NATIONAL MENTAL HEALTH ACT 2021 AS A SILVER LINING FOR THE PROTECTION OF THE FUNDAMENTAL RIGHTS OF THE MENTALLY ILL PATIENT IN NIGERIA*

Abstract

Prior to the enactment of the National Mental Act 2021, mental treatment in Nigeria was significantly misconstrued. The focus was on the confinement of persons with mental illnesses rather than effective treatment. The confinement was not always accompanied by proper mental care and treatment but often resulted in severe violation of the fundamental rights of the mentally ill. Many experienced harsh and inhumane treatments which achieved more harm than good. The new Mental Health Act provides some exciting innovations for the treatment of mental illness and offers extensive protection for the rights of mentally ill persons. The focus of this paper is to evaluate the adequacy of these provisions. The doctrinal and comparative research methodologies have been adopted. The findings of this paper reveal that the provisions of the mental legislation are robust enough for the protection of the rights of mentally ill patients. However, legislative intervention alone will not offer the deserving succour. Some socio-cultural and religious factors may impede the protection and enjoyment of the rights of mentally ill persons to effective medical treatment. This paper concludes by drawing lessons from international standards and best practices and recommends that advocacy, enlightenment, and investment in human and infrastructure will be required for the effective protection and treatment of mentally ill persons.

Keywords: Mental Wellness, National Mental Health Act 2021, Health Care, Fundamental Rights

1. Introduction

Mental health represents one of the core elements of health and indicates[1] a 'state of wellbeing by which a person realizes his or her abilities, can cope with the normal stresses of life, can work productively and can make a contribution to his or her community.[2]' Conversely, Mental illness or disorder may be described as a behavioural or psychological syndrome that causes significant distress or disability resulting in loss of freedom and increased risk of death, pain or important loss of freedom.[3] Mental illnesses include a range of disorders such as anxiety disorders, depressive disorders, trauma and stress-related disorders, personality disorders and psychotic disorders.[4] These illnesses vary in form and degree. Therefore, the manifestations and symptoms differ accordingly. Thus, while a person with depression may show symptoms of sadness, tiredness, loss of appetite and low self-worth, a person with schizophrenia may exhibit symptoms of hallucination and delusion.[5] Nevertheless, many mental illnesses can be properly managed through early intervention and adequate treatment. Treatment for mental illness ranges from medication and psychotherapy to brain stimulation treatment, outpatient treatment, and hospitalisation, depending on the severity of the disorder.[6] However, the wide classification of mental illnesses and the variety of treatment options were not available in previous times.[7] During the Middle Ages up until the 17th century, mentally ill persons were perceived to be witches or persons possessed by evil spirits/demons. Thus, they were either executed or burnt as witches, subjected to trephining (drilling of a hole in the skull to release the evil spirit) or exorcism. They were also chained, deprived of food, beaten and bloodletting. Others were regarded as 'town fools' or 'village idiots' and were either treated as charity cases or made the object of societal amusement.[8]

The 17th century, referred to as the period of 'The Great Confinement' in Europe, was characterised by the isolation and ostracism of mentally ill persons.[9] Thus, this period emphasised confinement rather than treatment of mentally ill persons. Initially, they were classified as deviant persons with vagrants and delinquents and were chained in prisons if found to be dangerous. Some were kept in workhouses under the care of clergymen, while wealthier families placed their mentally ill relatives in private homes or cared for them at home.[10] Mentally ill persons were regarded as insane

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[1] World Health Organization 'Mental Disorders' available at https://www.who.int/news-room/fact-sheets/detail/mental-disorders (accessed 19 21 February 2024)

[2] World Health Organization 'Mental health: strengthening our response' available at https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (accessed 19 21 February 2024)

[3] Shahrokh NC, Hales RE, Phillips KA, Yudofsky SC, 'The language of mental health: A glossary of psychiatric terms' *American Psychiatric Pub* (2011) 3, 7.

[4] Brandt, et al, *Vertigo and dizziness*. (Springer-Verlag London Limited, 2005)

[5] World Health Organization 'Mental Disorders' available at https://www.who.int/news-room/fact-sheets/detail/mental-disorders (accessed 19 21 February 2024)

[6] Bronfenbrenner U., 'Is early intervention effective?' *Teachers College Record*, (1974) 76(2), 279-303.

