

MENTAL HEALTH LEGISLATION AND INVOLUNTARY COMMITMENT IN NIGERIA: A CALL FOR REFORM

Mental health issues know no geographical or sociological boundaries. From East to West, developed to developing, cases of mental and behavioral disorders abound.¹ Often undiagnosed and frequently misunderstood, many individuals suffering from mental health issues have been placed on the fringe of society and given inadequate treatment, if any.²

Nigeria is no exception³—save for how it deals with those who suffer from these disorders. While much of the world has enacted or revised legislation and policies to protect and serve the mentally ill,⁴ antiquated

1. For example, in high-income OECD country Great Britain, a member of the Organisation for Economic Co-operation and Development, twenty-three percent of adults experience at least one diagnosable mental health problem in any one year. NICOLE SINGLETON ET AL., OFFICE OF NAT'L STATISTICS OF THE U.K., PSYCHIATRIC MORBIDITY AMONG ADULTS LIVING IN PRIVATE HOUSEHOLDS, 2000: SUMMARY REPORT (2001), available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068188.pdf. A study conducted from 2000 to 2001 in rural Bangladesh, a low-income country, showed sixteen percent of people suffered from mental disorders. G.M. Monawar Hosain et al., *Prevalence, Pattern and Determinants of Mental Disorders in Rural Bangladesh*, 121 PUB. HEALTH 18, 22 (2007). The percentage of individuals ages fifteen years or older in Thailand, a middle-income country, having a lower-than-average mental health condition in 2008 was 17.8. *Interesting Indicators*, NAT'L STATISTICAL OFFICE OF THAI (Dec. 2009), <http://web.nso.go.th/index1.htm>. Income level categories used above are based on the World Bank's income groups. See generally *Country and Lending Groups*, THE WORLD BANK, <http://data.worldbank.org/about/country-classifications/country-and-lending-groups> (last visited Aug. 29, 2011). Around twenty-six percent of adults in the United States suffer from a diagnosable mental disorder each year. Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617, 619 (2005).

2. WHO Urges More Investments, Services for Mental Health, WORLD HEALTH ORG., http://www.who.int/mental_health/who_urges_investment/en/index.html (last visited Nov. 11, 2010). "One in four patients visiting a health service has at least one mental, neurological or behavioural disorder but most of these disorders are neither diagnosed nor treated." *Id.*

3. Studies have shown that anywhere from ten percent to almost twenty-eight percent of the adult population of Nigeria experiences some form of mental health issue, depending on the population surveyed and the test used. See WORLD HEALTH ORG., MENTAL HEALTH ATLAS: 2005 348 (2005), available at http://www.who.int/mental_health/evidence/mhatlas05/en/index.html [hereinafter WHO MENTAL HEALTH ATLAS].

4. As of 2005, 84% of countries with mental health legislation (78% of countries) have updated that legislation since 1961. In addition, 52.9% of those countries have updated their laws since 1991. *Id.* at 18. The international community has also taken steps to prevent discrimination against those with mental disabilities by creating the Convention on the Rights of Persons with Disabilities. One hundred and three states have ratified this treaty. U.N. ENABLE, <http://www.un.org/disabilities> (last visited Aug. 28, 2011). The treaty requires, in part, that parties "adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention . . . [and to] take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with

colonial law still governs mental health in Nigeria.⁵ To make matters worse, stigma and abuse of the system, especially that of involuntary commitment,⁶ permeate Nigerian society.⁷ Many families that find their relatives' mental health issues too difficult or expensive to handle at home simply pass the responsibility to the prisons, creating a class of persons known as "civil lunatics."⁸ Instead of obtaining treatment at hospitals or mental health institutions, these "civil lunatics" are jailed in asylums within prisons, generally receiving no treatment.⁹ The current law in Nigeria allows any building to house an asylum,¹⁰ and contains no requirements for treatment of "inmates."¹¹

Fortunately, a movement has begun to remedy this grave situation. An organization called Prisoners Rehabilitation and Welfare Action (PRAWA) actively seeks release from asylums of those individuals who have committed no crime.¹² On a larger level, one senator in the Nigerian

disabilities." Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, U.N. Doc. A/RES/61/106, at 5 (Dec. 13, 2006).

5. See *infra* Part II.A.

6. For the purposes of this Note, "involuntary commitment" simply means the admission of a patient against his will.

7. The director of one of the eight Nigerian hospitals for people with mental illnesses has lamented the abuse: "The asylum in the prison is meant for clear forensic cases, like violent people who are suspected of murder, but this is being abused. People bring their mentally ill family members to the asylum. Once they are put in there, it removes them from paying for their care." Amnesty Int'l, Nigeria: Prisoner's Rights Systematically Flouted, AI Index: AFR 44/001/2008, at 38 (Feb. 2008), available at <http://www.amnesty.org/en/library/asset/AFR44/001/2008/en/4bd14275-e494-11dc-aaf9-5f04e2143f64/af440012008eng.pdf>. For examples of the stigma of mental health issues, see Julian Eaton & Terfa Tilley-Gyado, Mental Health Care in Nigeria; the Forgotten Issue, Next, <http://234next.com/csp/cms/sites/Next/Home/5397081-146/story.csp> (last visited Jan. 13, 2010).

8. AMNESTY INT'L, *supra* note 7, at 37. One description by a so-called "civil lunatic" is particularly haunting:

Only three or four men that I came into contact with while I was in the asylum were there because they had been accused of committing a murder or another serious crime. The rest were there simply because of a breakdown in the family relations. Maybe you and your relations had a dispute over a family inheritance. The relatives may go to the magistrate's court and allege you are a threat or a danger to their lives. This is how it is done: the individual may or may not appear at the magistrate's court, where the "prosecutor," usually a close relative, testifies that the individual is violent or that they had been threatened. The magistrate will then send such a person to the asylum for medical observation, with a date set to reappear in court for an assessment. But they usually stay for very much longer periods. Then God only knows if, or when, the individual will make it to the outside world again.

Equal Rights Trust, *An Invisible Victim: Testimony from a Man with Mental Disabilities in Nigeria*, 3 EQUAL RIGHTS REV. 75, 76-77 (2009), available at http://www.equalrightstrust.org/ertdocumentbank/testimony_ERR3.pdf.

9. See Amnesty Int'l, *supra* note 7, at 37.

10. See The Lunacy Act (1958) Cap. (112), § 3(1)(a) (Nigeria).

11. See *id.* §§ 4, 13, 14(1) (failing to mention treatment in the entire statute and instead using the term "confinement").

12. See Andrew Walker, *Locking up Nigeria's "Civil Lunatics,"* BBC NEWS (Apr. 29, 2009),

National Assembly sponsored a bill to repeal the current mental health legislation and replace it with a new Mental Health Act (“the Bill”).¹³ Unfortunately, support within the National Assembly did not follow the sentiment of human rights or health organizations and the Bill, first introduced in 2003, sat in the Senate awaiting further action until it was withdrawn in April 2009.¹⁴

This Note focuses on the topic of involuntary commitment and argues that, while the proposed Mental Health Act did not provide a perfect solution to the current problems, its withdrawal halted the change the Nigerian National Assembly needs to enact. Part I of this Note discusses a brief history of mental health in Nigeria. Part II provides an overview of the current mental health legislation. Part III then outlines the provisions of the Bill. Part IV analyzes the unrealized change found in the Mental Health Act for Nigeria based on the country’s international obligations, recommendations from the World Health Organization (WHO), and regional best practices. Part V suggests future action for Nigerian lawmakers.

I. WHAT HAS BEEN: A BACKGROUND OF MENTAL ILLNESS IN NIGERIA

The treatment of mental illness in Nigeria exists in a number of forms today. Traditional medicine plays an enormous role in the culture and practice of the different ethnic groups.¹⁵ The Yoruba and the Igbo people of Nigeria,¹⁶ for example, have established systems of traditional healing

<http://news.bbc.co.uk/2/hi/africa/8023067.stm>. As of April 2009, the group had secured the release of fifty-four prisoners. *Id.*

13. Laws of Nigeria, S.B. 183 (2008), available at <http://www.nassnig.org/legislation.php?page=10>; see also *infra* notes 65–67.

