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A comparative study of mental health legislations in two African countries – South Africa and Nigeria

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Abstract
Mental health legislation is imperative because people with mental disabilities suffer a wide range of deprivations in the society – especially in developing countries. This paper x-rays the various past and present legislations governing the provision of mental health care services in two African countries – South Africa and Nigeria. It presents the deficiencies in the various legislations. The paper states that the various legislations are hitherto tailored according to the dictates of their colonial masters. Comparatively, the discourse asserts that while South Africa has more often reformed its mental health legislations, Nigeria has been lacking in that regard. The paper concludes that mental health legislation is essential, first because of the unique vulnerabilities of people with mental illness, and secondly, people with mental illness face stigma, discrimination and marginalization in most societies. The paper therefore recommends that mental health legislation should be viewed as a process rather than as an event that occurs just once in many decades and that African countries should constantly reform their mental health legislations to meet international standards.

Keywords: Mental health, legislation, African Countries

Introduction

Mental Health Legislation is essential because of the vulnerabilities of people with mental illness. These vulnerabilities exist form two reasons. First, mental disorders can affect the way people think and behave, their capacity to protect their own interests and, on rare occasion, their decision-making abilities [1]. This was the issue in *Re C* *[2]*, where a 68 years old man serving a seven-year prison sentence was diagnosed as mentally ill and transferred to Broadmoor Hospital. He was diagnosed with gangrene in the right foot and it was considered that he would die if his leg was not amputated below the knee.

He refused to consider the medical opinion objecting to even future amputation as the hospital authority refused to give him an undertaking that it would not amputate in any future circumstances. He sought and obtained an injunction restraining the hospital from amputating his right leg without prior consent in the event his right leg in future threatened his life.

Second, persons with mental disorders face stigma, discrimination and marginalization in most societies. Marginalization and discrimination increase the risk of violation of their civil, political, economic, social and cultural rights by mental health service providers and others. The practice of psychiatry is influenced by the law particularly in regards to the rights of patients and the quality of care they are receiving. Psychiatry and law deal with human behaviours and therefore have a significant role to play in society's desire for control of undesirable behaviours. Issues of law and mental health significantly affect each other. Mental health professionals participate in a wide range of legal proceedings, from personal injury lawsuits to the imposition of capital punishment. In turn, legal issues have a clear impact on clinical practice, with key implications for the professionals responsibilities and roles. An acceptable legal framework is therefore necessary to provide for these requirements.

South Africa

The Mental Health Care Act, No.13 of 2002 regulates the practice of mental health in South Africa. It was assented to on October 28, 2002 and commenced on December 15, 2004 [3]. It replaced the Mental Health Act, 1973. The objects of the Act are to:

a. Regulate the mental health care in a manner that

1. Makes the best possible mental health care treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources;
2. Co-ordinate access to mental health care, treatment and rehabilitation services to various categories of mental health care users; and
3. Integrate the provisions of mental health care services into the general health services environment.

b. Regulate access to and provide mental health care treatment and rehabilitation services to

1. Voluntary, assisted and involuntary mental health care users,
2. Mentally-ill persons

c. Clarify the rights and obligations of mental health care users and the obligations of mental health care providers; and

d. Regulate the manner in which the property of persons with mental illness and persons with severe or profound intellectual disability may be dealt with by a court of law [4].

The intentions of the South African Mental Health Care Act, 2002, were to protect the mentally-ill. For example, persons with mental disorders are regarded as "mental health services users", since anyone would be predisposed as a case of mental health care services" [5].

Mental health services implementation in South Africa takes place through National, Provincial and District Structures. A national mental health authority – the National Directorate, Mental Health and Substance Abuse provides advice to government in mental health policies and legislations [6].

The implementation, in 2004, of the South African Mental Health Care Act was generally hailed as one of the most progressive pieces of mental health legislation in the world [7]. This is so because an entire chapter was dedicated to human rights for those with mental disabilities [8]. Furthermore, the Act contained articles addressing Compulsory Admission, Protection of Patients' Properties, Rights of Appeal, the reporting of abuses and the formation of independent review boards with various functions [9]. It also highlighted several important principles including:

The use of minimum possible compulsion, the importance of not just treatment but also rehabilitation and reintegration; the decentralization of mental health care from large psychiatric institutions into district and community-based health services and the integration of mental health into primary health care [10].

