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# A Sociological Perspective on the Medicalisation of Crime in the Nigerian Justice System

Queen, Edem & Sarah, Ogenekevwe Pupu

Department of Sociology,  
Faculty of the Social Sciences,  
Delta State University, Abraka  
08032188288, 08023295684

[abahqueen5@gmail.com](mailto:abahqueen5@gmail.com); [pupu\\_so@pti.edu.ng](mailto:pupu_so@pti.edu.ng)

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## Abstract

Medicalisation of crime reflects a shift in contemporary Justice System, where deviant behaviour is interpreted and managed through medical frameworks. Within the Nigerian context, this phenomenon has deep implications, particularly in the treatment of delinquents associated with drug abuse, murder, insurgency, terrorism, and cybercrimes. This paper examines the trend of medicalising crimes within the Nigerian Justice System through the lens of Medical Sociology, justified by the need to interrogate the thin line between criminality and illness, and its importance lies in its capacity to illuminate the intersection between health and justice. Drawing on the theoretical framework such as Conrad's theory of medicalisation, Foucault's concept of the medical gaze, and labelling theory by Howard Becker, this paper explores how criminal behaviour is reframed as a product of mental disorders rather than deliberate aberration. The paper employs a conceptual and interpretive methodology as it does not rely on field data, but engages with ideas, theories, and existing literature. The paper examines selected judicial cases like Faith Isoken v. The State (2018), Edoho v. The State (2016), and Kaza v. The State (2008), as well as the administrative initiative programs like Operation Safe Corridor (2016–date). The analysis reveals that while medicalisation introduces a more humane approach to justice by recognizing offenders as individuals in need of treatment, it also exposes systemic inequalities. The affluent, who can afford psychiatric evaluation and legal representation, often benefit from mitigated judgments, whereas indigent defendants are denied similar consideration due to lack of access to psychiatric expertise. The study finds that this uneven application reproduces social and class disparities within the criminal justice system, thereby reinforcing structural inequality under the guise of therapeutic reform. It concludes that equitable access to forensic psychiatric evaluation and mental health services must be institutionalized within Nigeria's Justice System to ensure justice that is both fair and restorative.

**Keywords:** Medicalisation of crime, Nigerian justice system, forensic psychiatry, mental health, social inequality, rehabilitation

## **Introduction**

Globally, scholars have documented the increasing tendency of States to treat certain categories of crime as medical problems. For example, drug addiction has been reframed from a moral failing to a chronic illness in many western societies (Room, 2003). Correspondingly, felony has often been attributed to psychological disorders, with rehabilitation programs emphasising therapy and counselling over imprisonment (Hirshbein 2021). In terrorism studies, some government have promoted de-radicalisation programs that blend psychiatric interventions with religious counselling, particularly in post-conflict societies (Ashour, 2009). In the U.S., the insanity defence and the use of psychiatric testimony in criminal trials exemplify how medicine penetrates the Justice System (Foucault, 1977).

These examples illustrate a global trend where boundaries between crime and illness are increasingly blurred, producing both opportunities for humane treatment and concerns about expanding social control. Medicalisation involves defining and treating social problem, behaviours, or conditions as medical issues, often shifting responsibility from the legal to the medical realm (Conrad, 2007; Conrad & Bergey, 2014). In the context of crime, this shift entails conceptualising offenders not solely as rational agents who violate the law but as individuals suffering from diagnosable mental or psychological conditions.

In Nigeria, this trend is emerging amidst a troubled Justice System burdened by over-incarceration, inadequate legal infrastructure, and limited rehabilitative services. Mental health issues often undiagnosed, untreated, or misunderstood frequently complicate criminal proceedings, especially in cases involving violent crime, drug-related offences, or acts interpreted as social deviance. For example, since 2016, the Nigerian government through Operation Safe Corridor has implemented a de-radicalisation, rehabilitation, and reintegration (DRR) program for “repentant” Boko Haram insurgents. Participants undergo psychological therapy, vocational training, and religious reorientation rather than prosecution. The program conceptualizes insurgency and violent extremism not primarily as criminal acts, but as outcomes of psychological indoctrination, trauma, and maladaptive cognition treatable through psychosocial interventions. This shift represents a clear case of medicalisation; reframing terrorism (a moral and criminal issue) as a condition amenable to treatment. Critics argue that this therapeutic framing delegitimizes victims’ suffering and undermines justice, while proponents see it as pragmatic rehabilitation (Onuoha, & George, 2023).

