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An Appraisal of Mental Health Legislations Vis-À-Vis Provisions of Mental Health Care in Nigeria

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Abstract

Recently, precisely January 5, 2023, the immediate past President of Nigeria, Muhammadu Buhari, GCON, signed into law, the extant Mental Health Act, 2023 to replace the defunct Lunacy Act, 1916, which was introduced into the country as a statute of General Application in Nigeria and also the subsequent 1958 Act. This paper x-rays the various mental health legislations that have existed in Nigeria till date. It also provides an insight into the provision of mental health care in various forms including both the traditional and orthodox modes and available facilities. The discourse also provides several failed attempts or efforts made by government, organizations, and even professionals at providing a contemporary and universally acceptable mental health legislation for the Nation. It highlights some flaws in the previous Acts which needed to be reformed. Finally, the paper advocates for a more frequent reform of our mental health legislation that will meet both the aspirations of persons with mental health disorders and international standards in accordance with the requirements of the World Health governing body, the World Health Organization (WHO).

Keywords: Legislation, Mental Health, Provisions

1. Introduction

The evolution of Nigeria's legal framework that regulates the affairs of mentally-ill persons is largely influenced by that of the United Kingdom which came into force in Nigeria as a Statute of General Application[190]. Consequently, Nigeria followed the same mental health legislation that was in force before it gained independence from its colonial masters, United Kingdom in 1960.[191]Originally called the Lunacy Ordinance, it was first enacted on December 21, 1916 and last amended in 1958.[192] This became the source of regional laws that appeared as the country evolved into regions thereafter. It assumed the status of a law rather than as an ordinance in 1958.[193] It is the legislation that was arched into state laws within the Federation.[5]

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[190] Ayorinde Bolaji, "Rashidi Yekini – The State of Mental Health Law in Nigeria" available at http://reibune. comp.ng/index.php/prisons-law/4305-ashidi-yekini'scase-and-the-stateofnation accessed on 01/04/2013

[191] A. H. Westbrook. "Mental Health Legislation and Involuntary Commitment in Nigeria: A call for Reform" – in Washington University, *Global Studies Law Review,* vol. 10. 397, p.403.

[192] Ibid

[193] O. Adegboyega and Ogunlesi Adegboyega, Ogunwale, "Mental Health Legislation in Nigeria: Current Learnings and Future Yearnings" in *International Psychiatry,* vol. 9, No.3, 2012. 62. [5] Ibid, p. 63

The latest versions of these laws have some minor alterations in terms of language and certain stipulations in order to reflect current realities but the principles of the ordinance have remained the same.[194] While the practice and procedure of the court in England has significantly developed over the years, same cannot be said in Nigeria as the obsolete laws which were in force ever since still operated in the management of the mentally disabled persons in the country.[7]

One of the most common situations in most jurisdictions is the presence of lunatics in the streets without care or any attempt to take them in and treat them.[195] In the Nigerian jurisdiction, there were no provisions for taking such lunatics in or detaining them. As such, they sleep on the streets and in public places – causing both private and public nuisance. This is because, the Nigeria legal system did not develop a proper and efficient legal framework to protect the most vulnerable of its citizens as "social and ostracization" remained the unfortunate order of the day in Nigeria in regards to the mentally-ill.[196]

2. The Lunacy Ordinance 1916/The Lunacy Act 1958

The Lunacy Ordinance, enacted in 1916 was drafted about four and half decades before Nigeria's independence from British rule. Titled "Lunacy Ordinance", it took effect from "21 December 1916".[197] Enacted two years after the amalgamation of the Northern and Eastern Protectorate into a single entity in 1914, the colonial influences in its terminology and expectations are thus obvious.

Perhaps, a good place to begin a review of the mental health legislation in Nigeria is by defining the conditions the law seeks to address. According to the Act, a "Lunatic includes an idiot" and any other "persons of unsound mind".[198] Besides using terms not in standard parlance today, the definition has the potential for broad and fluid interpretation. Such discretionary interpretation gives medical practitioners and magistrates wide discretionary powers to decide which citizens are covered by the law. This is because the law required two elements to commit a person against his will:

(a) A magistrate must find that a person is a lunatic, and
(b) A medical practitioner must examine and certify that person a lunatic.[199]

Section 10 of the Act provided that:

> *Whenever a medical officer has a course to suspect that any person is a lunatic and considers it expedient that such person should be placed forthwith under observation*

[194] Ibid. [7] Ayorinde Bolaji, "Rashidi Yekini's case and the State of Mental Health Law in Nigeria" op cit p.2. Chief Ayorinde Bolaji (SAN) was the Chairman, Legal Aid Council of Nigeria and former Pro-Chancellor and Chairman Governing Council, Ladoke Akintola University of Technology, Ogbomosho.

[195] Ayorinde Bolaji, "Rashidi Yekini's case and the State of Mental Health Law in Nigeria" op cit p.2

[196] Ibid, op cit p82

[197] See the Laws of the Federation of Nigeria and Lagos,1958.

