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Nigeria's Criminal Justice System: Legal Gaps, Human Rights Concerns and Comparative Lessons for Reform

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Abstract

Nigeria's criminal justice system lacks adequate mental health provisions, leading to human rights violations and worsening psychiatric conditions among offenders. This study examines Nigeria's compliance with international standards, particularly the Mandela Rules, using a descriptive research design. Based on the 2018 prison Audit Report, it examines mental health services, jail regulations, and legal protections. Structured oversight with respect to South Africa, the United States, and Canada has been highlighted through a comparative analysis. South Africa guarantees judicial oversight, whereas Canada's NCRMD structure ensures rehabilitation. States in the US differ in how they balance treatment and incarceration. Nigeria, in contrast to South Africa and Canada, lacks formal evaluations and reintegration programs and instead depends on administrative discretion. This paper argues for a human rights-based strategy, including legislative safeguards, frequent psychiatric examinations, and rehabilitation programs. The protection of mentally ill offenders, public safety, and justice can all be enhanced by putting these ideas into practice. Nigeria's mental health legislation will advance if it conforms to international best practices.

Keywords: Burden of proof, Insanity defense, Mental health, The Nigerian Correctional Service Act, 2022, Prison condition

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1. Introduction

The case of R v. M'Naghten (1843) remains one of the most significant in the development of criminal law, particularly in how courts assess the criminal responsibility of mentally ill defendants. Prior to this case, the legal system lacked a consistent standard for determining insanity. Decisions were often based on arbitrary reasoning, and public understanding of mental illness was rudimentary at best. Daniel M'Naghten, a Glasgow based woodturner, suffered from acute paranoid delusions. He believed that the British government, specifically members of the Tory Party were engaged in a conspiracy to persecute and harm him. Acting on this delusional belief, he attempted to assassinate Prime Minister Sir Robert Peel. In a tragic error, he instead shot Edward Drummond, Peel's private secretary, who later died from his injuries. At trial, medical experts testified that M'Naghten was suffering from a severe mental disorder and was incapable of understanding the nature or wrongfulness of his actions. The jury consequently returned a verdict of not guilty by reason of insanity, which, though legally sound, provoked an intense public backlash.

In response to the widespread uproar, the House of Lords consulted senior judges for clarification on the law. The result was the formulation of the M'Naghten Rules, which remain the cornerstone of the insanity defence in common law jurisdictions. These rules established that a defendant may be deemed legally insane if, at the time of the offence, they were suffering from a defect of reason caused by a disease of the mind, such that they either did not understand the nature and quality of their act or did not know that what they were doing was wrong.

The public reaction was shaped by several factors. Firstly, the high-profile nature of the case deeply unsettled the populace. The attempted assassination of a Prime Minister and the death of a senior public servant exposed a perceived vulnerability at the highest levels of government. Secondly, there was a growing concern that this precedent could open the door for future defendants to falsely claim insanity as a means to escape justice, eroding public confidence in the fairness and integrity of the legal system. Lastly, the general public held a limited and often fearful understanding of mental illness. Many equated the verdict with complete exoneration and

freedom, unaware that M'Naghten would in fact be confined indefinitely in a mental institution.

Winick challenges the frequently robotic nature of civil commitment hearings, highlighting how they can result in severe deprivations of liberty without adequate due process,[1] while Perlin criticizes the indefinite detention of people with mental disabilities, claiming that it violates their human rights and due process. When these sessions are only formalities, he contends, they do not provide people a real chance to be heard, which can worsen sentiments of helplessness and mistrust toward the legal system.[2]

According to Bruce Winick, civil commitment without due process can result in serious deprivations of liberty if procedural protections are not followed. The therapeutic capacity of the judicial system is further compromised by this lack of meaningful interaction, which also negatively impacts the person's mental health. He supports changes that would guarantee civil commitment hearings respect people's rights and dignity, bringing legal procedures into line with therapeutic goals.[3] La'Fond also highlights the need for clearer and enforceable rules to address these concerns.[4]The common law has been replaced in many jurisdictions by statutes that allow for the defendant's civil commitment as mental patients, with provisions for periodic review, assessment, and release.[5] The rationale behind these reliefs is that they actually exempt from liability a certain group of people who, by definition, could not be deterred by the threat of punishment because they

[1]Bruce J. Winick, The Civil Commitment Hearing: Applying the Law Therapeutically, in The Evolution of Mental Health Law 291 (L. E. Frost & R. J. Bonnie eds., Am. Psychol. Ass'n 2001).

[2]Michael L. Perlin, Mental Disability and the Death Penalty: The Shame of the States (Lanham, MD: Rowman & Littlefield 2013); Joseph M. Livermore et al., On the Justifications for the Insanity Defense, 69 Cal. L. Rev. 624, 624 (1981).

[3]Bruce J. Winick, Therapeutic Jurisprudence and the Civil Commitment Hearing, 10 J. Contemp. Legal Issues 37, 37 (1999).

[4]John O. LaFond, Law and Mental Health Professionals: Friction at the Interface, 1 J. Forensic Psychol. Prac. 1, 1 (1998).

[5]See Lawrence O. Gostin, Compulsory Civil Commitment and the Law: Balancing Public Safety and Individual Rights, 35 Harv. C.R.-C.L. L. Rev. 1 (2000).

lacked the capacity to make their own decisions, and for whom punishing them may therefore be pointless and unfair.[6]

This paper makes the case that defendants with mental illnesses are more likely to require specialist mental health care since they often belong to marginalized and disadvantaged groups and have already had significant psychological distress. However, despite the fact that most mental illnesses do not lead to criminal activity, there is an overemphasis on criminogenic aspects of mental illness, which is detrimental to the population's basic but unique mental health treatment needs. [7] According to this analysis, some nations, particularly those in sub-Saharan Africa, mostly rely on correctional care settings, while others prioritize specialized forensic medical care for mentally ill offenders. Penitentiary treatment facilities frequently lack the necessary resources to offer mentally ill inmates' proper medical attention. Instead, than emphasizing treatment and support, these establishments usually concentrate on punishment and rehabilitation. In addition to ignoring the defendant's medical needs, this strategy upholds the idea that they are being punished for their disease.

2. Insanity Defense in Nigerian Law

Nigerian criminal law incorporates the M'Naghten rules with specific modifications.[8] Under the Criminal Code Act,[9] Sections 27 and 28 explicitly define the presumption of legal insanity and its implication.

Presumption of Sanity - Section 27: Every person is presumed to be of sound mind, and to have been of sound mind at any time which comes in question, until the contrary is proved. This statutory provision establishes a fundamental legal presumption that all individuals are deemed mentally competent and criminally

[6]See generaly: Lawrence O. Gostin, Compulsory Civil Commitment and the Law: Balancing Public Safety and Individual Rights, 35 Harv. C.R.-C.L. L. Rev. 1 (2000).
[7]S.M. Rice *et al*., Unmet Mental Health and Criminogenic Needs Among Justice-Involved Young People: A Role for Clinicians in the Community, 27 *Clinical Psychologist* 259 (2023), https://doi.org/10.1080/13284207.2023. 2210280.
[8]Cyril O. Oba & Epiphany Idornigie, The Defence of Insanity in Nigeria and Mental Infirmity in the USA: A Comparative Study, in *A Colossus in the Legal Firmament* 47 (Austine Okoh et al. eds., Constellation Publishers 2008).
[9]Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria 2004, §§ 27–28.

responsible unless proven otherwise. Consequently, the burden of proving insanity rests squarely on the accused.

Legal Definition of Insanity – Section 28: 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 in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.

This provision unequivocally establishes that an accused is exonerated from criminal liability if, at the time of the offense, they suffered from a mental disease or natural mental infirmity to the extent that they lacked the capacity to understand their actions, control their conduct, or appreciate the wrongfulness of their behavior.

2.1 Elements of the Insanity Defense

2.1.1 Cognitive Impairment

Inability to Distinguish Right from Wrong: In order to successfully plead insanity, the accused must prove that they were completely incapable of understanding the nature and wrongfulness of their actions. *Guobadia v. State* reaffirmed this principle, ruling that a mental disorder diagnosis alone is not sufficient proof of insanity under the law; the accused must prove that their mental illness totally destroyed their ability to distinguish between acceptable and unacceptable behavior.[10]

2.1.2 Volitional Impairment

Inability to Control one's Actions: The understanding that some mental illnesses affect a person's capacity to regulate their behavior even when they are aware that it is unlawful is a substantial advancement in Nigerian jurisprudence. Capacity to control his action is specifically listed in Section 28 as a decisive factor in insanity defenses. This idea is supported by contemporary psychiatry, which admits that some people have uncontrollable

[10]Guobadia v. State, (2004) All N.L.R. 289 (Nigeria).

urges that drive them to commit crimes. Courts have upheld this idea in instances like those in which the defendant was judged legally ill despite being charged with murder. According to a medical expert's testimony, the accused's mental stability was compromised by a previous traumatic brain injury, which made it impossible for him to regulate his behavior.[11]

2.1.3 Delusions and Criminal Responsibility

In accordance with paragraph 2 of Section 28 of the Criminal Code, it is crucial to understand that a person suffering from delusions is nevertheless criminally responsible, even if their judgment is based on the reality that their delusions have created. The case *Iwuanyanwu v. The State* served as an example of this idea[12], where the appellant harbored a delusion that the victim intended to deploy malevolent spirits to lethally harm him during nocturnal hours. Consequently, he ambushed and fatally attacked the victim, leading to his conviction for murder. This adjudication is defensible under the aforementioned statutory provision, as even accepting the appellant's delusional belief as veridical that the victim possessed the capability to summon lethal spirits the preemptive act of homicide was neither a rational nor legally justifiable response.