Despite the existence of legal provisions such as the Nigerian Criminal Code Act (Sections 28-29), which recognizes insanity as a defence, the country lacks a robust forensic psychiatric infrastructure to adequately assess and manage mentally ill offenders (Ogunlesi & Adeyemi, 2009). Consequently, a significant number of individuals who may require medical care are either criminalised or subjected to prolonged detention without adequate psychiatric evaluation. For instance, a man arrested in 2010 for murder spent about 14 years in Kirikiri prison without a trial. While in custody, he developed a mental disorder. Finally, the Court of Appeal in Lagos freed him, noting the grave mental condition he had developed due to prolonged remand without trial (Punch, 14<sup>th</sup> May 2024).

Drawing on insights from Medical Sociology, this paper explores the implications of this trend within the Nigerian Justice System. Medical Sociology as a subfield investigates how health, illness, and medical institutions are socially constructed and maintained, with particular attention to how medical authority intersects with other forms of institutional power (Cockerham, 2021). Conrad (2007) theory of medicalisation, is relevant here as it highlights how non-medical problems become defined and treated as medical issues. Also the concept of the medical gaze, introduced by Foucault (1973), is relevant here, as it highlights the role of medical expertise in classifying and managing deviant bodies and behaviours, and likewise the framework of labelling theory by Howard Becker (1963), which posits that deviance is not inherent in an act, but is the result of social labelling. As psychiatric evaluations and mental health defences become increasingly prominent in Nigerian courtrooms, questions emerge about the shifting boundaries between law and medicine, and the implications for justice, accountability, and social control.

The paper contends that while the medicalisation of crime in Nigeria may promote more humane approach to offenders through therapy, rehabilitation, and institutional care, it also raises critical concerns. These includes the potential erosion of legal responsibility, the expansion of medical authority into legal domains, and the reproduction of social inequalities through differential access to psychiatric defences (Adebay & Aluko 2022; Nnochiri, 2023; Okorie, 2023; Oyewole, 2024). Using a sociological lens, the paper examines how this trend reflects deeper tension between punitive and therapeutic models of justice.

### **Objectives of the Study**

The main objective of this study is to examine the concept of medicalisation of crime within the Nigerian justice system. The specific objectives are to:

- (a) Analyse judicial decisions and legal provisions in Nigeria where mental health defences or psychiatric evaluations influenced criminal outcomes, and
- (b) Interrogate the sociological implications of medicalising crime.

### **Conceptual Clarification**

The conceptual foundation of this study is rooted in contemporary sociological interpretations of medicalisation, a process through which human problems and behaviours, once defined as moral, legal, or social, are reclassified as medical conditions requiring clinical diagnosis and treatment rather than punishment. While Conrad's (2007) seminal work remains central to understanding medicalisation as a socio-institutional process, more recent scholars has reconceptualised it in light of shifting global and local contexts (Halpin, 2025; Steel, 2022). These perspectives emphasize that medicalisation is not a singular transfer of authority from law to medicine, but a relational, negotiated process embedded in power dynamics, governance, and inequality. Under this paradigm, the state employs medical and psychiatric categories to manage deviance, transforming criminality into a form of pathology.

In Nigeria, this logic manifests in legal reliance on psychiatric evaluations to determine criminal responsibility, and in the framing of insurgency and violent extremism as symptoms of trauma or brainwashing requiring "healing." Medicalisation thus becomes a mode of therapeutic governance (Rose, 2007), where medical authority extends into the legal and political domains, legitimising state interventions that blur the boundary between care and control. The intersection between medical and legal institutions constitutes what Steel (2022) terms a symbiotic convergence, where both domains cooperate to redefine social deviance. This manifests when courts defer to psychiatric assessments in determining culpability, effectively shifting moral and legal judgment into medical expertise. This study views such convergence as a critical sociological phenomenon, in which medicine becomes a tool for both rehabilitation and social regulation. By drawing on these conceptual lenses, the study situates the medicalisation of crime within broader debates on power, inequality, and the transformation of justice in late modern societies.

