

**BALANCING PATIENTS RIGHT TO TREATMENT AND AUTONOMY FOR
PERSONS WITH PSYCHOSOCIAL DISABILITIES IN NIGERIA AND SOUTH
AFRICA**

BY

**Nwaka Magdalene OGORDI
PG/LAW2215478**

**FACULTY OF LAW
UNIVERSITY OF BENIN
BENIN CITY**

DECEMBER, 2025

**BALANCING PATIENTS RIGHT TO TREATMENT AND AUTONOMY FOR
PERSONS WITH PSYCHOSOCIAL DISABILITIES IN NIGERIA AND SOUTH
AFRICA**

BY

**Nwaka Magdalene OGORDI
PG/LAW2215478**

**A LONG ESSAY WRITTEN AND SUBMITTED TO THE FACULTY OF LAW,
UNIVERSITY OF BENIN IN PARTIAL FULFILMENT OF THE REQUIREMENT
FOR THE AWARD OF MASTERS DEGREE OF LAWS (LL.M) OF THE
UNIVERSITY OF BENIN, BENIN CITY**

DECEMBER, 2025.

CERTIFICATION

I, **Nwaka Magdalene OGORDI**, with Matriculation Number **PG/LAW2215478**, hereby certify that apart from references to other persons' works which have been duly acknowledged, the entire work is a product of my research, and this project has neither in whole nor in part been presented for another degree elsewhere.

Nwaka Magdalene OGORDI
PG/LAW2215478

APPROVAL

We certify that this project was written and completed by **Nwaka Magdalene OGORDI**, with Matriculation Number **PG/LAW2215478** in partial fulfilment of the requirements for the award of a Master of Laws (LL.M) degree.

DR. OFUANI. A. SOKOLO
PROJECT SUPERVISOR

SIGNATURE AND DATE

PROF. D. U ODIGIE
PROJECT COORDINATOR

SIGNATURE AND DATE

PROF. B. BAZUAYE
DEAN, FACULTY OF LAW

SIGNATURE AND DATE

DEDICATION

I dedicate this dissertation to God Almighty for the inspiration and guide all through the time of research, writing and supervision on the crucial areas of disabilities, as well as passion for human rights.

My humble dedication also goes to my husband, Professor Philip.U Ogordi, my children Kosi and Kamsi for their undiluted assistance and love shown to me during this period.

I dedicate this work to every person living with any kind of psychosocial disability and finally, to all who are doing their best in promoting and advocating for human rights globally.

ACKNOWLEDGEMENTS

In the course of writing this project and my entire master's program, a lot of persons remain valuable and contributed immensely to the product which we now see. I want to honestly and sincerely appreciate my beautiful supervisor, Dr. Ofuani. A. Sokolo for her show of love and patience in the course of this work. Also, my appreciation goes to Dr. Jacob Garuba whose constant care and counselling has made this master piece a reality.

Also, I want to use this opportunity to appreciate my never failly parents I, Chief and Mrs. Nzemeka for all their prayer, love and care all through this journey. My appreciation also goes to my cute friend Mary Ann Ebelejo Ideh, who does not leave me, always making sure that I am alright at anytime.

I want to sincerely appreciate my younger brother, Mr. Samuel Chukwuasiaokwu Nzemeka for his calls and good wishes during this time, I am grateful for all dear brother.

I want to also mention Laura Irabor, Sara Ohimai, Augustina Isah, and Omoye Egua(Aunty Omo), thank you all for always looking out for me when I was tied down with this dissertation, your constant show of love remains golden to me thank you all, I love you all.