The law that an individual suffering from delusions remains criminally responsible if, assuming their delusion was reality, their actions would still constitute an offense. In *R v. Omoni*,[13] the accused killed his victim under the belief that the victim was a witch intending to harm him. The court held that delusion alone does not excuse criminal responsibility unless it deprives the accused of knowing the act was wrong. Since murder remains unlawful regardless of motive, the accused was held liable. These precedents reinforces that delusional beliefs do not justify criminal acts unless they completely undermine the accused's capacity to distinguish right from wrong.

[11]Timothy A. Aguda & Isabella E. Okagbue. *Principles of Criminal Liability in Nigerian Law* (2d ed. 1991).
[12]Iwuanyanwu v. The State, (1964) 1 All N.L.R. 413 (Nigeria).
[13]R. v. Omoni, (1949) 12 W.A.C.A. 511 (Nigeria).

In the case of *R. v. Aliceeriyamremu*[14], the defendant was accused of killing her albino granddaughter, attributing her actions to the influence of her fellow practitioners in witchcraft. Justice Morgan determined that, even if she suffered from a mental disorder at the time of the act, it was likely self-induced through her intentional involvement in juju worship and witchcraft. Consequently, the insanity defense was deemed inapplicable. However, as *Okonkwo &Naish*[15] have noted, the court's introduction of the self-inducement principle whose precise boundaries are inherently challenging to define warrants careful consideration.

2.1.4 Burden of Proof in Insanity Defense

Nigerian law imposes a strict evidentiary standard for proving insanity, ensuring that only individuals genuinely incapable of understanding or controlling their actions evade criminal liability. Unlike standard criminal defenses, where the prosecution bears the burden of proof, an accused relying on insanity must establish it affirmatively. Section 139(1) of the Evidence Act 2011 stipulate that the burden of proving any fact essential to the establishment of an insanity defense rests upon the accused, who must prove it on the balance of probabilities[16]. This requires concrete evidence, including medical records, psychiatric evaluations, and expert testimony. Courts do not presume insanity, nor do they accept self-serving claims without compelling proof *DPP v. Beard, 1920*[17].

This evidentiary threshold, that a mental disorder diagnosis alone is not a legitimate defense unless the accused was totally devoid of cognitive or volitional ability at the time of the offense, was upheld by the Supreme Court in *Guobadia v. State*.[18] It is obvious from the above analysis that while Nigerian law firmly recognizes insanity as a defense, it does so with strict legal and factual criteria to avoid abuse. Insanity must be proven by the accused on the balance of probability, which calls for professional medical testimony. The insanity defense is rarely used and has a low success rate in Nigeria, according to empirical evidence. Only 26.5% (n = 9)

[14]R. v. Aliceeriyamremu, (1959) WRNLR 270 (Nigeria).
[15]Okonkwo & Naish, Criminal Law in Nigeria 279 (1980).
[16]Evidence Act (2011), Cap. E14, Laws of the Federation of Nigeria (LFN).
[17]DPP v. Beard, [1920] A.C. 479 (U.K.).
[18]Guobadia v. State, supra note 10.

of the 34 cases in which the insanity plea was presented were successful, according to a research that examined published appellate cases from 1948 to 2018. The majority of defendants in these cases were men.[19] The judiciary frequently disregards expert psychiatric opinions in favor of non-expert accounts of defendants' behavior and family history of mental illness, which has been blamed for this low success rate. Claims of insanity based only on the accused's testimony should be considered suspect and not taken seriously, according to rulings from Nigerian courts.[20]

2.2 Disposition of Insanity Acquittees in Nigeria

The judicial and administrative actions conducted following a person's conviction in a criminal case for not guilty by reason of insanity (NGRI) are referred to as the disposition of an insanity acquittee. The person is usually placed under psychiatric care, supervised therapy, or other suitable measures to protect public safety and their rehabilitation rather than being condemned to prison. Sections 28, 229, and 230 of the Criminal Code Act serve as the main legal framework in Nigeria that governs the treatment of people who have been found not guilty of a crime due to insanity.

These sections exempt those who were found to be insane at the time of the offense from criminal responsibility and punishment.[21] According to Section 229 of the Criminal Procedure Act, these people are acquitted. Until the Governor or President gives a directive, which may include placing them in a jail, asylum, or other suitable institution, people in this category must be kept in secure custody in accordance with Section 230 of the same Act. It appears that the treatment and potential reintegration of the individual, rather than merely incarceration, is the main goal of this legislative provision. But there are a number of important issues with this framework:[22]

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[19]Adegboyega Ogunwale & Oluwaseun Oluwaranti, Pattern of Utilization of the Insanity Plea in Nigeria: An Empirical Analysis of Reported Cases, 1 Forensic Sci. Int'l: Mind & L. 100010 (2020).

[20]Saidi Oseni v. The State, (2017) LCN/10139(CA) (Nigeria).

[21]Augustine U. Amadasun & Anthony Etuvoata, A Critical Appraisal of the Criminal Responsibility of the Insane Person Under the Nigeria Legal Jurisprudence, 10(3) J. Com. & Prop. L. 1 (2023).

[22]Criminal Procedure Act, Cap. C41, Laws of the Federation of Nigeria (LFN) 2004.

2.2.1 Indefinite Detention

The absence of a statutory provision mandating the release of a detainee once they no longer pose a threat to society or themselves grants the President or Governor discretionary power to detain the individual for an unspecified duration. This could lead to the prolonged detention of a person whose sole offense is mental illness. Non-Binding Medical Recommendations**:** Although Section 233 of the Criminal Procedure Act permits a medical professional to recommend the release of a mentally ill detainee deemed to have recovered, such recommendations are not binding on the President or Governor. Consequently, an individual may remain confined despite medical advice advocating for their release.

2.2.2 Lack of Legal Recourse

There is no explicit legal provision enabling the detainee to petition the court for release. This absence of a clear legal pathway may result in individuals being confined indefinitely without a formal mechanism to challenge their continued detention. This framework of indefinite detention without a clear, enforceable mechanism for release upon recovery challenges fundamental human rights principles. Reforms are necessary to establish definitive guidelines that protect both societal interests and the rights of individuals acquitted due to insanity.

2.3 Comparing Insanity Disposition in Other Jurisdictions

The disposition of insanity acquittees in Nigeria presents significant challenges, particularly in the areas of indefinite detention, non-binding medical recommendations, and the absence of legal recourse. The current legal framework, which vests absolute discretion in the executive authority without mandating release upon recovery, raises profound concerns about due process, human rights, and proportionality in the administration of justice. In contrast, several other jurisdictions have adopted more structured approaches to the management of individuals acquitted on the grounds of insanity.

Countries such as South Africa, the United States, the United Kingdom, and Canada have established judicial oversight, periodic mental health reviews, and enforceable procedures for release,

ensuring a more balanced framework that upholds both public safety and the fundamental rights of the detainee. Compering these jurisdictions will highlight alternative legal models, statutory safeguards, and judicial precedents that could inform potential reforms in Nigeria, particularly in ensuring periodic judicial review, limiting executive discretion, and providing detainees with access to legal remedies, the paper can identify best practices that may enhance the Nigerian legal framework. This comparative assessment will examine key statutory provisions, judicial decisions, and institutional mechanisms in South Africa and other selected countries, drawing insights into how Nigeria could restructure its insanity disposition laws to achieve a fairer and more legally sound approach.

2.3.1 Disposition of Insanity in South Africa

When an accused individual is judged unable to stand trial because of a mental illness or intellectual handicap, the alternatives accessible to judges are described in Section 77 of the Criminal Procedure Act in South Africa.[23] At first, these choices led to the accused being held in a prison or mental health facility without taking into account their unique situation or capacity for improvement. However, in order to update Section 77 and make sure it conforms with the Constitution, the Criminal Procedure Amendment Act 4 of 2017 was passed after the Constitutional Court ruled in *De Vos NO v. Minister of Justice and Constitutional Development* that some of its provisions were unconstitutional.[24]

The provisions of Section 77 and 78 of the Criminal Procedure Amendment Act No 4 of provides a framework for dealing with accused persons who may not be mentally competent to stand trial. Section 77 of the Act outlines the inquiry into the mental capacity of the accused, which may involve expert evidence from one or more appointed experts. The court must determine whether the accused is mentally competent to stand trial after considering the evidence. If the accused is found not to be mentally competent, the court may postpone the trial to allow for treatment or improvement, refer the

[23]Criminal Procedure Amendment Act 4 of 2017 (S. Afr.).

[24]De Vos N.O. and Others v. Minister of Justice and Constitutional Development and Others, [2015] ZACC 21; 2015 (2) SACR 217 (CC); 2015 (9) BCLR 1026 (CC) (S. Afr.).

accused to a mental health institution for observation, treatment, or care, or order a report on the accused's mental capacity. The court must review the accused's mental capacity at intervals not exceeding 12 months, and if deemed mentally competent, discharge the accused from the mental health institution and proceed with the trial.

The revision would give judges the authority to order more than only detention, according to the changes. In other words, if they receive outpatient therapy, those who don't need inpatient care can be discharged. A judge may order an accused individual to be held in the prison's medical unit for a period of time if they are a public risk, or they may order their release until a bed becomes available at a facility. The most significant change was that, unless it was temporary, the court officer could no longer order someone who was deemed to be mentally ill or intellectually challenged to be imprisoned.[25]

A complicated and sensitive process that needs careful thought and attention to correct procedures in order to ensure the safety and well-being of the person as well as the community is further provided by Section 78(6)(a)(cc) of the Mental Health Care Act.[26] The process begins with the assessment and diagnosis of the individual by qualified mental health professionals. The initial step is crucial in determining the appropriate level of care and support needed by the individual upon release. Once the individual has been assessed, a treatment plan is developed, outlining the necessary intervention and support services required for their successful reintegration into the society. While this is an essential step in their release process, there is often a lack of coordination and communication between different health care providers and social services, resulting in gaps in the delivery of care and support for the individual.

