Criminal Code of Nigeria contains the insanity plea provisions. The Section states that for an insanity defence to be raised, it must be proven that "(a) The accused person suffers from disease of mind/natural mental infirmity at the relevant time which deprived him of the capacity to understand what he

was doing, control his action or know that he ought not to do an act or make an omission" (b) "A person whose mind at the time of his doing/omitting to do an act is affected by delusions on some specific matter(s), but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for his acts/omissions, to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist"(Ogunwale & Oluwaranti, 2020, p.2). The similarity in the insanity clauses across jurisdictions in Africa is reflects the influence of the M'Naughton Rules and Brtish colonial heritage. The insanity clauses suggest a presumption of sanity until proven otherwise. Also, as seen from the examples, the insanity clauses across the jurisdictions in Africa generally do not have provisions for "partial delusion" except in the case of Nigeria. Section 28(b) of the Nigerian Criminal Code specifically notes instances where delusion present at the time of the offence may not be induced by "natural mental infirmity". These factors may be deep cultural beliefs such as witchcraft, juju or some other supernatural forces. However, case evidence suggest that insanity pleas based on such "persecutory delusions" have "never succeeded in Nigeria courts (Ogunwale & Oluwaranti, 2020, p.2).

Elements of Insanity Defence Legislation

The insanity defence legislations are characterized by two important elements; biological/pathological and psychological elements. The biological element requires that a person suffers from mental disorder or defect of reasoning at the time the offence was committed. The defect of reason should be a product of disease of the mind which is a legal, not medical, concept. That is, what qualifies as a disease of the mind is primarily determined by the court, not by forensic health practitioners. The relevant legal provisions in Ghana and some other

African countries do not articulate the exact constituents of the biological element. In the case of South Africa, this was clarified in *The State v Stellmacher* (1983), where the court made a finding that basically defined the criteria for a mental illness/disorder: that it must be pathological, and it must be endogenous, that is, not as a result of external stimuli (Mosotho, Timile, & Joubert, 2017). The psychological component requires that the person lacks the requisite mental capacity to appreciate the wrongfulness of the act (Stevens, 2015). The mere presence of a mental disorder of any sort is necessary but not sufficient for the defence to be raised successfully. Instead, it should be demonstrated that the mental disorder significantly impairs the psychological and mental capacity of the accused such that they are unable to appreciate the wrongfulness the act. For instance, in the case involving *Helegah vs The Republic of Ghana* (1973), the court reasoned that amnesia does not constitute insanity. The essential ingredient is that the defect in reasoning resulting from mental disorder should cause an individual not to know the nature and quality of the act or that it is wrong. More importantly, the nature and quality of an act refers to the physical, and not moral, element. Similarly, the wrongfulness of an act is defined in the sense of legal, and not moral, interpretation.

As with the provision in many African countries, the insanity defence legislation in Ghana has been criticized on several grounds, including being redundant and containing outmoded terminology. Adjorlolo et al. (2016) argued that it is needless for the second part of the legislation to focus exclusively on delusions. This is because delusions are a major part of mental disorders, either as symptoms or distinct disorders. Second, the emphasis on congenital mental incapacitation resulting in “idiocy” and “imbecility”, mental derangement arising from disease or natural degeneration, and disease of the mind as the conditions that can impair an individual’s knowledge of criminal acts is needless. These conditions, particularly those relating to congenital

mental retardations and terminologies such as “idiocy” and “imbecility”, apart from their pejorative overtone, also convey the notion that the mind must be in total deprivation for the insanity defence to be raised (Adjorlolo, Chan, et al., 2016). When jurors, for instance, are directed to consider this narrowed interpretation of the defence during the criminal adjudication process, the tendency that some individuals will be denied the defence may be high. The authors, therefore, propose the term “mental disorder” or its variant as a suitable replacement for all the aforementioned conditions. The Canadian insanity plea used to contain these outmoded terms such as “natural imbecility” “insanity,” “disease of the mind”, “idiocy” and “lunacy” (Section 2 of the Criminal Code of Canada 1992). When the legislation was revised in 1992, “mental disorder” was introduced to subsume all the previous descriptors. Canadian Criminal Code Section 16(1) now reads: “No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or knowing that it was wrong”(Zhao & Ferguson, 2013). In the United States, United Kingdom and across several European countries, the insanity legislation make reference to “mental illness”, “mental disorder”, and “mental defect” (Bal & Koenraadt, 2000).