[7] Agius, M., et al, 'Developing outcome measures for serious mental illness; using early intervention as an example' *Psychiatria Danubina* (2009) 21(1), 36-42

[8] Roberts Albert, 'Historical Perspectives on the Care and Treatment of the Mentally Ill' *The Journal of Sociology & Social Welfare*, (1987) 14, 77

[9] Foucault Michael, *Madness and Civilization; A History of Insanity in the Age of Reason* (Psychology Press, 2001)

[10] Foerschner,' The History of Mental Illness: From Skull Drills to Happy Pills.' *Inquiries Journal*, (2010) 2

or lunatic. [11]Asylums were also established as specialised hospitals for the mentally ill. These included the St. Mary of Bethlehem (Bedlam) Hospital in London and the Hôpital Général of Paris. The purport of asylums was to keep mentally ill persons away from the public. Many times, such persons were confined involuntarily, chained and sometimes displayed to the public for amusement.[12] Mentally ill persons were treated like animals and kept in dark, filthy and cold rooms. The initial purpose of asylums was not treatment, however, where treatment was attempted, it entailed harsh methods such as the Bath of Surprise (dropping a patient into ice-cold water), lobotomies, and confinement in narrow cages, strait jackets and chains.[13]

In the late 18th century, protests against the poor treatment of mentally ill persons led to the development of new approaches concerning the proper care of such persons. One of such was the notion of moral treatment proposed by Phillipe Pinel in Paris. His approach entailed treating mentally ill persons with kindness, consideration and compassion. Another approach was the mental hygiene movement led by Dorothea Dix in America.[14] The movement sought to establish hospitals that provided adequate care and comfort to mentally ill persons. The 19th century also featured an attempt to curb arbitrary and unlawful detention in asylums. Laws such as the English Lunacy Act 1890 introduced the requirement of judicial certification for compulsory admission of mentally ill persons in asylums.[15] Subsequently, mental hospitals such as the Bethlem hospital began to accept voluntary 'uncertified' cases. This led to the introduction of voluntary admission as a form of treatment under the 1930 Mental Health Treatment Act. By providing for voluntary admission, patients who were not certifiable could, nevertheless, obtain prompt treatment. This resulted in a rise in the number of institutionalized patients.[16]

However, developments in psychopharmacology in the 20th century and the success of drugs such as chlorpromazine and chlordiazepoxide in reducing the symptoms of psychosis and anxiety paved the way for the deinstitutionalisation of many persons with mental illnesses. Coupled with the introduction of community care, the onset of the use of antipsychotic drugs led to the release of many institutionalised patients. This period also witnessed the development of human rights standards concerning mental health, with the adoption of international instruments such as the United Nations (UN) Declaration on the Rights of Mentally Retarded Persons 1971 and Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991. These standards established the fact that mentally ill persons enjoyed the same rights as other persons, including the right to family and community life. However, where institutional care was necessary, it ought to follow a proper procedure that contained safeguards to prevent abuse. Subsequent national legislation and case law, therefore, began to emphasise the rights of mentally ill persons and the need for informed consent to treatment. With the existence of other forms of treatment, involuntary commitment and treatment became an exception rather than a primary option.[17]

Recently Nigeria enacted the National Mental Health Act 2021 to bring the treatment of mental health patients in Nigeria closer to the best global practices. This paper aims to interrogate the adequacy or otherwise of the provisions of the National Mental Health Act 2021. In addition, this paper highlights the significance of paying attention to other obstacles that may hinder the delivery of efficient mental health services in Nigeria. Lessons will be drawn from other jurisdictions. This research adopts the doctrinal and comparative legal research methods. These methodologies help to understand the provisions of different legislations and approaches to mental health in other jurisdictions and best practices across the globe. Part I is the introductory. Part II examines the rules and legal framework for the treatment of mentally ill persons in Nigeria. Part III highlights the international best practices. Part IV examines other factors that may impede the protection and treatment of mentally ill persons and Part V concludes with recommendations.

2. Legal Rules Relating to the Treatment of Mentally Ill Persons requiring Hospitalisation

There are several mental disorders that may be effectively treated without the need for hospitalisation. However, hospitalisation may be required where a person has a more severe form of mental illness, where they pose a risk of

[11] Lila P. Vrklevski, Kathy Eljiz, and David Greenfield, 'The Evolution and Devolution of Mental Health Services in Australia' *Inquiries Journal*, (2017) 9, 1

[12] NOBA 'History of Mental Illness' available at https://nobaproject.com/modules/history-of-mental-illness (accessed 23 February 2024)

[13] CVLT Nation 'Horrifying Psychiatric Treatments from The Age Of Reason' available at https://cvltnation.com/horrifying-psychiatric-treatments-from-the-age-of-reason/ (accessed 21 September 2021)

[14] Parry and Manson, 'Dorothea Dix' *American Journal of Public Health* (2006) 96 (4), 624–625. doi:10.2105/AJPH.2005.079152. PMC 1470530 accessed 20 January 2024

[15] Szmukler, Lawrence and Gostin, 'Chapter 8 - Mental Health Law: 'Legalism' and 'Medicalism' – 'Old' and 'New'' in *Part II - The Cogwheels of Change* (Cambridge University Press, 2021)