A crucial element of the South African release process that requires improvement is the participation of family members and

[25]Letitia Pienaar, The Unfit Accused in the South African Criminal Justice System: From Automatic Detention to Unconditional Release, 31 S. Afr. J. Crim. Just. (2018), https://hdl.handle.net/10520/EJC-107c02cb8c.

[26]Mental Health Care Act 17 of 2002 (S. Afr.).

caregivers in the process of rehabilitation and reintegration.[27] In order for mentally ill people to heal, family support is essential, but there aren't enough tools and programs available to inform and equip families to care for their loved ones when they are released from treatment. In addition, the existing process for releasing mentally ill people in South Africa does not include sufficient monitoring and follow-up mechanisms to guarantee the stability and continued well-being of those released. The present comprehensive and integrated approach to mental health care in South Africa is necessary since this lack of continuity of care frequently leads to readmissions and relapses.[28]

In Nigeria, individuals with mental illness frequently face neglect and a lack of proper care, depending solely on the decisions of the President or Governor. By improving its assessment, treatment, support, and monitoring systems, South Africa could serve as a model for effectively addressing these challenges.

2.3.2 Disposition in the United States

In the United States, the way in which insane defendants are treated upon acquittal has historically been uneven, with notable differences across states. Earlier than *Jones v. United States,*[29] Concerns about public safety were raised by the fact that those declared not guilty by reason of insanity (NGRI) were frequently freed without proper care or oversight.[30] NGRI defendants might be immediately committed to a mental hospital without a separate hearing, according to the U.S. Supreme Court's Jones decision. Although the Jones ruling first made it simpler for states to commit offenders declared not guilty by reason of insanity (NGRI) without holding further hearings, it eventually resulted in measures that directly benefitted insane acquittees. Jones underlined that such people could not be detained continuously without a regular evaluation of

[27]Victor Chikadzi, Challenges Facing Ex-Offenders When Reintegrating into Mainstream Society in Gauteng, South Africa, 53 Soc. Work/Maatskaplike Werk 288 (2017).
[28]Katherine Sorsdahl et al., A Reflection of the Current Status of the Mental Healthcare System in South Africa, 4 SSM - Mental Health 100247 (2023)
[29]The case Jones v. United States, 462 U.S. 354 (1983),
[30]Christopher Slobogin, The American Bar Association's Criminal Justice Mental Health Standards: Revisions for the Twenty-First Century, 44 Hastings Const. L.Q. 1 (2017).

their mental health, even if it maintained automatic commitment.[31] This contributed to strengthened due process safeguards, forcing several states to develop clearer processes for periodical assessments and release hearings. A forensic mental health program that emphasizes rehabilitation rather than incarceration has grown as a result of the ruling, which also reaffirmed the notion that insanity acquittees ought to be treated as patients rather than as prisoners.[32]

Jones also impacted court cases that reinforced safeguards against indefinite commitment, pushing lawmakers and judges to improve the standards for prolonged detention and guarantee equitable release practices. In response, several states introduced laws that raised the standard of proof for ongoing commitment or set more precise restrictions on the amount of time NGRI offenders may be detained. Jones's long-term effects helped bring about legislative and policy changes that enhanced the rights and treatment of insanity acquittees, even though it initially supported the state's extensive authority to hold them in custody.[33]

There are still notable differences across U.S. states in spite of these advancements. While some states require court review on a regular basis to avoid incarceration indefinitely and guarantee release upon recovery,[34] for others, release necessitates jury trials or judicial permission. There are discrepancies between jurisdictions since hospital managers in some have the authority to discharge patients while others say nothing about it.[35] This contrasts with Nigeria, where the executive solely determines the release of mentally ill individuals, with no judicial oversight or legal recourse to challenge prolonged detention. These disparities highlight the fragmented nature of the U.S. approach to insanity acquittees, where

[31]Megan Testa & Sara G. West, Civil Commitment in the United States, 7 Psychiatry 30 (2010).

[32]Suresh Bada Math, Channaveerachari Naveen Kumar & Sydney Moirangthem, Insanity Defense: Past, Present, and Future, 37 Indian J. Psychol. Med. 381 (2015).

[33]John B. Scherling, Automatic and Indefinite Commitment of Insanity Acquittees: A Procedural Straitjacket, 37 Vand. L. Rev. 1233 (1984), available at https://scholarship.law.vanderbilt.edu/vlr/vol37/iss5/6/.

[34]Jacqueline Landess, Ashley VanDercar & Brian Holoyda, Psychiatric Hospitalization and Civil Commitment, in Laws of Medicine 433 (Amir S. Pasha ed., Springer 2022), https://doi.org/10.1007/978-3-031-08162-0_28.

[35]Robert Greenwald, Disposition of the Insane Defendant after Acquittal—The Long Road from Commitment to Release, 59 J. Crim. L. & Criminology 1 (1969)

legal protections and treatment options vary widely based on jurisdiction. In states with more progressive policies, mental health courts and diversion programs provide structured pathways for rehabilitation, allowing individuals to receive supervised treatment rather than prolonged institutionalization. Some states have implemented conditional release programs, where NGRI defendant's transition back into society under strict supervision, periodic psychiatric evaluations, and mandatory compliance with treatment plans.

These mechanisms aim to balance public safety with the rights and well-being of mentally ill offenders. Conversely, other states take a more punitive approach, favoring long-term institutionalization over rehabilitation. In these jurisdictions, insanity acquittees may remain confined in psychiatric facilities for periods exceeding the maximum sentence they would have served if convicted. This raises concerns about due process violations and the indefinite deprivation of liberty, particularly in cases where individuals no longer pose a threat. Critics argue that the lack of uniform federal guidelines allows for systemic inequities, where access to treatment and the likelihood of release depend more on geography than medical necessity or legal principles.

Unlike South Africa and Canada, where periodic mental health assessments and structured legal safeguards prevent indefinite detention, the U.S. remains a patchwork of policies. Some states have taken progressive steps toward integrating treatment and legal oversight, while others maintain rigid institutionalization policies. This divergence underscores the need for a more cohesive, rights-based approach to mental health and criminal justice, ensuring that insanity acquittees receive fair treatment, appropriate care, and opportunities for reintegration. In contrast, Nigeria's reliance on executive discretion without judicial review leaves mentally ill individuals vulnerable to prolonged confinement without recourse, highlighting the urgent need for comprehensive legal reforms.

2.3.3 Disposition of Insanity Acquittees in Canada

In order to balance psychiatric rehabilitation, human rights, and public safety, Canada's legal system regulates the treatment of those declared Not Criminally Responsible on Account of Mental Disorder

(NCRMD). In contrast to Nigeria, where the President or Governor has unbridled authority over the release of insanity acquittees, Canada's strategy is based on court supervision, regular psychiatric assessments, and a methodical risk-based review procedure.[36]

Section 672 of the Canadian Criminal Code, subsections 34 to 89, include the main statutory rules governing the treatment of insanity acquittees in Canada.37 Section 16 establishes the NCRMD defense, stating that an individual is not criminally responsible if, due to a mental disorder, they were incapable of appreciating the nature and quality of the act or of knowing that it was wrong. Upon a finding of NCRMD, the individual is not convicted or acquitted but is subjected to a specialized Review Board process, which determines their placement based on risk assessment.38 Under Section 672(54) of the Criminal Code, three potential dispositions are available: absolute discharge (if the individual is no longer a significant risk to public safety), conditional discharge (supervised reintegration into society with strict conditions), or detention in a psychiatric hospital (if the individual poses an ongoing risk).39 This model stands in contrast to the Nigerian legal framework, where no statutory mechanism guarantees periodic review or the automatic release of an individual deemed to have recovered.

In Canada, Review Boards, composed of judges, psychiatrists, and legal experts, play a pivotal role in ensuring that detention is not indefinite or arbitrary. [40] The introduction of these procedural safeguards followed key judicial decisions, such as *R. v. Swain*'[41] where the Supreme Court of Canada ruled that automatic detention of insanity acquittees violated constitutional rights under Sections 7 and 9 of the Canadian Charter of Rights and Freedoms. This led to

[36]David MacAlister, Use of Risk Assessments by Canadian Judges in the Determination of Dangerous and Long-Term Offender Status, 1997–2002, in Law and Risk 20 (Thomas O. Hueglin & Bruce W. Hodgins eds., UBC Press 2003), https://doi.org/10.59962/9780774851510-003

[37]Criminal Code, R.S.C. 1985, c. C-46, §§ 672.34–672.89 (Can.).

[38]The Relevance of Fatal Alcohol Spectrum Disorder and the Criminal Law from Investigation to Sentencing, 41 U. Brit. Colum. L. Rev. 1 (2010).

[39]Tonia L. Nicholls, Johann Brink, Caroline Greaves, Patrick Lussier & Simon Verdun-Jones, Forensic Psychiatric Inpatients and Aggression: An Exploration of Incidence, Prevalence, Severity, and Interventions by Gender, 32 Int'l J.L. & Psychiatry 23 (2009)

[40]Winko v. British Columbia (Forensic Psychiatric Inst.), [1999] 2 S.C.R. 625 (Can.).