TABLE OF CONTENTS

Title Page	-	-	-	-	-	-	-	-	-	-	ii
Certification	-	-	-	-	-	-	-	-	-	-	iii
Approval	-	-	-	-	-	-	-	-	-	-	iv
Dedication	-	-	-	-	-	-	-	-	-	-	v
Acknowledgements	-	-	-	-	-	-	-	-	-	-	vi
Table of Contents	-	-	-	-	-	-	-	-	-	-	vii
Table of Statutes	-	-	-	-	-	-	-	-	-	-	ix
Table of Cases-	-	-	-	-	-	-	-	-	-	-	x
List of Abbreviations	-	-	-	-	-	-	-	-	-	-	xi
Abstract	-	-	-	-	-	-	-	-	-	-	xii
CHAPTER ONE: INTRODUCTION	-	-	-	-	-	-	-	-	-	-	1
1.1. Background to the Study	-	-	-	-	-	-	-	-	-	-	1
1.2. Statement of the Problem	-	-	-	-	-	-	-	-	-	-	2
1.3. Aim and Objectives of The Study	-	-	-	-	-	-	-	-	-	-	3
1.4. Scope and Limitations of the Study	-	-	-	-	-	-	-	-	-	-	3
1.5. Significance of the Study	-	-	-	-	-	-	-	-	-	-	4
1.6. Research Methodology	-	-	-	-	-	-	-	-	-	-	4
1.7. Chapter Analysis	-	-	-	-	-	-	-	-	-	-	5
CHAPTER TWO: CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW											6
2.1 Conceptual Framework	-	-	-	-	-	-	-	-	-	-	6
2.2 Literature Review	-	-	-	-	-	-	-	-	-	-	13
CHAPTER THREE: LEGAL AND POLICY ON PSYCHOSOCIAL DISABILITIES IN NIGERIA AND SOUTH AFRICA	-	-	-	-	-	-	-	-	-	-	27

3.1	Overview of Mental Health in Nigeria	-	-	-	-	-	-	-	27
3.2	Overview of Mental Health Law in South Africa	-	-	-	-	-	-	-	32
3.3	Regional and International Framework	-	-	-	-	-	-	-	33
3.4.									
3.5.	Comparative Analysis on the Implementation of Protection For Persons With Psychosocial Disabilities	-	-	-	-	-	-	-	41
CHAPTER FOUR: BALANCING RIGHTS, AUTONOMY, AND TREATMENT IN PRACTICE									48
4.1.	Tension Between Involuntary Treatment and Autonomy	-	-	-	-	-	-	-	48
4.2	Institutional Practices In Nigeria And South Africa	-	-	-	-	-	-	-	55
4.3	Case Law Analysis (Domestic And Regional)	-	-	-	-	-	-	-	60
4.4	Best Practices and Progressive Models	-	-	-	-	-	-	-	67
4.5.	Stakeholders' Roles	-	-	-	-	-	-	-	70
4.6.	Challenges	-	-	-	-	-	-	-	84
CHAPTER FIVE: SUMMARY, RECOMMENDATIONS AND CONCLUSION									89
5.1	Summary	-	-	-	-	-	-	-	89
5.2	Recommendations	-	-	-	-	-	-	-	90
5.3	Contribution to Knowledge	-	-	-	-	-	-	-	91
5.4	Areas for Further Studies	-	-	-	-	-	-	-	92
5.5	Conclusion	-	-	-	-	-	-	-	93
BIBLIOGRAPHY									95

TABLE OF STATUTES

African charter on Human and people's Rights (adopted 27 June 1981, entered into force 21 October 1986)

Constitution of the federal Republic of Nigeria 1999 (as amended)

Discrimination against persons Persons with disabilities (Prohibition) Act 2018 (Nigeria)

Lunacy Act Cap 18 Laws of the federation of Nigeria 1958 (Repealed)

Mental Health Act 2021 (Nigeria)

Mental Health Care Act 17 of 2002 (South Africa)

Protocol to the African Charter on Human and people's Rights on the Rights of Persons with Disabilities in Africa (adopted 29 January 2018)

United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008)

Universal Declaration of Human Rights (Adopted 10 December 1948)

TABLE OF CASES

Abacha v Fawehimi

Belane Nagy v Hungary (2016) Application No 53080/13, ECtHR 13 Dec 2016

Blokhin v Russia (2016) Application No 47152/06, ECtHR 23 Mar 2016

Castell v De Greef 1994 (4) SA 408 (C)

De Vos N.O. & Others v Minister of Justice and Constitutional Development [2015] ZACC 21

De Vos N.O. v Minister of Justice and Constitutional Development (De Vos, 2015, CCT 150/14)

De Vos NO v Minister of Justice and Constitutional Development (2015) ZAWCHC 391; 2015 (1) SACR 18 (WCC) (South Africa).