14. See SENATE OF THE FED. REPUBLIC OF NIGERIA, 88 VOTES & PROCEEDINGS 661 (Apr. 22, 2009), available at <https://nassnig.org/nass/votesenate.php?id=343>; see also *infra* notes 70–71 and accompanying text.

15. During the colonial era, most Nigerians preferred traditional methods to the institutions of the British. JONATHAN SADOWSKY, IMPERIAL BEDLAM: INSTITUTIONS OF MADNESS IN COLONIAL SOUTHWEST NIGERIA 2 (1999) [hereinafter SADOWSKY, *Imperial Bedlam*]. Today, preference for traditional healers is strong, although efforts have been made to integrate traditional healing into the health care system and encourage a belief in the value of orthodox medicine. See *That Traditional Medicine May Find Its Rightful Place*, GUARDIAN (NIGERIA), Sept. 8, 2009, available at http://www.nguardiannews.com/focus_record/article01//indexn3_html?pdate=080909&ptitle=That%20traditional%20medicine%20may%20find%20its%20rightful%20place&cpdate=080909; see also MARY OLUFUNMILAYO ADEKSON, THE YORUBÁ TRADITIONAL HEALERS OF NIGERIA 26–38 (Molefi Asante ed., 2003).

16. There are numerous ethnic groups in Nigeria, but the Yoruba and Igbo were chosen because they are two of the three largest ethnic groups in Nigeria. The Yoruba comprise 21% of the population and the Igbo 18%. *The World Factbook: Nigeria*, CENT. INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html> (last visited Jan. 22, 2011).

that have been well-documented.¹⁷ Existing mental health research has primarily focused on the Yoruba, and many of the revolutionary developments of Nigerian psychiatry have occurred in connection with this particular group; therefore, this discussion will also focus on the Yoruba.

Traditional treatment of mental illness among the Yoruba centers on *babaláwos*, or “fathers of the secrets.”¹⁸ Traditional healers are professionally organized in Yoruba society, and most deal with both physical and mental ailments.¹⁹ Treatment is based on the perceived causes of the illness.²⁰ A general description of the treatment process, particularly for illnesses of natural cause, follows.²¹ A family brings the patient, a relative, to the healer. If the patient is excited, or difficult to control, the healer places him in restraints.²² Healers commonly use the plant *Rauwolfia*, a relative of orthodox antipsychotic drugs, to sedate patients.²³ Once under control, the healer begins assessing the cause of the illness, which often takes place by simply beginning treatment based on one cause and changing treatment until the patient improves.²⁴ If the perceived cause of illness is preternatural or supernatural, the patient seeks treatment from a diviner.²⁵ Diviners use methods such as incantations, rituals, and

17. See, e.g., Julian Eaton & Ahamfeula O. Agomoh, *Developing Mental Health Services in Nigeria: The Impact of a Community-Based Mental Health Awareness Programme*, 43 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 552 (2008); RAYMOND PRINCE, *Indigenous Yoruba Psychiatry*, in MAGIC, FAITH, AND HEALING: STUDIES IN PRIMITIVE PSYCHIATRY TODAY 84 (Ari Kiev ed., 1964).

18. ADEKSON, *supra* note 15, at 7. The term *babaláwo* is synonymous with “traditional healer” and can include both herbalists and diviners. *Id.* *Babaláwo* and “traditional healer” will be used interchangeably throughout this discussion.

19. SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 14.

20. See PRINCE, *supra* note 17, at 98. Yoruba healers treat illness based on three types of causes: natural diseases, preternatural causes, and supernatural causes. *Id.* at 88–97. Some of the natural diseases include consideration of hereditary factors. Other considerations include diet, worms, etc. *Id.* at 89. The preternatural causes primarily come from sorcerers, curses, and witchcraft. *Id.* Often these causes, particularly witchcraft, are thought to have the power to inhibit the effectiveness of medicine. *Id.* at 91. The *Orisas* form the basis of the supernatural causes. *Orisas* are deities that may cause mental illness if an individual neglects or offends the deity. *Id.* at 95.

21. The practice of traditional healing continuously evolves, and modern studies may not paint an accurate picture of traditional healing before the arrival of Europeans or future practice. Nevertheless, they can provide an effective overview of current practice. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 13.

22. PRINCE, *supra* note 17, at 98.

23. SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 14.

24. PRINCE, *supra* note 17, at 98–99.

25. Ayodele Samuel Jegede, *The Notion of “Were” in Yoruba Conception of Mental Illness*, 14 NORDIC J. AFR. STUD. 117, 123 (2005). Patients may also seek treatment from a diviner in order to avoid the more intense herbalist treatment. See *id.* at 122–23.

sacrifices to attempt to remedy their patients' illnesses.²⁶ In selecting the method of treatment, diviners consult the sacred stories of *Ifá*.²⁷ Through the divining chain,²⁸ the healer may relay messages from *Ifá* to treat the patient.²⁹

Orthodox psychiatry 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 in the late nineteenth century as a reaction to "an apparent swarm of 'lunatics' on the streets."³⁰ At the time, Western-style treatment focused only on confinement, so the authorities built a pair of asylums.³¹ From the beginning, the mental health system struggled for resources, which only made later calls for reform less popular.³² One glaring example of the lack of resources provided to mental

26. *Id.* at 123.

27. Collectively called *Odù Ifá*, there are 256 *odù*, or chapters, passed down through the oral tradition of *Ifá*. ADEKSON, *supra* note 15, at 9.

[*Ifá*] was one of the four hundred and one divinities who was sent by *Olódùmarè* (the Yoruba High God) from *rín* (heaven) to *ayé* (earth) to assume certain responsibilities. "It is through the vision and direction of [*Ifá*]'s words, known as the sacred *odù*, that his wisdom and guidance are expressed on earth.

Id. at 7 (internal citations omitted).

28. Professor Adekson provides an explanation of the divining chain as follows:

The divining chain (*pèlè*) consists of "eight half seed shells held in the middle so that four shells fall in a line on each side. . . . [B]y casting the *òpèlè*, the *babaláwo* can, in a single toss, arrive at the necessary eight symbols to form a complete *odù*," thereby assisting clients to diagnose their problems and find appropriate solutions to these problems.

ADEKSON, *supra* note 15, at 10 (quoting AFOLABI A. EPEGA & PHILIP JOHN NEIMARK, THE SACRED IFÁ ORACLE xv (1995) (internal citations omitted)).

29. ADEKSON, *supra* note 15, at 8. Diviners generally believe that mental illness may only be stabilized, not cured. If the patient violates the taboos of the gods, then he will relapse. Jegede, *supra* note 25, at 123.

30. SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 1–2. "The spectacle of them roaming about the streets in the pitiable condition which they present is a reflection . . . upon our . . . Civilization." *Id.* at 22. Unlike in some of its colonies, such as India, the British in Nigeria focused mental health services on Nigerians, not Europeans. Richard Keller, *Madness and Colonization: Psychiatry in the British and French Empires, 1800–1962*, 35 J. SOC. HIST. 295, 305 (2001).

31. SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 2, 10. Previously the government had either sent those suspected of mental illness to asylums located in other colonies like Sierra Leone or to the lunatic ward of Lagos prison. *Id.* at 24. Much of the colonial administration therefore considered the two asylums, located in Lagos and Calabar, as extravagance. *Id.* at 10.

32. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 30. The first director of Yaba Asylum, the first and most prominent asylum, was a Nigerian, Dr. Curtis Crispin Adeniyi-Jones. At the time, he was one of four African doctors in the colonial medical service (out of sixty-eight total doctors). F. Oyebo, *History of Psychiatry in West Africa*, 18 INT'L REV. PSYCHIATRY 319, 321 (2006). Letters that Adeniyi-Jones wrote on the conditions at the asylum show that the government refused to provide adequate resources such as clothing and equipment, and that thieves often further reduced their supply levels. SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 30.

health services is that no asylum employed a professionally trained psychiatrist until the 1950s.³³

As a result of financial constraints, conditions in the asylums were poor.³⁴ One visiting psychiatrist from Great Britain noted that the asylums were little better than the prisons.³⁵ In fact, the inmates of asylums generally wore more physical restraints than convicted criminals.³⁶ Another visiting psychiatrist found the institutions far behind the times and lamented the lack of “remedial treatment.”³⁷

Even in the twenty-first century, conditions remain deplorable. One description placed approximately forty men in one cell about 270 square feet in size.³⁸ To make matters worse, until the middle of the nineteenth century, treatment and therapy barely entered into the discussion. Part of the reasoning may have been financial, but “cultural misunderstandings” and the policy of “Indirect Rule,” which directed the colonizers to try to preserve traditional ways of life, provided most of the support for the decision not to treat patients.³⁹ The colonial administration was intrigued by the “African mind,” but had difficulty distinguishing between true “insanity” and mere cultural differences, such as witchcraft.⁴⁰ When coupled with the policy of Indirect Rule, these misunderstandings essentially left the British with little desire to run asylums but fearful of failing to do so.⁴¹

In the 1950s, change finally began to take shape. The country hired its first full-time psychiatrist, Donald Cameron, who instantly focused on treatment.⁴² In the 1960s, Yaba Lunatic Asylum became Yaba Mental

33. Oyebo, *supra* note 32.

34. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 27; *see also id.* at 26–33.

35. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 31.

36. *Id.* at 32. “The Director of Medical and Sanitary Services expressed willingness to substitute restraint jackets for chains in the early 1940s, but chains were still in use a decade later.” *Id.* at 130 n.33.

37. See R. Cunyngham Brown, *Care of Lunatics in Nigeria*, 2 BRIT. MED. J. 900 (1938).

38. Equal Rights Trust, *supra* note 8, at 77. The description also complained of drinking water collected primarily from the roof, scarce food, and poor sanitation. *Id.* at 78.

39. Keller, *supra* note 30, at 306; SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 34 (noting that “financial restraint was justified by the goal of preserving the African way of life”).

40. See Keller, *supra* note 30, at 306. A prevailing belief at that time was that “civilization itself brought psychic disturbances to ‘deculturated’ Africans who were unprepared for rapid progress.” *Id.*

41. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 2. “Indirect Rule” became policy under the first governor of Nigeria, Lord Frederick Lugard. Under the policy, the British had a dual mandate in Africa: to profit Britain financially and to develop Africa. *Id.* “[O]ne result of the contradiction between ideology and practice was half-measures like asylums—measures which dimly recognized the social changes colonialism incurred but also denied responsibility for them.” *Id.* at 37.

42. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 40–41. Cameron had no trouble voicing his opinion regarding treatment, despite its lack of popularity among the colonial administration. “It [was] reported that he was transferred to Nigeria for disciplinary reasons from Jamaica after he opened

Hospital and started treatment using orthodox medicine and therapy.⁴³ A few years earlier, Aro Mental Hospital, had newly opened in Abeokuta.⁴⁴ It was there that T.A. Lambo created Nigeria's most influential contribution to psychiatry.⁴⁵ Through a mutual understanding with the local community, families hosted Aro patients in their homes in exchange for work and rent. The patients received treatment at the hospital in the morning and worked through the afternoon. The hospital provided other benefits to the community as incentives to participate, such as purified water and loans for additional housing.⁴⁶ Traditional healers aided in design and implementation of some of the social activities as well as assessments of patients.⁴⁷ The Aro village scheme was used as a model for similar systems in other African nations, and it provided stimulation for the world psychiatric community to rethink the institutionalization model.⁴⁸ Unfortunately for Nigeria and its citizens suffering from mental illness, the Aro model neither spread to other parts of the country nor provoked a change in the mental health law.

II. WHAT IS: NIGERIAN MENTAL HEALTH LAW—THE LUNACY ACT

Nigeria currently follows the same mental health legislation that was in effect before it gained its independence from the United Kingdom in 1960.⁴⁹ Originally called the Lunacy Ordinance, it was first enacted in 1916 and last amended in 1958.⁵⁰ Unfortunately for Nigerians suffering from mental disorders or disabilities, a “majority of the current effective methods for treating mental disorders were not available” before 1960,⁵¹

all doors of the Kingston Mental Hospital to spite the then Colonial Government for not complying with his requests for the patients.” *Id.* at 41.

43. JONATHAN SADOWSKY, *Confinement and Colonialism in Nigeria*, in *THE CONFINEMENT OF THE INSANE* 299, 309 (Roy Porter & David Wright eds., 2003) [hereinafter SADOWSKY, *Confinement and Colonialism*]. The transition from asylum to hospital began under a Nigerian, Abraham Ordia, the country's first trained psychiatric nurse. *Id.* at 311. Alexander Boroffka, a German psychiatrist, completed the process. *See id.* at 309.

44. *Id.* at 311.

45. *See id.*

46. *Id.*

47. T. Adeoye Lambo, *Patterns of Psychiatric Care in Developing African Countries*, in *MAGIC, FAITH, AND HEALING: STUDIES IN PRIMITIVE PSYCHIATRY TODAY*, *supra* note 17, at 449–50. The idea was that “the African patient must ideally be treated within his social environment.” *Id.* at 447.

48. *See* SADOWSKY, *Confinement and Colonialism*, *supra* note 43, at 312.

49. *See* WHO MENTAL HEALTH ATLAS, *supra* note 3, at 349.

50. *See* THE LAWS OF THE FEDERATION OF NIGERIA AND LAGOS 2291 (Donald Kingdon ed., 1958).

51. WHO MENTAL HEALTH ATLAS, *supra* note 3, at 19.

leaving Nigerian mental health law and the rights of its people decades behind those of other nations.⁵²

A good place to begin a review of mental health legislation is by defining the conditions the law seeks to address. According to the Lunacy Act, a “‘lunatic’ includes an idiot and any other person of unsound mind.”⁵³ Besides using terms not in standard parlance today,⁵⁴ the definition has the potential for broad, fluid interpretation.⁵⁵ Such discretionary interpretation gives medical practitioners and magistrates great power to decide which citizens are covered by the law.⁵⁶ 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.⁵⁷

Despite creating a potentially wide scope of affected persons, the Act does attempt to protect individuals who could possibly fall within its definition. The procedure for commitment, although subject to some discretion of the inquisitors,⁵⁸ requires that both a medical practitioner and a magistrate find that a person is a lunatic.⁵⁹ If a medical officer believes it necessary to detain a person for observation, that person may only be detained for seven days without the authorization of a magistrate.⁶⁰

52. *See supra* note 4.

53. Lunacy Act (1958) Cap. (112), § 2 (Nigeria).

54. When discussing the different options a state could use in mental health legislation to define mental ill health, the World Health Organization (WHO) does not include “lunatic” or “idiot.” *See* WORLD HEALTH ORG., WHO RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION ch. 2, § 3 (2005), available at http://www.who.int/mental_health/policy/resource_book_MHleg.pdf [hereinafter WHO RESOURCE BOOK].

55. Especially vulnerable to broad interpretation is the term “unsound mind.” The European Court of Human Rights has said that the term should not be given definitive interpretation because of its fluid nature. *Id.* at 23. The WHO is concerned that, because the term has no clinical definition, use in legislation will likely “impair dialogue between medical and legal disciplines.” *Id.* at 23, 25.

56. The Act requires two elements to commit a person against his will: (1) a magistrate must find that the person is a lunatic, and (2) a medical practitioner must examine and certify the person a lunatic. Once those elements are met, the magistrate then has discretion to make the final determination of lunacy. Lunacy Act (1958) Cap. (112), § 13 (Nigeria) (“[T]he magistrate *may* adjudge such suspected person to be a lunatic.” (emphasis added)). As discussed in note 55, *supra*, practitioners do not have a scientific definition of “unsound mind,” so they can use it as they please. The same idea holds with magistrates. As long as the practitioner certifies the person a lunatic—a certification that the magistrate could likely predict, given that he appoints the practitioner—the magistrate may consider a broad range of conditions to constitute unsoundness of the mind. Lunacy Act (1958) Cap. (112), § 12 (Nigeria).

