

Constraints, Ethical Dilemmas and Precautions in Psychiatric Practice within Non-Contemporaneous Mental Health Laws: A Nigerian Experience with Involuntary Commitment

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Abstract

Mental health laws play a major role in protecting the rights and privileges of mentally ill persons by providing a legal framework for their care, particularly in regards to involuntary commitment. Unfortunately, in many countries including Nigeria these laws are obsolete and therefore fail to meet current international best practices. Their inadequacy frequently leads to infringements on the rights of the mentally ill in the course of their treatment. Attempts at formulating new laws have been slow and psychiatrists have no option than to face constraints and ethical dilemmas posed by these obsolete laws in the care of the mentally ill in these countries. This paper highlights the unfortunate case of an individual treated against his wish without recourse to existing legal framework and his attempt to seek legal redress for perceived injustice. Difficulties frequently experienced by patients and psychiatrists alike are highlighted. The paper concludes by making suggestions on probable ways of offering appropriate and acceptable care to the mentally ill within extant mental health laws without necessarily breaching the rights of the mentally ill. There is a call for a speedy passage of an updated mental health law in Nigeria.

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1. Introduction

Mental health laws serve multiple functions. They protect the rights and privileges of mentally ill persons by providing a legal framework for involuntary commitment and treatment; paradoxically, they are also a supportive legal milieu within which psychiatrists and other mental health professionals are expected to function. (WHO 2003; www.mentalhealth.wa.gov.au)

Attempts have been made, particularly in developed countries to match scientific and social developments that impact mental health with periodic reviews of extant mental health laws (Cronin et al. 2017). Unfortunately, in some other countries, notably in Africa, mental health laws remain obsolete and unrevised for many years (WHO 2005; Ogunlesi et al. 2012). This has created difficult terrains of care both for the mental health professional and for the patient. Infringement on patient's rights in the course of administering interventions in psychiatric care or worse still, outright abuse of psychiatry for socio-political gains remain a real possibility in such circumstances (APA 1975; Keukens & Voren 2007).

These obsolete and nebulous mental health laws can be fertile grounds for paternalistic practice which conflict with psychiatrists' duty to respect the ethical principle of autonomy (Fistein et al. 2009). This ethical principle necessitates informed consent by the recipient of any intervention, even if such intervention is in the best interests of the recipient (Yusuff 2009). In Nigeria, there appear to be increasing literacy rates which may arguably be accompanied by concomitant increase in public awareness of basic human rights and privileges (<https://knoema.com/atlas/Nigeria/topics/Education/Literacy/Adult-literacy-rate>), further necessitating a shift from paternalistic to more autonomy-based principles in health care provision. The extent of knowledge of mental health laws or laws that bear directly on mental health among Nigerian health professionals may not be very different from the unfortunate scenario in some developed countries where such knowledge has been found to be lacking (Humphreys et al. 2000; Singh et al 2017). This creates a vulnerable milieu of practice for the psychiatrist in Nigeria who may unwittingly work in violation of such laws. Consequently, an informed patient or relative could therefore, rightly seek legal redress for perceived psychiatrist's infringement on their human rights in the course of involuntary commitment and/or treatment.

Psychiatrists practicing in countries with recently revised mental health laws which give greater consideration to patient autonomy are also faced with similar ethical dilemma in the course of their practice. It has been reported that involuntary treatment or commitment by these psychiatrists may be perceived as unacceptable exercise of social control, high-handedness, or failure to respect a person's autonomy. On the other hand, if they fail to treat a patient with/without capacity against his wishes they may face criticisms of dereliction

of duty and public endangerment (Semple & Smyth 2009). Such ethically precarious situations may lead to adverse effects on the flow of care or negatively impact the patient-doctor relationship. This scenario is arguably worsened in the Nigerian context where psychiatrists are faced with the consequences of practice within obsolete mental health laws.

