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Opinion Article

The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely?

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Abstract

Summary

A new Mental Health law was recently enacted in Nigeria to replace the Lunacy Ordinance of 1958. The passage of the new law was a major leap from the old. It was received with excitement because the former law was not only outdated but failed to address core issues such as the promotion of mental health and the protection of the rights of the mentally ill. Though the new law adequately makes provisions for these, it has considerable flaws that may hinder implementation. Parts of it lack clarity and other parts are somewhat overzealous in safeguarding the mentally ill, thus potentially defeating its purpose. It appears that certain aspects were not well thought out, or there was no 'looking well' before leaping to legislate. This paper aims to critically review flawed aspects of the new law and make recommendations on the way forward.

Keyword: Legislation; Mental Health; Nigeria

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Introduction

Until the 5th of January 2023, the mental health legislation in operation in Nigeria was the Lunacy Law of 1958. It originated as a Lunacy Ordinance in 1916 and was transformed into the Lunacy law in 1948 and amended in 1958 [1].

Nigeria's quest for a modern mental health law began in 2003 but the road to its enactment was tortuous. A Bill for the establishment of a Mental Health Act and to repeal the Lunacy Act was first proposed in 2003 by Senator Ibiabuye Martyns-Yellowe and Sen. Dalhatu Tafida. The bill passed a public hearing stage and was adopted by the Senate in 2004 but did not materialize by the expiration of the life of that Senate. A similar Bill was raised in each subsequent National Assembly up to the 8thbut none saw the light of day. It was on the 3rdof of December 2020, in the 9th National Assembly, that the Bill, which was sponsored by Senator Yahaya Ibrahim Oloriegbe was successfully passed. The Bill after being passed by the Senate was sent to the House of Representatives for concurrence on July 6, 2021. Thereafter, the Bill was transmitted to the Presidency in November 2022 and was assented to by the President on the 5th of January 2023 as the National Mental Health Act 2021. It is an Act to repeal the Lunacy Act cap 524 Laws of Nigeria 1964, and to establish a mental health department to promote and protect the rights of persons with intellectual, psychosocial, or cognitive disabilities, provide for the enhancement and regulation of mental health services in Nigeria; and for related matters[2].

The passage of the new law is therefore a major leap. Besides the former law being outdated, it failed to address core issues such as the promotion of mental health and the protection of the rights of the mentally ill. The new legislation addresses these. Its goals are to: provide direction for a coherent, rational, and unified response to the delivery of mental health services in Nigeria; promote and protect the fundamental human rights and freedom of all persons with mental health conditions and ensure that their rights are guaranteed; ensure national minimum standards for mental health services and better quality of life through access to integrated, well-planned, effectively organized and efficiently delivered mental health care services in Nigeria; promote community-based approach, recovery from mental health conditions, and rehabilitation and integration of persons with mental health conditions into the community.

The World Health Organisation (WHO) has are source book on Mental Health, Human Rights, and Legislation with the objective to assist countries in reviewing the comprehensiveness and adequacy of their mental health legislation [3]. The new legislation has been checklist against the WHO resource book and it scored well, confirming that it meets international standards[4].

It was therefore with excitement and high expectation that the news of the new law was received[5]. There are, however, lacunas in the law that may make implementation challenging[6]. There are provisions where the law is somewhat overzealous in safeguarding the mentally ill, thus potentially defeating its purpose. In some other provisions, there are deficiencies and a lack of clarity. This paper aims to critically review these aspects of the new law, identify the flaws, and recommend amelioration.

The frameworks for implementation

Generally, the law is divided into six parts with 58 sections and many sub-sections. Part, one deals with objectives, coordination, and administration, from sections 1 to 11. Section 2establishes the Department of Mental Health Services (DMHS) in the Federal Ministry of Health (FMoH), which shall have the power to administer the provisions of the Act. This is an improvement on the former which did not provide for a coordinating body, however, the coordination from the FMoH is overcentralized. The organization of the services from Abuja without appropriate delegation to the States could hamper

implementation. It will be appropriate for the States to enact their laws and have similar coordinating bodies since health is on the concurrent list of legislation.