57. The WHO notes that often “unsound mind” will include descriptions of people unaffected by mental disorders who may not necessarily need to be confined. WHO RESOURCE BOOK, *supra* note 54, at 23. Mere social deviants are one example. *See id.* at 21.

58. *See supra* notes 55–56 and accompanying text.

59. Lunacy Act (1958) Cap. (112), §§ 11–13 (Nigeria).

60. Cap. (112), § 10. A medical officer and a medical practitioner have two distinct definitions.

Nonetheless, some of the procedural elements leave room for potential abuse. For example, when a magistrate has decided to inquire into a particular person's state of mind, he may issue a warrant for that person's arrest if the magistrate fears the person would not appear in court.⁶¹ Detention pursuant to such an arrest may last up to one month.⁶²

The standards for conditions within an asylum are established by the regional governor, who may make regulations regarding the "government of asylums and the custody of the lunatics therein."⁶³ Further, the Act declares certain people to be "visitors," who may inspect the asylums and inquire into any complaints.⁶⁴ To ensure formal, regular review of the asylum conditions, the governor must appoint at least three "visitors" for each asylum. These visitors will then inspect the asylum and report their findings to the governor at least once per year.⁶⁵

The distinction is important because a medical practitioner may not order the detention of a person for any period of time. Only a medical officer can order a temporary detention. The Act does not define the terms, but the British Lunacy Act of 1890, from which Nigeria derives its current Lunacy Act, did. "Medical officer" means, in the case of an asylum, the medical superintendent, or if the superintendent is not a medical practitioner the resident medical officer of the asylum 'Medical practitioner' means a medical practitioner duly registered under the [medical licensing act]." Lunacy Act, 1890, 53 Vict., c. 5, § 341 (Eng.), reprinted in N. ARTHUR HEYWOOD, HEYWOOD & MASSEY'S LUNACY PRACTICE 442 (3d ed. 1907).

61. Lunacy Act (1958) Cap. (112), § 11(3) (Nigeria). It would be easy to imagine the frequent use of this provision, especially during the colonial era, given the public perception of and reaction to people with mental disorders. See SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 59 ("Many of the so-called civil lunatics were also detained by police or other authorities for being nuisances While the behavior could be simply odd, such as giving away money at random, it was usually bothersome to other people."); see also Femi Olu, *The World of Mental Health in Abuja*, THE NATION, Oct. 24, 2009, available at <http://thenationonlineng.net/web2/articles/22946/1/The-world-of-mental-health-in-Abuja--/Page1.html> ("And then there was the stigma and opprobrium widely associated in the people's minds, and in their actions, with all things to do with mental illness. Ignorance ruled the roost, even among medical practitioners.").

62. Lunacy Act (1958) Cap. (112), § 15(1) (Nigeria).

63. Cap. (112), § 31(a).

64. Cap. (112), § 7(1) ("The members of the Council of Ministers, all registered medical practitioners in the service of the Government whether in the medical or health branch of the service, and magistrates and such other persons as the Governor may nominate during pleasure shall be visitors of any asylum. The members of the House of Representatives shall be visitors of any asylum within the Colony."). The Act then gives visitors the power to "enter and inspect an asylum at any hour of the day or night, and see and examine any inmate, and may examine into and give directions concerning any complaint." Cap. (112), § 7(2).

65. Cap. (112), § 9.

(1) The Governor shall appoint three or more of the visitors to be a visiting committee for each asylum.

(2) The committee shall meet once a year or oftener if necessary at such asylum, and shall inspect the wards, cells, stores and every other place, and shall receive and inquire into any complaints which shall be preferred [sic] by or against any officer, servant or inmate.

(3) The committee may in any inquiry administer an oath to the superintendent of the asylum or to any officer or servant employed in the asylum.

A final notable aspect of the Act is not found within the text, but in what is missing from it. The Act makes no mention of treatment; nor does it use any words synonymous with treatment. The extent of the reasons provided for detention of a person under the Act is that a person is “a lunatic and a proper subject of confinement.”⁶⁶ In fact, the full title of the Act is “An [Act] to Provide for the Custody and Removal of Lunatics.”⁶⁷ The absence of any provision for treatment may have been one of the biggest factors influencing the movement for reform of the country’s mental health law.⁶⁸

III. WHAT ALMOST WAS: FORMER SB 183, MENTAL HEALTH ACT FOR NIGERIA

“Movement for reform” may not be the best term to describe the largely unheeded calls for change in Nigeria’s mental health law. Despite prominent voices making calls for reform, no movement in the direction of change has materialized.⁶⁹ A bill to repeal the Lunacy Act was originally proposed in 2003, but, after years of little activity, was withdrawn from the Senate in 2009.⁷⁰ Still, on a positive note, at least one senator found the issue important enough to propose the Bill.⁷¹

(4) After inspection, the committee shall make a report to the Governor, and shall draw up and transmit to the Governor such other reports or returns as they shall from time to time deem necessary, or which the Governor may call for in respect of any matter relating to the asylum.

Cap. (112), § 9(1)-(4).

66. Lunacy Act (1958) Cap. (112), § 13 (Nigeria).

67. Cap. (112), tit.

68. At a World Psychiatric Association regional meeting the Head of Communicable and Non-Communicable Diseases of the Federal Ministry of Health, Dr. Michael Anibueze, said when discussing the proposed Mental Health Act for Nigeria that the current mental health law is “‘the one we inherited from our colonial masters which is the British asylum law, which means that if you have mental illness your people can decide to take you to an asylum and dump you there to die,’ a law which is not applicable to the Nigerian society.” Ruby Rabi, *Nigeria to Review Mental Health Policy*, DAILY TRUST, Oct. 26, 2009 (on file with author). The WHO has advocated that “‘if a particular condition is not responsive to treatment, or if no treatments are available, [or if no treatment will even be attempted!] it is difficult to justify [that person’s] involuntary admission.” WHO RESOURCE BOOK, *supra* note 54, at 21. Even during colonial reign, “Nigerians . . . frequently question[ed] the [colonial] institutions’ ability to care adequately for mad persons, and traditional treatment was sought as an alternative.” SADOWSKY, *Imperial Bedlam*, *supra* note 15, at 55.

69. In 2001 the Minister of State for Health lamented that “‘the country [was] still operating ‘one of the most outmoded and irrelevant mental health laws’” as she announced the proposal of the bill to replace the Lunacy Act. Lillian Okenwa, *Bill to Repeal Lunacy Act Coming*, THIS DAY, Apr. 6, 2001, available at <http://www.thisdayonline.com/archive/2001/04/06/index.html>. The Head of Communicable and Non-Communicable Diseases of the Federal Ministry of Health said in 2009 that review of the mental health law was necessary. Rabi, *supra* note 68.

70. The bill passed a public hearing stage and was adopted by the Senate in 2004, but it never

An analysis of the provisions in the Bill shows that its enactment into law would indeed have marked progress in Nigeria's mental health law toward modern international standards. 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."⁷² The latter term is much more accessible to the medical community than the term "lunatic,"⁷³ and the definition specifically excludes "social deviance or conflict alone" from coverage.⁷⁴ The Bill also defined additional terms, which would have provided more guidance in application than the Lunacy Act.⁷⁵

Beyond narrowing the coverage of the law, the Bill would have provided additional procedural protections for those subject to it by creating three types of compulsory admission: temporary admission for observation, admission pursuant to an emergency application, and admission for treatment.⁷⁶ Magistrates would no longer play a role in the admission decision, which would have relied solely on medical classification.⁷⁷ For each type of admission, the applicant (i.e., the person

passed the House of Representatives. See WHO MENTAL HEALTH ATLAS, *supra* note 3, at 349. As described so eloquently by one journalist, the "draft Mental Health Law went into the throes of a hypoxia-induced convulsion, and then expired, ending up in the dark bottom of a drawer in some minor functionary's office in the House." Olu, *supra* note 61. On April 22, 2009, the sponsoring senator requested the withdrawal of the bill from the Senate. The request was granted. SENATE OF THE FED. REPUBLIC OF NIGERIA, 88 VOTES & PROCEEDINGS 659, 661 (Apr. 22, 2009), available at <http://nassnig.org/nass/votesenate.php?id=343>.