The South African Mental Care Act, 2002 is believed to be a step forward in Africa in addressing mental health as a major public health issue in South Africa and protecting the human rights of people with mental health illness. The Act is consistent with international human right standards [11].

However, Lund C, Stein D. J. and Flisher A.J assert that the implementation of the new Act poses three challenges to health services in South Africa. According to the writers, the first challenge is to "systematically address the lack of resources for mental health care and begin to plan appropriate services for mental health". The second is for health services to develop information systems to monitor the mental health services that they do deliver and to become transparent and accountable in this regard." And thirdly, to improve "quality assurance measures for mental health care among both psychiatric and general hospitals in South Africa [12].

On his part, Burns J.K writes that unfortunately, the mental health care Act was "an unfunded mandate with very little preparation, training was not provided, facilities were not developed at district and primary care levels, and no budget was allocated by the government for the implementation of such a "potentially transformative piece of legislation" [13].

A comparative review of the mental health laws of four African countries was undertaken by the Mental Health and Poverty Project (MHAPP), 2008, a project to identify the steps required to strengthen mental health systems of poor countries. Using the world Health Organization (WHO) checklist of Mental Health Legislation, the laws of Ghana, South Africa, Uganda and Zambia were analysed. It also highlighted a number of issues that are critical to consider in the formulation of modern mental health legislations to include "competence, capacity, and consent, rights of people with mental disabilities, the role of the family and promoting care in communities [14].

The analysis revealed that the Mental Health Care Act of South Africa, 2002, encompasses current international best practices and human rights standards, while the other three older laws of Ghana, Uganda and Zambia failed to do so [15]. The Uganda law was noted to be outdated and not in line with contemporary issues in mental health care, while the Zambia law protects society from the patient with no mention of treatment and rehabilitation [16].

On capacity, competence and consent, the older laws, that is, Ghana, Zambia and Uganda focused mainly on issues related to incapacity and involuntary treatment and failed to adequately promote voluntary treatment on the basis of free and informed consent. Contrary to international human rights standards, these laws reflect a presumption that people with mental disabilities lack capacity and this often extends beyond the issue of mental health treatment to questions of general legal competence to make a range of decisions and to exercise one's human rights [17]. The only form of care available in many African countries is through institutionalization, that is, confinement of patients in psychiatric hospitals. This is often associated with human rights violations including poor quality of care. The older laws adopted this mode, zeroing almost entirely on treatment in psychiatric institutions and thus neglecting critical need to promote community-based care [18].

The study also revealed that the laws of Uganda, Ghana and Zambia allow families to make important decisions about admission and treatment, but do not contain sufficient safeguard to protect the rights of the family members with the mental disability. The role of the family is neither clearly stipulated nor regulated, and there is little to stop individuals from being forcibly admitted by their families for psychiatric treatment [19]. Additionally, rights are often inadequately protected or over looked in the laws of Ghana, Uganda and Zambia. The laws fail to promote the dignity, respect, autonomy and non-discrimination of people with mental disabilities or to incorporate safeguards against abuses associated with involuntary admission and treatment. Also, critical issues related to free and informed consent are overlooked [20].

However, despite the various challenges facing the South Africa's Health Care Act, 2002, the Act illustrates how the language and content of a mental health law can be. Developed through wide consultation, it "has driven service reform" at the provincial and district levels. While the South Africa Act has a legal provisions that allow for application for retirement from work on mental health grounds, that is, the Compensation for Occupational Injuries and Diseases Act of South Africa, 1997 (as amended). Nigeria has no specific provisions for compensation for mental health injury [21].

The Nigeria Position

Nigeria follows the same mental health legislation that was in effect before it gained independence from the United Kingdom in 1960. Originally called the Lunacy Ordinance, it was first enacted in 1916 and amended in 1958 [22].

