Nigerian Mental Health Act 2013 Assessment: A Policy towards Modern International Standards

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Abstract. The Nigerian Mental Health Act 2013 was re-introduced to the National Assembly by Hon. Samuel Adejare and Hon. Solomon Adeola. The Bill was first introduced in 2003 by Sen. Ibiapuye Martyns-Yellowe and Sen. Dalhatu Tafida until it was withdrawn in April 2009. The paper has two key aims, firstly to analyse the content of the Mental Health Act 2013, and secondly, examines the proposed Mental Health Act whether it provides a perfect solution to the current problems with regards to international best practices. The method study utilized secondary source of data from the Mental Health Bill Act 2013 and other documentary sources. The findings revealed that the Bill protect the rights of persons with mental disorders, ensure equal access to treatment and care, discourage stigma and discrimination and set standards for psychiatric practice in Nigeria. The paper recommends that Nigeria government should create inpatient mental health units and outpatient clinics to be integrated in the general hospitals; recruiting and training a sufficient number of health workers at all levels; training and supporting traditional healers in mental health and concluded that the Mental Health Act has made enough specific provisions to satisfy the World Health Organization (WHO)'s recommendations.

Keywords: Mental Health, lunacy, World Health Organisation, constitution, act, bill

1. INTRODUCTION

The World Health Organisation (WHO) estimates that about 20 percent of Nigerians suffer mental illnesses with mental disorders account for 13 percent of the global burden of disease. Experts have tasked government on the need to increase its investment in mental health, pass the Mental Health Bill and have a health policy on mental health as practiced in international experiences such as in Gambia among others (See http://www.businessdayonline.com/NG/index.php/music-a-gadget/52380-mental-health-on-the-rise-in-nigeria). Mental health systems are subsystem of the health care system, and how these services are organized, delivered and financed is significantly influenced by the way in which the overall health services system are run (Olson, 2006; cited by Jack-ide, et al 2012).

The WHO endorsed mental health as a universal human right and a fundamental goal for health care systems of all countries (WHO, 2005). Unfortunately, mental health systems in many low and middle income countries in sub-Sahara Africa face challenges in ensuring optimal mental health care services (Saraceno et al., 2007). A large number of the countries do not have mental health policies and appropriately trained mental health personnel, and are constrained by the prevailing public-health priority agenda and its effect on funding. Other challenges include resistance to decentralization of mental health services, resources and stigma and discrimination (Patel et al., 2007).

In Nigeria, the issue of mental health has attracted little attention, with mental health victims often stigmatised, scorned and neglected by families in the belief that their problem is beyond remedy. Many persons with symptoms of mental problems are not diagnosed, and many of those diagnosed often do not get treatment. The patients are often shackled, locked up and beaten. Many families that find their relatives' mental health issues too difficult or expensive to handle at home simply pass the responsibility to the prisons, creating a class of

persons known as "civil lunatics" (See http://www.businessdayonline.com/NG/index.php/music-a-gadget/52380-mental-health-on-the-rise-in-nigeria and AMNESTY INT'L, *supra* note 7, at 37). Instead of obtaining treatment at hospitals or mental health institutions, these "civil lunatics" are jailed in asylums within prisons, generally receiving no treatment (*See* Amnesty Int'l, *supra* note 7, at 37). The current law in Nigeria allows any building to house an asylum (*See* The Lunacy Act (1958) Cap. (112), Section 3(1)(a) (Nigeria)), and contains no requirements for treatment of "inmates" (*ibid. Subsection* 4, 13, 14(1)).