[16] Jonathan Andrews, Asa Briggs, Penny Tucker, Keir Waddington, *The History of Bethlem* (Psychology Press, 1997) 653 - 655

[17] Anna Saya, Chiara Brugnoli, Gioia Piazzi, Daniela Liberato, Gregorio Di Ciaccia, Cinzia Niolu, and Alberto Siracusano, 'Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review' *Frontiers in Psychiatry,* (2019) 10, 2

harm to themselves or others, or where the mental health professional recommends such for closer observation and treatment. Owing to the peculiar history of poor treatment of mentally ill persons, legal principles and guidelines have been developed regarding the treatment of such persons, particularly in hospital settings, to ensure their protection from abuse and inhumane treatment. Hospitalisation due to mental illness may take the form of voluntary admission, involuntary commitment or emergency detention. Each form of hospitalisation possesses separate legal and medical rules and consequences. These shall be discussed in detail below.

Voluntary Admission

Voluntary admission refers to the admission of a patient to a psychiatric hospital or other medical facilities without coercion. Initially, it was believed that mental illness was equivalent to incompetence. It was wrongly believed that anyone suffering from mental illness does not have the free will to request admission for treatment and that the hospitalisation of a mentally ill person required the intervention of the court. However, with the support of psychiatrists, particularly during the psychoanalytic movement, who emphasised the importance of a patient's cooperation in providing effective treatment, voluntary admission became recognised.[18] Voluntary admission has now been recognised and supported by legislation and case laws across the globe. One of the key features of voluntary hospitalisation is volition i.e. a person must consent to voluntary admission. This raises the issue of competency to consent to voluntary admission. In the American case of *Zinermon v Burch*[19] Mr Burch, who had supposedly been admitted as a voluntary patient, brought an action against the Florida state mental hospital, claiming that he lacked the capacity to consent to such admission at the time he was brought in. Upon arrival at the hospital, he was confused, disoriented and believed that he was 'in heaven'. He was, nevertheless, asked to sign consent forms for admission and treatment. He, therefore, argued that he had been denied the procedural safeguards of an involuntary commitment process. Although the court did not make a ruling regarding the merits of Mr Burch's case, the court held that 'it is hardly unforeseeable that a person requesting treatment for mental illness might be incapable of informed consent, and that state officials with the power to admit patients might take their apparent willingness to be admitted at face value'. The court also expressed the view that this could have been avoided if the State had guided the hospital's power to admit patients. Another core aspect of voluntary admission is the right to request discharge. This was affirmed in the case of *In re Clement*[20] where the court established the unqualified right of a voluntary patient to request to leave a mental health facility at any time. According to the court, this is the 'focal point of his voluntary status.'

Emergency Detention and Police Powers to Apprehend and Restrain the Mentally Ill

Certain situations involving the risk of harm to self and others such as a potential suicide or disturbance of public peace by a person with a mental illness may necessitate the intervention of the police, particularly when the courts and medical care are unavailable. In such instances, it may be dangerous or impracticable to delay hospitalisation until the full procedure for admission can be adhered to. Hence, the police are vested with powers to apprehend such persons without a warrant and restrain them under emergency detention. Emergency detention laws permit the apprehension and restraint of mentally ill persons in short term-custody.[21] The power of the police to apprehend and restrain can be traced to the early concept of 'police powers', which permitted the state to curtail the liberty of individuals who pose a risk of harm to the health and safety of the society; and '*parens patriae'* under which the king acted as the 'parent of the country.[22]' For instance, under the English Vagrancy Act of 1744, justices of peace were authorised to apprehend mentally ill persons who were 'dangerous to be permitted to go abroad[23]' The right to restrain a mentally ill person was also recognised by common law. In *Warner* v. *State*[24], the court noted the power to restrain at common law 'summarily and without court process, an insane person who was dangerous at the moment. The power was to be exercised, however, only when necessary to prevent the party from doing some immediate injury either to himself or others. Mental health legislation has therefore established the power of the police to apprehend a mentally ill person. For example, the British Columbia's Mental Health Act 1996 permits a police officer or constable to take a person who is 'acting in a manner likely to endanger that person's own safety or the safety of others and is apparently a person with a mental disorder'. Another example can be found in New York's Mental Hygiene Law which permits any peace office or police officer to take into custody 'any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in harm to himself or others.