Section 6creates the Mental Health Fund (MHF) whose source includes grants from development partners, voluntary contributions from non-governmental organizations, and discretionary appropriation from the Ministry of Health. The provision for funding, missing in the previous Lunacy Law, is key to the successful implementation of the Act, but it would have been more helpful to have obligatory rather than discretionary contributions to this fund. For example, a proportion of the budgetary allocation to the Ministry of Health could be devoted to the fund.

Section 9 institutes the Mental Health Assessment Committee (MHAC) which is a five-member group appointed by the Minister of Health. It is saddled with the responsibility to investigate complaints of persons, and to hear and determine appeals against decisions made by mental health care facilities in respect of the treatment of persons with mental health conditions. Where it ascertains, it has the power to discharge any person under this Act. The establishment of MHAC is a welcome development because it will safeguard people with mental illness (PWMI) from arbitrary or prolonged detention. It is, however, yet to be constituted and thus a vital safety net to protect PWMI against abuse is in limbo. The law should have provided a deadline for the constitution (and re-constitution) of the committee.

The rights of PWMI

Part Two of the Act deals with the rights of PWMI, namely: rights of persons in need of mental health services (Sec 12), employment rights (Sec 13), right to the quality standard of treatment (Sec 16), right to appoint legal representatives (Sec 17), right to participate in treatment planning (Sec 18), right to privacy and dignity(Sec 19)right to access to information (Sec 20), right to confidentiality (Sec 21) and the protection of persons with mental health conditions (Sec 23).

These rights are laudable because they attempt to guard against the abuse of PWMI and uphold their dignity. There are associated punishments, either fines or/and jail terms when these rights are violated in Sec 54, though they appear harsh and too stiff. However, a few challenges are identified in these sections of the Act that will make implementation a challenge. Many of the rights cannot be realized without putting other factors into place. The housing right (Sec 14), for example, says a landlord cannot evict a tenant who develops a mental illness, solely on the grounds of his mental health condition. This rightfully recognizes the right to housing, but constructs this right narrowly, by failing to consider other reasons why PWMIs can be ejected -- such as the inability to pay house rent and lack of economic means, which perhaps the main reason why many PWMIs are homeless. The right to housing is therefore defeated with no proper arrangement from the government for sheltered accommodation.

The right to mental health services in Sec 15 accords the PWMI the right to appropriate, affordable, accessible mental health care and services that should provide counselling and rehabilitation. The Act further specifies, among others, that every facility providing such mental health services must uphold the dignity of the person and allow for treatment options that help a person to manage the condition and participate in political, social, and economic aspects of his life. This latter section regrettably neglects the right to participate in religious activities as an aspect of their life. Religion in mental health services provision is considered far more pertinent than politics and other socioeconomic activities because not only do the majority of Nigerians consider religion an important variable, but research has shown that it aids mental health recovery [7].Furthermore, enjoyment of the right to available and accessible mental health services is constrained by the limited availability of personnel and facilities. There are less than 300 practicing psychiatrists to serve millions of PWMI in the country and the distribution of mental

health facilities is skewed towards the urban area; these have created a wide gap for the majority of rural dwellers in accessing treatment for mental illness.

The right to legal representation is another right that is susceptible to implementation failure. The Act in Sec 22 says that a PWMI is entitled to appoint a legal practitioner to represent them in a situation where they have a complaint or an appeal. Where the person is unable to exercise the right, perhaps because of lack of capacity, his legal representative (someone he has appointed to oversee his welfare and health, usually a relative) may appoint a legal practitioner to represent him. If the PWMI or his legal representative cannot afford the services of a legal practitioner, the State is obligated to provide legal assistance to the patient. This is where the problem lies, how committed and ready is the State to fund the legal assistance provided to the PWMI, given that there is no specific provision for a legal aid scheme?