Enebeli v Chief of Naval Staff (2007) 18 NWLR (Pt 1066) 540 (CA) (Nigeria)

I.E v Moldova (2020) Application No 45422/13, ECtHR 26 May 2020.

Inseher v Germany (2017) Application No 11261/11, ECtHR 4 May 2017.

Madjemu v The State

Makana People's Centre v Minister of Health & Others [ZACC 15/2023]

Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo (SC 213/1999) [2001] NGSC 14; (2001) All N.L.R. 305 (Supreme Court of Nigeria, 2 March 2001)

MH v Minister of Health (2012) ZAWCHC 46; 2012 (2) SA 450 (WCC) (South Africa).

Paposhvili v Belgium (2016) Application No 41738/10, ECtHR 13 Dec 2016.

Purohit and Moore v The Gambia (2003) Communication No 241/2001, African Commission on Human and Peoples' Rights, 29 May 2003.

S v Mabena and Another (373/06) [2006] ZASCA 178; [2007] 2 All SA 137; 2007 (1) SACR 482 (SCA)

Stanev v Bulgaria (Application no. 36760/06) [2012] ECHR 46 (Grand Chamber, 17 January 2012).

W.D v Belgium (2016) Application No 73548/13, ECtHR 6 Sept 2016

Winterwerp v The Netherlands (Application no. 6301/73) [1979] ECHR 4 (24 October 1979).

Ximenes Lopes v Brazil (2006) Inter-American Court of Human Rights, Judgment of 4 July 2006, Series C No 149.

LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ADHD	Attention-Deficit Hyperactivity Disorder
ADs	Advance Directives
AU	African Union
CAT	Committee against Torture
CBR	Community-Based Rehabilitation
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with disabilities
DEI	Diversity, Equality and Inclusion
ECHR	European Convention on Human Rights
FMOH	Federal Ministry of Health
GCI	General Comment Issued
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Convention on Economic, Social and Cultural Rights
IRLJ	International Review of Law and Jurisprudence
MHCA	Mental Health Care Act
NALT	Nigerian Association of Law Teachers
NCPWD	National Commission for Persons with Disabilities
NHRC	National Human Rights Commission
NMHA	National Mental Health Act
NOA	National Orientation Agency
OCD	Obsessive Compulsive Disorder
OPDs	Organizations of Persons with Disabilities
PTSD	Post-traumatic Stress Disorder
SADAG	South African Depression and Anxiety Group
SAHRC	South African Human Rights Commission
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO,	World Health Organisation