The Act had a short title "Lunacy Ordinance" [23] with an interpretation section which defined "lunatic" to include "an idiot" and any other person of "unsound mind" [24]. This definition is not in standard parlance today and does not conform with international best practices.

The Act provides that a Governor of a Region may, by notice in the Regional Gazette appoint the "whole or part of any building to be a lunatic asylum and may be in like manner declare that any place shall cease to be a lunatic asylum [25].

On the temporary detention of a suspected lunatic, section 10 [26] of the Act provides that:

Whenever a medical officer has cause to suspect that any person in a lunatic and considers it expedient that such person should be placed forthwith under observation in any

asylum, he may grant a certificate of emergency as in Form A in the Schedule, and shall cause such persons to be taken to an asylum, and it shall be lawful for any person acting and the instruction of the medical officer to take such person to the asylum specified, and for the superintended of the asylum to receive and detain such a person in the asylum; provided that no person shall be detained in an asylum under any such certificate for a longer period than seven days except with the authority of a magistrate.

The inference of this provision is that the Act requires two elements to commit a person against his will. First, a magistrate must find that the person is a lunatic, and secondly, a medical practitioner must examine and certify the person a lunatic. Once these conditions are met, the magistrate then has the discretion to make the final determination of lunacy. The Act also provides for the procedure for the discharge of lunatics upon a certificate of sanity. To this effect, section 17 [27], provides that:

A magistrate shall grant an order of discharge as in Form A in the schedule in respect of any person detained in an asylum with regard to whom a certificate of sanity as in Form I in the Schedule has been granted by the superintended of the asylum in which such person is detained or by any two qualified medical practitioners of whom one at least shall be a medical officer, and the superintendent shall discharge such persons in accordance with such order; provided that no such person detained in an asylum under the authority of order under section 223 and section 230 of the Criminal procedure Ordinance or under the provisions of any Ordinance or Law establishing a magistrate court.

The standards for condition within an asylum are established by the Regional Governor who may make regulations regarding the "government asylums and the custody of the lunatics therein" [28]. Furthermore, the Act declares certain people to be "visitors" who may inspect the asylums and inquire into any complaints [29].

To ensure formal regular review of the asylum auditions, the government may appoint at least "three visitors" to be a visiting committee for such asylum [30] and the committee shall meet once a year or more often if necessary at each asylum and "shall inspect the wards, cells, stores, and every other place, and shall receive and inquire into any complaints" [31]. However, a notable defect in the Act is that it neither made no mention of treatment nor did it use any words synonymous with treatment.

The extent of the reason provided for detention of a person under the Act is that "a medical officer has cause to suspect that the person is a lunatic and considers it expedient that such a person be placed forthwith under observation in an asylum" [32]. Infact, the full title of the Act is "An Act to provide for the Custody and Removal of Lunatics" [33].

The areas of deficiency in the Act include its failure to define "mental disorder" or "mental disability" and its "overwhelming emphasis on custodian care without adequate provision for treatment in the community" [34]. Furthermore, its use of highly derogatory terms such as "asylum, lunatic, idiot and unsound mind demonstrates its antiquity" [35].

Similarly, the law did not accord specific recognition to the human rights of persons with mental disorder as recommended by the World Health Organization (WHO) and has no provision for vulnerable groups who fall within its ambit [36].

The absence of any provisions for treatment and the exclusion or omission of other fundamental issues may have been the several factors influencing the clarion call and movement for the reform of the Act.

However, respite came with the birth of the extant Mental Health Act 2023. It was assented to by the former President of Nigeria, Muhammadu Buhari, GCON, on January 6, 2023. The objectives of the Act are provided in section 1(a-g) of the Act. They include:

a. To provide direction for a coherent, rational and unified response to the delivery of mental health services in Nigeria.
b. Promote and protect the fundamental human rights and freedom of all persons with mental health conditions and ensure that the rights are guaranteed.
c. Ensure a better quality of life through access to an integrated well-planned, effectively organized and efficiently delivered mental health care services in Nigeria.
d. Promote the implementation of appropriate national minimum standards for mental health service in Nigeria.
e. Promote recovery from mental conditions and enhance rehabilitation and integration of persons with mental health conditions into the community.
f. Facilitate the adoption of community-based approach to the provision of mental health care services; and
g. Facilitate the coordination of mental health services in Nigeria [37].