[198] Lunacy Act, 1958, Cap 12, Laws of Nigeria and Lagos, 1958

[199] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform" – in Washington University, *Global Studies Law Review,* vol. 10. 397, 403.

> *in any asylum, he may grant a certificate of emergency as in form A in the schedule and shall cause such a person to be taken to an asylum ....*[200]

On it part, *section 11* provided that:

> *Any magistrate, upon information on oath in the terms of Form B in the schedule, may examine the suspected persons therein referred to and hold an inquiry as to his state of mind.*[201]

Once these elements are met, the magistrate then has the discretion to make the final determination of lunacy. It is worthy of note that as practitioners do not have a scientific definition of unsound mind, they can use it as they please. As long as a practitioner certifies the person a lunatic, a certification that the magistrate would like to predict, given that he appoints the practitioner, the magistrate may initiate a broad range of conditions to constitute unsoundness of the mind.[202]

As related to involuntary detention, the flexibility of the definition can lead to an over-inclusive application of the law resulting in wrongful confinement of mentally healthy individuals. Despite creating a potentially wide scope of affected persons, the Act did not attempt to protect individuals who could possibly fall within its definition. The Procedure for commitment, although subject to some discretion of the inquisitors, required that both a medical practitioner and a magistrate find that person is a lunatic. If a medical officer believed it is necessary to detain a person for observation, that person may only be detained for seven days without the authorization of a magistrate.[203]

Nonetheless, some of the procedural elements leave room for potential abuse. For example, when a magistrate decides to inquire into a particular person's state of mind, he may issue a warrant for that person's arrest if the magistrate fears that person would not appear in court and detention pursuant to such an arrest may last up to one month.[17] Furthermore, the Act provided that the standards for conditions within an asylum are to be established by the Regional Governor, who may make regulations regarding the "Governor of Asylums and the custody of the lunatics therein".[204]

A microscopic look at the area of deficiency of the Lunacy Act, 1958 include its failure to define "mental disorder" or "mental disability" and its overwhelming emphasis on custodian care without adequate provision for treatment in the community.[19] Its use of highly derogatory terms such as

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[200] Section 10, Lunacy Act, 1958
[201] Section 11, Lunacy Act, 1958
[202] Westbrook A. H. "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p. 404
[203] Westbrook A. H. "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p. 405
[17] Ibid.
[204] *Section 6, Lunacy Act, 1958* [19] Mental disorder was defined in the United Kingdom in 1983 Mental Health Act as "any disorders or disability, impairments and psycho-pathetic disorders" which are included in the Lunacy Laws in Nigeria. A Lunatic was described as a "person found unlawfully adjudged to be a lunatic by the magistrate … persons suicidal or dangerous to himself, or persons not dangerous to others, but dangerous to himself and not dangerous to others, incapable of managing himself, or persons capable of managing himself and not dangerous to either to himself or others... a criminal lunatic while insane or under confinement. Any person not detained and not found to be a lunatic but whom through mental infirmity arising from managing his affairs.

"asylum, lunatics, idiot, and unsound mind" demonstrated its antiquity. The law did not accord specific recognition to the human rights of persons with mental disorders as recommended by the World Health Organization (WHO). It also had no provision for vulnerable groups who may fall within its ambit. Other notable aspects of the Act are that it neither made mention of treatment nor did it use any words synonymous with treatment. The extent of the reason provided for detention of a person under the Act is that a person is a lunatic and a proper subject of confinement.[205] In fact, the preamble to the Act was "An Act to provide for the Custody and Removal of Lunatics".[206] The absence of any provision for treatment may have been one of biggest factors influencing the clamour for reform of the country's mental health law.

In spite of these shortcomings, the Act managed to ensure some degree of compliance with the World Health Organization (WHO) recommendations in the areas of provisions for emergency and involuntary admission (although not separate from treatment).[207] It metamorphosed into the Lunacy Act, 1958.

However, while the Lunacy Act, 1958 was able to address certain basic issues, as stated earlier relating to mental health care, its age (at almost a century), clearly suggested that it must suffer from some deficiencies, and indeed, it did in four principal areas:

(a) The altered political and social climate;
(b) The antiquated definitions and terminologies;
(c) Non-application of later developments in psychopharmacology;
(d) Non-incorporation of certain human rights charters (United Nations 1948, 1991).[208]

3. The Mental Health Bill, 2003

There have been a series of unheeded calls by scholars and stakeholders in the mental health sector for change in Nigeria's mental health law. Despite these prominent calls for reform, no significant movement in the direction of change materialized. One of such attempts to reform the Lunacy Act, 1916, was made during the democratic dispensation of the 4th Republic (1999-2003). During that period, a Mental Health Bill, called "Mental Health Bill, 2003" was sponsored as a Legislative Bill in the Nigerian Senate.[209] This task was undertaken by two senators who were also medical practitioners of whom was a Psychiatrist, Senator George Anthony Manzo (PDP) – the lead sponsor (now deceased). The Bill passed its first reading on the floor of the House. Unfortunately, in the interval between the first and second readings, the Bill suffered a set-back with the expiration of the life of that Senate and the death of the lead sponsor, Senator Manzo.[25] However, efforts were made to represent the Bill as an Executive Bill sponsored by the Federal Ministry of

[205] A. H., Westbrook "Mental Health Legislation" op cit. p. 406
[206] See preamble to the Lunacy Act, 1958
[207] Mental disorders were defined in the United Kingdom 1983 Mental Health Act as "any disorders or disability … op cit.
[208] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria" op cit. p. 63.
[209] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria" op cit. p. 63
[25] Ibid.