[18] Paul S. Appelbaum, Thomas G. Gutheil, *Clinical Handbook of Psychiatry & The Law* (Lippincott Williams & Wilkins, 2007) 38.
[19] 494 U.S. 113 (1990)
[20] 34 III. App. 3d 574, 340 N.E.2d 217 (1975)
[21] Arthur R. Jr. Matthews, Observations on Police Policy and Procedures for Emergency Detention of the Mentally Ill' *Journal of Criminal Law and Criminology*, (1970) 61 284.
[22] Neil B. Posner, 'The End of Parens Patriae in New York: Guardianship under the New Mental Hygiene Law Article 81' *Marquette Law Review,* (1996) 79 604-606
[23] Larry Gostin, Mental Health Services: Law and Practice (Shaw & Sons Ltd, supplement issue no 18, June 2000) 1.02.2
[24] 297 N.Y. 395 (1948)

At common law, the power to restrain could only be exercised where there was a risk of harm to self or to others. In the case of *Look v. Dean*[25], the court held that 'as to persons who are not dangerous, they are not liable to be thus arrested or restrained by strangers. However, mental health legislations of certain jurisdictions extend the power of the police to arrest and restrain to cases where a person is at risk of substantial mental or physical deterioration. For example, Section 14 Nova Scotia's Involuntary Psychiatric Treatment Act 2005, allows a peace officer to take a person into custody where he has reasonable ground to believe that 'the person, as a result of the mental disorder, is likely to suffer serious physical impairment or serious physical deterioration, or both'. It is important to note that it has been held that a delay in providing appropriate psychiatric treatment to a person who has been apprehended by the police may amount to degrading treatment. In the case of *M.S v United Kingdom*[26], a man was found in his car, agitated and pressing the horn repeatedly. He was taken to a police station where it was determined that he suffered from a mental illness of a nature warranting detention in hospital in his interest and that of the safety of others. However, they were unable to secure his admission at a mental health facility until after the 72-hour limit for emergency restraint. During this period, his mental state deteriorated to the point where he removed his clothing and began waving his testicles about. The European Court on Human Rights (ECtHR) held that though it was not intended, the conditions in which the applicant was kept amounted to 'an affront to human dignity' and amounted to degrading treatment.

Civil Commitment/Involuntary Hospitalisation

Civil commitment/Involuntary hospitalisation refers to the process by which a person is admitted for mental health care without their consent. Civil commitment finds its origin in the concepts of police powers and *parens patriae* in English law. *Parens patriae* refers to the power of the king to act as 'the general guardian of all infants, idiots, and lunatics. By assuming this role, he had the duty to cater for all persons who were incompetent to care for themselves (Stromberg & Stone, 1983). Police powers denote the power of the state to safeguard the welfare, safety, health and morals of the public. The power to order the involuntary hospitalisation of a mentally ill person, being one which leads to a restriction of liberty, cannot be exercised arbitrarily. As was noted by the court in *O'Connor* v. *Donaldson*[27] 'a finding of 'mental illnesses alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement'. A civil commitment must, therefore, adhere to the criteria prescribed by the mental health law applicable within the relevant state. Different countries have adopted their individual criteria for civil commitment. Nevertheless, among the many laws on civil commitment, the standard of dangerousness appears to be the most prominent. It was recognised in the case of *State* v. *Sanchez*[28], where the court upheld the detention of a man on the grounds that he was 'mentally ill and likely to injure himself if allowed to remain at liberty'. Also, in the case of *O'Connor* v. *Donaldson*, the court noted that 'a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. Conversely, courts have expressed displeasure concerning vague and overbroad commitment standards. For example, in the case of *Bell* v. *Wayne County General Hospital at Eloise*[29]where a statute provided a person who is mentally ill may be detained where it appears that it is 'necessary and essential so to do', the court held that such a provision would allow the commitment of anyone who fell within the description of a mentally ill person. Thus, it was regarded as 'fatally vague and overbroad'. The court noted that to justify the massive curtailment of liberty occasioned by civil commitment, it must be based on 'threatened or actual behaviour stemming from the mental disorder, and of a nature which the state may legitimately control i.e., that causing harm to self and others.'

The problem that arises with the singular application of the dangerousness criteria becomes evident in cases of *anosognosia* and refusal to receive treatment. This occurs where a person lacks insight into their mental illness and therefore refuses to seek treatment for it. In cases where such people do not pose a threat of immediate harm to self or others, they would not meet the criteria for involuntary commitment.[30] This has led to devastating consequences in certain cases. For example, on the 10th of January 2001, a man named Scott Thorpe shot and killed three people including a 19-year-old lady named Laura Wilcox. He had suffered from paranoia but had refused to be hospitalised and since he posed no immediate risk of harm, he could not be committed involuntarily (BBC, 2018). Laws may therefore provide for the commitment of persons who are at risk of mental deterioration. For instance, Brian's Law (Mental Legislative Reform) 2000, a Canadian law which was passed after the killing of Brian Smith by a man who suffered from untreated schizophrenia, amended the Ontario Mental Health Act to include the standard of substantial mental or physical deterioration. See Brian's Law (Mental Health Legislative Reform) 2000. This criterion was