71. The sponsoring senator was Senator George Anthony Manzo (People's Democratic Party), of the State of Taraba. Nigerian Senate Member's Biographical Page, <http://www.nassnig.org/nass/portfolio/profile.php?id=sen.anthonymanzo> (last visited Nov. 11, 2010).

72. 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. Social deviance or conflict alone without disturbance of mental functioning is not mental disorder." S.B. 183, § 2(a) (Nigeria 2008). The bill also defines "mental impairment," *see id.* § 2(b), but only uses the term in the context of criminal proceedings, which are beyond the scope of this note. *See id.* pt. IV.

73. The WHO has said that the term "disorder" implies the "existence of a clinically recognizable set of symptoms or behavior," WORLD HEALTH ORG., THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS: CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES 11 (1992), and is "compatible with medical classificatory systems," WHO RESOURCE BOOK, *supra* note 54, at 24 tbl.1. It is important for countries using the term "mental disorder" to define it in the legislation, as it can potentially include mental illness, mental retardation, personality disorders, and substance dependence. However, all of these categories are recognized conditions, not subject to interpretation outside of their medical description. *Id.* at 21.

74. S.B. 183, § 2(a) (Nigeria 2008).

75. *See id.* § 34.

76. *Id.* §§ 5-7.

77. Compare S.B. 183, § 8 (Nigeria 2008) (directing applications for compulsory admission to the medical director of the hospital to which admission is sought), with Lunacy Act (1958) Cap. (112), §§ 11-13 (Nigeria).

applying to admit another person) would have had to base the application on two grounds: (1) the subject “is suffering from mental and behavioural disorder of a nature or degree which warrants his compulsory admission,” and (2) the subject “ought to be so detained in the interest of his own safety or with a view to protecting the safety and interest of other persons.”⁷⁸

Temporary admission would have required the recommendation of one medical practitioner who found that the person met the required qualifications.⁷⁹ An emergency application would not have required the recommendation of a medical practitioner, but could only be filed in case of “urgent necessity” and when an application for temporary admission would “involve undesirable delay.”⁸⁰ A person could only be detained for up to three days pursuant to an emergency application.⁸¹ Similarly, a police officer or social welfare worker could remove a person suspected of suffering from a mental and behavioral disorder to a place of safety if it was in the interest of protecting the person detained or others.⁸² The police officer or social welfare worker could not have detained the person under this section for more than seventy-two hours.⁸³

Admission for long-term detention would have had greater procedural requirements than the other two types of admission, and much greater requirements than involuntary commitment under the Lunacy Act.⁸⁴ A health worker or the nearest relative of a person could initiate the admission process by filing an application.⁸⁵ If a health worker filed the application, then the nearest relative must have at least consented to the filing.⁸⁶ Next, *two* medical practitioners would have needed to recommend

78. S.B. 183, § 5(1)(a)-(b) (Nigeria 2008).

79. *Id.* § 5(2). The maximum duration of detention based on this type of application would be twenty-eight days. *Id.* § 5(3).

80. *Id.* § 6(1). Only a health care worker or a relative of the person could make an emergency application. *Id.*

81. *Id.* § 6(2).

82. S.B. 183, § 14(1) (Nigeria 2008) (requiring further that the person detained be in “immediate need of care or control” and that the police officer or social welfare worker intend to file an application for admission). The Criminal Code Act also allows any person to use force, presumably including detention, which is “reasonably necessary in order to prevent a person whom he believes, on reasonable grounds, to be of unsound mind, from doing violence to any person or property.” Criminal Code Act (1990) Cap. (77), § 281 (Nigeria).

83. S.B. 183, § 14(2) (Nigeria 2008).

84. *Compare* S.B. 183, pt. 3 (Nigeria 2008), *with* Lunacy Act (1958) Cap. (112), §§ 11–13 (Nigeria).

85. S.B. 183, § 8(1) (Nigeria 2008). “Nearest relative” had a broad definition. It included “a husband or wife, son or daughter, father or mother, [brother] or sister, grandparent or grandchild, uncle or aunt, nephew/niece or cousin.” *Id.* § 34(i).

86. *Id.* § 8(2) (excepting cases where to obtain consent would cause “unreasonable delay”).

admission after examination within seven days of each other.⁸⁷ Upon proper completion of an application, the applicant or any person authorized by the applicant would have had fourteen days from the date of the last medical examination (on which the application was based) to take the detainee to the mental health facility.⁸⁸ In a major departure from the Lunacy Act, which does not limit the duration of detention when the full procedural process is followed, the Bill would only have allowed detention for a maximum of 365 days without renewal of the application.⁸⁹ A person detained could challenge their detention by applying to the Mental Health Review Tribunal, the only legal party involved in compulsory admission cases, within six months of admission.⁹⁰

Given that one of the main problems with the Lunacy Act is its lack of provision for treatment of people detained for mental health issues, the Bill clearly identified treatment as the purpose of detention.⁹¹ The Bill would have also placed restrictions on the type of treatment provided and the circumstances under which it could be provided. For example, consent would have been generally required for any treatment,⁹² and the patient could have withdrawn consent at any time.⁹³ Additionally, the Bill would have protected those detained by requiring facilities to meet minimum standards set by the Minister of Health.⁹⁴ Finally, while the Bill would

87. *Id.* § 9(1). The practitioners were required to find one or more forms of mental disorder as defined by section 2(a) of the bill and the recommendation had to be based on the two grounds required of all compulsory admissions found in section 5(1)(a) and (b). *Id.* § 7(3)(a)-(b). One of the two practitioners was required to be a “specialist psychiatrist,” or have “experience in the diagnosis and treatment of mental disorder.” *Id.* § 9(2).

88. S.B. 183, § 10(1)(b) (Nigeria 2008). The applicant could also authorize the police to take the detainee to the facility. *Id.* § 15(5).

89. *Id.* § 13(1).

90. *Id.* § 10(4). The Minister of Health could have created any number of Tribunals with the President’s approval, *id.* § 23(1), and each would have consisted of any number of members to be selected by the Minister of Health, *id.* § 23(2). The functions of the Tribunals would have been to “review treatments that require a second opinion, visit detained patients and investigate complaints, keep under review the exercise of statutory power relating to detained patients, and carry out any other function as may be directed by the Minister.” *Id.* § 23(3).

91. *See, e.g.*, S.B. 183, § 4 (Nigeria 2008) (voluntary admission for “any person who requires treatment for mental disorder”); *id.* §§ 7(1)–(2) (“application for admission for treatment”); *id.* § 7(3) (“application for treatment”); *id.* § 10(4) (“application for admission and treatment”); *id.* pt. VI (“Treatment”).

92. S.B. 183, § 27(3)(a)(Nigeria 2008). Section 27(3)(b) excepted cases where “the medical officer . . . certifies in writing that the patient has not consented to the treatment for reason of incapacitation or other, but that having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given.” *Id.* § 27(3)(b).

93. *Id.* § 27(4).

94. *Id.* § 3(4) (“as it relates to the quality and number of personnel, the number of beds in the hospital, the equipment and facilities provided in the hospital”).

have repealed the Lunacy Act in its entirety,⁹⁵ it did recognize as valid any orders for involuntary detention made under the Lunacy Act.⁹⁶

IV. WHAT COULD HAVE BEEN: ANALYSIS OF THE MENTAL HEALTH ACT FOR NIGERIA

The above comparison of Nigeria's antiquated mental health legislation with a more recent proposal shows that, at the very least, Nigerian mental health law has room for improvement in detailing protections for its citizens with possible mental health issues. The major differences between the Lunacy Act and the former Bill are the amount of time a potentially mentally ill person may be involuntarily detained and the procedure for compulsory admission.⁹⁷ But, beyond improvement on the Lunacy Act, any updated Nigerian mental health law should seek to advance the human rights of those it covers. Furthermore, human rights should not be judged on a subjective, improvement-based scale; objective standards provided in a country's constitution and international law should determine the criteria for measurement.