Health.[210] The enactment of the Bill into law would have marked progress in Nigeria's Mental Health law towards modern international standards.[211] First, the Bill would have narrowed the coverage of the existing law by removing the broad definition of "lunatic" and replacing it with the term "mental disorder".[212] The latter term is much more accessible and acceptable to the medical community than the term "Lunatic", and the definition specifically excludes social deviance. The Bill, as it were, also defined additional terms which would have provided more guidance in application than the obsolete Lunacy Act 1958 (as amended).[213]

Broadly speaking, the proposed Bill seemed to contain satisfactory provisions in the following areas of the World Health Organization (WHO) checklist on Mental Health Registration (WHO, 2005).

> *Definitions of mental disorder, with proper coverage of dissocial personality disorder and substance use disorders, rights of families or other careers of patients, mental capacity issues (although there is in fact no clear definition of capacity in the draft Nigerian legislation) voluntary admission and treatment, involuntary admission (not clearly separated from treatment); proxy consent for treatment; emergency situations, specification of competence required for determination of mental disorders; oversight and review mechanisms; (mental health tribunal; judicial review at the level of a State High Court); some mention of police responsibilities; provisions for minors with mental health justice systems; and a description of offences under the Act with appropriate sanctions outlined.*[214]

Other anticipated benefits of the proposed Bill included, but not limited to the provisions of additional procedural protections for those subject to it by creating three types of compulsory admission such as "temporary admission for observation, admission pursuant to an emergency application and admission for treatment.[215]

Similarly, as it was in the Lunacy Act, Magistrates would no longer play a role in the admission decision which would have relied solely on medical certification[32] given that one of the main problems with the Lunacy Act was its lack of provision for treatment as the purpose for detention.[216] The Bill would have also placed restrictions on the type of treatment provided and

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[210] Ibid. The Federal Ministry of Health and other stakeholders in the Mental Health sector made frantic efforts at representing the Bill at the Senate.

[211] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op. cit. p.407.

[212] The proposed Bill 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". The Bill also defined "mental impairment" but only uses the term in the context of criminal proceedings.

[213] Westbrook A. H. "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.407.

[214] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria" op. cit. p.63.

[215] A.H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.407.

[32] Ibid

[216] Ibid.

the circumstances under which it could be provided, for example, consent would have been generally required for any treatment and the patient could have withdrawn consent anytime.[217]

The World Health Organization (WHO) made a number of recommendations to protect the right of individuals admitted to a mental health facility and the proposed Bill complied with many of them.[218] However, the Bill left some gaps in the provisions and would have benefited from greater details in certain sections. For instance, both the WHO checklist and the Bill began with the assumption that treatment should require consent of the patient. [36] However, the checklist recommended further protection involuntary treatment that were absent from the Bill. [37] The checklist provided for oversight and reviewed mechanisms to protect the rights of those subject to involuntary detention. While the Bill would have set up a Mental Health Review Tribunal and given the Minister of Health the power to determine the number of tribunals plus their composition and their rules of procedures, it did not provide enough specific provisions to satisfy the WHO's recommendations.[219] In terms of providing for the protection of human rights, the Bill would have set up a framework for the creation of a system in which those rights could be protected.[220] Some other defects of the Bill include its failure to provide a clear statement on the "promotion of fundamental human rights of people who are mentally ill, and did not specifically guarantee the rights of users of mental health services in relation to issues of confidentiality.[221] Similarly, the Bill was silent on provisions regarding "non-protesting", patients and involuntary treatment in community settings and did not regulate special treatments such as "Electroconvulsive Therapy (ECT), the use of seclusion and restraint issues related to consent, discrimination, housing, employment, social security, civil issues such as voting rights, parental rights, among others".[222]

However, a National Human Rights Commission established by an Act in 1995 existed in Nigeria.[223] But it had no specific monitoring activities for mental health but did conduct visits to prisons. Also, no mental hospital, community-based inpatient psychiatric units or community residential facilities have review inspections of human right protection of patients at any time.[43] Finally, the Bill would have repealed the obsolete Lunacy Act in its entirety.

4. Mental Health Act, 2023

The extant mental health legislation in Nigeria, the Mental Health Act, 2023 was assented to by former President, Muhammadu Buhari, GCON on January 6, 2023. The objectives of the Act are provided in *Section 1(a-g)* of the Act. They include:

(a) To provide direction for a coherent, rational and unified response to the delivery of mental health services in Nigeria.