[41]R. v. Swain, [1991] 1 S.C.R. 933 (Can.).

reforms mandating regular review of NCRMD cases and shifting the burden of proof to the government, as reaffirmed in *Winko v. British Columbia*,[42]where the court held that an NCRMD individual must be released unless it is proven that they pose a significant risk to public safety. Similarly, in *R. v. Owen*,[43] the Supreme Court emphasized that the government must justify continued detention with clear psychiatric evidence.[44] Unlike the Nigerian model, where a medical recommendation for release is not binding on the authorities, Canadian law mandates that risk assessments be conducted periodically, ensuring that individuals are not detained beyond what is necessary for public safety.[45]

Despite the strengths of Canada's system, criticisms persist regarding potential over-detention and inconsistencies in risk assessments. While the Review Board system is designed to ensure fairness, some individuals spend more time in psychiatric detention than they would have if convicted and sentenced in the criminal justice system. [46] This concern is amplified by subjective risk assessments, as determining when an individual is no longer a risk to society remains a complex and often contentious issue. The case of *R. v. Conway* further highlighted concerns over the prolonged detention of NCRMD individuals, as the Supreme Court ruled that Review Boards must apply a therapeutic, rather than punitive, approach when determining continued detention.[47]

Despite these concerns, Canada's system remains far more structured and rights-protective than Nigeria's, where detainees may remain confined indefinitely due to executive discretion rather than a transparent legal process. The absence of clear legal recourse

[42] See generally: Kent Roach, Exceptional Procedures to Correct Miscarriages of Justice in Common Law Systems (July 21, 2017), https://ssrn.com/abstract=3006704

[43]R. v. Owen, [2003] 1 S.C.R. 779 (Can.).

[44]Id. See generally: Anne G. Crocker, Tonia L. Nicholls, Gilles Côté, Eric A. Latimer & Michael C. Seto, Not Criminally Responsible Due to Mental Disorder: Do We Offer the Same Protection and Comparable Access to Mental Health Services Across Canada? 29 Can. J. Cmty. Mental Health 2 (2010).

[45]Stanley N. Verdun-Jones, Forensic Psychiatry and the Ethics of Care, 11 J. Forensic Psychiatry 241 (2000).

[46]Elaine Gunnison & J. Brett Helfgott, Process, Power, and Impact of the Institutional Review Board in Criminology and Criminal Justice Research, 16 J. Empirical Res. Hum. Res. Ethics 263 (2021), https://doi.org/10.1177/15 56264621992240.

[47]R. v. Conway, [2010] 1 S.C.R. 765 (Can.).

in Nigeria means that even individuals deemed mentally stable may continue to be detained, as there is no binding requirement for their release, unlike in Canada, where detainees can challenge their continued confinement before a Review Board or court. [48] Additionally, while Canada integrates mental health treatment and community reintegration programs, Nigeria lacks a structured mechanism to transition insanity acquittees back into society.[49]This gap underscores the need for reform in Nigeria's legal framework, particularly the introduction of judicial oversight, statutory release criteria, and independent psychiatric assessments.

Canada's disposition of insanity acquittees offers a compelling model for balancing public safety and the rights of mentally ill offenders. The legal requirement for periodic risk assessments and judicial oversight ensures that detention remains justifiable and not punitive.[50] Moreover, the structured role of Review Boards prevents indefinite confinement by mandating regular hearings and evidence-based decision-making.[51]While challenges remain, such as subjective psychiatric risk assessments and potential over-detention, the system is designed to protect fundamental human rights while ensuring public security. Nigeria, on the other hand, lacks the essential safeguards present in Canada's framework, leading to arbitrary detention, lack of clear discharge mechanisms, and an absence of enforceable psychiatric recommendations.

To align with best practices, Nigeria must implement statutory periodic reviews, clear legal avenues for release, and a shift away from executive discretion to an independent tribunal-based system. [52] The establishment of specialized forensic psychiatric

[48]See generally Mental Health Act, R.S.B.C. 1996, c. 288, § 25 (Can.), detailing the rights of detained individuals to periodic review of their detention status.

[49]See Illegal Powers of AGF and Govs to Detain, THISDAYLIVE (Sept. 23, 2020), https://www.thisdaylive.com/index.php/2020/09/23/illegal-powers-of-agf-and-govs-to-detain/, discussing the indefinite detention of individuals with mental illness in Nigeria without clear legal recourse.

[50]Heng Liu et al., Trauma Exposure and Mental Health of Prisoners and Ex-Prisoners: A Systematic Review and Meta-Analysis, 89 Clinical Psych. Rev. 102069 (2021), https://doi.org/10.1016/j.cpr.2021.102069.

[51]Bernadette Capili & Jeanette K. Anastasi, Ethical Research and the Institutional Review Board: An Introduction, 124 *Am. J. Nursing* 50 (2024), https://doi.org/10.1097/01.NAJ.0001008420.28033.e8.

[52]Kent & Bailey, fn. 42.

institutions, similar to Canada's psychiatric hospitals for NCRMD detainees, would ensure that mentally ill offenders receive appropriate treatment rather than punitive incarceration**.** The cases of *Winko* v. *British Columbia*[53] *R. v. Swain*,[54] and *R. v. Owen*[55] demonstrate the importance of legal safeguards in preventing abuse and ensuring fair treatment**.** Thus, while Canada's model is not without flaws, its emphasis on due process, periodic review, and expert decision-making presents a significantly more humane and structured approach than Nigeria's current system**.**

3. Bridging Mental Health, Human Rights and Condition Of Prisons In Nigeria

In developing nations like Nigeria, where prisons frequently house inmates with untreated mental health disorders, resulting in human rights violations and difficulties in criminal rehabilitation, the intersection of mental health, human rights, and the criminal justice system is a critical area of concern. This paper examines the current state of mental health services in Nigerian prisons using data from the National Human Rights Commission and scholarly literature from the International Journal of Mental Health Systems.

3.1 Mental Health Issues

According to a study by Iheanacho et al., which examined 179 inmates in two urban prisons over a four-year period, 49.3% of them had a diagnosis of schizophrenia, 29.6% had a mood disorder, and roughly 46.5% had a history of psychoactive substance use. These statistics probably understate the actual prevalence because of systemic difficulties in the prison system with regard to mental health assessment and reporting.[56]

A crucial problem in Nigeria's prison system was revealed in a 2018 study by the Human Rights Commission of Nigeria: the poor care given to prisoners suffering from mental diseases.[57] 182

[53]Winko v. British *Columbia* (Forensic Psychiatric Inst.), [1999] 2 S.C.R. 625 (Can.).
[54]R. v. Swain, [1991] 1 S.C.R. 933 (Can.)..
[55]R. v. Owen**,** [2003] 1 S.C.R. 779 (Can.).
[56]Tobechukwu Iheanacho *et al*., Mental Health Screening in Nigerian Prisons: A Four-Year Review, 26(1*) J. Correctional Health Care* 27 (2020).
[57]Nat'l Hum. Rts. Comm'n (Nigeria), Prison Audit 2018, at 26 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf.

mentally ill inmates from different jails were recorded by the audit, which is fewer than the 672 cases recorded in 2012.[58] Even with this decrease, there is still a serious problem with the lack of qualified mental health professionals and specialized treatment centers.[59] Regional disparities reveal uneven access to mental health services. For instance, there were 22 mentally ill prisoners in the North-Western Zone, whereas there were 56 in the North-Eastern Zone in 2018 (up from 20 in 2012).[60] Significant declines were noted in the South-South and South-Western Zones, where the number of cases decreased from 79 to 40 and from 21 to 7, respectively.[61] On the other hand, 56 mentally ill inmates were held in the South-Eastern Zone, mainly in the prisons of Owerri and Abakaliki.[62]

These discrepancies highlight the unequal allocation of resources for mental health in various geographical areas.[63]Without medical evaluation or care, many mentally ill prisoners are held for extended periods of time.[64]Some inmates have been behind bars for more than 30 years without access to rehabilitation or mental health treatment.[65]The absence of educational, recreational, and vocational activities within the jail system further restricts rehabilitation prospects.[66] Furthermore, mentally ill inmates are at risk of worsening health conditions and frequently dying young due to the lack of formal psychiatric care.[67] Poor infrastructure and insufficient healthcare services make the problem worse.[68] Due to severe deterioration, many prison buildings that date back to the colonial era now have cruel living conditions.[69] Few jails have medical clinics

[58]*Id.* at 27.
[59]*Id.* at 28.
[60]National Human Rights Commission (Nigeria), Prison Audit 2018, at 29 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[61]*Id.*
[62]National Human Rights Commission (Nigeria), Prison Audit 2018, at 29 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[63]*Id.* at 30.
[64]supra note 62
[65]National Human Rights Commission (Nigeria), Prison Audit 2018, at 31 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[66]*Id.*
[67]supra note 65
[68]supra note 65 at 32.
[69]National Human Rights Commission (Nigeria), Prison Audit 2018, at 32 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf

with physicians, nurses, and pharmacists on duty, and some use dispensary assistants who lack the necessary skills to provide mental health services.[70] In severe situations, some prisons like Lafia Prison in Nasarawa State, have no medical staff at all, while others like Minna Prison have a small number of medical staff members but no psychiatric specialists.[71] Because of this severe lack of healthcare services, mentally ill prisoners are unable to receive necessary diagnosis or treatment, which exacerbates their suffering.[72]

The situation of prisoners, especially those with mental health disorders, is made worse by problems with infrastructure and sanitation.[73] Numerous prisons have unstable electricity, poor sanitation, and insufficient water supplies, all of which have a negative influence on inmate hygiene and general health.[74] Water shortages are caused by regular maintenance failures, even though some facilities rely on municipal water supplies or boreholes.[75] For example, Jos Maximum Security Prison uses a well to augment its borehole supply, whereas Bauchi Prison relies on a reservoir constructed by the Central Bank of Nigeria.[76] Nevertheless, there are still irregularities in the availability of clean water.[77] The state of sanitation is also worrisome, with crumbling restrooms and broken water systems providing serious health hazards to prisoners.[78]

These filthy circumstances are best illustrated by prisons like Koton Karfe Prison, Benue State Prison, and Makurdi Minimum Prison.[79] Furthermore, unstable energy further impairs vital jail activities.[80] For example, in Koton Karfe Medium Jail and Minna Old Prison, the lack of operational backup generators makes it difficult