[25] 108 Mass, 116 (1871)
[26] (2012) ECHR 804
[27] 422 U.S. 563 (1975),
[28] 457 P.2d 370 (1969)
[29] 384 F. Supp. 1085 (E.D. Mich. 1974),
[30] Jacob, B. R et al, 'Developments in the Law—Civil Commitment of the Mentally Ill' *Harv. L. Rev*., (1974) 87, 1190, 921.

upheld in the case of *Thompson and Empowerment Council* v. *Ontario*[31] where the court held that the law was not overboard, arbitrary or disproportionate to legitimate state interest.

In relation to involuntary commitment, courts have also established the need to follow due process in commitment proceedings. In the case of *Lessard* v. *Schmidt*[32] Miss Lessard was picked up outside her home by two police officers and taken to a mental health centre where she was detained on an emergency basis. Pursuant to *ex parte* proceedings, she was detained for ten days under an order of court. She was subsequently detained for an additional ten days following an inquiry by a doctor who claimed that she suffered from schizophrenia and required permanent commitment. She was not previously informed of these proceedings. She was also not given proper notice of her commitment hearing, where she was committed for thirty more days. The court held that she ought to have been given sufficient notice of the commitment hearing and that such notice should include the necessary details as to the date, time, reason for the detention and the standard used. The court in *Lake v Cameron*[33] also emphasised the need to consider the Least Restrictive Alternative in civil commitment. Hence, where alternatives are available instead of institutionalisation/hospitalisation, they should be employed to ensure that the restriction of liberty is as minimal as possible, given the circumstances surrounding commitment. Another important factor to note regarding involuntary hospitalization is that it does not connote involuntary treatment[34]. Hence, where a person is admitted involuntarily, they may become competent to give consent to treatment and where they refuse treatment such a decision may be upheld. In *Stein v NYC Health and Hospitals Corporations*[35], the court held that an involuntarily admitted patient, could, nevertheless refuse consent to Electro-convulsive therapy (ECT).

3. Nigerian Legislation on the Treatment of Mentally Ill Persons

Recent History and the Lunacy Act 1964

Until 2021 the mental health legislation in Nigeria was the Lunacy Act 1964. Being only a slight modification of the Lunacy Ordinance of 1916, the Act did not reflect many concepts in modern-day mental health care. The Act whose purport was ‘to provide for the custody and removal of lunatics’, unsurprisingly failed to provide for voluntary admission and voluntary treatment. Section 10 of the Act provided for the temporary detention of a suspected ‘lunatic’ pursuant to the issue of a certificate of emergency by a medical officer. Such detention may be for a period of up to seven days, which may be further extended with the authority of the magistrate. Section 11 of the Act empowered a magistrate to hold an inquiry into the state of mind of a person where it is suspected that he is a ‘lunatic and a proper subject for confinement’. Under this power, a magistrate may issue a warrant for the arrest of a suspected person to compel him to appear for the inquiry. The magistrate shall then appoint a medical practitioner to examine the suspected person. Where the medical practitioner is satisfied that the suspected person is indeed a ‘lunatic and subject for confinement’, he shall issue a medical certificate indicating so, after which the magistrate shall issue an order for committal to an asylum. If the person is not found to be a ‘lunatic’, he will be discharged. The Act also provides that a person cannot be detained for the purpose of inquiry into the state of his mind beyond a period of one month. Where a person is adjudged to be a ‘lunatic’ and committed, he may be discharged upon the issue of a certificate of sanity or an order of the Governor.

The Lunacy Act 1964 was an outdated piece of legislation. This is evident in the use of words such as ‘lunatic’ and ‘insane’ to refer to mentally ill persons. The Act was problematic in many ways. First, the Act failed to properly define what a mental illness is. The term mental illness is completely absent from the Act which instead employs the word ‘lunatic’ (an ‘idiot’ and any other person of unsound mind). Without an adequate definition of mental illness, it would be impossible to recognise who can be admitted for the purpose of treatment. Secondly, the Act did not provide for voluntary admission of mentally ill persons. It, therefore, did not view mentally ill persons as competent to take charge of their own treatment. Furthermore, the Act adopted a vague criterion for involuntary commitment as it did not attempt to define the phrase ‘proper subject for confinement’. By adopting a vague standard for involuntary commitment, it puts mentally ill persons at risk of abuse, unlawful detention and forced treatment.[36] The Act also failed to provide any procedural safeguards with regard to involuntary commitment. It contained no provisions concerning the need for due process, the right to appeal or review commitment or the right to be treated in the least restrictive environment. Thus, it reflected no attempt to balance the right to autonomy and liberty against the need to