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[217] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.409.

[218] A.H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.414 [36] Ibid, p. 415 [37] Ibid.

[219] Ibid.

[220] Ibid

[221] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria". Op cit. p. 64

[222] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria". Op cit. p. 64

[223] WHO – Aims Report in Mental Health Systems in Nigeria, WHO and Ministry of Health, Ibadan, Nigeria, 2000, 14 [43] Ibid

(b) Promote and protect the fundamental human rights and freedom of all persons with mental health conditions and ensure that the rights are guaranteed;
(c) Ensure a better quality of life through access to an integrated well-planned, effectively organized and efficiently delivered mental health care services in Nigeria;
(d) Promote the implementation of appropriate National minimum standards for mental health services in Nigeria;
(e) Promote recovery from mental health conditions and enhance rehabilitation and integration of persons with mental health conditions into the community;
(f) Facilitate the adoption of community-based approach to the provision of mental health care services; and
(g) Facilitate the coordination of mental health services in Nigeria.[224]

It is worthy of note that the provisions of the Act covered virtually all aspects of mental health care in consonance with globally accepted standard as against the previous Lunacy Act 1916, Lunacy Act 1958, among others.

Worthy of specific mention is Part II of the Act which provided for the Rights of persons with mental health conditions. *Sections 12-14* of the Act provide for "Rights of persons in need of mental health care services, employment rights; housing, right to mental health care services, right to quality and standard treatment, right to appoint legal representation, right to participate in treatment planning; to confidentiality and protection of persons with mental conditions" [225] respectively. These were obviously omitted in the previous defunct mental health legislations in the country.

Another significant achievement of the Act is provided for in *Part IV, sections 46-48* titled "Persons with Mental Health Conditions and Criminal Proceedings". [226] These sections made provisions for "admission of a criminal patient, compulsory order with restriction; and removal to hospital of an inmate",[47] among others. Again, these provisions were not included in the previous Acts.

It is heart-warming to note that the present Act is comparable with the extant Mental Health Legislation of our colonial master, Britain and some other countries, such as Canada, United States of America and even some African countries such as South Africa, Egypt and Kenya.

However, one major aspect that is missing in the Act is that bordering on after care following detention and discharge. For example, *section 117 of the Mental Act (England and Wales)* places a statutory duty on health and social services providers to provide after care services for patients who have been discharged from detention. [227] It also provided for the creation of the *Care*

[224] Section 1 (a – g), National Mental Health Act, No. 46, 2023
[225] Sections 12-23, National Mental Health Act, No. 46, 2023
[226] Sections 46 – 48, National Mental Health Act, No. 46, 2023
[47] Ibid
[227] Section 117, Mental Health Act, (England and Wales).

Programme Approach (CPA) which was introduced in 1991 to be used for all patients where appropriate, even if they have not been detained in the hospital.[228]

Another remarkable provision in the extant Mental Health Act is that concerning the violation of the rights of person with mental health disorders. *Section 51(1-3) (a & b)* provide that "No person shall violate the right of persons as specified under the Act".[229]*Subsection 2,* specifically provided that:

> *Without prejudice to the provisions of any other law, any person who contravenes the provisions of subsection (1), commits an offence and is liable on conviction to a fine of at least not less than N500,000 or imprisonment for a term of at least one year.*[230]

The provision of this subsection is to the effect that it is not uncommon to find cases of sexual harassment and abuse being perpetrated against mental health patients admitted into mental health facilities thereby taking undue influence of the state of health of the parties. Consequently, *section 55(1)(2)* of the Act provides punishment for an officer, staff or employee who engages in sexual relationship with a patient. *Subsection 2* specifically provides that:

> *Any person who commits an offence under this section is liable on conviction to life imprisonment with no option of fine and this shall not be prejudicial to any other sanctions and such a person may be liable to penalties from professional bodies to which he may belong as a member.*[231]

This provision was absent in the defunct Lunacy Act 1916 and subsequent Mental Health Legislations in Nigeria.

Suffice to say that the newly enacted Mental Health Act 2023 covered a wide range of areas in Mental Health Legislation and it is comparable with contemporary Mental Health Legislation the world over.

5. Mental Health Care in Nigeria

Historically, Nigeria's mental health care dates back to 1904 when the first asylum was opened in the Southern City of Calabar.[232] In 1907, Yaba asylum opened in Lagos and another facility followed in Lantoro, Abeokuta[54]. But the treatment of mental illness in Nigeria have existed in a number of forms with the basic method of treatment being orthodox and tradition modes. Traditional medicine plays a significant role in the culture and practice of the different ethnic groups.[233] The Yoruba and the Ibo people of Nigeria, for example, have established systems of traditional healing. Existing mental health research has primarily focused on the Yoruba and many

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[228] Ibid.