[70]*Id.* at 33.
[71]supra note 69
[72]National Human Rights Commission (Nigeria), Prison Audit 2018, at 34 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[73]*Id.*
[74]supra note 72 at 35
[75]National Human Rights Commission (Nigeria), Prison Audit 2018, at 35 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[76]*Id.*
[77]supra note 73
[78]National Human Rights Commission (Nigeria), Prison Audit 2018, https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf
[79]*Id.* at 36.
[80]supra note 78

to provide medical services and conduct security.[81] These problems are made worse by the fact that many prisons, some of which date back to the early 19th century, are in poor condition.[82]The problems experienced by mentally ill inmates are made worse by the extreme congestion in these antiquated facilities, which puts more demand on already few resources. [83] Regarding the clinical impacts of extended incarceration on inmates' mental health, experts are still at odds. [84] While some studies indicate that incarceration can exacerbate mental health owing to environmental pressures, other research indicates that certain psychological diseases may eventually improve.[85]In order to present a thorough picture of the effects of long-term incarceration on prisoners' psychological health, we combine two opposing findings in this report: one from a longitudinal analysis (Section A) and another from a cross-sectional examination (section B)

Section A: Longitudinal Observations of Psychological Adaptation: In contrast to the widely held belief that prolonged incarceration results in a progressive decline in psychological disorders, a longitudinal study conducted by Dettbarn that looked at 87 inmates over an average of 14.6 years compared psychiatric evaluations at the beginning and at the end of the incarceration period. Initially, roughly 25.2% of the inmates had adjustment disorders, but over time, personality assessments revealed a stabilization in traits like depressive attitudes and emotional instability, as well as a decrease in hostility.[86] According to the study, these gains could be the result of an adaptive process known as prisonization, a term coined by Clemmer to describe how prisoners form close relationships with other prisoners and a sense of

[81]National Human Rights Commission (Nigeria), Prison Audit 2018, https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf

[82] *Id.* at 37.

[83]supra note 81

[84]National Human Rights Commission (Nigeria), Prison Audit 2018, at 38 (2018), https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf

[84] National Human Rights Commission (Nigeria), Prison Audit 2018, https://nigeriarights.gov.ng/publications/prison-audit-2018.pdf

[85] *Id*

[86]Elke Dettbarn, Effects of Long-Term Incarceration: A Statistical Comparison of Two Experts' Assessments at the Beginning and the End of Incarceration, 35 *Int'l J.L. & Psychiatry* 236 (2012), https://doi.org/10.1016/j.ijlp.2012.02.014.

community that, in part, protects them from the stress of incarceration.[87] This process is further divided into discrete stages by Wheeler's concept of prisoner adaptation, which implies that some inmates eventually adapt to the restrictions of prison life.[88]The total frequency of mental health illnesses in this group was still significantly greater than in the general population, nevertheless, in spite of these advancements. Notably, while some psychological conditions appeared to diminish over time, this study also reported that many inmates continued to experience significant mental health challenges, highlighting that adaptation does not equate to recovery.

Section B: Cross-Sectional Evidence of Elevated Psychiatric Morbidity: In contrast to the findings of Dettbarns' other studies focusing on psychiatric morbidity within Nigerian prisons report persistently high rates of mental health disorders. Iheanacho *et al* conducted a study in a medium-security prison in Benin City that revealed an alarming prevalence of various psychiatric conditions.[89] About one-third of the 100 prisoners evaluated, according to their statistics, satisfied the requirements for psychological illnesses. In particular, 21% of prisoners were diagnosed with recurring moderate depression, 8% with generalized anxiety disorder, and a lower percentage with serious depression and schizophrenia. Additionally, one convict had symptoms of modest intellectual disability, while six inmates were diagnosed with antisocial personality disorder. Physical health problems were also prevalent; 15% of prisoners reported having previously abused drugs, primarily alcohol and cannabis, and 15% had chronic diseases. One especially alarming discovery was that some of these mental health issues were not pre-existing, but rather emerged during the time in jail. This suggests that the prison environment characterized by stress, overcrowding, and inadequate mental health services may

[87] Clemmer, Donald. *The Prison Community*. 2d ed. New York: Rinehart, 1958.

[88] Stanton Wheeler, Socialization in Correctional Communities, 26 *Am. Socio. Rev.* 697 (1961).

[89]Titus Iheanacho, Michael Obiefune, Chinyere O. Ezeanolue, Gbenga Ogedegbe, Surya K. Panigrahi & Echezona E. Ezeanolue, Mental Health Screening in Nigerian Prisons: A Four-Year Review, 26 *J. Correctional Health Care* 27 (2020). DOI: https://doi.org/10.1177/1078345819895380

play a significant role in triggering or exacerbating mental health problems.

In addition to negatively impacting inmates' mental health, untreated mental health issues in jail also have a major impact on recidivism and criminal activity. According to research, prisoners who have untreated mental health conditions are more likely to commit crimes again after being released from prison because of the combined consequences of poor judgment, poor impulse control, and the long-lasting impacts of untreated mental health symptoms.[90]For instance, Fazel and Hayes have demonstrated that the prevalence of mental disorders among incarcerated individuals is markedly higher than in the general population, and these untreated conditions are closely linked with a greater likelihood of recidivism.[91] Inmates with disorders such as major depression, bipolar disorder, and schizophrenia often struggle to reintegrate into society. Lack of proper mental health care while incarcerated results in symptoms that remain after release, compromising rehabilitation efforts and raising the risk of reoffending. These symptoms can range from emotional dysregulation to cognitive impairments.[92]

Additionally, according to Baillargeon et al., people with a history of psychiatric morbidity are much more likely to engage in criminal activity again.[93]This is due in part to the fact that untreated mental illnesses make it difficult for people to adjust to post-release environments, which makes it harder for them to find work, keep stable housing, and manage relationships with others all of which are essential for a successful reintegration.[94] Furthermore, the jail environment itself which is marked by severe living circumstances, restricted access to therapeutic services, and overcrowding often acts as a fertile ground for additional psychological suffering. These environments' persistent stresses have the potential to exacerbate

[90] Philip Daniel & Xia Wang, Mental Health and Recidivism: The Impact of Untreated Psychiatric Disorders on Former Inmates, 58 *Crime & Delinq*. 765 (2020).

[91]Seena Fazel *et al*., Mental Health of Prisoners: A Review of Prevalence, Adverse Outcomes, and Interventions, 3 *Lancet Psychiatry* 871 (2008

[92]*Id.*

[93]Jacques Baillargeon *et al*. Psychiatric Disorders and Repeat Incarcerations*:* The Impact of Mental Health on Recidivism, 61 *Am. J. Psychiatry* 109 (2009).

[94] Jacques Baillargeon et al., Psychiatric Disorders and Repeat Incarcerations: The Impact of Mental Health on Recidivism, 61 *Am. J. Psychiatry* 109 (2009).

pre-existing disorders or cause new mental health symptoms. Maladaptive coping mechanisms, such as substance misuse and violent conduct, can result from these situations and are important indicators of recidivsm.[95]

The absence of continuity of care is another important aspect. Comprehensive measures to guarantee that prisoners receive the proper mental health care while incarcerated or after their release are lacking in many prisons. Many inmates leave prison with unresolved mental health difficulties and without the support networks needed to manage their illnesses in the community due to this service delivery gap. According to studies, ex-offenders are far more likely to commit crimes if they do not receive continuing mental health assistance.[96]The persistent nature of untreated mental disorders undermines rehabilitation efforts, resulting in a cycle of reoffending that not only affects individual lives but also increases the burden on the criminal justice system. Ignoring mental health needs in prisons has two detrimental effects: it either directly worsens the psychiatric condition of inmates or indirectly contributes to higher rates of recidivism.

Merging the Findings: A number of aspects that require serious consideration come to light when these two sets of findings are combined. First, the contradictory findings suggest that while certain prisoners may, over time, have a decrease in specific psychiatric symptoms, maybe as a consequence of adaptive processes or modifications to diagnostic standards, this does not mean that longer incarceration is harmless. In actuality, the total prevalence of mental illnesses remained significantly higher than that of the non-incarcerated population even in Dettbarn's longitudinal research.[97] This implies that the jail environment may only change the nature of psychological issues rather than fostering rehabilitation, even while certain elements of mental health may stabilize.

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[95] Nat'l Ctr. for Biotechnology Info. *Mental Health and Recidivism: The Role of Substance Abuse and Aggression*, NIH Pub. No. 14-7896 (2014).

[96]Prison Pol'y Initiative: *The Consequences of Inadequate Mental Health Support for Former Inmates*, (2021). DOI: https://www.prisonpolicy.org/reports/pie2025.html.

[97] Elke Dettbarn, supra note 81.

Additionally, Iheanacho *et al* underline that the genesis of new mental problems during detention might be caused by the stressful conditions of prison life, such as isolation, overcrowding, and the lack of proper psychiatric treatment.[98]This is especially troubling because it suggests that rather than just serving as a place to sustain pre-existing disorders, the jail system itself may be a contributing factor to the decrease of mental health. Psychotherapy and educational programs, for instance, are not always available, even though they seem to be associated with better emotional stability and less violence among some prisoners. Many prisoners continue to suffer without receiving effective treatment due to a lack of organized mental health services, which feeds the vicious cycle of declining mental health. The divergent results also draw attention to crucial methodological issues.

Although they are relatively rare and sometimes constrained by brief observation periods or small sample sizes, longitudinal studies like the one conducted by Dettbarn offer insights into the temporal dynamics of mental health in jail. Iheanacho et al's cross-sectional study gives a glimpse of psychiatric morbidity, but it might not show how these illnesses change over time. The differences between these methods highlight the necessity for longer-term, more thorough studies to completely comprehend the therapeutic impacts of prolonged incarceration. The distinct populations that each research looked at provide another tenable reason for the differing results between Analysis A and Analysis B. Analysis "A" concentrated on a group of ordinary inmates who did not have serious mental health problems before being imprisoned. Various prisoners seemed to adjust to the prison environment over the lengthy incarceration term; this process is frequently referred to as prisonization, and it led to a decrease in various psychological problems.[99]

Even if the overall frequency of diseases including adjustment problems and personality abnormalities is still greater than in the

[98]Titus Iheanacho et al, Mental Health Screening in Nigerian Prisons: A Four-Year Review, 26 *J. Correct. Health Care* 27 (2020), https://doi.org/10.1177/1078345819895380.