One other commonality in the insanity legislation across African jurisdictions is the lack of a definition of mental illness or mental disorder (Adjorlolo, 2016; Mosotho et al., 2017; Ogunwale & Oluwaranti, 2020). That is, unlike the Mental Health Acts, the criminal laws, which contain the insanity clauses that guide decisions of the courts, do not define mental illness or “insanity”. Thus, the criminal law may consider adopting the term “mental disorder” not only because other jurisdictions have done so, but also because it will conform to the definition used in the Ghanaian Mental Health Act, 2012 (Act 846). Act 846 defines mental disorder as “a

condition of the mind in which there is a clinically significant disturbance of mental or behaviour functioning associated with distress or interference of daily life and manifesting as disturbance of speech, perception, mood, thought, volition, orientation or other cognitive functions to such degree as to be considered pathological but excludes social deviance without personal dysfunction" (p. 4–42). The Mental Health Act of Zimbabwe (Act No 23 of 1976) also defined mentally disordered or mentally defective as 'suffering from mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of the mind' (Menezes, Oyebode, & Haque, 2009). Similarly, in South Africa, the definition of mental illness contained in the Mental Health Act is at variance with the definition in the criminal laws (Mosotho et al., 2017). To improve the efficiency of the adjudication process, it is important that the discrepancies between criminal laws and mental health legislations in the definition of mental disorder is addressed.

Insanity Defence and Criminal Adjudication Process

Trials that involve a consideration of the mental state of the offender at the time of the offence (insanity plea) have some essential elements, including the following: (1) raising the question about mental state at the time of offence, (2) request for mental state examination, (3) mental state evaluation stage, (4) judicial determination of appropriateness of insanity plea; (5) disposition of insanity acquittees and commitment to treatment (Adjorlolo, Agboli, & Chan, 2016; Adjorlolo, Chan, et al., 2016). Every accused is presumed not to suffer from a mental incapacitation and so is criminally liable, unless the issue is raised otherwise. Although, in principle, the insanity defence can be raised by either the defence or prosecution, in practice the

defendant mental state at the time of offence is mostly raised by the defence attorney who has the burden of proof (Adjorlolo, Agboli, et al., 2016; Adjorlolo, Chan, et al., 2016; Swanepoel, 2015).

To ensure due process prevails and that the rights of defendants are not violated, the trial court normally requests a retrospective assessment of the defendant's mental state at the time of the offence. The court can refer an accused at any stage of the trial for a psychiatric or psychological assessment of his or her mental state (Swanepoel, 2015). Defendants referred for assessments are mostly committed to a psychiatric hospital or to any other place designated by the court.

Consistent with practices elsewhere, the assessments are conducted by mental health professionals. Because most African countries do not have forensic psychiatrists and/or forensic psychologists, mental state examinations are undertaking by "general" psychiatrists and psychologists with little or no training in forensic assessment and issues. These mental health professionals mostly conduct interviews and collect third-party information, such as collateral reports, witness statements, police reports, crime scene information and other demographic, biopsychosocial, medical and psychiatric histories (Mosotho et al., 2017; Ogunwale & Oluwaranti, 2020; Stevens, 2015). Another source of data involve the administration of traditional/forensic assessment instruments. However, because the majority of forensic assessment instruments are not validated or standardized on local samples, others have questioned the validity and reliability of the assessment results (Adjorlolo, Agboli, et al., 2016; Adjorlolo & Chan, 2019; Mosotho et al., 2017; Shepherd & Lewis-Fernandez, 2016). Likewise, the use of neuroimaging techniques such as computed tomography scans for mental state assessment for criminal responsibility decisions have been questioned (Mosotho et al., 2017). The court is then furnished with the assessment reports to assist in determining the defendant

mental state at the time of offence. When one or all the parties contesting a case is/are not satisfied or convinced with the assessment result, the medical officer is called in open court and cross-examined. During this cross examination, issues such as qualification, experience, assessment methods, procedures and findings are thoroughly probed (Adjorlolo, Agboli, et al., 2016). In providing their expert opinion, mental health professionals are prohibited from commenting on the criminal responsibility of the defendant based on the assessment report, the so-called the ultimate issue (Stevens, 2015). The court in Ghana, for instance, addressed the ultimate issue in *Kwadwo Mensah* vs. *The Republic* (1959) when it stated that the determination of insanity at the time of the offence is the sole preserve of the trial court (judge/jury) in view of all the available evidence. The court in the *State* vs. *Van As* (1991) in South Africa also noted that it is not the responsibility of the mental health professionals to take over or replace the function or duties of the court in deciding on the culpability of the defendant.