[229] Section 51(1), National Mental Health Act, No. 46, 2023

[230] Section 51(2), National Mental Health Act, No. 46, 2023

[231] *Section 55(1-2), National Mental Health Act, No. 46, 2023*

[232] Jack Ide, I. O., Uyls L. R. and Middleton L. E., "A Comparative Study of Mental Health Services in two African Countries, South Africa and Nigeria" available at http://www.academicjournals.org/ijam accessed on 12/12/2014, p.53. [54] Ibid.

[233] A. H. Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria: A call for Reform" – in Washington University, *Global Studies Law Review,* vol. 10. 397, .4399.

revolutionary developments of Nigeria's psychiatry have occurred in connection with the Yorubas.[234]

Traditional treatment of mental illness among the *Yorubascentred on "Babalawos*" or "fathers of the secret".[57] Traditional healers are professionally organised in Yoruba society and most deal with both physical and mental ailments.[235] Treatment is based on the perceived causes of the illness and a general description of the treatment process particularly for illness of natural cause follows.[59] A family brings the patient, relative, to the healer. If the patient is excited, or difficult to control, the healer places him or her on restraints – using the plant, "*Raowolfia"* – a relative of orthodox antipsychotic drugs to sedate the patient.[60] Once under control, the healer begins assessing the causes of the illness, which simply takes place by simply beginning treatment based on one cause and changing treatment until the patient improves[236]. If the perceived cause of the illness is preternatural or supernatural, the patient seeks treatment from a diviner. Diviners use methods such as "incantations, rituals, and sacrifices" to attempt remedy their patients illness.[237]

Orthodox psychiatry, courtesy our British masters, also exists in Nigeria and has played a significant role in the management of mental health issues. The British introduced western style treatment of mental illness into Nigeria in the late nineteenth century as a reaction to an "apparent swarm of lunatics on the streets in Nigeria.[238] At the time, western style treatment of mental illness focused only on confinement, so the authorities built a pair of asylums. From the beginning, the mental health system struggled for resources which only made later calls for reform less popular. One of the glaring examples of the lack of resources provided for mental health services is that no asylum employed a professionally trained psychiatrist until the 1950.[239] As a result of financial constraints, conditions in the asylums were poor. Westbrook cited one visiting psychiatrist from Great Britain, Jonathan Sadousky to have noted that the asylums were "little better than prisons".[240]In fact, the inmates of asylums were generally subjected to more physical restraints than convicted criminals.[241] Westbrook also quoted another psychiatrist to have said that "the institution is far behind the times and lamented the lack of remedial treatment"[242]

Even in the twenty-first century, conditions in psychiatric institutions in Nigeria remained deplorable. One description placed approximately forty men in the cell about 270 square feet in

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[234] Ibid, 400
[57] Ibid.
[235] A. H. Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.400.
[59] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.400.
[60] Ibid.
[236] Ibid.
[237] Ibid. 401
[238] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.402.
[239] Ibid, p. 402
[240] A. H., Westbrook "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.402.
[241] Ibid – The transition from asylum to hospital began under a Nigerian. Abraham Odeas, the country's first trained psychiatrist nurse. Alexandra Boroffa, a German psychiatrist completed the process.
[242] A.H., Westbrook, "Mental Health Legislation and Involuntary Commitment in Nigeria" op cit. p.402.

size.[243] To make matter worse, until the middle of the nineteenth century, treatment and therapy were barely considered. Part of the reasoning may have been financial but "cultural misunderstanding" and the policy of "Indirect Rule" which directed the colonisers to try to preserve the traditional ways of life provided most of the support for the decision not to treat patients because of the belief that the disorder is caused by witchcraft. [244] The colonial administration was intrigued by the "African Mind" but had the difficulty distinguishing between "true insecurity and mere cultural differences such as witchcraft.[245]

In the 1950s, change finally began to take shape. The country hired its first full-time psychiatrist, Donald Cameron who instantly focused on treatment.[71] In the 1960s, Yaba Lunatic Asylum became Yaba Mental Hospital and started treatment using orthodox medicine therapy. A few years later, Aro Mental Hospital opened in Abeokuta.[246] A Nigerian psychiatrist, Dr. Thomas Adeola Lambo spearheaded service delivery on his return from the United Kingdom in 1952 when the Neuropsychiatric Hospital in Aro, Abeokuta was still under construction. Lambo had just completed his training in psychiatry at the Maudsley Hospital, London. This played a significant part in the development of psychiatry in Nigeria with community practice been developed in collaboration with World Health Organization (WHO) initiatives.[73]

In Nigeria, with a population of over 200million people, there are a "few psychiatric hospitals.[74] Within the 36 States of the federation and the Federal Capital City, Abuja, there are only eight Neuropsychiatric Hospitals owned, administered and financed by the Federal Government. [247] These hospitals are located in Benin, Calabar, Abeokuta, Kaduna, Yaba, Maiduguri, Enugu and Sokoto.