Provisions/Summary of Mental Health Bill, 2013
The Bill has 31 Sections, and is divided into 6 Parts with subsections:
(Starting from Short Title and Interpretation)
Parts I focuses on establishment of an institution for the care of persons with mental disorders.
Part II deals with admission of patient, medical recommendation, Order of discharge, removal of patient to a place of safety, child Offender and setting up of Mental Health Review Tribunal.
Part III is on application for admission and power of Court to Order Hospital Admission.
Part IV deals with property of patients and function of the Judge with respect to the property.
Part V focuses on consent to treatment, forgery or false entry of statement, relationship

Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state-owned mental hospitals financed and managed by various state governments, for a population of over 160 million people. Given the limited number of these hospitals, their catchment areas often go beyond their immediate location in terms of city or even state. None of the facilities have beds for children and adolescents. There is only one private community residential facility available in Lagos State with 10 beds, and it is administered by a religious organization for rehabilitation of persons with drug problems (WHO-AIMS, 2006). Nigeria also lacks clinical psychologists, occupational therapists, medical sociologists and social workers. Ironically, of the 506 African psychiatrists in the United Kingdom, 214 are Nigerians (see http://leadership.ng/news/110513/poverty-takes-toll-citizensmental-health).

Nigeria currently follows the same mental health legislation that was in effect before it gained independence from the United Kingdom in 1960 (*See* WHO MENTAL HEALTH ATLAS, *supra* note 3, at 349); and is yet to have an effective legal framework to regulate, cater for, or provide for the management of mentally ill persons and their affairs. The existing law is clearly insufficient to meet the challenges of proper regulation of mental health (See http://tribune.com.ng/index.php/tribune-law/43805-rashidi-yekinis-case-and-the-state-of-mental-health-law-in-nigeria). The lack of appropriate legislation has resulted in the poor state of mental health services, which violates the principles of the primary health care system. Mental health was adopted into the nation's Primary Health Care (PHC) in 1991, which in effect became its mental health policy (Federal Ministry of Health [FMOH], 1991). Since its adoption, the policy has not been fully implemented, and has not been revised (WHO-AIMS, 2006).

The proposed Mental Health Bill introduced by Hon. Samuel Adejare and Hon. Solomon Adeola of the House of Representatives, when passed, is expected to make elaborate provisions for the management of Mental Health in Nigeria. It repeals all existing legislation concerning the admission, treatment and care of persons suffering from mental disorder, and creates an environment for persons suffering from mental disorder to seek voluntary admission to and discharge from a mental Health Institution.

To this end, the objective of this position paper is to critically analyse the content of the Nigerian Mental Health Act 2013 with the view to assessing it based on the country's

international obligations and recommendations from the World Health Organization (WHO). Against this backdrop, this paper is organised into five sections: Introduction is in Section 1. Section 2 and Section 3 reviewed cross country comparisons and relationship with existing laws. Section 4 provided analytics comprising of major issues: comments, significance and challenges of the Bill while Section 5 concludes the study, respectively.

2. BRIEF LITERATURE REVIEW

This section reviews international countries experience in the enactment of mental health Act.

2.1 Cross-country comparison

In 1983, the United Kingdom Parliament passed the Mental Health Act 1983 (c.20) which applies to the people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property, and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes. The practice, described unofficially known as sectioning, is reviewed and regulated by the Care Quality Commission. The Act has been significantly amended by the Mental Health Act 2007. The main purpose of the Mental Health Act 1983, as amended in 2007, is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with and safeguards for patients (Read more http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034).

Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies. Part 2 also sets out the procedures for making an application for someone to be received into guardianship under the Act. While Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order, on the basis of two medical recommendations, for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a guardianship order. A restriction order may be imposed at the same time as a hospital order to place restrictions on the movement and discharge of a patient for the protection of the public; all movement is then subject to the agreement of the Secretary of State for Justice. This part of the Act also contains powers to transfer prisoners to hospital for treatment of a mental disorder (see http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034).

In United States, the Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services. In September 2007 the Senate passed legislation that would require health insurers to provide the same level of coverage for treatment of mental illnesses as they do for physical illnesses. A House companion bill passed in committee in October 2007, and was signed into law, as a last-minute addition to the Emergency Economic Stimulus Act on October 3, 2008 (See http://www.ehow.com/list_6903292_mental-health-laws-united-states.html#ixzz1Yd57bYLo).

The 2008 bill, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was not simply a renewal of the 1996 legislation. Similar to the 1996 legislation, the new measure requires health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses and includes an exemption for small business with fewer than 50 employees.