Thus, the conceptual framework adopted in this study views the medicalisation of crime as a multidimensional process involving sociological, legal, and political dynamics. On one hand, medicalisation can humanize offenders by recognizing legitimate mental health conditions; on the other, it can obscure structural violence and depoliticize crime by framing it solely as a medical or psychiatric matter. This duality makes the concept analytically useful for

understanding the Nigerian justice system, where insurgency, terrorism, and violent crime are at times reconstructed as matters of rehabilitation, treatment, or de-radicalisation rather than punishment.

### **Literature Review**

The medicalisation of crime has attracted scholarly attention particularly within the field of Sociology. A substantial body of literature has explored how deviant behaviour is increasingly understood and managed through medical discourses. Conrad (2007) highlights the expanding domain of medicalisation, noting that behaviours once treated as moral failings or criminal acts, such as alcoholism, drug use and violence are now subject to psychiatric categorization. This reclassification, according to Conrad (2007) often leads to social control under the guise of care and treatment.

Literature on the medicalisation of crime in Africa is less voluminous. Studies revealed that psychiatric involvement in criminal justice is increasing, although unevenly. In South Africa, Petersen and Lund (2011) documented how mental illness defences are inconsistently applied, especially in marginalized communities. A similar pattern exist in Kenya and Ghana, where forensic psychiatric services are minimal, leading to delays in justice and indefinite detentions of mentally ill suspects (Muga & Jenkins, 2008; Osei Baidoo, & Owusu-Damoah, 2019). These studies highlight a common issue across African systems: underdeveloped forensic infrastructure, poor interagency coordination, and stigmatization of mental illness, which constrain effective use of medical defences. The problem is compounded by colonial legacies that fused western legal systems with customary laws, often ignoring indigenous understanding of illness, deviance, and justice.

### **Judicial Decisions and Legal Provisions in Nigeria**

In Nigeria, crime has historically been framed through legalistic and punitive lenses, yet recent development point to element of medicalisation. Studies on drug abuse (Adelekan, (2010); Obot, (2016) highlight how offenders are increasingly subjected to rehabilitation centres rather than purely panel sanctions. Similarly, counter terrorism efforts against Boko Haram have incorporated rehabilitation and reintegration programs, treating former insurgents as candidates for psychological reprogramming rather than solely criminals (Onuoha, 2014).

The criminal code (Section 28) and penal code (Section 51) of Nigeria recognize the insanity defence, allowing exemption from criminal responsibility when an offender is found to be of

unsound mind. However, researchers argue that implementation is weak, fragmented, and biased. Obioha (2018) identifies a growing reliance on psychiatric evaluations in homicide and violent crime cases, but notes that courts often lack training to assess the validity of psychiatric claims. Moreover, many judges operate with limited understanding of psychiatric terminology, leading to either blind reliance on or outright dismissal of expert testimony.

Onu and Chukwu (2021) argue that social stigma surrounding mental illness often deters genuine use of psychiatric defences. Many defendants fear being labelled “mad” for life, especially when mental illness is still seen in spiritual or supernatural terms in many African communities. This suggests a cultural disparity between Western psychiatric models and local social realities, a point further developed by Akinyemi (2019), who urges for an Afrocentric approach to forensic and indigenous frameworks. Ihejirika (2022) conducted a critical analysis of Nigerian court judgements and found that elite defendants are more likely to invoke and succeed with mental health defences than poorer individuals, this reflects a classed medicalisation, in which psychiatric privilege becomes a tool for evading full legal accountability, a finding that echoes Becker’s (1963) labelling theory and the notion of institutional bias in deviance attribution.