[99]Liam Martin, "Free but Still Walking the Yard": Prisonization and the Problems of Reentry, 47 *J. Contemp. Ethnography* 671 (2018), https://doi.org/10.1177/0891241617737814.

general population, this adaptation may help explain the observed decline in these conditions over time. Analysis B, on the other hand, focuses on prisoners who were previously diagnosed with serious mental illnesses and are sometimes referred to as insane acquittees. This category usually consists of people who already had mental health issues when they joined the criminal justice system and whose disorders were made worse by the demanding, overcrowded, and underfunded prison environment. In these situations, mental illnesses including depression, anxiety, and psychosis seem to persist or even worsen throughout incarceration due in part to inadequate psychiatric treatment and therapeutic approaches.

Therefore, the baseline mental health state of the corresponding inmate groups may account for the divergent results between the two analyses. Inmates who already suffer from severe psychiatric morbidity (as in Analysis B) are more susceptible to the negative consequences of extended incarceration, whereas those who have no history of significant mental health issues (as in Analysis A) may exhibit some stabilization or even a slight improvement as a result of adaptive mechanisms. This unequal impact emphasizes how crucial it is to provide targeted mental health treatments since it implies that a one-size-fits-all strategy is insufficient and that interventions need to be customized to meet the unique requirements of prisoners according to their mental health prior to imprisonment. Reducing the cycle of crime and recidivism caused by untreated mental health conditions requires such an approach.

In conclusion, the data points to a complicated interaction between maladaptive and adaptive psychological changes linked to extended imprisonment. The overall high rates of psychiatric morbidity show that the prison environment continues to be a substantial risk factor for mental disease, even when certain inmates may show evidence of stability in specific mental health parameters over time. Conditions including depression, anxiety, and personality disorders are likely to develop or worsen as a result of the pressures present in the prison environment and the lack of access to psychiatric care. The results of both researches highlight a crucial point: meeting the mental health requirements of prisoners is a significant issue for the Nigerian prison system, similar to correctional systems in other environments with limited resources.

3.2 Human Rights Issues

There are serious human rights issues with Nigeria's protracted detention of mentally ill defendants. Vulnerable people are kept in detention for long periods of time due to a combination of ineffective legal procedures, inadequate mental health treatments, and inadequate access to justice. In addition to violating basic human rights norms, this circumstance jeopardizes the likelihood of rehabilitation and reintegration into society. As a custodial and rehabilitative institution, the prison system is an essential component of the criminal justice system. It is also a crucial tool for preserving legal supervision, guaranteeing social order, and defending the rule of law. The laws that govern prisons in Nigeria are antiquated and inadequate.[100]

From simple detention facilities to native authority jails and finally to the federal prison system, the nation's correctional system has seen substantial change throughout the years. Despite these modifications, the 1917 prison regulations that later served as the foundation for the 2004 Correctional Service Act only offer broad guidelines for the admission, custody, and classification of inmates; they make no special provisions for mentally ill inmates. However, the Correctional Service Amendment Act, which was recently passed, grants state governments the authority to create and oversee custodial facilities.

The Constitution of 1999,[101] International Covenant on Civil and Political Rights,[102] International Covenant on Civil and Political Rights,[103] as well as international guidelines such as the UN Standard Minimum Rules for the Treatment of Prisoners (Mandela

[100]Vearumun v. Tarhule, Synoptic Appraisal of the Nigerian Correctional Service Act, 2019, *Benue State Univ. L.J.* (2019).

Constitution of the Federal Republic of Nigeria (1999, as amended), Cap. C23 L.F.N. 2004 (Nigeria).

[102]International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 999 U.N.T.S. 171.

[103]International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 993 U.N.T.S. 3.

Rules),[104] the Bangkok Rules for the treatment of female prisoners,[105] and the Tokyo Rules for the treatment of un-convicted prisoners establish global human rights standards for prison conditions and inmate treatment. Several other treaties, both general and specific, address the rights of detainees with mental illnesses, including the Universal Declaration of Human Rights [106] and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, (here-in- after referred to as CAT)[107] As Nigeria is a signatory to these international conventions, they serve as valuable benchmarks for assessing prison conditions and inmate rights in the country.

3.2.1 Access to Justice and Legal Representation

A fair and equitable criminal justice system is built on access to justice. In Nigeria, both domestic and international human rights instruments guarantee the right to a fair trial, effective legal representation, and a speedy hearing. For example, Article 10(1) of the International Covenant on Civil and Political Rights mandates that all prisoners be treated with humanity and dignity.[108] Similarly, Sections 34 and 42 of the Nigerian Constitution guarantee the right to dignity and protection from discrimination. Despite these legal protections, recent audits of Nigerian prisons reveal serious shortcomings in practice.[109]

According to records, 2,873 of the detainee population in Nigerian prisons received legal representation in 2018, and 425 of

[104] United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), G.A. Res. 70/175, U.N. Doc. A/RES/70/175 (Dec. 17, 2015).

[105]United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules), G.A. Res. 65/229, U.N. Doc. A/RES/65/229 (Dec. 21, 2010).

[106]Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948).

[107]United Nations. (1984). Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. (CAT)United Nations Treaty Series, Vol. 1465, p. 85.

[108]International Covenant on Economic, Social and Cultural Rights, art. 10(1), G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 993 U.N.T.S. 3.

[109]Constitution of the Federal Republic of Nigeria (1999, as amended), §§ 34, 42, Cap. C23 L.F.N. 2004 (Nigeria).

them were unable to pay fines that had been levied on them.[110] Long-term case delays have also been caused by procedural problems like missing case files and witnesses' unavailability. [111] Systemic inefficiencies clearly limit timely access to justice, as seen by the 2,915 prisoners detained without charge and the 891 detainees who spent more than five years in custody. In addition to denying detainees a fair trial, these delays exacerbate the psychological suffering of those who are already dealing with mental illness.[112]

3.2.2 Inadequate Mental Health Services and the right to Health

The situation of insane defendants in Nigerian prisons is greatly worsened by the absence of effective mental health treatment. Research has indicated that a significant percentage of inmates experience mental health issues. For instance, Iheanacho *et al* discovered that about one-third of prisoners in a medium-security prison in Benin City had a diagnosis of a serious mental disease, such as generalized anxiety disorder or recurrent moderate depression. The fact that a significant number of these conditions seem to arise while incarcerated raises concerns that the prison environment which is characterized by overcrowding, inadequate sanitation, and little therapeutic intervention may be a factor in the decline of inmates' mental health. Many mad defendants go untreated due to inadequate mental care. The failure to provide adequate mental health services directly violates the right to health as enshrined in the Universal Declaration of Human Rights due to the lack of qualified psychiatric personnel and the lack of routine mental health evaluations, which prevent the timely diagnosis and treatment of psychiatric conditions. [113] As a result, inmates with mental disorders are detained for extended periods of time without receiving the care they need, which exacerbates their condition and the International Covenant on Economic, Social and Cultural Rights, both of which

[110] 2018 Nigeria Prison Audit Report, Nat'l Hum. Rts. Comm'n, at 13 (2018), https://www.nhrc.gov.ng/files/publications/PRISON-REPORT-min.pdf.
[111] *Id*. at 14.
[112] supra note 110, at Executive Summary, 9.
[113] Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948).

obligate states to ensure the highest attainable standard of physical and mental health for all individuals. [114]

3.2.3 Inadequate Mental Health Services and Right to Humane Treatment and Rehabilitation:

Every person's inherent dignity is the cornerstone of all human rights. Article 10(1) of the International Covenant on Civil and Political Rights, to which Nigeria is a party, expressly requires that all prisoners be treated with humanity and respect for their inherent dignity in recognition of the propensity to disregard the dignity of those who are detained.[115] However, because Nigeria is a dualist state, international treaties are not automatically incorporated into its domestic legal system unless they are expressly passed into national law. Section 34 of the Federal Republic of Nigeria 1999 Constitution, which forbids torture and cruel or humiliating treatment, upholds this idea by guaranteeing the right to human dignity.[116] Furthermore, Section 42 protects the right to be free from discrimination, guaranteeing that no Nigerian person is treated unfairly or refused benefits because of their political beliefs, gender, ethnicity, or religion.[117]

Beyond humane treatment, the rehabilitative function of imprisonment is crucial. Article 10 of the ICCPR emphasizes that the primary objective of incarceration should be reformation and social reintegration, rather than mere punitive deprivation of liberty. Financial constraints cannot justify the failure to provide qualified mental health professionals, appropriate facilities, and necessary treatments for inmates. This requires prison authorities to provide adequate mental health care for detainees with psychological conditions, along with humane conditions of confinement.[118] The implementation of policies that improve the likelihood of successful reintegration into society is emphasized by this principle, which

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[114] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 993 U.N.T.S. 3.

[115]International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 999 U.N.T.S. 171.

[116]Constitution of the Federal Republic of Nigeria (1999, as amended), §§ 34, CAP P 29 Laws of the Federation of Nigeria, 2004

[117]*Id*., s 42.

[118]supra note, 107, art. 10.

means that prison administration must actively support rehabilitation in addition to confinement, making sure that inmates have access to opportunities for skill development, psychological support, and social reintegration after release.