Minimum standards of care in treatment facilities

Part 3 (Sec 24-45) deals with facility-based treatment. Sec 24 & 25 set minimum standards of the treatment program for mental health conditions. It also ensures that the FMoH maintains and periodically publishes a list of licensed mental health treatment centers and facilities in Nigeria. Thus, treatment facilities are expected to meet the minimum standard to be operational. This regulation is protective and ensures PWMI obtains a quality standard of care. Further, Sec 26 specifies that valid consent must be obtained for voluntary treatment which entails providing adequate information on the purpose and explanation of treatment, treatment options (including no treatment), likely benefits, risks, and chances of success. It also states that written consent must be given for treatment to proceed. The essence is to protect patient autonomy, however, this provision fails to consider that the literacy level in the country is only slightly above 60% (World Bank Group, 2018), and many PWMIs will be unable to express themselves in writing. The Act says that the literacy level of the patient shall be taken into consideration when informing them and makes provisions for supported decision-making at no cost when the patient is unable to understand the information but, in practice, obtaining a patient's written consent will be a problem in the majority of cases. It could have referred to the Illiterates Protection Act of the Federal Capital Territory and the corresponding laws of the States. These provide for a literate person (not a lawyer) to write a letter on behalf of an illiterate person, but the letter must carry a Verification Statement by the writer. This legal requirement could pose an additional administrative hurdle in the path of an illiterate citizen.

Involuntary treatment

Sec 28 deals with the criteria for involuntary treatment. The criteria for such admission are well spelt out and certain principles, such as standard care, autonomy, justice, right of appeal, dignity, and freedom from torture and exploitation, are guaranteed. This ensures that abuse experienced by this group of persons in the past is prevented, but a closer look at the practicability of the criteria shows that they may be counterproductive and will make access to treatment difficult for those who need it. For instance, the law requires that involuntary admission be offered when there is a serious likelihood of imminent harm to that person or other persons. The second situation that the law permits for involuntary committal is where there is evidence that the mental health condition is so severe that failure to admit the person is likely to lead to a serious deterioration in the condition of that person or hinder the provision of appropriate treatment that can only be given by admission to a facility. The additional requirement of 'a likelihood of a *serious* deterioration to occur' to merit involuntary admission for a mental health condition that is already serious is unnecessary; any deterioration in the (severe) condition should suffice. Having to wait for the deterioration to be severe helps no one.

Secondly, sub-section (2-7) of the same section deals with the procedure for involuntary admission. A written application is necessary by relatives or any other person if relatives are unavailable. The

application shall set out grounds on which admission of the person is necessary and in his best interest. Two independent qualified medical practitioners must examine the person and complete a form referred to as Form A. The practitioner or head of the facility shall admit the patient, but forward the application, the completed Form A, and the written recommendations by the two practitioners to the Committee as soon as practicable. The entire process of involuntary admission is burdensome and cumbersome. For instance, to qualify as an independent doctor, one must not be a staff or partner of the facility, hence, it will be a tall order to obtain an independent assessment. This bureaucracy will slow down the admission process and ultimately cause inefficiency. Further, the issue of illiteracy will pose an obstacle to the relatives writing an application for admission. The challenge envisaged here will be far greater than writing a consent because the Act demands clarity in stating the ground for admission. Only in a few cases will it be likely that relatives of the patient requiring admission are able to express themselves in writing to the extent demanded by the law.

Sec 28 (8-16) deals further with the procedure for extending involuntary admission. The admission duration is a maximum of 28 days, but this can be extended for 14 days, though further extensions may be secured. The same requirement for the first admission applies to the extension of admission and the application must be made before the expiration of the 28 days. The duration of 28 days is rather too short because, from experience and anecdotal reports, it takes an average of 6 weeks to get an in-patient stabilized.

Lastly, the law in Sec 28 requires that the treatment plan must be formulated by a medical officer with at least five years of experience. The training of a doctor to become a specialist (psychiatrist) is in two phases. Each phase requires a minimum of two years to progress for the qualification examination. It is expected that after the first level of training (junior residency), which is about 2-3 years, the doctor is equipped enough to formulate a treatment. Further, the situation in this country where there are insufficient health personnel does not permit raising a high bar for one to be qualified to institute management. Thus, the five-year peg is not only needless but detrimental as it will further worsen access to mental health treatment.