### **The Sociological Implications of Medicalising Crime.**

The framing of crime as medical or psychological condition raises fundamental questions about social control, and deviance. From a sociological lens, it changes the way society defines deviance, moving it from the realm of law and morality into the authority of medical professionals. This reduces individual responsibility and shifts blame to illness or external factors. Conrad (2007) posits that, when offenders are treated as sick, their behaviour is reframed from a moral or legal violation into a medical condition. One of the implications is that legal sovereignty can be eroded, as courts increasingly defer to psychiatric evaluations, reinforcing Foucault’s (1977) argument about medicine as a tool of social control. If serious crimes (e.g., homicide, terrorism, sexual deviance) are reframed as illnesses, victims and society may feel justice is denied. This undermines the deterrent function of punishment, possibly leading to moral outrage and distrust in the legal system. Medicalisation promotes treatment and rehabilitation over retribution. While this may humanize offenders and reduce recidivism, it may also fuel perceptions of leniency. In Nigeria for instance, initiatives like Operation Safe Corridor reflect this dilemma; reintegrating insurgents as “rehabilitated” may be seen as prioritizing medical/social treatment over justice for victims.

## **Theoretical Framework**

This study draws on key sociological theories that elucidate how medical authority intersects with legal systems in framing deviance. Central to this analysis is Peter Conrad (2007) theory of medicalisation, which explains how non-medical problems become defined and treated as medical issues, often with clinical language and intervention. Conrad outlines three core dimensions of medicalisation: conceptual (defining a condition as medical), institutional (the role of medical professionals in social institutions), and interactional (the physician-patient dynamic). In the context of crime, these dimensions reveal how the Justice System increasingly defers to psychiatric expertise in defining responsibility. Additionally, Michel Foucault's (1973) concept of the medical gaze is employed to analyse how medical institutions produce knowledge that legitimize their involvement in legal adjudication. Foucault theorizes that the clinical gaze does not merely observe illness but constructs it within systems of power and classification. This is especially relevant in Nigeria courts where psychiatric evaluations may demand sentencing outcomes or absolve criminal culpability.

The framework also draws on the sociological theories of deviance, particularly the labelling theory by Howard Becker (1963), which posits that deviance is not inherent in an act, but is the result of social labelling. In the case of medicalisation, criminal acts are reclassified through psychiatric diagnosis, thereby shifting the label from "criminal" to "patient." This reclassification alters the offender's legal status and redirects the part from punishment to treatment. These theoretical tools allow for a critical interrogation of how the Nigerian Justice System navigates the boundaries of law and medicine, and how this navigation reshapes institutional responses to crime.

## **Methodology**

This study adopted a conceptual and interpretive qualitative research design rooted in the sociological tradition of critical inquiry. The choice of methodology was guided by the three research objectives: to examine the concept of medicalisation of crime within the Nigerian justice system, to analyse judicial decisions and legal provisions in Nigeria where mental health defences or psychiatric evaluations influenced criminal outcomes, and to interrogate the sociological implications of medicalising crime.

The study employed a desk-based analytical approach, drawing upon secondary sources of data, including legal judgments, statutory provisions (especially Section 28 of the Criminal Code Act and Section 270 of the Administration of Criminal Justice Act), government policy

documents, and academic literature on medical sociology, and criminology. Media reports and scholarly articles were also used to illustrate contemporary cases that bridge psychiatry and justice.

## Results

Below is a table of some selected cases where mental-health defences or psychiatric evidence were central to the outcome. Each summary gives the core holding and why it matters for the study.

**Table 1: Nigerian Law Cases and Medicalisation of Crime**

| Case   | Year           | Court                            | Legal Issue   | Holding   | Implications for study   |
|--|----------------|----------------------------------|---|---|--|
| Faith Isoken v. The State                        | 2025           | Federal High Court, Lagos        | woman convicted of drug possession                    | The court discharged her based on health condition even though she had pleaded guilty.            | This is where medical or health condition influenced a legal outcome (leniency rather than full punishment), aligning with medicalisation tendencies.          |
| Edoho v. The State                               | 2016           | Supreme Court of Nigeria         | Insanity plea based on delusional belief (witchcraft) | Defence accepted that there was evidence of mental abnormality at the time of the offence.        | The case demonstrates judiciary's increasing readiness to accept psychological and behavioural evidence as legitimate ground for re diminished responsibility. |
| Kaza v. the State                                | 2008           | Court of Appeal Kaduna Division  | Insanity plea based on mental instability             | Defence rejected insanity plea, holding that the defence failed to discharge the burden of proof. | The case strictly demonstrates inequity in the medicalisation of crime.  |
| Operation Safe Corridor (administrative program) | 2016 – present | Executive/Administrative Program | Rehabilitation of Boko Haram/insurgents               | Offenders diverted into de-radicalization, most times avoiding prosecution                        | Illustrates non-judicial medicalisation, producing inequality in accountability  |