3.2.4 Inadequate Mental Health Services and Right to be Free from Abuse

Article 7 of the ICCPR, provides that no one "shall be subjected to torture or to other cruel, Inhuman or degrading treatment or punishment".[119] This provision is also highlighted by the CAT, to which Nigeria is a member.[120] According to the Human Rights Committee, no justification or extenuating circumstances may be invoked to excuse a violation of Article 7 for any reason. According to the CAT, torture is defined as an act in which a public authority purposefully causes someone to endure from extreme pain or suffering, whether it be mental or physical. Cruel, inhuman, or humiliating treatment is the infliction of suffering, or frequently the acceptance of suffering that does not qualify as torture because it is less severe or not purposefully inflicted. Both wilfully refusing treatment to relieve mental pain and failing to administer it may be violations of Article 7. It is recommended that the ban be expanded to cover the broadest range of safeguards against physical and psychological abuse.

3.2.5 Forensic Psychiatry and Informed Consent Rights

The scenario in Nigeria is similar to a controversial discussion about forensic psychiatry performed without the consent of those who were found not guilty due to insanity that is currently taking place in the United States. Significant ethical and legal issues are raised by the fact that forensic psychiatric evaluations frequently continue in the United States even after a person has been ruled not guilty by reason of insanity (NGRI). Critics contend that these assessments, which are carried out without the acquitted person's consent, violate informed consent principles, which are fundamental to

[119] supra note 107, art. 7.
[120] supra note. 97, art.7.

contemporary medical ethics, and undermine human autonomy.[121] The U.S. debate highlights the tension between protecting public safety and respecting individual rights, which is equally relevant in the Nigerian context. However, Melton et al. contend that forced forensic assessments can result in a form of coercive psychiatry, where individuals are subjected to further involuntary treatment even after the court has determined that they are not criminally responsible. This practice raises questions about the legitimacy of continued detention as well as the wider human rights implications of circumventing a person's right to consent to medical procedures.[122]

3.2.6. Condition of Prisons in Nigeria

The United Nations Standard Minimum Rules for the Treatment of Prisoners establish standards for how inmates should be treated.[123]It states that people must be treated with dignity and that no one should be treated in a dehumanizing fashion, even if the institution of law has taken away their right to liberty.[124]The rules cover issues related to: minimum standards of accommodation; personal hygiene; clothing and bedding; food and exercise; medical services; discipline and punishment; the use of instruments of restraint; complaints; contact with the outside world; the availability of books and religion; retention of prisoners' property; notification of death, illness and transfer; removal of prisoners; the quality and training of prison personnel; and prison inspections.[125] Part II contains rules applicable to special categories of prisoners such as those with

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[121] Thomas Grisso & Paul S. Appelbaum, Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals 31 (Oxford Univ. Press 1998).

[122] See Gary B. Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers *(3d ed., Guilford Press 2007); Thomas Grisso & Paul S. Appelbaum,* Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals 31 (Oxford Univ. Press 1998).

[123] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, U.N. Doc. A/RES/70/175, at 4 (Dec. 17, 2015), https://undocs.org/A/RES/70/175.

[124] *Id.* at 5.

[125] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, U.N. Doc. A/RES/70/175, at 4 (Dec. 17, 2015), pg. 6-9 https://undocs.org/A/RES/70/175.

mental disability and/or health conditions (Rule 109).[126] It stipulates that people with mental disabilities must be housed in mental health facilities as quickly as feasible, under the supervision of trained medical professionals, rather than being held in jails.[127] If it is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provisions of social-psychiatric after care, the health care service will cover the psychiatric treatment of any other inmates who require it.[128]

Prison should be used to ensure, to the extent possible, that upon his return to society, the offender is not only willing but able to lead a law-abiding and self-supporting life, according to the SMR. The SMRs offer guidelines for domestic and international law for citizens detained in jails and other types of custody, but they are not legally obligatory. It is clear that Nigerian prisons fall short of these requirements. It is blatantly against their human rights to hold insane defendants for extended periods of time without providing them with proper mental health care. When detainees are held for years without receiving the necessary mental health interventions, their capacity to recover and reintegrate into society is severely hampered, endangering not only their personal well-being but also posing a risk to public safety by fostering a cycle of recidivism. The situation in Nigeria is in sharp contrast to practices in jurisdictions that have incorporated comprehensive mental health services into their correctional systems, which lessens the long-term detrimental effects of incarceration on health.[129]

3.3. The Nigerian Correctional Service Act, 2022

With the passage of the Nigerian Correctional Service Act, 2019, the nation's penal system underwent a dramatic change from a punitive to a rehabilitative paradigm. Notably, by emphasizing the

[126]*Id*. at 20–21 (Rule 109).

[127]supra note 125

[128]United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, U.N. Doc. A/RES/70/175, at 4 (Dec. 17, 2015), pg.22 https://undocs.org/A/RES/70/175.

[129]Seena Fazel et al., *Mental Health of Prisoners: Prevalence, Adverse Outcomes, and Interventions*, 3 *Lancet Psychiatry* 871 (2016), https://doi.org /10.1016/S2215-0366(16)30142-0.

compassionate treatment, rehabilitation, and reintegration of offenders, the Act complies with international human rights norms. In order to alleviate prison overcrowding and humanize incarceration, Section 2 of the Act clearly requires adherence to international human rights standards and establishes both custodial and non-custodial methods, such as probation, parole, and restorative justice.[130] By enforcing basic living conditions, including sufficient food, water, sanitation, and medical care, in compliance with the United Nations Standard basic Rules for the Treatment of Prisoners, and by outlawing cruel and humiliating treatment, the Act further enhances the welfare of inmates,[131] requires female prisoners to be housed in separate facilities,[132] and creates vocational and educational initiatives to support rehabilitation.[133] Additionally in line with international correctional best practices is the clause enabling correctional personnel to turn away new inmates when facilities are overloaded.[134] Together, these changes improve Nigeria's adherence to its international human rights commitments under agreements like the International Covenant on Civil and Political Rights and reinforce the protection of prisoners' dignity.[135]

The Act nonetheless raises a number of human rights issues in spite of these improvements. First of all, it does not abolish the capital penalty; rather, it permits death sentences to be commuted to life in prison if an offender is kept on death row for ten years without being executed.[136] Although this clause lessens ongoing psychological anguish, it ignores the death penalty's larger human rights issue and runs counter to UN General Assembly resolutions calling for its repeal.[137] Furthermore, even though the Act aims to reduce prison overcrowding through non-custodial sentencing, eligible offenders may continue to be held in custody due to unclear

[130]Nigerian Correctional Service Act 2019, § 2(a).

[131] *Id.* s 14(8).

[132]supra note 130, s 34(1).

[133]Nigerian Correctional Service Act 2019s 14(4) (a).

[134]*Id.* s 12(8).

[135]International Covenant on Civil and Political Rights (ICCPR), G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966), 999 U.N.T.S. 171.

[136]Nigerian Correctional Service Act (2019), s 12(2).

[137] Moratorium on the Use of the Death Penalty, G.A. Res. 73/175, U.N. Doc. A/RES/73/175 (Dec. 17, 2018).

parole and probation implementation procedures. Furthermore, because the Act does not specifically forbid the detention of pregnant women or offer them alternative sentencing choices, gender-sensitive measures are still lacking.[138] Since the Act requires juvenile detention facilities but makes no provisions for community-based rehabilitation programs, the rights of young offenders are also not sufficiently safeguarded.[139]

Another crucial issue is the absence of independent oversight mechanisms for correctional facilities, since effective human rights protection necessitates the existence of independent monitoring organizations to look into infractions and guarantee adherence to norms for humane treatment. [140] The Correctional Service Amendment Act, 2024, which gives state governments the authority to build and run prisons, makes these issues even more pressing. In addition to decentralizing penal services, this legislative change raises concerns about how federating states will uphold human rights, especially in areas with less robust human rights histories.[141]It is unclear if federating states will strengthen or weaken human rights safeguards in their penitentiary services now that state control has been placed over correctional institutions.

3.3.1 Mental Health Assessment of the Nigerian Correctional Service Act

The mental health of crazy acquittees is not well protected by the Nigerian Correctional Service Act, despite its progressive views on prison reform. The Act does not offer a thorough framework for the mental health care of detainees with severe psychiatric problems, despite its emphasis on humane treatment, rehabilitation, and conformity to international human rights norms. It does not include provisions for forensic psychiatric hospitals, regular mental health evaluations, or organized reintegration programs, despite guaranteeing basic medical treatment. In the absence of such safeguards, mentally ill inmates are nonetheless at risk of being held indefinitely in circumstances that could worsen their disorders

[138]Nigerian Correctional Service Act (2019), s 34(1).
[139] Nigerian Correctional Service Act (2019), s.35.
[140] Nigerian Correctional Service Act (2019), s. 21
[141]Correctional Service Amendment Act (2024).

Furthermore, even while the Act forbids cruel, inhuman, or humiliating treatment, it does not clearly outline procedures for recurring mental health assessments or filing a lawsuit to stop ongoing imprisonment on the basis of mental illness. It is unclear if crazy inmates or their closest friends, family, or legal counsel can successfully invoke the Act to obtain appropriate treatment or release, as is typical in countries like the US and Canada, given the lack of legally binding mental health provisions.

The Criminal Code of Canada regulates the care of those who are deemed 'Not Criminally Responsible on Account of Mental Disorder' (NCRMD), guaranteeing that their incarceration is continuously monitored. Based on psychiatric assessments, review boards determine whether an NCRMD person should be hospitalized, released on conditional release, or discharged completely under Section 672 (54).[142] In *Winko v. British Columbia Forensic Psychiatric Institute,* the Supreme Court of Canada affirmed that detention must be supported by continuous psychiatric evaluations and ruled that an NCRMD person cannot be held forever unless they represent a serious risk to public safety.[143] In a similar vein, detainees declared 'Not Guilty by Reason of Insanity' (NGRI) in the US are required by the Insanity Defense Reform Act of 1984 to undergo recurring mental health assessments to ascertain if they represent a risk to themselves or society.[144]

This legal framework ensures that mentally ill detainees are not forgotten within the correctional system and provides a structured mechanism for their periodic review and potential release. In *Jackson v. Indiana*, the U.S. Supreme Court ruled that the indefinite detention of a mentally ill defendant without periodic competency evaluations violated due process, emphasizing that continued confinement must be linked to therapeutic progress and public safety rather than punitive objectives.[145] Comparable protections are absent from the

[142] Criminal Code, R.S.C. 1985, c. C-46, s 672.54 (Can.).
[143]Winko v. British Columbia (Forensic Psychiatric Institute), [1999] 2 S.C.R. 625 (Can.).
[144]Insanity Defense Reform Act of 1984, Pub. L. No. 98-473, s 403, 98 Stat. 2057 (U.S.).
[145]Jackson v. Indiana, 406 U.S. 715 (1972).