The MHPAEA actually expands parity by including deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital days, and covered out-patient visits. Another major improvement is that the new law includes parity for substance abuse treatment (See http://www.advocacyoncall.org/health/mental_health_parity/).

In South Africa, no official mental health policy, its Mental Health Care Act (MHCA) No. 17 of 2002 drives its mental health services and programs. The legislation made mental health a major public health issue and identified steps needed to address relevant services and improved quality of care. The Act is grounded in the principles of respect for human rights, and the promotion and protection of those rights (See WHO, 2010).

The Act ensures that hospitalizing persons involuntarily due to harm of self and others does not take away their right. It requires certifying such persons within a 72-hours assessment period, allowing a period where they can potentially be stabilized and be cared for in the community. Certification was usually done by psychiatrists and doctors, but the new Act recognizes that there are few psychiatrists, particularly in rural areas, and it enables mental health care practitioners to make such decisions (MHCA, 2002). A mental health care practitioner includes psychiatrists, psychologists, doctors, nurses, or social workers who trained in mental health. Once certified, patients are admitted to a hospital to be seen by qualified personnel. The intentions of the South African MHCA 2002 were to protect and destigmatise the mentally ill. For example, persons with mental disorders are regarded as 'mental health services users', since anyone could be predisposed as a user of mental health care services. The review and appeal process protects the rights of service users, giving them a right to representation, and the right to appeal against decisions made by mental health care practitioners concerning their care (Jack-ide, et al, 2012).

3. RELATIONSHIP WITH EXISTING LAWS

The objectives of the present Bill is to protect the rights of persons with mental disorders, ensure access to treatment and care, discourage stigma and discrimination and set standards for psychiatric practice in Nigeria. Compare section 13 of the Lunacy Act, which places no sentencing limit on magistrates after holding an inquiry into the person's state of mind and receiving a signed statement from a medical officer, with Section 36(1) of the (constitution of Nigerian, 1999), which gives any person detained the right to a "fair hearing within a reasonable time by a court or other tribunal". The provision of the Lunacy Act no doubt violates the Nigerian constitutional rights of those with mental disorders. Therefore, the proposed Bill is an updated Nigerian mental health law which seeks to advance the human rights of those its covers.

4. ANALYTICS

The enactment of the Bill into law would indeed mark progress in Nigeria's mental health law toward modern international standards. First, the present Bill narrowed the coverage of the existing law by removing the broad definition of "lunatic" and replacing it with the term "mental disorder" (i.e. the proposed Bill (HB. 13.02.465, Section 2(a) (Nigeria 2013) defined "mental disorder" as "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning. Social deviance or conflict alone without disturbance of mental functioning is not mental disorder"). The latter term is much more accessible to the medical community than the term "lunatic" (The WHO, 1992 has said that the term "disorder" implies the "existence of a clinically recognizable set of symptoms or behavior..."). The Bill also defined additional terms, which provided more guidance in application than the Lunacy Act (see HB. 13.02.465 Section 2 (Nigeria 2013).

Second, Lunacy Act (1958) Cap. (112), Subsection 11–13 (Nigeria), allowed magistrates to play a longer role in the admission decision but the proposed Bill under Section 9 (1)b, directing applications for compulsory admission to the medical director of the hospital to which admission is sought. For each type of admission, the applicant (i.e., the person applying to admit another person) had to base the application on two grounds: (1) the subject "is suffering from mental and behavioural disorder of a nature or degree which warrants his compulsory admission," and (2) the subject "ought to be so detained in the interest of his own

safety or with a view to protecting the safety and interest of other persons" (See Ibid Section 5 (a-b)).

Third, in a major departure from the Lunacy Act, which does not limit the duration of detention when the full procedural process is followed, the present Bill allowed detention for a maximum of 180 days with renewal of the application. Since a person detained could challenge their detention by applying to the Mental Health Review Tribunal, the only legal party involved in compulsory admission cases, is within 180 days of admission (see HB.13.02.465, Section 8(5-6)).