ABSTRACT

This dissertation examines the intricate balance between treatment, rights, and autonomy for persons with psychosocial disabilities within the legal, institutional, and policy frameworks of Nigeria and South Africa. It explores how both countries have responded to the international human rights standards established under the United Nations Convention on the Rights of Persons with Disabilities (CRPD), particularly in relation to the principles of informed consent, legal capacity, non-discrimination, and supported decision-making. The study adopts a qualitative doctrinal research methodology supported by a comparative approach, relying on constitutional provisions, mental health legislation, case law, policy instruments, and academic commentaries to evaluate the extent to which national laws and practices conform to or deviate from global and regional human rights obligations. It finds that although Nigeria and South Africa have both made legislative and policy strides toward protecting the rights of persons with psychosocial disabilities, the balance between compulsory treatment and respect for personal autonomy remains deeply problematic. In Nigeria, mental health governance is constrained by outdated laws, weak institutional capacity, and pervasive stigma that justify coercive and custodial models of care. The Mental Health Act, though recently enacted, lacks the necessary mechanisms to ensure informed consent and safeguard against arbitrary detention and treatment. South Africa, on the other hand, has a more advanced legal regime under the Mental Health Care Act 2002, complemented by strong constitutional guarantees and an active judiciary that has recognized the rights and dignity of vulnerable persons. Yet, in practice, the country continues to face challenges of resource limitations, uneven enforcement, and persistent discrimination within mental health facilities. Both jurisdictions demonstrate the tension between medical paternalism and the human rights-based approach envisaged by the CRPD. The research argues that genuine respect for autonomy requires dismantling institutional practices that prioritize control and containment over empowerment and inclusion. It proposes a shift toward supported decision-making frameworks, community-based mental health services, and participatory models that integrate persons with psychosocial disabilities into policy design and implementation. Furthermore, the dissertation emphasizes that the protection of rights cannot be achieved solely through legislative reform but must be supported by adequate funding, awareness campaigns, professional training, and judicial oversight. Comparative analysis reveals that while South Africa offers valuable lessons in legal reform and rights-based policy, Nigeria's experience underscores the urgent need for implementation strategies tailored to socio-cultural realities and institutional constraints. The study concludes that balancing treatment, rights, and autonomy is not merely a legal or medical issue but a multidimensional challenge that demands collaboration among government institutions, civil society, health professionals, and the affected communities themselves. By integrating comparative insights and human rights perspectives, this dissertation contributes to the growing body of scholarship advocating for the full realization of the rights of persons with psychosocial disabilities in Africa. It highlights the necessity of harmonizing domestic mental health laws with international standards and creating sustainable enforcement mechanisms that protect individuals from coercion while ensuring access to quality and compassionate mental health care. Ultimately, the study contends that only through a comprehensive, rights-oriented, and inclusive framework can both Nigeria and South Africa achieve a true balance between necessary treatment interventions and the fundamental autonomy and dignity of persons with psychosocial disabilities.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Psychosocial disabilities arising from mental health conditions such as schizophrenia, bipolar disorder and severe depression are increasingly recognized not just as medical issues but also as human rights concerns.¹ These disorders may significantly impact the social, emotional or cognitive functions of the sufferers. They have historically faced marginalization, stigma and systemic discrimination. Globally, there have been significant shifts in mental health discourse from a purely biomedical model to a human rights-based approach, particularly after the adoption of the United Nations Convention on the Rights of Persons with disabilities (CRPD) in 2006. The CRPD promotes respect for inherent dignity, individual autonomy and rights to make one's own decisions, including in mental health settings. However, this has raised critical debates on how to balance the need for medical treatment with the rights and autonomy of individuals, especially in countries like Nigeria and South Africa, where mental health systems are still evolving.

In Nigeria, the legal and institutional framework for mental health remains inadequate.² The primary legislation, the Lunatic Act of 1958, is outdated and fails to align with contemporary human rights standards. Although efforts have been made to pass new mental health laws, progress has been slow and involuntary admission, coercive treatments and stigma persist. Persons with psychosocial disabilities are often denied their rights to informed consent, Liberty, and community-based care. Conversely, South Africa has made more progressive strides. The Mental Health Care Act of 2002 emphasizes rights-based care, de-

¹ United Nations, Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) UN Doc. A/RES/61/106.

² Federal Ministry of Health Nigeria. (2013) *National Mental Health Policy*.

institutionalisation and community integration.³ The country also has a constitution that strongly protects individuals' rights. However, implementation challenges, resource constraints and systemic discrimination still result in gaps between the law and practice.⁴

The central challenges in both countries are how to balance treatment, particularly where individuals may lack insight into their conditions, with their legal rights and personal autonomy. This includes determining when, if ever, it is justifiable to override an individual's decision to receive treatment and how to ensure that mental health interventions respect dignity, self-determination, and social inclusion.

This dissertation will critically assess legal frameworks, policies and practices in Nigeria and South Africa, using the lens of international human rights norms, particularly the CRPD and principles of bioethics and social justice. The goal is to propose reforms that reconcile the need for effective mental health treatment with the protection of rights and autonomy for persons with psychosocial disabilities.

1.2 STATEMENT OF THE PROBLEM

While international human rights law increasingly recognizes the rights of persons with psychosocial disabilities to equality, non-discrimination and autonomy, domestic mental health laws often permit involuntary treatment, substitute decision making and institutionalization. This legal dichotomy creates a tension between protection and autonomy. The central problem is whether current legal frameworks strike a fair balance between providing treatment and safeguarding the rights and autonomy of persons with psychosocial disabilities

³ Dube, k (2020). Mental Health Human rights in South Africa. *South African Journal of Psychiatry*, 26 (0) a 1449. <https://doi.org/10.4102/sajpsychoiatry.v26i0.1449>

⁴ Ogunlesi, AO & Ogunwale A (2012) Mental Health Legislation in Nigeria: Current leaning and future needs, *South African Journal of Psychiatry*, 18 (1): 24-28. <https://doi.org/10.4102/sajpsychoiatry.v18i1.282>

1.3 AIM AND OBJECTIVES

This study evaluated the balancing of treatment, rights and autonomy for persons with psychosocial disabilities in Nigeria and South Africa.