The use of restraint or seclusion

Sec 34 deals with the use of restraint or seclusion. Persons with mental health conditions shall be protected from the use of forced treatment, seclusion, and any other method of restraint in facilities except in accordance with the provisions of the Act. It states that it shall be unlawful for any individual, group of persons, or faith-based institution to employ the use of restraints. Also, all facilities shall implement guidelines developed by the Ministry for de-escalating potential crises. Before restraint can be applied, the Act mandates that the mentally ill person must have first received adequate care by a medical officer for at least forty-eight hours, and upon the expiration of that time, two medical officers shall examine the person and certify in writing that restraint/seclusion is the only means available to prevent immediate or imminent harm to the person. It is, thereafter, the head of the facility who can authorize the adoption of this measure, and the authorization must be in writing. Also, the facility must be accredited as having adequate capacity for undertaking such a measure safely. This places restraint as a method of last resort in management, even though, in the practical sense, it is often part of the first line of management of an aggressive patient when de-escalation does not work. Hence, for a severely violent patient, having to wait for the expiration of 48 hours before restraint can be applied, is non-practicable. Whilst the aim is to ensure that seclusion or restraint is not carried out for punishment or the convenience of staff, the law's goal of ensuring prompt treatment is defeated. Additionally, the Act handicaps the health care worker in appropriately managing the patient and possibly makes them vulnerable to aggressive patients.

Mentally abnormal offenders

Part four has only three sections (46-48) and deals with persons with mental health conditions and criminal proceedings. The law appears to be discriminatory towards mentally abnormal offenders (MAO). Section 46 states that the court may by a hospital order authorize the admission of a convicted person for observation in a hospital and decide that the most suitable method of disposing of the case is using that order if it is satisfied on written evidence made within seven days of admission of two medical practitioners, one of whom is recognized to have special experience in the diagnosis and treatment of mental disorders. Further, on receiving a medical report indicating the need for further detention, the court can issue a compulsory order for the detention and treatment of the patient for another period of six months and for multiple periods of six months if there is no progress in treatment. This raises a few questions. Firstly, why should the provision of compulsory treatment of the MAO permit a treatment duration of 6 renewable months while the duration for those who are not offenders is 28 days, with only 14 renewable days? This seems biased and unfair. Secondly, who pays for the funding of an order of transfer to the hospital? The services will likely be financed by funds from the MHF; however, the Act is silent about this. Thirdly, sub-section4 of this section says the patient shall be advised on his right to appeal to the "Mental Health Review Tribunal". There is no mention of this Tribunal anywhere else in the law; there is a lack of knowledge about the definition, the constitution, and the role of this Tribunal.

The property and affairs of PWMHI

Part five of the law covers the property and affairs of persons with mental health conditions, starting from sections 49 to 58. This part includes the application of the property of persons with mental health conditions; the power of the judge in an emergency; violation of the right of persons under this Act; refusal to supply information; forgery or false entry of statements; assisting patient with unlawful leave of absence; sexual relationship with a patient; and limitation of suits against the Ministry. There is no major criticism of this part.

Recommendations

It appears that the National Mental Health Act 2021 mirrors mental health laws from Western countries without considering the unique challenges of our locale. Considering the defects discussed above, its enactment can be regarded as a gigantic leap from the old law to the present one without looking well enough. There is a need to remedy the defects identified, to ensure that the new legislation is implementable and effective.

Thus, the States need to swiftly pass their laws and have their DMHS and MHAC operational. This will reduce the workload on the DMHS and MHAC at the FMoH in Abuja, leading to improved efficiency. Further, the States should devise a viable MHF to fund the implementation of their law, such as the provision of legal assistance to the PWMI. We recommend a proportion of their budget be ring-fenced for the MHF, rather than have obligatory contributions to this fund. Further, the law should have provided not more than six months as the deadline for the constitution of the MHAC. Since this proposed timeline has been exceeded, we recommend an immediate setting up of the Committee.