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

Worthy of specific mention is Part II of the Act which provided for the rights of persons with mental conditions. Sections 12-14 of the Act provide for "Rights of persons in Need of mental health care services, employment rights, housing right to mental health care services; right to quality and standard treatment; right to appoint legal representation, right to particulate in treatment planning, to confidentiality, and protection of persons with mental condition" [38]. These were manifestly omitted in the previous defunct mental health legislations in Nigeria.

Another significant achievement of the Act is provided in Part IV, sections 46-48 titled "Persons with mental health conditions and criminal proceedings" [39]. These sections made adequate provisions for "admission of a criminal patient, compulsory order with restriction; and removal to hospital of an inmate," [40] among others. Again, these provisions were not included in the previous Acts.

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

However, one major aspect of mental health legislation that is missing in the new Act is that bordering on after care following detention and discharge. For example, section 117 of the Mental Health Act (England and Wales) places a statutory duty on health and social services providers to provide after care services for patients who have been discharged from detention [41]. The section also provided for

the creation of the Care Programme Approach (CPA) which was introduced in 1991 to be used for all patients where appropriate, even if they have not been detained in the hospital [42].

Another remarkable provision in the Nigerian Mental Health Act 2023 is that concerning the violation of the rights of persons with mental health disorders. Section 51 (1-3) (a and b) provide that "no person shall violate the rights of persons as specified under the Act [43]. Subsection 2 specifically provided that:

Without prejudice to the provisions of any other law, any person who contravene the provisions of subsection (c), commits an offence and is liable on conviction to a fine of at least not less than N500,000 or imprisonment for a term of at least one year [44].

The implication of this subsection is to the effect that it is not uncommon to find, for example, cases of sexual harassment and abuse being perpetrated against mental health patients admitted into mental health facilities thereby taking undue influence of the state of health of the patients.

Consequently, section 55(1)(2) of the Act provides punishment for an officer, staff or employee who engages in sexual relationship with a patient. Subsection 2 specifically provides that:

Any person who commits an offence under this section is liable on conviction to life imprisonment with no option of fine and this shall not be prejudicial to any other sanctions that such a person may be liable to penalties from professional bodies to which he may belong as a member [45].

Again, this provision was not included in the previous mental health legislations in Nigeria. Suffice to say that the newly enacted Mental Health Act 2023 covered a wide range of areas in mental health legislation and it is comparable with accepted contemporary mental health legislations the world over.

However, South Africa has made tremendous efforts at providing its country with up-to date mental health legislations. The South Africa Mental Health Care Act, 2002 has gained global recognition because it encompasses current international best practices and human right standards.

The South Africa legislation, for example, was developed through wide consultations, promote an integrated approach to "mental health" and has "driven reform at the provincial and district levels [46]. The Act also codifies a number of rights for people with mental disabilities and promote voluntary treatment, free and informed consent including oversight mechanism such as the "Mental Health Review Board to protect against violations" [47]. Gladly, Nigeria has just joined the league.

Conclusion and Recommendations

Mental health legislation is essential because of the unique vulnerabilities of people with mental illness. These vulnerabilities exist for two reasons. Fist, mental disorders can affect the way people think and behave, their capacity to protect their own interests and, on rare occasions, their decision-making abilities. Second, persons with mental illness face stigma, discrimination and marginalization in most societies. Marginalization and discrimination increase the risk of violation of their civil, political, economic, social and cultural rights by mental health service providers and others. It becomes imperative therefore, that adequate legislations should be provided for the mentally-ill persons to make them have a sense of belonging in the society.

This paper therefore recommends that mental health legislation should be viewed as a process rather than an event that occurs just once in many decades. African countries, most especially, should encourage their Law Reform Commissions to constantly review their mental health laws to cater for these vulnerable and under privileged group in the society. Such legislations should be made to meet internationally accepted standards in order to gain global acceptance and recognition.

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