Nigeria's current mental health legislation is precolonial. It was enacted as a lunacy ordinance in 1916 and last revised in 1958. Recent attempts at its revision have so far remained unsuccessful (Ogunlesi et al. 2012; Onyemelukwe 2016; Westbrook 2011). Unsurprisingly, this law is fraught with serious limitations for current psychiatric practice. The title of the law, viz. "A law to Provide for the Custody and Removal of Lunatics" readily portrays a narrowed and paternalistic view of mental illness and its sufferers. In his 2011 work, Westbrook further observes that the scope of the law is virtually limited to custodial care of mentally ill persons without any provision for treatment (Westbrook 2011). Such custodial care is activated by joint certification of a medical practitioner and a magistrate. A medical practitioner who deems it necessary to detain a suspected mentally ill person for observation can do so for a maximum of seven days without the authorization of a magistrate (Westbrook 2011; FGN 1958). It is doubtful if in recent years any magistrate has made an input in the admission of any patient to a psychiatric ward in Nigeria on short or long term basis and instances where mentally ill patients are from the outset admitted for several weeks or months are arguably the norm in Nigeria rather than the exception. This current legal requirement for magisterial input in involuntary commitment which is being regularly violated can prove to be a serious legal ensnarement for practicing psychiatrists in Nigeria. Again, the "Lunacy Act" only requires a person to be considered "a lunatic and a proper subject of confinement" for him to be detained (Westbrook 2011; FGN 1958), thus creating a major leeway for potential abuse of the rights of persons, even by clinicians or relatives. Unfortunately, these yawning deficiencies in the law are further worsened by the fact that there is no provision for appeal against confinement in the Act (FGN 1958).

The case report that follows is a recent experience by a psychiatric team in a specialist psychiatric hospital facility in Nigeria.

2. Case presentation

SO is a 25year old male Christian tertiary student who was brought to the emergency unit of the Federal Neuropsychiatric Hospital Benin City, Nigeria by his brother-in-law on the 1st of May 2017 with unusual beliefs of being monitored by unknown persons; undue suspiciousness; people trying to kill him and conspiracy against him by family members in the past four months; hearing the voice of the 'Holy Spirit' telling him his mother is the cause of his problems; destruction of household properties; and sleep difficulties in the past month. These symptoms were of one month duration. He had a significant antecedent history of alcohol use for over one year. These complaints were later corroborated by the patient. He had been sedated prior to presentation and later made a complaint of speech difficulties which he attributed to the injections used in sedating him.

He was from a relatively stable monogamous home and had no family history of mental illness. His developmental history was normal and his educational history showed a high-performing individual and at presentation SO was a third year philosophy student of the University of Benin. He had no history of conflict with law enforcement agencies and described himself as cheerful but conscious about people's perception of him.

Examination of his mental state revealed a young adult male with athletic build, kempt and appropriately attired. He was agitated and uncooperative. He had a flat affect and his speech was low tone, coherent and relevant. Other aspects of the mental state examination were deferred on account of his uncooperativeness.

His physical examination did not reveal any significant findings. Axis I diagnoses of paranoid schizophrenia and co-morbid harmful use of alcohol, was made. He was also diagnosed with extrapyramidal side effects (Parkinsonism) arising from pre-presentation depot antipsychotics (20mg Flupenthixol decanoate and an unknown dose of Fluphenazine decanoate) that had been administered to him by a community nurse.

All requested investigations at presentation, including liver function tests and ECG were within normal limits. His toxicology screen only showed positive for benzodiazepine, reflective of the 30mg of diazepam he had been sedated with.

On account of his lack of insight and agitated behaviour, he was observed for 24 hours in the emergency and assessment unit following which an assessment of paranoid schizophrenia was made. He was then admitted to the ward against his wishes and started on Olanzapine.

By his fourth day on admission, SO pointedly asked the psychiatrist why he had not deemed it fit to investigate his allegations against his family and others prior to admitting him. He stated, "if my relatives have problem with me and have brought me to the hospital, they have made themselves judges over this case and they are culpable". He expressed intentions to sue when he is discharged from the hospital. The psychiatrist consequently reviewed the dose of SO's antipsychotic medication upward to 15mg every night. The Nurse's report up till this time revealed the patient had been calm in the ward. By the 17th day SO confided in his consultant that a secret cult in his school was interested in him and had been monitoring him. He had told his mother about it but she informed other family members; this resulted in a quarrel between him and his family.