State governments also have psychiatric units in their Central Hospitals while some teaching hospitals attend to patients in universities with Colleges of Health Sciences.[248] For example, in Delta State, Nigeria, there are 44 hospitals but only five of these have "miniature psychiatric units.[249] In Edo State, Nigeria, there are 34 State Government owned hospital spread across the three senatorial districts.[250] None of these has any psychiatric presence. Only in the then Central Hospital, Benin City operated an out-patient psychiatric services.

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[243] Ibid.

[244] Ibid.

[245] Ibid.

[71] Ibid.

[246] I. O., Jack Ide, and others "A Comparative Study of Mental Health Services in two African Countries, South Africa and Nigeria" op. cit. p.43 [73] Ibid, op. cit. p. 53. [74] F. O., Emiri "Mental Law and Practice in Nigeria", Malthouse Press Ltd, Lagos, 2002, p.383.

[247] Ewhrudjakpor, C. "Psychiatric Institution and Emerging Institutional Scene in Nigeria" in *African Research Review, An International Multi-Disciplinary Journal, Ethiopia, Vol. 4(1)* January 2010, 136.

[248] Ibid.

[249] Ibid

[250] Health Information Bulletin of Edo State Hospitals Management Board (at it then was), Benin City, December 2005. [79] Adegboyega and Adegboyega, "Mental Health Legislation in Nigeria: Current Learnings and Future Yearnings" op. cit. p. 62.

Nigeria, acclaimed to be the most populous country in Africa has a multi-ethnic and multi-religious population of over 200 million people. Despite the large population, and the significant social burden of metal disorder, resources for mental health remains scare and over concentrated in urban areas. Apart from the obvious low priority accorded to mental health in terms of policy, funding and personnel, the legal framework for the provision of mental health care in Nigeria remains a major concern to psychiatrists as well as other stakeholders.

The World Health Organization (WHO_ has estimated that only 50% of countries in the African region have mental health policies, while 79.5% (compared with 91.8% in Europe), have mental health legislation. Only about 30% of these laws were enacted after 1990, with some dating back to the colonial era[79]. Regrettably, Nigeria falls into this category.

There are facilities both at the federal and state levels to assist the mental health patient but owing to resource constraints, the number of these facilities have remained relatively small and grossly insufficient to meet increasing demand. Similarly, because there was no adequate legislative framework in Nigeria in regards to the care and treatment of the mentally ill, it is uncommon to find mentally incapacitated individuals roaming the streets and soliciting alms in public places, living in abandoned buildings or scavenging for food in dumpsites.[251] The WHO recommends a minimum of "ten (10) beds per 100,000 population".[252] As at 1993, only a total of "300 beds were available for mental health care in Nigeria.[253] Also, in 1993, "one psychiatrist was available for two (2) million of the population".[83]

6. Relationship between Mental Health and Law

Mental health, as much as any medical specialty such as medicine, pediatrics, gynecology, surgery, to mention but a few, has a most intimate relationship with law. The relationship is bilateral and comprises both the giving of psychiatric information in various local contexts and the use of law for clinical purpose and for the regulation of clinical practice. It is also at the heart of forensic psychiatry.[254] The practice of forensic psychiatry is dependent on legislation, the criminal justice system and local service provision.[255] Some branches of mental illness are associated with a greater frequency of involvement with legal questions, or with special types of legal questions than others.[256] However, all patients dealt with by all psychiatrists come with the terms of common law and statute laws relevant to medical treatment.[257]

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[251] N., Obiajulu. "The Right to Health in Nigeria – Right to Health in the Middle East" – *Project, Law School, University of Aberdeen,* available at http://www.abn.ac.uk/law/hhr.shtml accessed on 27/5/2014, p.19

[252] World Health Organization (WHO) 2005, Resource Book on Mental Health: Human Resource and Legislation LSBN 924156282.

[253] Ibid.

[83] Ibid.

[254] N., Eastman, "Legal Use of Psychiatry and Law as an Instrument of Psychiatric Practice", in New Oxford Textbook of Psychiatry, vol.2, Oxford University Press, 2007, p.2097.

[255] David Sample and Roger Smyth, Oxford Handbook of Psychiatry, 2nd edition, Oxford University Press, 2009, p.612

[256] Ibid

[257] Ibid

The relationship between mental health and law also involves the provision of reports and the giving of oral evidence to both civil and criminal courts by mental health scientists. It also involves delivering of information derived from science whose purposes are entirely difficult from those of law.[258] Although there are many fields of law where the law essentially uses psychiatry or mental illness towards its own very special eras, sometimes, the law is itself a tool of public policy which is directed specifically at mental health care objectives.[259]

The relationship between mental health and law was considerably highlighted with the publication in 1947 of *Gray's Law and the Practice of Medicine* which contained chapters on mental illness *in criminal cases, amnesia, and sex offenders.*[260] *A year later, Gray presented his classic paper "What is Forensic psychiatry?"* to the Ontario Neuropsychiatry Association. In it, he classified psychiatry into two main divisions, one of which designated "psychiatric jurisprudence" as encompassing primary legal issues.[261] These included the "custody of the mentally-ill, custody of the estate of the mentally incompetent persons' mental illness and testamentary and contractual capacity; mental illness and liability for torts; mental illness in relation to marriage and divorce; abortion and sterilization; and mental illness and crime".[92]