For trials involving jurors, the presiding judge has the sole responsibility of directing the jurors on the facts to consider in order to determine the culpability or otherwise of the defendant. In the case involving *Abugiri Frafra* vs. *Republic of Ghana* (1974), the defendant was accused of murder, and the psychiatrist who testified diagnosed the defendant with paranoid schizophrenia, which took the form of persecutory delusions. The trial court instructed the jurors to "ask themselves whether there is evidence from which they can infer that at the time of offence the mind of the accused was in a high degree of disorder and that he was incapable of controlling his conduct"(Adjorlolo, Chan, et al., 2016). Defendants found to be insane at the time of offence are traditionally rendered the special verdict of not guilty by reason of insanity (NGRI). However, for reasons such as to appease the public or victims, the NGRI has been reworded in such a manner to place some responsibilities on the accused. Countries such as Ghana and Zimbabwe

prefer guilty but insane verdict (also known as guilty but mentally ill; GBMI)(Adjorlolo, Chan, et al., 2016; Menezes et al., 2009) whereas others such as South Africa and Nigeria still maintain NGRI (Kaliski, 2012; Ogunwale & Oluwaranti, 2020). The GBMI arguably makes Ghana's defence of insanity a partial defence, and therefore raised an interesting topical issue not only in Ghana but also in other jurisdictions rendering a similar verdict. In particular, it appeared to conflict with the underlying philosophy of the law that an insane person is not morally responsible because of the defective mind, and so cannot form *mens rea* or criminal intent (Adjorlolo, Chan, et al., 2016). Of particular interest is the pattern of utilization of the insanity plea on the continent. Though this topical issue has not been explored, a recent study found that the insanity plea has been successful in a modest number of cases in Nigeria (Ogunwale & Oluwaranti, 2020). The authors examined the judgments from appeal cases since 1948 and found that, out of 34 cases adopting the insanity plea, the rate of plea success was 26.5% ($n = 9$). It further emerged that the main factors contributing to a successful insanity defence plea is an inability of the accused to comprehend his/her action. Defendants who are not satisfied with the decisions of the trial courts can make an appeal to a higher court (e.g., the High Court, the Appeal Court, and the Supreme Court). In the case involving *Collins* vs *The Republic of Ghana* (1987–1988), the defendant, diagnosed with schizophrenia, was convicted of murder by the trial court. On appeal, the appellate court substituted the guilty verdict with GBMI on the ground that the trial court erred by failing to recognize and include the defendant's history of schizophrenia.

Disposal of Insanity Acquittees

Although there are some variations in the wording of a successful insanity defence verdict, the disposal arrangement for insanity acquittees (i.e. disposal of insanity cases) across

the continent appear largely the same. More specifically, the disposition associated with a successful insanity plea is commitment to treatment as prescribed by the criminal laws and Mental Health Acts of the various countries. Depending on factors such as the nature and seriousness of offence, the court will ensure the accused is admitted to a psychiatric hospital, forensic psychiatric facility or even an outpatient facility, for further treatment and rehabilitation. Section 28 of the Mental Health Act No 23 of 1976 of Zimbabwe states that, when an accused is found to be guilty but insane, the court will commit the accused to treatment and The President may give such directions as he deems fit as to the further detention, care, management and treatment of the patient concerned in an institution, special institution or other place, including a prison."(Menezes et al., 2009). Ghana, for instance, does not have forensic psychiatry hospitals or prisons. However, the psychiatric institutions have "forensic units" where all categories of offenders with mental illness (e.g., insanity acquittees, defendants who are incompetent to stand trial, and prisoners who have been administratively transferred to the hospitals) are accommodated, catered for, and treated. These individuals are brought together in the same unit because of their involvement in the criminal justice system without recourse to the nature of their crimes and mental disorders. That is, extremely violent and aggressive offenders with severe mental disorders (i.e., psychosis with bizarre delusions and hallucinations) are housed in the same units with nonviolent offenders with less severe mental disorders (Adjorlolo, Abdul-Nasiru, Chan, & Bambi, 2018).

In jurisdictions such as South Africa and Ghana, an insanity acquittee who has committed a serious offence (e.g. murder, rape and assault with the intent to do grievous bodily harm), is declared a state patient and will be discharged back to their community once they are stable (Houidi & Paruk, 2018). The purpose of the admission as a state patient is not punishment but

rather treatment, care and rehabilitation, while simultaneously monitoring and managing their potential risk to the community (Houidi, Paruk, & Sartorius, 2018). State patients may be discharged, conditionally or unconditionally, or reclassified as involuntary mental healthcare users (Marais & Subramaney, 2015).