OBJECTIVES

This included the

1. Analyzes of international and regional legal standards on the rights of persons with psychosocial disabilities.
2. Evaluation on how domestic laws (e.g, Nigeria Mental Health Act 2021) align with international human rights principles.
3. Identifying legal gaps and inconsistencies in mental health or psychosocial disabilities in Nigeria and South Africa.
4. Investigating the extent to which treatment frameworks respect the autonomy and legal capacity of persons with psychosocial disabilities
5. Recommending reforms that enhance legal protection and promote supported decision-making.

1.4 SCOPE AND LIMITATION OF THE STUDY

The study focused on the legal treatment of persons with psychosocial disabilities, particularly in Nigeria. It drew comparisons from other countries like South Africa and referenced international instruments like the CRPD. Internationally, the existing conversations, declarations and treaties were considered, and laws and policies on mental health rights was also considered.

Autonomy in mental health or psychosocial disabilities refers to the rights of individuals with mental health conditions to make informed decisions about their treatment, free from coercion,

manipulation or undue influence. This study focused on the legal framework and practices related to the treatment, rights and autonomy of persons with psychosocial disabilities in Nigeria and South Africa. These two jurisdictions are selected due to their comparable socio-legal contexts and emerging legal reforms. Nigeria's Mental Health Act 2021 offers a new foundation for analysis, while South Africa's progressive constitution and Mental Health Care Act 2002 provide a contrasting approach based on jurisprudence.

LIMITATION OF STUDY

The study was limited to the legal and policy framework and does not include empirical field work or interviews with affected persons or stakeholders. It focuses specifically on psychosocial disabilities, thereby excluding physical or intellectual disabilities except where they intersect with mental health laws. The scope restricted to Nigeria and South Africa, which may limit the generalisability of findings to other jurisdictions. Resource constraints may limit access to some recent or regional, specifically from the South African provincial health sectors

1.5 SIGNIFICANCE OF THE STUDY

This study contributes to the growing discourse on disability rights, particularly in the African context. It offers critical insights into how legal frameworks can be reformed to uphold human dignity for persons with psychosocial disabilities. The findings no doubt, will be beneficial to policymakers, legal practitioners, mental health professionals and disability rights advocates

1.6 RESEARCH METHODOLOGY

The research adopted the doctrinal method, relying on primary legal sources such as statutes, international treaties and case laws. A comparative approach was used to evaluate foreign countries like Canada and the UK, and secondary sources such as journals, articles, books and reports from international organizations (WHO, UN special rapporteurs) was also be considered

1.7 CHAPTER ANALYSIS

Chapter one introduced the dissertation, highlighting the background of the study, stating the statement of the dissertation problem, before proceeding to highlight the research questions, as well as the aim the objectives of the dissertation. The chapter also discusses the dissertation scope and the anticipated limitations constrained to just two jurisdictions. It also highlighted the significance of the study and concluded with the research methodology, which is the library-based doctrinal method.

Chapter two synthesises scholarly work previously published on the dissertation topic, reviewing literature on psychosocial disabilities. It also conceptualised certain terms before delving into relevant legal and ethical principles, as well as the relationship between mental health and human rights.

Chapter three introduced the discussion in detail of the legal framework on psychosocial disability in the selected jurisdictions. It looked at an overview of the legal framework in Nigeria and South Africa, and with a brief comparison on the Implementation of Protection for Persons with Psychosocial Disabilities in both South Africa and Nigeria

Chapter four introduced the balancing of rights, autonomy, and treatment in practice by describing the tension between involuntary treatment and autonomy as well as institutional practices in Nigeria and South Africa. Moreso, case laws as they pertain to domestic and regional, and best practices and progressive models were analysed. The role of various stakeholders like Medical professionals, Courts, Family, and state were not left out, as well as the implicating challenges in balancing right, autonomy, and treatment in practices.

CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

2.1 CONCEPTUAL FRAMEWORK

The study is underpinned by a conceptual framework that seeks to reconcile three competing but interconnected dimensions in the treatment of persons with psychosocial disabilities, rights, and autonomy. The research recognizes that legal systems and mental health practices in Nigeria and South Africa have long struggled to balance these dimensions, often leaning towards coercive or paternalistic approaches. This imbalance calls for a rights-based conceptual lens grounded in international law and modern disability theory. Central to this framework is the United Nations Convention on the Rights of Persons with disabilities (CRPD), particularly articles 12, 14 and 25, which enshrine the rights to equal legal capability, liberty and access to health care based on free and informed consent. These provisions reject substituted decision making, promoting autonomy and equal recognition before the law.

Nigeria ratified the CRPD in 2007 and enacted the Discrimination against Persons with disabilities (Prohibition) Act in 2019,⁵ while South Africa, though yet to domesticate the CRPD in a standalone law, has incorporated its principles into the mental health and equality framework.⁶

The framework also adopts the social model of disability,⁷ which views disability as a product of social and legal barriers rather than individual impairment. This contrasts with the medical model, which still dominates mental health laws in both countries and often justifies institutionalization or involuntary treatment based on a diagnosis. To challenge this, the

⁵ Federal Republic of Nigeria, Discrimination against persons with disabilities(Prohibition) Act, 2019(National Assembly of Nigeria)

⁶ Republic of South Africa, Mental Health Act 17 of 2020(Government Gazette, Cape Town, 2002)

⁷ T Degener, 'A Human Rights Model of Disability' in P Blanck and E Flynn(eds), Routledge Handbook of Disability law and human right(2017)

research draws on the theory of legal capacity developed by disability rights scholars such as Bach and Kerzner,⁸ who argue that capacity should not be denied due to psychosocial conditions but supported through mechanisms that respect individual will and preferences.

Furthermore, the concept of therapeutic jurisprudence is integrated into this framework to explore how legal practices, whether courts, legislation or Institutional process, can either enhance or diminish the psychosocial well-being and dignity of persons with psychosocial disabilities.⁹ The concept helps assess the extent to which the law contributes to healing or harm.

2.1.1 Definition of Key Terms.

Psychosocial Disability

Psychosocial disability is one of the greatest words, where the meaning can be broken down. Psycho represents a person's psychological state, and social represents society and the environment around us. The word Psychosocial is used to describe the relationship between the individual, behaviour, thought and their environment. The CRPD does not define psychosocial disability directly, it affirms that persons with disabilities includes "those with long term physical, mental, intellectual or sensory impairment which in interaction with various barriers, may hinder their full and effective participation in the society on an equal basis with others"(Article 1 CRPD) This includes persons with mental health disorders, commonly referred to in human rights discourse as persons with psychosocial disabilities, stating the barriers not the condition it's self that result in disability.

The World Health Organization (WHO) recognizes psychosocial disabilities as resulting from the interaction between a person with mental health conditions and the social and

⁸ M Bach and L Kerzner, A new paradigm for protecting autonomy and right to legal capacity(law commission of Ontario, 2010)

⁹ D B Wexler, 'Therapeutic Jurisprudence and Criminal courts' (2000) 35 court review 30.

environmental barriers they face. In all, psychosocial disability refers to the disabilities that arise from mental health conditions, cognitive impairment or emotional challenges that impact an individual's ability to function in daily life, social and other areas. Psychosocial disorders have three conditions, and they include Schizoid disorder, such as schizophrenia disorder; Anxiety disorder, such as obsessive compulsive disorder (OCD), a mental disorder when an individual feels compelled to perform, for example, excessive cleaning, arranging, etc and Post-traumatic stress disorder (PTSD), another of anxiety disorder which develops after a person experiences traumatic event. Lastly, mood and social phobia disorders such as depression and bipolar.

Autonomy

Autonomy refers to the capacity of individuals or groups to make informed decisions and act independently, free from external influence or coercion.¹⁰ In the context of DEI (diversity, equality and inclusion), autonomy involves granting individuals the freedom to express their identities, make choices and pursue opportunities without facing discrimination or prejudice based on factors such as race, gender, sexual orientation or disability. It emphasizes freedom from coercion, respect for personal dignity and recognition of legal capacity even in situations where mental health conditions are present.