Finally, the Bill has repealed the Lunacy Act in its entirety (i.e. Ibid. Section 31(a). Any other law in force dealing with the "admission, treatment, discharge, or any other issue relating to mentally disordered patients" at the time the Bill would have come into force was to be trumped by any provision in the Bill. *Id.* section 31(2)(a)), it did recognize as valid any orders for involuntary detention made under the Lunacy Act (Ibid. Section 31(3)).

However, the significant step in enacting any bill is to understand and articulate major issues, significance and challenges. Understanding these towards the enactment of mental health Bill, 2013 cannot be over-emphasised. Some of these issues are briefly examined below:

4.1 Major issues: comments

Nigeria has entered into two binding international legal agreements that govern human rights and provide general principles by which to judge any Nigerian mental health law. First, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) Art 12(1) December 16, 1966, 993 "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The general language in this covenant does not provide states much guidance on how to ensure this right for their citizens, but the principles of a new law should at least comply with the broad rights guaranteed by the covenant (See U.N. Econ. & Soc. Council, Comm. on Econ., Soc., & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000)). To this end, the proposed Mental Health Act recognized the need to address mental health issues as they relate to the health of the individuals affected as well as the safety of the public" (see HB.13.02.465, Section 5(b)).

Second, the Bill also sought to ensure a high quality of health for patients once confined in treatment facilities by directing the Minister of Health to establish minimum standards for such facilities (See Ibid Section 3(2)). The purpose appeared to be well-intentioned and legitimate attempts to guarantee "the highest standard of physical and mental health" (see ICESCR, *supra* note 99, art. 12(1)).

Third, Nigeria has also committed to recognize and give effect to the rights declared in the African Charter on Human and Peoples' Rights (Also read more on African Charter on Human and Peoples' Rights art. 1, June 27, 1981, 21 I.L.M. 58, *available at* http://www.africa-union.org/root/au/Documents/Treaties/Text/Banjul%20Charter.pdf (signed by Nigeria Aug. 31, 1982; ratified June 22, 1983). Beyond including language identical to that of the ICESCR, as quoted above, the Charter provides for the general right to an environment favorable to further development and specifically requires "special measures of protection for the disabled" (See Ibid. art. 18(4) "The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs"). The proposed Bill have complied with the provisions of the Charter on its face by requiring treatment facilities to meet minimum standards (see HB.13.02.465, Section 3(2)), separate units for mental health in hospitals and primary care centers (See Ibid. Section 3(8)), and stricter procedures for compulsory admission for treatment (see Ibid. Section 20(1)).

Also, the World Health Organization (WHO) has compiled a resource book to "assist countries in drafting, adopting, and implementing" mental health legislation. This book describes different provisions that countries should incorporate into their mental health legislation in order to protect the rights of those with mental disorders, It does not recommend that countries follow the provisions discussed in the book exactly, as every legislative system is different and each country has its own particular needs (See WHO RESOURCE BOOK, *supra* note 54, at xv. Id. See *Id.* at xv, 19). Annexed to the Resource Book is the WHO Checklist on

Mental Health Legislation ("the Checklist"), which provides a way for countries to assess their mental health legislation by answering the questions, posed in the document (see *Ibid.* at xv, 19. *Ibid.* at annex 1. See ib*id*. at 120-121).

The procedural elements of compulsory admission in the Bill largely complied with the recommendations in the Checklist, which represented a dramatic improvement from the current law. Second, the proposed Bill narrows the requirements for involuntary detention from the mere presence of a mental disorder, as recommended by the WHO. It also mirrored the recommendations regarding the number of medical practitioners who must certify the patient as qualified for involuntary detention, the qualifications of those medical practitioners, and the patient's right to appeal. In dealing with emergency situations, the Bill followed the general principles implied in the Checklist. On the other hand, the Bill's provisions that allow for the use of members of the police force in certain circumstances closely track the recommendations of the WHO.

Finally, the Checklist calls for oversight and review mechanisms to protect the rights of those subject to involuntary detention. The proposed Bill make provision for setting up Mental Health Review Tribunal and given the Minister of Health power to determine the number of tribunals, their composition, and their rules of procedure (See http://law.wustl.edu/WUGSLR/Issues/Volume10_2/p%20397%20Westbrook%20Note%20book%20pages.pdf).