The grounds for involuntary admission should be reviewed. The clause requiring a likelihood of a *serious* deterioration to occur' to merit involuntary admission for a mental health condition that is already serious should be expunged. The first part of the clause is sufficient to justify involuntary admission. Moreover, the restriction stipulating that an independent doctor must not be a staff or partner of the facility should be relaxed to include staff from the same facility. Also, the requirement for the two practitioners to forward all the application letters, the completed Form A, and the written recommendations to the MHAC for involuntary admission of the patient, should be eased to only special cases of appeal. We would

suggest that admission should be decided by the head of the facility after two practitioners have made their recommendations. However, a patient can appeal to the Committee if they wish; it is only the appeal cases that the MHAC will decide. This will remove the bottleneck previously identified in involuntary admission and significantly reduce the work of the Committee.

Admission duration should be extended to a minimum of 6 weeks and a renewable period of 6 weeks. We suggest that the law be reevaluated to enable a treatment plan to be formulated by a medical officer with a minimum of two years of experience instead of five. Lowering this bar will lead to wider mental health coverage in the country. Lastly, the law on restraint should be re-examined to make it less difficult to apply restraint. It should be considered as the next line of management of an aggressive patient in an accredited facility once de-escalation does not work. This will ensure that careers are protected in the course of their duty.

The Act entails writing some letters such as consent for treatment, an admission application for involuntary admission, and a discharge notice. To circumvent the obstacle that illiteracy may present in these instances, the treatment facility can either design a sample for the clients involved to copy or design a form to be filled.

The Act is a step in the right direction, however, the political will and capacity to implement the provisions of the law must be in place. It is the will that determines how speedily the MHAC and the DMHS will be constituted. The provisions of the Act are hinged on the functioning of the DMHS while ensuring justice for patients under treatment or care is determined by the activity of the MHAC. Further, it is the political will that will dictate how well the MHF will be funded. All these will invariably impact other agencies and tools required for the effective operation of the Act, such as the timely release of the accreditation guidelines for restraint & seclusion, career support, and accreditation of treatment institutions.

A revised Act should accommodate patients' right to participate in religious activities in their treatment. It should be known that for certain rights in the Act to be enjoyed, the government will have to further commit itself beyond the setting up of the Act. The Act provides only a legal framework for the protection of the mentally ill and guaranteeing their rights. For instance, in securing the right to housing, the government should provide sheltered accommodation for PWMI who are at a high risk of becoming homeless. The government should implement the Abuja Declaration of 2001 [9]which recommends increasing budgetary allocation to health to15%. The more financial resources for health, the higher the prospects of the implementation of the Act.

The government should vigorously pursue the implementation of the WHO mental health Gap Action Program (mhGAP) which aims to scale up the accessibility to mental health treatment and improve mental health coverage by training health workers in primary health care[10]. This is one of the means to achieving one of the objectives of the Act which is to ensure that the mentally ill have rights to appropriate, affordable, and accessible mental health care services.

Public enlightenment of the law is necessary for PWMI to know their rights. Ignorance on the part of the beneficiaries (PWMI) will deprive them of their rights, whereas awareness of the law will empower them to assert their right. Mass education will not only benefit the PWMI but also the people involved in their care so that they do not run afoul of the law and develop liabilities.

All the states except for Lagos (which has done the same) should enact similar laws at sub-national levels since health is on the concurrent legislation. They should immediately domesticate the law in their state.

The shortcomings detected in the national law can be corrected at the subnational level during the legislation. All these will facilitate wider health coverage and further protection of the mentally ill.

Finally, there is an urgent need to set in motion an amendment process to take care of the major flaws identified. No matter how impracticable and inoperable a part of the law is, it still subsists and does not void the law. The necessary machinery and mechanism should be put in place to commence amendment.

Conclusion

There is a 'big leap' in moving from the Lunacy Act of 1958 to the Mental Health Act of 2021.The rights of the mentally ill are well protected in the law which places a huge responsibility on the government, health care workers, and all stakeholders. There are deficiencies that may hamper implementation. For the law to be effective, these should be addressed.

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