## Discussion

Faith Isoken v. The State (Tribune Online, 2025). Faith, a woman convicted of drug possession, fell gravely ill while serving her prison term. Moved by her deteriorating health, the Federal High Court in Lagos granted her release on compassionate grounds, citing the constitutional right to dignity and life. At face value, this decision was an act of mercy. But sociologically, it represents something deeper; a shift from punitive justice to therapeutic justice. The court no longer saw Faith merely as a criminal to be punished but as a human being in need of care. In doing so, the court turned medical evidence into a tool of justice. Her illness became a legitimate reason for leniency. This is what sociologists call medicalisation; a process where non-medical problems, like crime, are reframed as health issues that require treatment or compassion rather than punishment (Conrad, 2007). However,

not everyone gets this kind of justice. Those who can prove they are sick or afford medical documentation are more likely to benefit. This means that medicalisation, though humane, can unintentionally create new inequalities in how justice is applied. Faith's case shows the courtroom as a place where medicine and law meet, but also where privilege can quietly determine who deserves "compassion" or "punishment".

In *Okon Nsibehe Edoho v. The State* 2016. (The nation September 17, 2024). Edoho was charged with the murder of his father-in-law. The court faced a troubling question: Can someone who is mentally ill truly be held responsible for murder? Psychiatric evaluations confirmed that Edoho suffered from a mental disorder that impaired his judgment at the time of the act. The Supreme Court accepted this evidence and invoked Section 28 of the Criminal Code, which exempts an individual from full criminal responsibility if proven insane at the time of the offense. Here again, we see the justice system giving power to medical authority. Instead of judging only through moral or legal reasoning, the court leaned on psychiatric science to determine culpability. Sociologically, this case marks the "scientification" of justice, where the courtroom depends increasingly on medical expertise to decide right and wrong. By replacing moral blame with medical diagnosis, the law becomes more compassionate, but also more dependent on expert power."

The case of *Mr. Kaza v. The State* (LLJR-SC-LawGlobal Hub, 2008), Kaza a farmer from a rural community in Adamawa State, was charged with the murder of his wife following a domestic altercation. During trial, the accused displayed erratic behaviour and was alleged by neighbours to have been "mentally unstable" for some time before the incident. However, unlike in high-profile cases, no psychiatric evaluation was conducted because neither the accused nor his family could afford it. The defence counsel made a verbal plea of insanity but failed to provide any medical evidence or expert testimony to support the claim. The Court rejected the insanity plea, holding that the defence failed to discharge the burden of proof required under Section 27 of the Criminal Code (now Section 28). The court stated that mere assertions or community claims of "madness" do not suffice in law. Since there was no psychiatric assessment or credible evidence of mental disease, the court upheld the conviction for murder and affirmed the death sentence. This exposes a subtle form of inequality: only defendants with access to psychiatric evaluation can use such a defence. Poorer offenders, often without mental health support, remain trapped in the traditional punitive system. Consequently, the justice system reproduces class-based disparities, where medical defences

become tools of the privileged rather than justice. The sociological implication is that medicalisation, though presented as a humane reform, creates a two-tier justice system.

Beyond the courtroom, the Nigerian government has also embraced a more medicalised approach through Operation Safe Corridor, a rehabilitation program for former Boko Haram members. Instead of punishing them through long prison terms, the program offers therapy, counselling, vocational training, and spiritual guidance. On paper, it sounds like a bold step toward peace building, it recognizes that many insurgents may themselves be victims of indoctrination, trauma, or mental instability. By treating them as patients in need of healing rather than simply criminals, the state seeks to reform rather than destroy. However, this initiative has divided opinion. Many victims and citizens feel betrayed, arguing that while common criminals receive harsh punishment, insurgents who caused widespread suffering are given therapy and reintegration packages. From a sociological lens, Operation Safe Corridor shows how the state uses therapeutic language to manage conflict and maintain order. It represents what Foucault (1977) called disciplinary power, a subtle form of control that hides behind the language of care. Safe Corridor may heal the body politic, but it also reveals how the state can turn therapy into a tool of control.”