The relationship between mental health and law manifested in the case of *Re C.*[262]The issue for determination in this case was whether persons of full age suffering from a disease of the mind or mental illness have the capacity to allow or refuse anticipated treatment for their ailments. In this case, C, a 68year-old man was diagnosed with gangrene in the right foot and the hospital considered amputation. C refused and sought an injunction. But the hospital authority argued that by virtue of C's chronic mental illness, he had no capacity to make an informed choice. The court held that in considering capacity, the important question to be decided is whether it has been established that C's illness prevented him from understanding the "nature, purpose and effect of the proposed amputation"[263]. His Lordship, used as decision-making analysis, the three stage enquiry, namely:

i. the patient's ability to comprehend and retain treatment information;

ii. believe in the treatment; and

iii. balance of risks and benefits ratio.[264]

Applying these three decision-making analyses, the court found that C's mental illness had not displayed his right of self-determination and his choice was informed.[265]

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[258] N., Eastman, "Legal Use of Psychiatry and Law" op cit., p. 2097.
[259] N., Eastman, "Legal Use of Psychiatry and Law" op cit., p. 2097.
[260] R. E., Turner, "Psychiatry and Law" *Osgoode Hall Law Journal* (1973) 11(1) op cit p.163.
[261] Ibid.
[92] Ibid.
[262] Unreported. The Independent of 15th, October 1993, p. 341.
[263] F. O. Emiri, Medical Law and Ethics in Nigeria, (Malthouse Press Ltd, Lagos, 2012), 304
[264] Ibid.
[265] Ibid.

In Nigeria, there is a dearth of decided cases showcasing the relationship between mental health and law. However, *section 28* of the Criminal Code provisions that;

> *A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural infirmity as to deprive him of capacity to know that he ought not to do the act or make the omission. A person whose mind, at the time of his doing or omitting to do act is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.*[266]

The Penal Code, on its part, in *section 51,* states thus:

> *Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is capable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law.*[98]

In the Nigerian Criminal Procedure, the defense of insanity can be raised at different stages.[267] The accused may be insane at the relevant time of committing the act or of making the omission or at the time of trial of the matter itself.[268] In *Madojemu v State,*[269]the appellant was arraigned for the murder of his wife. He pleaded not guilty to the charge. At the conclusion of the trial, the trial court found him guilty as charged and sentenced him to death because from available evidence, there was no proof that the appellant was insane or that he was suffering from mental infirmity that deprived him of the capacity of understanding what he was doing or control his actions, or to know that he ought not to do that act or to make the omission. He appealed to the Court of Appeal which dismissed the appeal. He further appealed to the Supreme Court which also dismissed the appeal and upheld his conviction. The Apex Court emphasized that the raising of defense of insanity provided in section 28 of the Criminal Code is *prima facie* an acceptance of responsibility for the act complained of.

Also, in *Alfa v State,*[102]the appellant, as the accused was arraigned before the Kogi State High Court, sitting at Okpo for committing culpable homicide, an offence punishable under *section 221(s)* of the Penal Code. The appellant, Pastor Sunday Alfa, on the fateful day of 24th February, 2014, left his bedroom and entered the bedroom of his wife, Rose Alfa, the deceased at about 3.00am and thereafter inflicted several cuts on her with the use of a cutlass. She suffered several injuries and died on the way to the hospital. The trial court in its considered judgment convicted and sentenced the appellant to death by hanging. Dissatisfied with the judgment of the trial court,

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[266] Section 28, Criminal Code Act, Cap 38, 2004.
[98] Section 51, Penal Code.
[267] G. W., Ekaitatie "The Defence of Insanity" – Being an *LLM Thesis* submitted to the Faculty of Law, Ambrose Alli University, Ekpoma, 2003.
[268] Ibid. If found insane at the time of committing the offence, section 28 of the Criminal Code applies - which means he will not be criminally liable. But if it is at the trial, he will be sent to an asylum or mental hospital till he is well enough to stand trial.
[269] (2001) FWLR (Pt. 52) 2210 S.C.
[102] (2016) 14 W.R.N. CA 115.

the appellant appealed to the Court of Appeal. On whether it is the court that determines if an accused person was insane when he committed the offence, the court held that it is solely for the judge to determine whether the accused person was indeed insane or suffering from insane delusion, or is mentally deluded at the time of committing the offence. It added that any medical report available to the court is only a guide and does not tie and bind the hands of the court.

Similarly, in *Edoho v The State*[270], the court, in determining whether the evidence of insanity of an accused person's ancestors or blood relation is admissible, held that "evidence of insanity of his ancestors or blood relation is admissible, "but, medical evidence, though probative, is not essential". And in *Adamu v State*[271], the court in defining insanity stated that it is "any mental disorder severe enough that it prevents a person from having legal capacity and excuses the person from criminal or civil responsibility". The court added that "it is a legal, not a medical standard".