[31] 2013 ONSC 5392
[32] 349 F.Supp. 1078 (1972)
[33] 364 F.2d 657 (1966)
[34] Agius, M. et al, ‘Developing outcome measures for serious mental illness; using early intervention as an example’. *Psychiatria Danubina* (2009) 21(1), 36-42.
[35] 335 N.Y. 2d. 461 (Sup. Ct. 1972)
[36] Obayi, N. O. K., et al, ‘Universal Health Coverage and Healthy Living in South-East Nigeria: How Far with Mental Health?’ *Open Journal of Psychiatry*, (2017) 7(03), 199.

protect the interest and welfare of the individual and the State. Additionally, the Act did not provide for police powers to apprehend and restrain. The failure to do this led to the poor handling of mentally ill persons by police officers who were left with no choice but to detain a mentally ill person in prison where an emergency occurs.

Mental Health Law, Lagos State 2018

In 2018, the Lagos State House of Assembly passed the Mental Health Law of Lagos State, repealing the Lagos State Lunacy Law. In contrast to the Lunacy Act, the Lagos State Mental Health Law speaks to the concepts of voluntary admission, involuntary admission and police powers to restrain mentally ill persons. Section 30 of the Law provides for voluntary admission, stating that a person in need of treatment for a mental health disorder may receive treatment at any mental health facility in the state. Section 31 outlines the process for the admission of a voluntary patient, addressing areas such as informed consent and discharge. Section 33 provides for the right of a voluntary patient to discharge. However, where a request for discharge is made and the conditions for involuntary admission are present, such discharge would not be granted. Section 34(1) of the Law makes provisions for short-term involuntary admission and treatment. It states that upon application by the nearest relative of a patient or a certified medical worker, a person may be involuntarily admitted where the person (i) is at risk of serious harm to self or others; or (ii) where there is a substantial risk of deterioration of mental illness. Section 34(2) further states that such treatment shall be in the least restrictive environment 'as is compatible with the health and safety of the person and the society'. Section 34(5) and 35 of the Law provide safeguards against undue detention by establishing a right to review and stating that short-term involuntary admission shall not exceed 28 days from the day of admission. Where a person needs to be admitted for a period exceeding 28 days, this shall be done upon a subsequent application. Section 36 of the Law further provides for the admission of a person who is likely to benefit from treatment in a facility, whether the person is willing and incapable of expressing such willingness or the person refuses treatment. Such person shall be received as an involuntary patient. Additionally, the Law provides for the power of the police to take mentally ill persons into custody where such person is found within his jurisdiction and (i) is dangerous to self or others, (ii) is likely, owing to mental illness, to act in a manner which offends public decency; or (iii) is mentally ill and not under proper care or is being mistreated or neglected. The Law mandates such a person to be taken to a mental hospital within twenty-four hours of being taken into custody. It also states that where it is impracticable for the person to be admitted to a mental health facility, he shall be admitted into safe custody for a period not exceeding 48 hours and that the police officer bears the onus to show that the person was taken to a mental health facility. The person shall be admitted for the purpose of examination, after which arrangements shall be made for their treatment.

National Mental Health Act 2021

After several attempts to enact a new mental health law for Nigeria, the National Mental Health Act 2021 was passed by the National Assembly on the 6th of July, 2021 and received assent from President Buhari on the 5th of January, 2023. In comparison to the Lunacy Act which it replaced the Act is a more detailed and structured piece of legislation that highlights the key concepts relating to the treatment of mentally ill persons in Nigeria. Sections 13 to 22 guarantee and protect the rights of the mentally ill to employment, housing, mental health services, quality and standard treatment, to appoint legal representatives, to participate in treatment planning, to privacy and dignity, access to information, confidentiality, and to legal representation. Section 27 provides for voluntary admission of a person for the purpose of treatment of a mental condition. It states that the voluntary patient shall not be given treatment without their prior consent. It also provides that the voluntary patient shall be informed of their right be to discharged within 24 hours unless the criteria for involuntary admission is met at the time the request is made. Section 26 of establishes the right to give informed consent and provides what informed consent should entail. Section 28 stipulates a detailed process for involuntary admission of a person with a mental condition. If such a person does not have the mental capacity to make a choice. It adopts the criteria of serious risk of harm to self and others, serious risk of deterioration, and need for treatment. It also outlines the process for making an application for involuntary commitment, as well as the persons permitted to make such an application. Section 29 allows an involuntary patient to change their status to that of a voluntary patient where a medical practitioner certifies that the patient understands the nature of such change and it is in his best interest. Section 30 provides for the discharge of an involuntary patient where treatment is no longer required.