4.2 Significance and challenges of the bill

The significance and challenges of the mental health Bill is briefly summarised below for clarity purposes:

4.2.1 Significance of the bill

- The Bill have protected those detained by requiring facilities to meet minimum standards set by the

Minister of Health (see *HB.13.02.465,* Section 3(4)).

- The Bill have also placed restrictions on the type of treatment provided and the circumstances under which it could be provided. For example, consent have been generally required for any treatment (see HB.13.02.465, Section 25(3)(a-b)), and the patient can withdraw consent at any time (see Ibid. Section 25(4)).
- The Bill have provided additional procedural protections for those subject to it by creating four types of compulsory admission: Voluntary Admission, Involuntary admission for observation, admission pursuant to an emergency application, and Involuntary admission for treatment (See Ibid Section 4-8).
- One of the main problems with the Lunacy Act is its lack of provision for treatment of people detained for mental health issues; the Bill clearly identified treatment as the purpose of detention (see Ibid. Section 8(2)).

4.2.2 Challenges of the bill

- There may be a tendency by health care providers to stick to rigid guidelines which might not fit the profile of all patients. People are too complex and giving client-centered care may suffer when trying to pigeon-hole patients into a system that might not meet their immediate needs. A breakdown in communication between parties can also cause confusion as to what part of the process the patient is in. Also, bureaucracy has a way of throwing a wrench in things and can get in the way of important care (See http://synapticgymnastics.blogspot.com/2010/10/benefits-and-disadvantages-of-mental.html).
- An emergency application would not have required the recommendation of a medical practitioner, since it could only be filed in case of "urgent necessity" (see HB.13.02.465, Section 18(1) only a health care worker or a relative of the person could make an emergency application. *Id)*

5. Conclusion

The Proposed Bill have succeed in providing for protection of human rights by keeping with the WHO's recommendations in its Mental Health Checklist and also provide a greater improvement from the current law in Nigeria. The experiences of international best outlooks such as South Africa could aid in assessing the quality of the present Bill. South Africa adopted new mental health legislation in 2002, repealing its outdated apartheid-era law. The former law, much like Nigeria's current law, "embodied a custodial approach to mental disorder and had not only dismally failed to protect a range of human rights that people with mental disability are entitled to, but was itself responsible for certain abuses of human rights." The proposed Bill included similar procedural protections for involuntary commitment as the South African Mental Health Care Act. Therefore, the similarity between the provisions should influenced the decisions of the Nigerian legislature to pass this Bill into law with the fact that the Bill have also provide enough specific provisions to satisfy the WHO's recommendations.

References

Jack-Ide, Uys & Middleton (2012). A comparative study of mental health services in two African countries: South Africa and Nigeria. *International Journal of Nursing and Midwifery*, 4(4), 50-57.

Mental Health Legislation and Involuntary Commitment In Nigeria: A Call For Reform. [Vol: 10: 397: 2011]. Retrieved 20 May, 2013 from http://law.wustl.edu/WUGSLR/Issues/Volume10_2/p%20397%20Westbrook%20Note%20book%20pages.pdf .

Olson, P.R. (2006). *Mental Health Systems Compared:* Great Britain, Norway, Canada, and United States. Illinois: Charles Thomas, 7.

Saraceno B, Van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. (2007). *Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries.* Lancet. 370: 1164-74.

World Health Organization (2005). *WHO Resource Book for Mental Health, Human Rights and Legislation.* Stop Exclusion Dare to Care. Geneva. Available at http://www.who.int/mental_health/policy/resource_ book_ MHLeg.pdf (Accessed 10 May 2013).

World Health Organization-Assessment Instrument for Mental Health Service (2006).

WHO-AIMS Report on Mental Health in Nigeria. World Health Organization and Ministry of Health Ibadan, Nigeria. Available at http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf (Accessed 8 May 2013).

Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, et al. (2007). *Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries.* Lancet, 370(9591): 991-1005.