A. *International Conventions and Constitutional Obligations*

The Bill would not per se violate the Nigerian constitutional rights of those with mental disorders. While every person has the right to personal liberty, the Constitution of Nigeria excludes persons of "unsound mind" when detained for the "purpose of their care or treatment or the protection of the community."⁹⁸

95. *Id.* § 33(1)(a). Any other law in force dealing with the "admission, treatment, discharge, or any other issue relating to mentally disordered patients" at the time the Bill would have come into force was to be trumped by any provision in the Bill. *Id.* § 33(2)(a).

96. *Id.* § 33(3).

97. Compare section 13 of the Lunacy Act, which places no sentencing limit on magistrates after holding an inquiry into the person's state of mind and receiving a signed statement from a medical officer, with section 13 of the Bill, which limited detention to 365 days without further review when the fullest procedural requirements (including recommendations by two medical practitioners) are met. Under other specified circumstances with lower procedural requirements, the maximum detention could be no more than twenty-eight days, S.B. 183, § 5(3) (Nigeria 2008), or three days, *id.* § 6(2).

98. CONSTITUTION OF NIGERIA (1999), § 35(1)(e). A deeper analysis of the Nigerian Constitution could reveal that the Bill would not adequately protect the rights of the mentally ill. Section 36(1) gives any person detained the right to a "fair hearing within a reasonable time by a court or other tribunal." CONSTITUTION OF NIGERIA (1999), § 36(1). While the Constitution does not define "reasonable time" for non-criminal detentions, it requires a hearing within one day (if a court is within a radius of forty kilometers) for those suspected of criminal offenses. CONSTITUTION OF NIGERIA (1999), § 35(5). Considering that involuntary detention for mental illness imposes the same restrictions on liberty as detention for criminal actions, "reasonable time" should be defined similarly, if not

Beyond its own constitution, Nigeria has entered into two binding international legal agreements that govern human rights and provide general principles by which to judge any Nigerian mental health law. First, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) “recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁹⁹ The general language in this covenant does not provide states much guidance on how to ensure this right for their citizens, but the principles of a new law should at least comply with the broad rights guaranteed by the covenant.¹⁰⁰ To this end, the proposed Mental Health Act recognized the need to address mental health issues as they relate to the health of the individuals affected as well as the safety of the public.¹⁰¹

Under the covenant, perhaps the most important change frustrated by the withdrawal of the Bill is the movement toward inclusion of legislative provisions for treatment of patients, which are absent in the current legislation.¹⁰² The Bill also sought to ensure a high quality of health for patients once confined in treatment facilities by directing the Minister of

identically, to criminal cases. Thus the provisions in the Bill for compulsory admission outside of criminal cases may not have given persons a fair hearing within a “reasonable time.” The only review of admission by a court or tribunal in cases of compulsory admission would have come upon application by the person admitted to the Mental Health Review Tribunal. S.B. 183, § 10(4) (Nigeria 2008). The actual hearing would not likely take place within the limited number of days considered reasonable in criminal cases, as the person admitted must be informed of his right to apply to the Tribunal, the Tribunal must accept the application, and then a hearing may occur. However, since a review mechanism is in place for those who exercise the right, one could consider any period needed to process an application to the Tribunal “reasonable time.”

99. International Covenant on Economic, Social, and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR] (Nigeria acceded July 29, 1993). However, the National Assembly has not enacted implementing legislation as required by the Constitution, so technically the ICESCR does not yet have the force of law within Nigeria. See CONSTITUTION OF NIGERIA (1999), § 12(1).

100. The U.N. Committee on Social, Economic, and Cultural Rights has commented on its interpretation of what the right to health means. U.N. Econ. & Soc. Council, Comm. on Econ., Soc., & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *Gen. Comment No. 14*]. Included in this interpretation is the “essential element” of acceptability. Acceptability means that “[a]ll health facilities [must be designed to] . . . improve the health status of those concerned.” *Id.* ¶ 12(c). Article 12(2)(d) of the ICESCR additionally provides for “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.” ICESCR, *supra* note 98, art. 12(2)(d). The Committee has interpreted this provision to include “access to basic preventive, curative, rehabilitative health services,” including those for mental health, as well as appropriate treatment. See *Gen. Comment No. 14, supra*, ¶ 17.

101. One of the grounds for compulsory admission was that the person “ought to be so detained in the interest of his own safety or with a view to protecting the safety and interest of other persons.” S.B. 183, § 5(1)(b) (Nigeria 2008).

102. See *supra* notes 91–93 and accompanying text.

Health to establish minimum standards for such facilities.¹⁰³ The purpose appeared to be well-intentioned and a legitimate attempt to guarantee “the highest standard of physical and mental health.”¹⁰⁴

Second, Nigeria has also committed to recognize and give effect to the rights declared in the African Charter on Human and Peoples’ Rights.¹⁰⁵ Beyond including language identical to that of the ICESCR, as quoted above, the Charter provides for the general right to an environment favorable to further development¹⁰⁶ and specifically requires “special measures of protection” for the disabled.¹⁰⁷ The Bill would have complied with the provisions of the Charter on its face by requiring treatment facilities to meet minimum standards,¹⁰⁸ separate units for mental health in hospitals and primary care centers,¹⁰⁹ and stricter procedures for compulsory admission for treatment.¹¹⁰ The context of recommended international guidelines promoted by the World Health Organization (WHO) could further inform whether the provisions in the Bill would comply with Nigeria’s international obligations.

B. The World Health Organization’s Mental Health Legislation Checklist

As part of its function to “make recommendations with respect to international health matters”¹¹¹ and to “foster activities in the field of

103. See S.B. 183, § 3 (Nigeria 2008).

104. ICESCR, *supra* note 99, art. 12(1).

105. African Charter on Human and Peoples’ Rights art. 1, June 27, 1981, 21 I.L.M. 58, available at <http://www.africa-union.org/root/au/Documents/Treaties/Text/Banjul%20Charter.pdf> (signed by Nigeria Aug. 31, 1982; ratified June 22, 1983). The National Assembly has enacted implementing legislation. See African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act (1990) Cap. (10) (Nigeria).

106. African Charter on Human and Peoples’ Rights, *supra* note 105, art. 24 (“All peoples shall have the right to a general satisfactory environment favorable to their development.”).

107. *Id.* art. 18(4) (“The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.”). “Disabled” in this context generally includes mental disorders. See WHO RESOURCE BOOK, *supra* note 54, at 23.

108. S.B. 183, § 3(4) (Nigeria 2008). However, requiring minimum standards will not create environments favorable to development if the Minister sets those standards too low. See discussion *infra* Part IV.B (discussing proper minimum standards for treatment facilities).

109. S.B. 183, § 3(7)-(8) (Nigeria 2008).

110. *Id.* § 7. Diligent protection of those suffering from mental illness from forced institutionalization follows the interpretation of the Working Group on Economic, Social, and Cultural Rights of the African Commission on Human and Peoples’ Rights of the Charter, which is to avoid institutionalization as far as possible. African Comm’n on Human and Peoples’ Rights, Working Group on Econ., Soc., & Cultural Rights, *Draft Principles and Guidelines on Economic, Social, and Cultural Rights in the African Charter on Human and Peoples’ Rights*, ¶ 54(lviii), available at http://www.achpr.org/english/other/Draft_guideline_ESCR/Draft_Pcpl%20&%20Guidelines.pdf.