Clinical Characteristics of Insanity Acquittees

A study in Ghana found that out of 138 insanity acquittees, 31% were diagnosed with schizophrenia, 20.2% with drug-induced psychotic disorder, and 13.3% with non-specified psychosis (Turkson and Asante, 1997). Nearly half (48.6%) of the offenders charged with murder or attempted murder were diagnosed with schizophrenia. Data on 273 (males = 251) insanity acquittees from Zimbabwe revealed that the majority were diagnosed with schizophrenia (n = 195), whereas 11 (4.02%) had a diagnosis of substance misuse disorder, six (2.19%) had psychopathic personality disorder, seven (2.56%) had mental impairment, and 44 (16.11%) had other diagnoses (Menezes et al., 2009). In this sample, insanity acquittees diagnosed with schizophrenia more often committed homicide, compared with other violent and non-violent crimes. They also used different methods, namely blunt and sharp instruments, firearms and strangulation, to commit the crimes. Males comprised the bulk of patients (N = 251), with females in the minority (N =22). Ages ranged from 17 to 59 years. More than half of the acquittees were not married (Menezes et al., 2009).

Relatedly, a review of insanity acquittees admitted to a forensic unit in KwaZulu-Natal (South Africa) from 2013 to 2016 revealed that 33 (36.26%) had a diagnosis of intellectual disability, 26 (28.57%) had diagnosis of schizophrenia and 52 (57.14%) had substance use disorder (Houidi & Paruk, 2018). Further analysis revealed that the majority of the acquittees had

comorbid diagnoses (n = 70, 76.92%), with substance use disorder, head injury and other general medical conditions emerging as the three most occurring co-morbidities. In terms of demographics, males were overrepresented (n = 90, 98.90%). Although the ages of the insanity acquittees ranges from 15 to 45 years and above, it was observed further that the majority were within the age group of 15 to 35 years (Houidi & Paruk, 2018). The majority of the acquittees were unemployed (n = 89, 97.80%) and single (n = 89, 97.80%). In yet another study from South Africa, Marais and Subramaney (2015) reported that psychotic disorders were commonly diagnosed among insanity acquittees and individuals declared unfit to stand trial. More specifically, 44% (*n* = 50) were diagnosed with schizophrenia and 20% (n = 23) with psychosis. A total of 34 patients were diagnosed with mental retardation (*n* = 18), organic brain syndrome (*n* = 6), dementia (*n* = 5) and epilepsy (n = 5). The majority of patients committed offences against persons such as murder and rape (n = 103, 68%). Property offences were committed by 25% of the patients (n = 38). In terms of demographic characteristics, the majority of patients were males (n = 99, 87%). The age of the patients also ranged from 10 to 69 years; however, individuals aged between 20-49 years old were overly represented. The majority of the patients were single (n = 91, 80%), unemployed (n = 89, 78%) and had less than 12 years of form education (n = 88).

In summary, emerging studies from Africa have revealed that the majority of insanity acquittees are diagnosed with schizophrenia and other psychotic spectrum disorders. Acquittees were also likely to be males, young adults, unemployed with low or no educational background. In terms of offence history, the majority of acquittees committed violent acts, including murder and rape. These preliminary findings are largely consistent with extant literature from Western countries (Adjorlolo, Chan & DeLisi, 2019). In their review of the insanity defence literature,

Adjorlolo et al (2019) observed that the commonest diagnosis among insanity acquittees is schizophrenia. Males were also found to dominate the insanity acquittees population across jurisdictions. Lastly, the authors found that violent crimes dominated the crimes committed by insanity acquittees.

Rehabilitation of Insanity Acquittees

Once at treatment centers or forensic institutions, insanity acquittees are expected to undergo rehabilitation. Rehabilitation has two principal elements. The first relates to the provision of treatment to restore sanity. In this context, insanity acquittees are put on treatment regimens and supervised by health professionals. Psychopharmacological management, involving the administration of psychotropic medications, is the dominant management practice across the continent. Due to the financial and logistical challenges besetting the provision of mental health on the continent, typical (e.g., haloperidol and chlorpromazine) rather than atypical antipsychotic (e.g., clozapine and olanzapine) medications are often used in the treatment and management of insanity acquittees and other patients with mental illness (Adjorlolo et al., 2018). These medications not only prolong the treatment period but also induce unpleasant side effects, prominent among which are the extra-pyramidal symptoms such as Parkinsonism (Üçok & Gaebel, 2008). These symptoms generally make it difficult for patients to adhere to treatment while on admission and after discharge, thus adversely affecting the outcome of treatment, both in the short and long term. The limited use of psychotherapy and other psychosocial interventions to complement the pharmacological treatment is another notable issue (Adjorlolo, 2015). The second phase of rehabilitation, following a reduction in and stabilization of the symptoms of mental disorders, is occupational therapy. Here, the insanity acquittees are taken

