

# Manifestation and Treatment of Mental Health in Nigeria: A Call for Responsive and Efficient Legislation in Compliance with Global Best Practices

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**How to cite this paper:** Odusote, A. (2021). Manifestation and Treatment of Mental Health in Nigeria: A Call for Responsive and Efficient Legislation in Compliance with Global Best Practices. *Beijing Law Review*, 12, 1268-1283.  
<https://doi.org/10.4236/blr.2021.124065>

**Received:** November 11, 2021

**Accepted:** December 21, 2021

**Published:** December 24, 2021

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## Abstract

In earlier times in Nigeria, the concepts of mental health and mental illness were substantially misconstrued, with the focus being on the confinement of persons with mental illnesses rather than effective treatment. The law allowed such persons to be detained until they were deemed to be “sane”, resulting in prolonged detention. Such confinement was not always accompanied by proper treatment for the mental illnesses suffered by persons detained. Rather, many experienced harsh and inhumane treatments which achieved more harm than good. However, modern developments in psychiatry and the adoption of international standards on the rights of mentally ill persons have led to a shift in the structure for the treatment of such persons. This structure reflects a move from institutionalisation to other forms of treatment, stricter criteria for civil commitment, and respect for the right of mentally ill persons to autonomy and self-determination. The role of the State has also developed into one which entails balancing the need to protect and preserve the rights of mentally ill persons, with the need to protect the society from harm, on one hand, and the need to preserve the individual’s welfare on the other hand. Unfortunately, the present national legal framework on mental health in Nigeria fails to adapt to these developments and reflects no attempt to balance the rights of mentally ill persons with the public interest and individual welfare. This paper outlines the legal structure for the assessment and treatment of mental illness in Nigeria, juxtaposing it with international standards and best practices. It establishes a case for the amendment of the present law in line with the stated standards.

## Keywords

Mental Illness, Mental Health Confinement and Treatment

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## 1. Introduction

Health refers to “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. Mental health, thus, represents one of the core elements of health, and indicates that 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” (WHO, 2018). 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 increased risk of death, pain or important loss of freedom (Shahrokh, 2011).

Mental illnesses include a range of disorders such as anxiety disorders, depressive disorders, trauma and stress-related disorders, personality disorders and psychotic disorders (Brandt, Dieterich, & Strupp, 2005). 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 (WHO, 2019). 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 (Bronfenbrenner, 1974). However, the wide classification of mental illnesses and the variety of treatment options were not available in previous times (Agius, Shah, Ramkisson, Murphy, & Zaman, 2009). During the Middle Ages up until the 17<sup>th</sup> 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 (Roberts, 1987). They were also chained, deprived of food, beaten and bloodlet. Others were regarded as “town fools” or “village idiots” and were either treated as charity cases or made the object of societal amusement (Roberts, 1987).

The 17<sup>th</sup> century, referred to as the period of “The Great Confinement” in Europe, was characterised by the isolation and ostracism of mentally ill persons (Foucault, 2001). 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 (Foerschner, 2010). Mentally ill persons were regarded as insane or lunatic (Vrklevski, Eljiz, & Greenfield, 2017). 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 dis-

played to the public for amusement (Farreras, 2021). Mentally ill persons were treated like animals and kept in dark, filthy and cold rooms (Foerschner, 2010). 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, straight jackets and chains (CVLT, 2020).

In the late 18<sup>th</sup> 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 Philippe 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 (Parry, 2006). The movement sought to establish hospitals that provided adequate care and comfort to mentally ill persons. The 19<sup>th</sup> 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 (Szmukler & Gostin, 2021). 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 (Andrews, Briggs, Tucker, & Waddington, 1997).

However, developments in psychopharmacology in the 20<sup>th</sup> 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 (Saya, Brugnoli, Piazzini et al., 2019).

However, the treatment of mental health patients in Nigeria still lags behind best global practices significantly because of a weak and inefficient legal frame-

work. Hence, this paper aims to interrogate the treatment of the mentally ill and the legal framework that underpins mental health and treatment 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 on mental health in other jurisdictions and best practices across the globe.

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

In the present day, several mental disorders 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 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 (Saya, Brugnoli, Piazzi et al., 2019). 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.

### 2.1. 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 and that the hospitalisation of a mentally ill person required the intervention of the court. It was also thought that the ability of a mentally ill patient to leave the psychiatric facility at will could jeopardise their treatment. 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 (Appelbaum & Gutheil, 2007). Voluntary admission has now been recognised and supported by legislations 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* 494 U.S. 113 (1990) 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*, 34 III. App. 3d 574, 340 N.E.2d 217 (1975) 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". In the same vein, the court in *In re Hays* 102 III. 2d 314, 465 N.E.2d 98 (1984) held that a petition for involuntary commitment of a patient who had not requested to be discharged was a violation of his rights. Likewise, in *Appeal of Niccoli*, the court held that involuntary commitment proceedings could not be brought against a patient who had indicated a desire to remain in the mental facility voluntarily, in the absence of anything which showed that the legitimate purposes of the Act could not be achieved.