111. Constitution of the World Health Organization art. 2(k), July 22, 1946, 14 U.N.T.S. 185, available at http://www.who.int/governance/eb/who_constitution_en.pdf.

mental health,”¹¹² the WHO has compiled a resource book to “assist countries in drafting, adopting, and implementing” mental health legislation.¹¹³ This book describes different provisions that countries should incorporate into their mental health legislation in order to protect the rights of those with mental disorders.¹¹⁴ It does not recommend that countries follow the provisions discussed in the book exactly, as every legislative system is different and each country has its own particular needs.¹¹⁵ Annexed to the Resource Book is the WHO Checklist on Mental Health Legislation (“the Checklist”),¹¹⁶ which provides a way for countries to assess their mental health legislation by answering the questions posed in the document.¹¹⁷ This section will use the Checklist to assess whether the proposed Mental Health Act would have improved Nigeria’s mental health legislation.¹¹⁸

Once again, the definitions will begin the analysis.¹¹⁹ The former Bill substantially met the WHO recommendations for definitions of specific terms. The Bill had a clear definition of “mental disorder” and defined other important terms as well.¹²⁰ The definition of “mental disorder” left some ambiguity regarding coverage for conditions such as substance abuse,¹²¹ which the WHO warns against,¹²² but explicitly excluded mere social deviance to curb misinterpretation.¹²³

The procedural elements of compulsory admission in the Bill largely complied with the recommendations in the Checklist, which would have represented a dramatic improvement from the current law. First, the Bill

112. *Id.* art. 2(m).

113. WHO RESOURCE BOOK, *supra* note 54, at xv.

114. *Id.*

115. *Id.* at xv, 19. The book does claim that it shows ways in which countries with limited resources can comply with international human rights standards. *Id.* at xv.

116. *Id.* at annex 1.

117. The WHO recognizes that the Checklist does not cover “each and every issue that could or should be included in legislation,” *id.* at 121, nor does it claim that “all provisions will be equally relevant to all countries,” *id.* at 120.

118. The questions answered are limited to those relevant to involuntary detention, and due to the number of relevant questions, discussion will be somewhat general.

119. The Checklist begins with the preamble and objectives. *See* WHO RESOURCE BOOK, *supra* note 54, at 121. However, the Bill did not have a preamble or explicitly stated objectives, so that section is not applicable.

120. *See id.* at 122–23 (questions (B)(1), (4)). Other important terms defined included “medical director,” “medical practitioner,” “mental health professional/welfare,” and “nearest relative,” all of whom play important roles in the admission process. *See* S.B. 183, § 34(d)-(e), (g), (i) (Nigeria 2008).

121. When under the influence of a particular drug, for example, a person could fall under the definition in the Bill as temporarily having impairment of mental functioning. *See* S.B. 183, § 2(a) (Nigeria 2008).

122. *See* WHO RESOURCE BOOK, *supra* note 54, at 123 (question (B)(3)).

123. *See* S.B. 183, § 2(a) (Nigeria 2008).

proposed to narrow the requirements for involuntary detention from the mere presence of a mental disorder, as recommended by the WHO.¹²⁴ It also mirrored the recommendations regarding the number of medical practitioners who must certify the patient as qualified for involuntary detention,¹²⁵ the qualifications of those medical practitioners,¹²⁶ and the patient's right to appeal.¹²⁷ The WHO further recommends that an independent body review all or at least certain categories of involuntary admissions,¹²⁸ but the Bill lacked any similar provision. In dealing with emergency situations, the Bill followed the general principles implied in the Checklist,¹²⁹ but lacked detail regarding when the emergency provisions apply.¹³⁰ On the other hand, the Bill's provisions that allow for the use of members of the police force in certain circumstances closely track the recommendations of the WHO.¹³¹

The WHO also makes a number of recommendations to protect the rights of individuals admitted to a mental health facility,¹³² and the Bill complied with many of them. However, the Bill left some gaps in the provisions and would have benefited from greater detail in certain sections. For example, both the Checklist and the Bill begin with the

124. See WHO RESOURCE BOOK, *supra* note 54, at 131–32 (questions (I)(1)(a)-(c)). At the same time, the severity of mental disorder necessary for involuntary detention is not specified. See *id.* (question (a)).

125. See *id.* at 132 (question (I)(2)).

126. See *id.* at 137 (questions (N)(1)-(2)).

127. See *id.* at 133 (question (I)(8)).

128. See WHO RESOURCE BOOK, *supra* note 54, at 51, 132 (question (I)(5)).

129. The general principles include a limitation on the duration of detention (frequently seventy-two hours), see *id.* at 136 (question (M)(4)), and direction that the applicant should intend to apply or apply for compulsory admission as soon as possible, see *id.* at 136 (question (M)(5)). The Bill fell short in regard to who may file the application. In particular, the WHO recommends that a “qualified practitioner” should be able to determine the existence of an emergency, see *id.* at 60, which was not a requirement under the Bill.

130. See *id.* at 136 (question (M)(1)). The Bill did not provide a clear answer to when the emergency provisions would apply, as only “urgent necessity” was required. S.B. 183, § 6(1) (Nigeria 2008).

131. See WHO RESOURCE BOOK, *supra* note 54, at 146 (questions (S)(1), (4)). Recommended restrictions on police to prevent unlawful arrest and detention include allowing police to take individuals causing mental health-related public disorder to “places of safety,” and limiting the period of detention following such action. See *id.* at 74. A “place of safety” should not normally include police custody. Typically it is a mental health facility or a private office (of a psychiatrist, for example), see *id.* at 73, or in the case of the Bill, any place of reverence, see S.B. 183, § 34(k) (Nigeria 2008). However, the WHO recognizes that in some developing countries it is not possible to immediately take a person to a location other than the police station. In those situations, the limitation on duration of detention is particularly important. See *id.* at 73. The Bill, recognizing that importance, allowed for police to hold individuals in their custody, but limited detention to seventy-two hours. See S.B. 183, § 14(1)-(2) (Nigeria 2008).

132. See WHO RESOURCE BOOK, *supra* note 54, at 53.

assumption that treatment should require consent of the patient,¹³³ and the Bill would have required criteria similar to those of the Checklist for allowing involuntary treatment.¹³⁴ However, the Checklist recommends further protections against involuntary treatment that were absent from the Bill.¹³⁵ Outside of treatment recommendations, the Checklist recommends that any facility admitting and/or treating mental health patients should be accredited before accepting patients.¹³⁶ The Bill required facilities to meet specified minimum standards, but gave the Minister of Health plenary power to determine those standards.¹³⁷

Finally, the Checklist calls for oversight and review mechanisms to protect the rights of those subject to involuntary detention.¹³⁸ While the Bill would have set up the Mental Health Review Tribunal and given the Minister of Health power to determine the number of tribunals,¹³⁹ their composition, and their rules of procedure,¹⁴⁰ it did not provide enough specific provisions to satisfy the WHO's recommendations.¹⁴¹ 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. Creation of the detailed structure in compliance with the recommendations would depend on the Minister of Health.¹⁴²

133. *See id.* (allowing involuntary treatment only when certain conditions are met); *see also* S.B. 183, § 27(3)(a)-(b) (Nigeria 2008).

134. *See* WHO RESOURCE BOOK, *supra* note 54, at 53 (including within criteria the inability of the patient to consent, that the treatment is necessary to prevent a deterioration in the patient's condition or to improve the patient's condition, etc.); *see also* S.B. 183, § 3(b) (Nigeria 2008) (waiving consent requirement when the patient cannot consent because of incapacitation, etc., and when the treatment is likely to alleviate or prevent deterioration of condition).

135. An example of a further protection is the agreement of a second practitioner on the treatment plan. *See* WHO RESOURCE BOOK, *supra* note 54, at 134 (question (J)(3)). Another is review of involuntary treatment by an independent body. *See id.* at 134 (question (J)(4)). Finally, a decision of involuntary treatment is appealable. *See id.* at 134 (question (J)(6)).

136. *See id.* at 132 (question (I)(3)).

137. *See* S.B. 183, § 3(4) (Nigeria 2008).

138. *See* WHO RESOURCE BOOK, *supra* note 54, at 142–46 (section (R)).

139. *See* S.B. 183, § 23(1) (Nigeria 2008).