through vocational training to enable them to acquire skills in basic vocations such as basket weaving, beads making and carpentry. The effectiveness of the occupational program is mostly hampered by limited resources. Thus, most insanity acquittees are not able to acquire the requisite skills that could set them on independent pathways from their caregivers after they have been discharged from the psychiatric institutions (Adjorlolo, 2016). In Ghana and perhaps other jurisdictions, it is not uncommon for insanity acquittees to escape from treatment centers. This observation may have fueled the conception that the insanity defence is abused, or those pleading insanity at the time of the offence are not truly insane, culminating in negative attitudes toward the insanity defence (Adjorlolo et al., 2018). The aforementioned challenges have created situations where insanity acquittees and patients with mental disorders in general spend longer times at the treatment centers than they would have serving their prison terms.

Conclusion and Future Directions

The M'Naughton Rule established the foundational principle for safeguarding the fundamental rights of one of the most vulnerable groups of people in society, mentally disordered offenders. In this chapter, we examined the laws and legal safeguards afforded to offenders laboring under some form of mental disorder and the varied ways these insanity clauses operate in selected countries in Africa. We reviewed and compared the adjudication processes in relation to cases involving suspected offenders with mental disorders. The varied disposal options available to the courts in different juridictions on the continent were also examined. Finally, we reviewed the clinical characteristics of insanity acquittees and effectiveness of rehabilitation regimes across particular jurisdictions.

With regards to the law, it is clear that much of what passes as an insanity legislation in African jurisdictions are colonial inheritances which have seen very little reform. The evidence of this is seen, for example, in often pejorative and vague terminologies such as “idiocy”, “imbecility” or “disease of the mind” within insanity legistlations in various jurisdictions. These terminologies inherited from the McNaughton Rules of 1843 have been the subject of intense criticism (Bradley 2009; Law Commission, 2013; Syed 2019). The often vague and varied interpretations these terminologies invoke in the minds of judges and juries could result in unfair verdicts. For example, as shown, the legal definition of insanity or disease of the mind is considered out of step with medical understanding of what consistutes a “disease of the mind” (Fennell, 1992; Law Commission 2013; Syed 2019). It is therefore important to research and interrogate these termininologies, their meanings and appropriateness in the jurisdictions such as Ghana where they continue to be used. This is particularly important given concerns about the stigmatising effect of some of these terminologies.

The lack of qualified forensic mental health practitioners to support the adjudication process must be addressed to ensure justice delivery. While the determination of guilt or otherwise is the sole preserve of the judge/jury, it is important that verdicts are based on the most rigorous assessment and evidence. To achieve this, it is essential to develop culturally appropriate assessment tools informed by contextually relevant research into mental disorders. There is also the need for research into the charactersitics of insanity acquittees to better understand the category of mental disorders that increase the risk for offending, particularly serious violence. As the evidence from the limited research shows, mentally disordered offenders are likely to suffer from schizophrenia and psychosis (Adjorlolo, Chan, & DeLisi, 2019; Ogunwale & Oluwaranti, 2020). The evidence also shows that young males are

disproportionately represented in the mentally disordered offender population (Adjorlolo, Chan, & DeLisi, 2019; Ogunwale & Oluwaranti, 2020). However, this finding confirms what we already know about offenders generally based on evidence from previous research. That is, there is gender disproportionality in offending population generally with young males more likely to offend whether it is violent (Boakye, 2020; Lauritsen, Heimer, Lynch, 2009) or non-violent offending (Boakye, 2013; Loeber et al. 1998). Further research is needed that investage multilevel factors to identify unique characteristics that distinguish mentally disordered offenders from other offenders in the normal population. To achieve this longitudinal studies in different African countries are required that will allow us to estimate the prevlance of mental disorders and to establish factors that explain offending among the mentally disordered population. There is a clear urgent need to address the lack of forensic psychiatric hospitals across Africa. Also, there remains the question of the effect of institutionalisation and the opportunities for diversions that may exist in the African context, including community-based intervention programmes, especially for low-level and non-violent mentally disordered offenders.

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