When we place these three examples side by side, a clear pattern emerges. The Nigerian justice system is slowly becoming a space where medicine and law merge. However, the outcomes depend heavily on context, it also raises new concerns: As medical experts, particularly psychiatrist gain more influence in courtrooms, there is a growing expansion of clinical authority into traditionally legal domains. Psychiatric reports are often treated as decisive evidence, particularly in cases involving violent crimes, insanity pleas, or capital punishment. The reliance on medical testimony introduces new form of institutional power, as judges frequently defer to psychiatric recommendations without clear guidelines or consistent regulatory oversight (Ogulesi & Adeyemi, 2009). The process reflects Conrad’s (2007) model of institutional medicalisation, where non-medical institutions adopt medical approaches to managing deviance. However, in Nigeria, the weak forensic psychiatric infrastructure and lack of standardized protocols often result in uneven outcomes. While some defendants benefit from therapeutic diversion, others particularly those without access to legal counsel or psychiatric evaluation remain subject to conventional punitive measures, revealing structural inequalities within the system (Ihejrika, 2022). In today’s Nigeria, the boundary between the criminal and the patient is blurring. Justice is learning to speak the language of care, but care itself has become another face of control.

## **Conclusion**

This paper explored medicalisation of crime in the Nigerian Justice System through a sociological lens, revealing a complex interplay between legal, medical and institutional discourses. Drawing on foundational theories from medical sociology, particularly the works of Conrad, Foucault, and Becker, it has shown how medical narratives are increasingly employed to reframe criminal behaviour, shifting the offender's identity from a moral transgressor to a patient in need of treatment. While this shift may offer opportunities for more humane and rehabilitative responses to crime, it also raises critical concerns about justice, accountability, and institutional power. The expansion of clinical authority into legal domain has created new hierarchies of expertise, often without adequate regulatory oversight. Furthermore, unequal access to medical defences exacerbates social inequality, limiting the benefits of medicalisation to a privileged few. Importantly, the Nigerian context demonstrates both the potential and pitfalls of this phenomenon. The weak mental health infrastructure, absence of standardized forensic protocols, and ethical ambiguity surrounding indefinite psychiatric detention, calls for urgent institutional reforms.

## **Recommendations**

As the Criminal Justice System continues to navigate the blurred boundaries between punishment and treatment, there is a pressing need for a framework that protects both public safety and individual rights. Based on this the following recommendations are made:

- (i) Legal reforms should incorporate sociological insights on deviance, labelling, and social control. This would help policymakers design Justice Systems that avoid over-anthologizing crime while addressing social determinants of deviance.
- (ii) Initiatives like Operation Safe Corridor should include community dialogue, victim restitution, and long-term monitoring to ensure reintegration does not compromise justice.
- (iii) Educational programs should differentiate between genuine psychiatric conditions and criminal deviance, reducing misuse of medical language while promoting public awareness.
- (iv) Mental health services should be integrated into legal aid programmes to ensure that indigent defendants can access psychiatric evaluations and representation when needed.
- (v) Train Legal and Medical Professionals on Interdisciplinary Justice: Legal and medical practitioners should receive interdisciplinary training on mental health laws, psychiatric conditions, and the ethical boundaries of forensic psychiatry to prevent misuse or overreliance on psychiatric evidence.

- (vi) Rather than framing deviance as a medical problem, policymakers should recognize and address structural factors like poverty, unemployment, inequality, political marginalization, and weak institutions that foster crime and insurgency. Crime must be understood within its broader socio-economic context, not only as a medical condition.
- (vii) Justice must also consider victims. Treating offenders only as “patients” risks neglecting victims’ rights and reinforcing perceptions of injustice.

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