140. *See id.* § 23(2).

141. The specific recommendations are numerous. A short list of some of the recommendations are: the reviewing body should assess each involuntary admission, *see* WHO RESOURCE BOOK, *supra* note 54, at 142 (question (R)(1)(a)(i)), its composition should include “an experienced legal practitioner and an experienced health care practitioner, and a ‘wise person’ reflecting the ‘community’ perspective,” *see id.* at 143 (question (R)(1)(b)), and the legislation should “outline procedures for submissions, investigations and resolution of complaints,” *see id.* at 144 (question (R)(3)(a)).

142. The WHO reasonably advocates the inclusion of specific structure in the legislation as opposed to delegating regulation to the different ministries given the reputation of many governments for inadequate protection of their citizens (Nigeria included). *See* TRANSPARENCY INT'L, GLOBAL CORRUPTION REPORT 2009: CORRUPTION AND THE PRIVATE SECTOR 200 (2009), *available at* <http://>

As discussed above, many parts of the Bill would have provided protection of human rights by keeping with the WHO's recommendations in its Mental Health Checklist. There still would have been gaps where the Bill fell short of the recommendations, but, overall, the legislation would have been a great improvement from the current law in Nigeria.

C. Comparison with Best Practices for the Region

In addition to comparison with Nigeria's international obligations and international recommendations, viewing the former Bill in light of developments in mental health legislation in similarly situated countries could aid in assessing its quality. One such country is South Africa, which only acted within the last decade to correct the failures of its former mental health law, and also faced challenges related to resource constraints.¹⁴³

South Africa adopted new mental health legislation in 2002, repealing its outdated apartheid-era law.¹⁴⁴ The former law, much like Nigeria's current law, "embodied a custodial approach to mental disorder and had not only dismally failed to protect a range of human rights that people with mental disability are entitled to, but was itself responsible for certain abuses of human rights."¹⁴⁵ The proposed Nigerian Bill included similar procedural protections for involuntary commitment as the South African Mental Health Care Act.¹⁴⁶ Unfortunately, the similarity between the provisions has not influenced the decisions of the Nigerian legislature. One important difference in the legislative process that likely caused disparate outcomes is the failure of Nigerian lawmakers to openly seek input from diverse stakeholders.¹⁴⁷ Despite a few positive developments in

www.transparency.org/content/download/46187/739801 (Nigeria scored 2.7/10 on the Corruption Perception Index; 121st out of 180 countries).

143. See WORLD HEALTH ORG., BEST PRACTICES: WHO AFRICAN REGION, 6–7 (2007), available at http://www.who.int/mental_health/policy/country/BestPractices4_AFRO.pdf [hereinafter BEST PRACTICES].

144. See *id.*; see also Mental Health Care Act 17 of 2002 (S. Afr.).

145. BEST PRACTICES, *supra* note 143, at 6.

146. Both the Mental Health Act for Nigeria and South Africa's Mental Health Care Act would only allow involuntary commitment when the safety of the patient or others is in question, S.B. 183, § 5(1)(a)-(b) (Nigeria 2008); Mental Health Care Act 17 of 2002 § 26(b)(i) (S. Afr.), require the recommendation of two medical practitioners, S.B. 183, § 9(1) (Nigeria 2008); Mental Health Care Act 17 of 2002 § 33(4)(a) (S. Afr.), and provide for review of the admission decision by a specialized body, S.B. 183, § 10(4) (Nigeria 2008); Mental Health Care Act 17 of 2002 § 35 (S. Afr.). However, one additional safeguard in the South African legislation is judicial review of the specialized body's decision. Mental Health Care Act 17 of 2002 §§ 35(4), 36 (S. Afr.).

147. Compare Olu, *supra* note 61 (reporting extensive preparation by those in "mental health circles" but ultimate failure because of naïveté towards other key stakeholders), with BEST PRACTICES,

the treatment of mental illness in Nigeria, further action must be taken in order to obtain the results that will protect those Nigerians suffering abuse and stigmatization because of mental illness.

V. WHAT'S NEXT FOR NIGERIA?

The most important step Nigeria can take to improve its involuntary commitment system is to reform its mental health legislation. It had the opportunity to do so with the Mental Health Act, and the National Assembly should have seized the opportunity to create positive change. Although the Bill did not provide the perfect solution to the country's problems, it far surpassed the quality of the current law. In a perfect world, a senator would propose a bill that fills the gaps left in the Mental Health Act as described in the last section. Members of the National Assembly would hear their constituents voice support for the reform and pass such a bill into law. The Minister of Health would look to internationally recognized standards when creating regulations for aspects such as standards of facilities. Alas, this is not a perfect world. Ignorance and stigma regarding mental health span the world, including Nigeria.¹⁴⁸

Therefore, all interested stakeholders, from politicians to psychiatrists, families to drivers in Lagos,¹⁴⁹ must work together to bolster support for

supra note 143, at 6–7 (describing extensive efforts to gather input from and inform a wide range of stakeholders). At the same time, consultation of a wide range of stakeholders does not guarantee speedy success. Ghana requested assistance from the WHO to reform its colonial mental health legislation and during the development process consulted key stakeholders. *See* WORLD HEALTH ORG., GHANA: A VERY PROGRESSIVE MENTAL HEALTH LAW 3–4 (2007), *available at* http://www.who.int/mental_health/policy/country/GhanaCountrySummary_Oct2007.pdf. Despite finalizing the draft and submitting it to the Minister of Health for presentation to Parliament in June 2006, *see id.* at 5, the bill was only recently presented to Parliament as of August 2011, *Ghana's New Mental Health Bill Aims to Address Stigma*, GUARDIAN, Aug. 29, 2011, <http://www.guardian.co.uk/global-development/2011/aug/29/ghana-new-mental-health-bill>.

148. Said the husband of a woman with schizophrenia: "It has been hard for us, especially me, the husband, because of the costs, work and shame that I have to bear." And the sister of a man suffering from mental illness described the family's feelings this way: "We have learnt to live with the stigma of being related to a mad man but the fact is that his illness is eating deep into our purse." Eaton & Tilley-Gyado, *supra* note 7. One journalist has described the stigma as the

biggest threat to mental health care in Nigeria The average Nigerian does not want to be seen with a mentally ill person or be associated with anything that is remotely suggestive of madness. The level of community intolerance is so high, and this has implications for the treatment of mentally ill persons or the integration of mental patients into society.

Reuben Abati, *Beyond the Romantic Appeal of Madness*, NIGERIAN VILLAGE SQUARE, Oct. 24, 2008, *available at* <http://www.nigeriavillagesquare.com/articles/reuben-abati/beyond-the-romantic-appeal-of-madness-13.html>.

149. "There are parts of Lagos where mad men control the traffic at major junctions, and supposedly sane motorists have been heard to remark that mad men are better traffic controllers than the Nigerian police!" Abati, *supra* note 148.

reform and encourage lawmakers to act. It may be that the Bill proposed by Senator Manzo has flaws irreconcilable with certain groups within the country.¹⁵⁰ In that respect, proponents of a new bill should seek input from a broad range of affected groups and individuals, as in South Africa, to create a new draft. Assistance from the WHO or other entities could help guide the process, but, ultimately, change must come from Nigerians. Only internal forces can overcome the current negative mindset.¹⁵¹ The country has shown great ability in progressive treatment of mental health in the past;¹⁵² it is time for new leaders to step up and lead Nigeria and its mental health law into the modern age.

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150. An article in *The Nation*, at least in this author's reading, attributed the failure of the bill to the lack of dialogue with a broader set of stakeholders. Olu, *supra* note 61 ("A post-mortem analysis by a sympathetic lobbyist who knew the ropes discretely furnished the egg-heads with the information that their bill was dead in the water since they had not thought it fit to 'see' the legislators in the recognised way.").

151. "But nobody could be more catholic than the Pope. Nobody could bring the mental health of Africans into the modern day [but] Africans themselves." *Id.*

152. See *supra* notes 44–48 and accompanying text.

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