## **2.2. Emergency Detention: 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 (Matthews, 1970). 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 (Matthews, 1970). 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" (Posner, 1996). 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" (Gostin, 2000).

The right to restrain a mentally ill person was also recognised by common law. In *Warner v. State*, 297 N.Y. 395 (1948) 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 officer 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".

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*, 108 Mass, 116 (1871), 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, S.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* (2012) ECHR 804, 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.

### 2.3. 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* 422 U.S. 563 (1975), “a finding of ‘mental illness’ 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* 457 P.2d 370 (1969), 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*, 384 F. Supp. 1085 (E.D. Mich. 1974), 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 (Jacob, Sharma, Andalman et al., 1974). This has led to devastating consequences in certain cases. For example, on the 10<sup>th</sup> 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 upheld in the case of *Thompson and Empowerment Council v. Ontario* 2013 ONSC 5392 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* 349 F.Supp. 1078 (1972) 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* 364 F.2d 657 (1966) 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. 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* 335 N.Y. 2d. 461 (Sup. Ct. 1972), the court held that an involuntarily admitted patient, could, nevertheless refuse consent to Electro-convulsive therapy (ECT).

### 3. Nigerian Legislations on the Treatment of Mentally Ill Persons

#### 3.1. The Lunacy Act 1964

The present mental health legislation in Nigeria is the *Lunacy Act 1964*. Being only a slight modification of the *Lunacy Ordinance of 1916*, the Act does 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 fails to provide for voluntary admission and voluntary treatment. Section 10 of the Act provides 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 empowers 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”. Pursuant to 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.

### **Criticisms of the Lunacy Act 1964**

The Lunacy Act 1964 is 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 is problematic in many ways. First, the Act fails 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 does not provide for voluntary admission of mentally ill persons. It, therefore, does not view mentally ill persons as competent to take charge of their own treatment. Furthermore, the Act adopts a vague criterion for involuntary commitment as it does 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 (Obayi, Asogwa, & Ugwunna, 2017). The Act also fails to provide any procedural safeguards with regard to involuntary commitment. It contains 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 reflects no attempt to balance the right to autonomy and liberty against the need to protect the interest and welfare of the individual and the State.

Additionally, the Act does not provide for police powers to apprehend and restrain. The failure to do this may either lead to the poor handling of mentally ill persons by police officers or leave them with no choice but to detain a mentally ill person in prison where an emergency occurs.

### **3.2. The Mental Health Law of 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 1) is at risk of serious harm to self or others; or 2) 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 1) is dangerous to self or others, 2) is likely, owing to mental illness, to act in a manner which offends public decency; or 3) 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.

### 3.3. The National Mental Health Bill 2021

After several attempts to enact a new mental health law for Nigeria, the **National Mental Health Bill 2021** was passed by the National Assembly on the 6<sup>th</sup> of July, 2021. The Bill has, however, not received assent from the President. In comparison to the Lunacy Act which it repeals, the Bill is a more detailed and structured piece of legislation that highlights the key concepts relating to the treatment of mentally ill persons in Nigeria.

Clause 27 of the Bill 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 to be discharged within 24 hours

unless the criteria for involuntary admission is met at the time the request is made. Clause 26 of the Bill establishes the right to give informed consent and provides what informed consent should entail.

Clause 28 stipulates a detailed process for involuntary admission of a person with a mental condition. 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. Clause 29 of the Bill 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. Clause 30 provides for the discharge of an involuntary patient where treatment is no longer required.

Clause 32 and 33 of the Bill also provides 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, Clause 41 of the Bill allows a Police Officer above the rank of an Inspector or a 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 Bill 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**

### **4.1. International Human Rights Standards Relating to the Treatment of Mentally Ill Persons**

#### **4.1.1. The 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 pro-

vides 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.

#### **4.1.2. Specific International Instruments on Mental Health Treatment**

##### **1) The 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.

##### **2) The 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 1) there is a serious likelihood of immediate or imminent harm to self or others; or 2) 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.

#### **4.2. 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 (Appelbaum & Gutheil, 2007).

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 is 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.

With regard to police powers, the Resource Book highlights the fact that the police in exercising its 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. 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. Mental health legislation ought to exhibit a preference for voluntary admission, in recognition of the right to autonomy and self-determination. It must also uphold the right to informed consent and provide particular guidelines for the administration of treatment without consent, where necessary. In recognition of the right to liberty, mental health legislation must uphold the right to be treated in the least restrictive environment, stipulate definite standards for involuntary commitment and provide procedural safeguards which prevent abuse. It should also define 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. In order to ensure the prompt and effective treatment of mental illness, especially more severe disorders, it is necessary to have a new law that provides for these important areas. It is, therefore, recommended that the Lunacy Act be repealed and the new and more comprehensive Mental Health Bill is given assent to create a better and more effective structure for the treatment of mentally ill persons in Nigeria.

## Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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