Sections 32 and 33 also provide certain safeguards to prevent abuse. These include the right to appeal against involuntary admission and the requirement for accreditation of a facility that provides involuntary care

Concerning police powers of apprehension, Section 41 allows a Police Officer above the rank of an Inspector or staff of the Social Welfare Department of the Government to remove a person to a safe place of custody where he has reasonable cause to believe that such person has a mental health condition and is not under proper care or is being treated cruelly or neglected by a relative; or where such person is dangerous to himself or others. The Act defines a 'place of safety' as 'a shelter run by the government or an accredited organisation for persons requiring support and accommodation. It does not include a prison, police cell or related facility'. The power of apprehension can only be

exercised for a duration of 48 hours for examination by a medical officer and determination of the next steps for treatment and care.

4. Global Standards on the Treatment of Mentally Ill Persons

International Human Rights Standards Relating to the Treatment of Mentally Ill Persons

International Bill of Rights

The International Bill of Rights refers to the Universal Declaration of Human Rights (UDHR) 1948, the International Covenant on Civil and Political Rights (ICCPR) 1966, and the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966. These documents do not speak specifically to mental health treatment. They, however, establish important rights which are relevant to the treatment of mentally ill persons. In relation to involuntary commitment, Article 3 of the UDHR provides that every person has the right to life, liberty and security of person. Article 9 of the UDHR affirms this right, stating that no one shall be subjected to arbitrary arrest or detention. Likewise, Article 9(1) of the ICCPR states that everyone has the right to liberty and security of person. Article 9(4) of the ICCPR establishes the right to judicial review of arrest or detention. Article 10(1) of the ICCPR provides that where a person is deprived of their liberty, they shall be treated with respect for their dignity and humanity. In relation to voluntary treatment and the right to give consent to admission and treatment, Article 18 of the UDHR provides for the right to freedom of thought, conscience and religion. Article 19 of the UDHR further establishes the right to freedom of opinion and expression. Article 7 of the ICCPR provides that everyone has the right to not be subjected to medical or scientific experimentation without consent. Further establishing this right, General Comment No. 20 of the UN Human Rights Committee explains that this right imposes a duty on State Parties to protect persons who cannot give valid consent, especially persons under any form of detention or imprisonment. Article 1 of the ICESCR also provides for the right to self-determination. The right to access to mental health treatment has also been recognised in international law. Article 12 of the ICESCR provides that every person shall have the right to the highest standard of physical and mental health. State Parties are charged with the responsibility of providing access to healthcare.

Specific International Instruments on Mental Health Treatment

Declaration on the Rights of Mentally Retarded Persons 1971 (The MR Declaration)

The MR Declaration is one of the first specific international instruments on the rights of mentally ill persons. Though the word mentally retarded has been abandoned in modern times and replaced with intellectually disabled. Article 1 of the Declaration provides that mentally retarded persons enjoy the same rights as other persons to the maximum degree of feasibility. Article 7 further provides that where such a person cannot exercise their rights owing to the severity of their illness, or when it becomes necessary to restrict certain rights, such restriction or denial must contain proper safeguards to prevent abuse. The procedure for denial or restriction of a right available to a mentally retarded person must be based on expert evaluation and subject to periodic review and the right to appeal. Article 2 of the Declaration guarantees the right to proper medical care. Article 6 also provides for the right to freedom from abuse, exploitation and degrading treatment.

UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles) 1991

The UN MI Principles outline important guidelines concerning the care of mentally ill persons. Principle 1.1 establishes the right of a mental illness to the best available mental health care. Principle 4 provides that the determination of mental illness shall be made according to international standards, and shall not be made on reasons not relevant to health status. Principle 5 provides that a person shall not be compelled to undergo a medical examination to determine the existence of a mental illness, except in accordance with a procedure provided by law. With respect to treatment, Principle 9.1 recognises the right of a mentally ill person to be treated in the least restrictive environment and with the least intrusive treatment. Principle 11.1 establishes the right of a mental health patient to give informed consent to treatment. Principle 11.6, however, permits treatment of a patient where he was involuntarily admitted and where an independent authority is satisfied that he lacks the capacity to give informed consent. The independent authority must also be satisfied that the treatment plan is in the best interest of a patient. Concerning voluntary admission, Principle 15.1 provides that efforts should be made to avoid the involuntary admission of a patient. Principle 15.3 also establishes the right of a voluntary patient to leave the mental health facility at any time, and that he shall be informed of this right. However, where he meets the criteria for involuntary admission, he cannot be discharged. On involuntary admission, Principle 16.1 provides that a person may be involuntarily admitted where a qualified mental health practitioner authorised by the law determines that a person has a mental illness and that (i) there is a serious likelihood of immediate or imminent harm to self or others; or (ii) in the case of a person with a severe mental illness and impaired judgement, failure to admit or retain may result in serious deterioration of their condition. Principle 16.2 states that involuntary admission shall only be for an initial short period for observation and

preliminary treatment, pending review by a review body. Principle 17.4 establishes the right of an involuntary patient to review for release or voluntary status. Principle 18 also provides for certain procedural safeguards such as the right to appoint legal counsel and the right to an interpreter, where necessary.