He also accepted that he had been socially withdrawn prior to being hospitalised.

By the 25th day in hospital, SO had accepted virtually all presenting complaints and that they were symptoms of psychological disturbance; but he was uncertain of the reason for his improvement in hospital, 'it is because I am here and facing reality'.

His medication was further increased to 20mg Olanzapine at night.

After 31 days in hospital, SO was discharged on the request of his family; they were satisfied with his improvement in mental state. He was to continue his antipsychotic. His first follow-up visit was two weeks later, accompanied by his sister. He had been adherent to his medications and now admitted to having a mental illness and being aware that it might possibly reoccur. He was given psychoeducation on the nature of schizophrenia and the need to continue his medication. He progressively improved over his next series of visits which were at monthly intervals.

By the 16th week after discharge from the ward, he had started attending clinics unaccompanied.

However, he defaulted from follow-up visits for about three months only to surface with a letter from his lawyer applying for 'a certified true copy of his medical history/report with intention to discontinue treatment'; the letter also served as a 'pre-action notice' which gave the hospital a one-month notice of the patient's intention to commence legal action against the hospital management for what was termed 'the wrong and stage-managed treatment of the patient without a proper diagnosis, forcing the patient to be treated for Paranoid Schizophrenia which the patient was not suffering from and based on the instruction of the patient's relatives'.

2.1 Hospital response

The hospital, after due consultations with its legal department and obtaining a written informed consent from SO, wrote a response to the patient's lawyers giving them a summary of the patient's history. It was subsequently decided to informally relate with and educate the lawyers on the nature of delusional experiences. The hospital was also informed by SO's family members that they were applying pressure on him to withdraw the case. These arguments appeared to have convinced the lawyers to act otherwise as they eventually failed to continue with any legal action.

3. Discussion

The mentally ill, particularly those with a diagnosis bordering on psychotic illness frequently require hospitalised care at some point in the course of their illness. This may result from difficulties associated with medication adherence, lack of insight, aggressive behaviour, or from relatives being in need of respite from the burden of care. Unfortunately, most of this hospitalisation is involuntary, being initiated by carers or other concerned persons as with SO in this case report. In current practices in Nigeria, patients may be hospitalised for indefinite periods, subject to when they are deemed fit for discharge to the community by the psychiatrist. In other instances relatives of mentally ill persons may seek to extend the stay of these patients with the cooperation of doctors in a bid to enjoy some form of respite from the burden of care. It is uncertain if this was a primary consideration in the case of SO's relatives.

Mental health in Nigeria, including involuntary commitment, is currently practiced within a weak legal framework that was drafted in colonial times and has not been reviewed since. Under these laws, the legal procedure required for involuntary commitment of a person is that a medical officer suspects that person to be a lunatic and considers it expedient that such person should be placed forthwith under observation in an asylum; he may then grant a certificate of emergency and shall cause such person to be taken to an asylum for a period of no more than 7 days, unless the medical officer has obtained authorisation of a magistrate for a longer period of commitment (FGN 1958). The law also empowers any magistrate, upon information on oath to examine a person suspected of being a "lunatic" and hold an enquiry as to his state of mind. Such magistrate may issue a warrant for the arrest of the suspected person and appoint a qualified medical practitioner to examine the person. If it then seems to the magistrate that the person is a lunatic and a proper subject for confinement and a medical practitioner has signed an appropriate certificate, such a person may then be held for periods longer than seven days.

Although this law has been severely criticised for its extensive limitations and openness to abuse in the light of current realities, all the same it provides, and is the current framework for psychiatric practice in Nigeria. Unfortunately, as in the case of SO, mentally ill patients are frequently admitted to hospital by psychiatrists in Nigeria without recourse to the legal procedures outlined in this law. Difficulties with operationalization of the law, burdensome nature of the processes involved, and possibly "tradition" handed down among psychiatrists from older colleagues, including during periods of training may account for non-utilization of these laws for involuntary commitment among Nigerian psychiatrists.