Nigerian Correctional Service Act, however, leaving mentally ill inmates in a legal limbo where their incarceration may continue indefinitely.

4. Recommendations

Comprehensive reforms are required to guarantee a more equitable and efficient criminal justice system for mentally ill offenders in Nigeria. Enacting explicit legal protections, instituting regular psychiatric evaluations, enhancing mental health services in prisons, putting in place organized rehabilitation and reintegration programs, bolstering judicial oversight, and bringing policies into compliance with international norms like the Mandela Rules should be the main goals of the following recommendations.

4.1. Legal and Procedural Reforms

Section 230 of the Nigerian Criminal Procedure Code, which empowers the president or governor to detain an insane defendant indefinitely, should be amended to transfer this authority to the judiciary. Courts should be empowered to order periodic assessments, diagnoses, and treatments for mentally ill detainees by qualified mental health professionals, with such evaluations forming the basis for release decisions. This reform would ground continued detention in medical necessity rather than indefinite executive discretion. Improving access to justice and accelerating legal processes are critical to avoiding unnecessary delays that prolong incarceration. Strengthening legal representation and ensuring timely hearings would help reduce the backlog that traps mentally ill inmates in prison. Ideally, a defendant's family or designated best friend should be authorized to initiate discharge applications, submitting them to a mental health review board established to oversee the treatment and management of mentally ill defendants. This would prevent cases from stagnating due to bureaucratic or procedural inertia.

The Nigerian Correctional Service Act of 2019, alongside its 2024 amendment, requires targeted reforms and more robust implementation to align with human rights standards. In line with global trends and United Nations recommendations, Nigeria should abolish the death penalty and introduce a mandatory judicial review of death row cases before the ten-year mark. Independent

monitoring bodies should be established to oversee prison conditions and investigate human rights violations. Additionally, the role of the Legal Aid Council within correctional facilities should be strengthened to ensure indigent prisoners have access to competent legal counsel. The Act must also include gender-sensitive provisions that provide alternative sentencing options for pregnant and nursing mothers. For juveniles, the focus should shift from institutional detention toward community-based rehabilitation, emphasizing reintegration over punishment. As states now have constitutional authority to construct and manage prisons, they must prioritize human rights, ensure humane treatment of inmates, and adhere to both national and international correctional standards. Without strong federal oversight, decentralization risks undermining the gains of the 2019 reforms, resulting in inconsistent human rights protections across states.

4.2 Enhancing Mental Health Services

Preventing violent incidents and reoffending can be achieved by incorporating risk assessment, reduction, and management into routine mental health evaluation and discharge planning. Nigerian prisons must incorporate regular psychiatric evaluations and therapeutic interventions into their standard operating procedures. Hiring licensed mental health professionals and setting up specialized forensic psychiatric units are essential steps toward reducing the negative effects of prolonged detention on mental health.[146] Clinicians can create focused treatment plans by using structured risk assessment methods, which can yield accurate and trustworthy outcomes. About one-fifth of participants in the mental health survey that was carried out in the two prisons in Nigeria were deemed to be at high risk for violence-dangerousness based only on clinical examination. To guarantee that prisoners receive the treatment and assistance they require to meet their complex mental health needs, legislators, mental health specialists, and correctional

[146]Graham D. Glancy & Gary A. Chaimowitz**,** The Clinical Use of Risk Assessment in Forensic Psychiatry, 33 *J. Am. Acad. Psychiatry & L.* 157 (2005); Matthew Large & Olav Nielssen, The Relationship Between Mental Illness and Violence, 17 *J. Forensic Psychol. Prac.* 151 (2017).

authorities must collaborate.[147] This entails setting aside enough funds and specialized knowledge to facilitate the delivery of forensic mental health services, creating uniform policies and procedures for the practice of correctional mental health, and funding studies on correctional mental health services to guide the creation of best practices and policies.

To bring Nigeria's prison system into compliance with the Mandela Rules and guarantee the humane treatment of all inmates, immediate reforms are required, such as greater funding for mental health facilities, improved training for prison employees, and independent prison inspections. The UK's National Health Service Liaison and Diversion program, which incorporates mental health services into the criminal justice system and offers early intervention and specialized care for mentally ill inmates, may serve as a model for change. Nigeria can follow suit by creating specialized psychiatric sections within prisons and encouraging cooperation between the criminal justice and medical fields. Nigeria should think about the moral ramifications of forced psychiatric assessments for crazy acquittees in light of the U.S. controversy around non-consensual forensic psychiatry. Even for forensic evaluations, policies that prioritize informed consent may support human rights and preserve individual liberty.

5. Conclusion

The relationship between psychiatry and the law has always been controversial, especially when it comes to the insanity defense. When someone is acquitted of a crime on the grounds of insanity, it presents a significant problem because it suggests that they were not guilty of the crime but still acknowledges their involvement in it. Various strategies have been used by state legislators in response, such as criminal commitment legislation, which have frequently been challenged under the constitution on the basis of equal protection and due process. The difficulties and worries previously mentioned seem to be reflected in the Nigerian legislature's approach to insanity laws, especially when it comes to striking a

[147] James R. P. Ogloff, The Role of Forensic Psychology in the Criminal Justice System, 3 *J. Forensic Psychol. Prac.* 1 (2003); Simon N. Verdun-Jones, Forensic Psychiatry and the Ethics of Care, 11 J. *Forensic Psychiatry* 241 (2000).

balance between the rights of defendants declared not guilty by reason of insanity and public safety. Ongoing discussions over the standards for judging insanity, the terms and length of commitment, and the procedures for evaluation and release are reflected in the legislative framework. These concerns are in line with more general international debates about how to guarantee that laws defending mental illness uphold the fundamental rights of criminals as well as the interests of society.

In Nigeria, an individual acquitted by reason of insanity may be held in a psychiatric hospital or prison, supposedly for treatment and rehabilitation, but in practice, many of these individuals are held in facilities that are ill-equipped to provide adequate care and treatment. The insanity defense is governed by the Criminal Procedure Act (CPA) and the Criminal Code Act (CCA), both of which have been criticized for being antiquated and insufficient. Many people agree that Nigeria has some of the worst jail conditions in the world. Among the problems plaguing the nation's jails include overcrowding, inadequate medical treatment, poor sanitation, and violence. The harsh treatment of those who have been exonerated of crimes because they are insane is unacceptable. Furthermore, mentally ill criminals frequently get subpar care and treatment due to a lack of specialized facilities and skilled staff. This may worsen their circumstances and cause their mental health to further deteriorate.[148]

Prisons were never created as facilities for the mentally ill, but that is one of their main functions today. Many men and women who are unable to receive mental health treatment from society are thrown into the criminal justice system after committing a crime. Unfortunately, prisons in Nigeria are ill-equipped to respond appropriately to the needs of inmates with mental illness due to mental health services that are frequently woefully deficient, crippled by under-staffing, insufficient facility, and low funding. Human rights experts have long criticized prolonged or indeterminate confinement of the mentally ill without psychiatric care as amounting to cruel, inhuman, degrading treatment or

[148] Oyeyipo Eyitayo Joseph *et al.*, Prison Overcrowding Trend in Nigeria and Policy Implications on Health, 7 *Cogent Soc. Scis.,* no. 1, 2021, https://doi.org/10.1080/23311886.2021.1956035.

punishment, and in some cases may be tort. As a result, many seriously ill prisoners receive little or no meaningful treatment.

Prolonged confinement under such conditions are found in Nigerian prisons are psychologically harmful to any prisoner with the nature and severity of the impact depending on the individual, the duration, and the specific conditions, it can provoke anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis.[149] But the risk of harm is particularly grave for prisoners who have serious mental illnesses. Everyone finds prison time difficult. In institutions that are often stressful, overcrowded, violent, isolated from families and communities, and lack possibilities for meaningful education, employment, or other beneficial activities, prisoners find it difficult to preserve their mental stability and sense of self.[150] It is difficult, if not impossible, for the few dedicated mental health professionals who work in Nigeria's prisons to meet the needs of their patients because of impossibly high caseloads and physically unsuitable facilities.[151]

[149]Michael Jeffery & David Joel, *An Overview of Correctional Psychiatry*, 29 *Psychiatric Clinics N. Am***.** 761, 761–72 (2006).

[150]Oyeyipo Eyitayo, Asamu Festus Femi, Arisukwu Ogadinmma C. & Jide Olorun mola, Prison Overcrowding Trend in Nigeria and Policy Implications on Health, 7(1) *COGENT SOC. SCI***.** 1956035 (2021), https://doi.org/10.1080/23311886.2021 .1956035**;** Frank D. Baffour, Francis A. P., M. D. Chong & Nathan Harris, Prison Overcrowding and Harsh Conditions: Health and Human Rights Concerns to Persons in Custody, Staff, and the Community, 51(3) *CRIM. JUST. & BEHAV*. 375 (2024), https://doi.org/10.1177/00938548231219803.

[151]Ayodele O. Ogunlesi & Akinhanmi Ogunwale, Correctional Psychiatry in Nigeria: Dynamics of Mental Healthcare in the Most Restrictive Alternative, 15 *BJPsych INT'L* 35 (2018), https://doi.org/10.1192/bji.2017. 13.