World Health Organization (WHO) Resource Book on Mental Health, Human Rights and Legislation
The WHO Resource Book on Mental Health, Human Rights and Legislation was published in 2005 as a tool for lawmakers in drafting comprehensive mental health legislations. It contains guidelines with regard to voluntary admission, involuntary admission, involuntary treatment and police responsibilities with respect to mentally ill persons.

On voluntary admission, it emphasises the fact that management and rehabilitation of most mentally ill persons should be premised on free and informed consent. It is imperative that all patients be initially presumed to be competent. All attempts must be made to provide them with the means to accept voluntary treatment or admission before the protocol for involuntary procedures are implemented. Legislations should encourage voluntary admission as a first resort. In the case of involuntary admission, the Resource Book recognises that for a person to be involuntarily admitted, he must be suffering from a mental disorder as defined by international standards and there is a serious risk of immediate or imminent danger or where there is a need for treatment. It also states that involuntary admission should only be done where there it serves a therapeutic purpose. Concerning police powers, the Resource Book highlights the fact that the police in exercising their duty to maintain public order have a duty to protect vulnerable persons including those with mental disorders. The police may be caused to apprehend mentally ill persons where they pose a risk of harm to others or to themselves. The Book further states that the period of detention should not be excessive and may be specified in the legislation. The person so detained is to be placed in a place of safety which may be a mental health facility or a private place but should not be a prison facility.

5. Other Factors that Hinder the Efficient Delivery of Mental Health Care in Nigeria
The Mental Health Act 2021 is a federal enactment by the National Assembly exercising its powers under the concurrent list of the 1999 Constitution of the Federal Republic of Nigeria as amended. It remains to be seen whether the Act will be applicable through the Federation. The State House of Assemblies may need to replicate the same at the state level as Lagos State has done by the enactment of the Mental Health Law of Lagos State 2018. The onus is on all tiers of government to embark on advocacy to enlighten the generality of the people that mental illness is not a taboo and anyone with mental illness should seek mental health care in recognised and registered health care facilities across the country. Religious and traditional institutions should be discouraged and prohibited from admitting mental health patients to non-mental care facilities. It is common practice amongst some religious sects across Nigeria to believe that mental illness can be treated by isolating and dehumanising the mental health patient through fasting, flogging and deliverance, by attempting to exorcize the 'evil' out of the mentally ill patient. Advocacy, unrelenting and vigorous enforcement of the National Mental Health Act should be initiated and pursued otherwise the Mental Health Act would not serve its purpose. Furthermore, to achieve the objectives of the Mental Health Act 2021, all tiers of government must invest substantially in both human resources and infrastructure for mental health care. It is generally agreed that Nigeria has a huge deficit of both medical personnel and required mental care facilities. Government and private sector partnerships should be explored as it is doubtful that the meagre budgetary allocations for the health sector in budgetary allocations can have any significant impact in turning around the almost non-existent mental health care in Nigeria.

6. Conclusion and Recommendations
Mental health legislations are important frameworks that provide a structure for the treatment of mentally ill persons, particularly in cases that require hospitalisation. Where mental health legislation is comprehensive and contains detailed provisions regarding the process for voluntary and involuntary admission, voluntary and involuntary treatment and emergency detention, it reduces the risk of abuse to the mentally ill persons within its jurisdiction. It is pleasing to note that the Nigerian National Mental Health legislation exhibits a preference for voluntary admission, in recognition of the right to autonomy and self-determination. It also upholds the right to informed consent and provides particular guidelines for the administration of treatment without consent, where necessary. In recognition of the right to liberty, the mental health legislation upholds the right to be treated in the least restrictive environment, stipulates definite standards for involuntary commitment and provides procedural safeguards which prevent abuse. It also defines the powers of the police to apprehend and restrain a mentally ill person during emergencies. Unfortunately, the Lunacy Act falls below these standards and fails to provide for many of these key areas. However, for a better and more effective realization of the treatment and well-being of mentally ill persons in Nigeria, all tiers of government must commit substantial funding to the realization of the objectives of the National Mental Health Act 2021. Agencies of government should also engage in impactful advocacy and put structures in place to enforce the provisions of the National Health Act to curb certain socio-cultural and religious tendencies of some sects that are capable of undermining the laudable provisions of the National Mental Health Act 2021.