As with SO, the Nigerian populace is getting increasingly enlightened on their rights and many patients are beginning to realise that they have a say in how they may be medically treated, even if they are mentally ill and if such treatment may ultimately be to their benefit. Such persons are more than willing to seek legal redress both

against their families or carers and the psychiatric profession for perceived infringements of their right to autonomy. Moreover, there are many in the legal profession who are also willing to defend the rights of the mentally ill, ensure that appropriate procedures for involuntary commitment are followed, even if the extant laws are obsolete, and may challenge any perceived abuse of the rights of these individuals. It is probable also, that some of these lawyers do this primarily for pecuniary gains. A patient may also initiate legal proceedings against psychiatrists/hospitals out of a delusional mind as was arguably the case with SO; it must be remembered that this does not necessarily invalidate such suits. This was the case in this report where the solicitors accepted SO's complaints and quickly notified the hospital of their intention to commence legal proceedings on his behalf over the perceived injustice he suffered in being hospitalised against his will. In such instances it may be necessary for psychiatrists to explain the difficulties of the patient to lawyers, even if informally without necessarily breaching confidentiality, as was the case in this scenario when the hospital was able to avoid a needless legal tussle by educating SO's lawyers. Lawyers in Nigeria may actually not be very conversant with the mental health laws under which psychiatry is practiced in Nigeria and the limitations it poses for both the patient and the psychiatrist.

In view of the outdated nature of extant mental health laws under which the psychiatrist in Nigeria is currently forced to practice, the authors recommend the following as safeguards for both the patient and the psychiatrist while practicing in Nigeria, particularly when involuntary commitment is necessary.

Psychiatrists must thoroughly understand and imbibe the ethical principles of beneficence and non-maleficence in their practice, as this can be a defence should legal problems arise. Also, as much as possible, patients' views should be respected as a reflection of autonomy while remembering that such autonomy may be limited by consequences of the patient's behavioural disturbances on others. Poor record keeping and failure of documentation by psychiatrists must be avoided. Rather, there should be comprehensive and clear documentation of problems, reasons for admission and particular forms of treatment to be initiated. Family members or other carers must be carried along in the course of treating the patient, and where necessary, written informed consent obtained.

Psychiatrists must also be aware of the thoughts of the Nigerian constitution to which all other laws operational in the country are expected to conform, or in the very least, not to violate. This instrument declares in Chapter 4, section 35(1e) (right to personal liberty), "every person shall be entitled to his personal liberty and no person shall be deprived of such liberty save in the following cases and in accordance with a procedure permitted by law: In the case of persons suffering from infectious or contagious disease, persons of unsound mind, persons addicted to drugs or alcohol or vagrants, for the purpose of their care or treatment or the protection of the community"(FGN 1958). This may prove to be helpful to the Psychiatrist in ensuring that patients who need involuntary commitment for adequate treatment are not denied and also supportive to the Psychiatrist while discharging such care.

Finally, if it happens as it did in this case that a legal suit is to be filed against the practising psychiatrist, the approach of educating counsels involved is key.

4. Conclusion

This case report again brings to fore the urgent need for Nigeria to review its mental health laws to be in tune with current international best practices. Gladly, as at the time of writing, there is a mental health bill that is before the national legislative body and awaiting passage. This bill is reported to have made the process of involuntary commitment less burdensome and free of unnecessary encumbrances for the mental health worker while respecting the autonomy of the patient. Until this new law comes into effect however, the tendency for psychiatrists in Nigeria to practice defensively is a real possibility and such practice has been found to be non-beneficial to the patient.

5. Ethical issues

Ethical clearance for this report was obtained from the Ethics Committee of the Federal Neuro-Psychiatric hospital, Benin City and informed consent obtained from the patient while assuring him of anonymity in the publication.

6. Conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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