Also, in a more recent case of *Haruna Rabi v The State*[105], the Supreme Court was to determine whether medical evidence as to the cause of death was necessary in determining the responsibility of an accused for murder. In this case, the appellant was arraigned before the High Court of Kaduna State on a one-count charge of culpable homicide punishable with death contrary to *section 221 of the Penal Code Law of Kaduna State, 1991.* It was alleged that on or about August, 13th, 2013, the appellant had attacked one Musa Bello (the deceased) by hitting a pestle, twice on his head while he was asleep in his room as a result of which he sustained injuries and subsequently died. The appellant pleaded not guilty to the charge.

At the trial, the prosecution/respondent called four witnesses to prove its case, and tendered four exhibits in the course of trial. The court, but its judgment delivered on July 28th, 2016 found the appellant not guilty of the charge, and consequently discharged and acquitted the appellant.

Dissatisfied with the judgment, the respondent lodged an appeal at the Court of Appeal, Kaduna Division (hereinafter, referred to as "Lower Court"). The court Lower Court found merit in the appeal and reversed the judgment of the trial court. It sentenced the appellant to death. Aggrieved by the said judgment, the appellant appealed to the Supreme Court which unanimously dismissed the appeal. The Apex Court held that:

> *Now, the law is that a medical report on the cause of death is desirable but is not a necessity. The cause of death can be inferred by the trial judge. Indeed, in determining the responsibility of an accused person for murder, the important consideration is whether the death was caused by injuries sustained through the act of the accused and not whether from the medical point of view death was caused by such injuries. Medical evidence is at best stating opinion … no medical evidence as to the cause of death will be necessary*.

However, despite the close relationship between mental health and law, there may be some areas of disagreement between the two concepts which explains why they do not accommodate more

[270] (2011) Vol. 192 LRCN.
[271] (2014) Vol. 32 WRN 1-181 S.C.
[105] (2023) 1 WRN 1. S.C.

harmoniously. While law tends to be "absolutist" mental health, on the other hand is "relativist".[272] Law tends to see the word in terms of black and white, mental health in gradations.[273] It has been said in America Literature that;

> *To date, the interaction between psychiatry and the criminal law system has been frustrating and unproductive. This failure is explained as the basis that psychiatry has always been involved at the guest of the legal system and worse, that its tasks and roles have been delineated and defined by the legal system. Psychiatry has accepted this uncritically and unimaginatively … psychiatry has been involved with the criminal law system for quite some time but to date, this has not been a happy or, for that matter, a productive relationship.*[274]

Significantly, law and mental health share a common interest in deviant behaviour .[275] Over the years, the principles of and finding deriving from psychiatric practice have been increasingly relevant in the judicial process.[276]

7. Recommendation

Here are few recommendations to further improve the status of mental health victims in Nigerians'

a. Training of Human Resources: the human resources of Nigeria should be properly trained to address the issue of mental health by improving and increasing the number of professionals in the psychiatry to handle challenges of mental disorders.

b. Investment in Mental Healthcare: the need to make substantial investment in the counselling of people suffering from mental disorders and integrating the mental health care system into the existing health and social protection programs and protocols.

c. Mental health victims should be accorded fundamental rights because health challenges is inherent in human wellbeing with such services forming part of primary care, budgeting allocations need to be maintained for as package for national benefits plan as practice in develop countries.

8. Conclusion

Mental health legislation should be viewed as a process rather than an event that occurs just once in many decades as is the case with Nigeria mental health legislation. This allows it to be amended in response to advances in the treatment of mental disorders and to developments in service delivery systems. However, frequent amendments to legislation are not feasible because of the tie and financial resources regarded and the need to consult stakeholders.[277] A possible alternative or solution is to lay down regulations that are separate from legislations but can be enforced through it. The most important advantage of regulations is that they do not require law makers to be

[272] R. E., Turner "Psychiatry and Law"; *Osgoode Hall Law Journal,* (1973) 11 (1), p168.
[273] Ibid.
[274] R. E., Turner, "Psychiatry and Law"; *Osgoode Hall Law Journal,* (1973) 11 (1), p168.
[275] Ibid.
[276] R. E., Turner, "Psychiatry and Law"; *Osgoode Hall Law Journal,* op. cit p169.
[277] "Mental Health Policy and Service Guidelines" op cit p.2

repeatedly voting for amendments. In some countries, executive decrees or service orders are used as an alternative to regulations.[278]

It is hoped that Nigeria will periodically review or reform her mental health legislation to enhance the quality of mental health services and promote the integration of persons with mental disorders into the community in accordance with international standards.

[278] Michelle F. "Mental Health Legislation and Human Rights" in *Mental Health Policy and Service Guideline Package,* WHO, 2003, op. cit. p.3.