According to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), particularly Article 12 on equal recognition before the law and Article 3 on general principles, autonomy involves the freedom to make one's own decisions and the provision of support when needed to exercise that autonomy. The World Health Organization, WHO, reinforces this view by advocating for a mental health care system and human rights, urging a

¹⁰ Matheson, J. (2024). The Philosophy of Epistemic Autonomy: Introduction to Special Issue. *Social Epistemology*, 38(3), 267–273. <https://doi.org/10.1080/02691728.2024.2335623>

move away from involuntary treatment and institutionalization.¹¹ Autonomy plays a vital role in creating an inclusive environment where all individuals feel valued and respected.

Involuntary Treatment

Involuntary treatment is the compulsory assessment or treatment of persons with psychosocial disabilities or mental health conditions without the person's consent. This is described as a form of restrictive practice, and it's mandated under certain conditions. Merriam-Webster's style dictionary defines involuntary treatment as "treatment administered to an individual without their consent, typically under legal authority in situations where the person is considered mentally ill or a threat to self or others.

Human Rights-Based Approach

Psychosocial disability or mental health is gaining international attention, particularly since the COVID-19 crisis.¹² The evidence of the increased demand and support for mental health and psychosocial disability is good, but at the same time, the question remains on how to ensure a rights-based approach in such services so that the rights of persons with disabilities are adequately respected. Human rights bodies and experts have noted that there are still human rights challenges associated with the provisions of mental health services, such as institutionalization, stigma, abuse, coercion and discrimination. The Convention on the Rights of Persons with disabilities (CRPD) represents the highest standard of protection of the rights of persons with disabilities. It calls for the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind based on disability. The general principles (Article 3) reflect the CRPD's adherence to universal human

¹¹ World Health Organization, Mental health: promoting and protecting human rights (2022) <https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights> accessed 26 August 2025.

¹² n 11

rights principles and values. However, the human rights model of disabilities, underpinned by the CRPD, challenges the medical model of disability.

From the medical perspective, the problem is seen to be with the patient, and the ultimate aim is to cure or 'fix' the person, whereas from the human rights model of disability, the problems are the social barriers, preventing persons with disabilities from participating in society on an equal basis alongside others. The human rights model of disability recognizes that disability is a social construct and impairment, which is not to be taken as a legitimate ground for the demand of human rights.¹³

The human rights model or approach to disability also moves beyond anti-discrimination; upholding a complex substantive model of equality, which seeks to address structural and indirect discrimination, values different layers of identity and acknowledges intersectional discrimination. It is interesting to know that the human rights model of disability does not deny the role of medical intervention in people's lives but questions social responses that reduce persons with disabilities to mere recipients. Persons with disabilities, including children, must be consulted and actively involved in all public decisions affecting them.¹⁴ While the CRPD and its human right based model of disability have had a powerful influence over international, regional, national law and policies, the medical approach is still prevalent in societal responses to the needs of persons with psychosocial disabilities.¹⁵

¹³ Degener, Theresia. 2024. The Human Rights Model of Disability in Times of Triage. *Scandinavian Journal of Disability Research* 26(1): 437-449. doi: 10.16993/sjdr.1088.

¹⁴ UN committee on the Rights of the child(CRC) General committee No 12, (2009)

¹⁵ United Nations General Assembly, Human Right council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc A/HRC/35/21 (2017)

2.1.2. Relevant Legal and Ethical Principles of Psychosocial Disability.

Legal Principles

Equality and non-discrimination: Persons with psychosocial disabilities are entitled to equality before the law and freedom from discrimination.¹⁶ This principle is entrenched in international human rights law and regional African instruments.

Legal capacity and autonomy: The principle of autonomy recognizes that persons with psychosocial disabilities must enjoy legal capacity on an equal basis with others. The law now encourages supported decision making rather than substituted decision making.¹⁷

Right to health and access to services: Every person has the right to the highest attainable standard of mental and physical health, free from discrimination. This includes access to appropriate mental health services.¹⁸

Ethical Principles

Respect for autonomy: Ethical framework requires recognition of the agency and decision-making capacity of persons with psychosocial disabilities. This principle often guides debates on voluntary treatment and consent.

Beneficence and Non-maleficence: Health care providers are ethically obligated to act in the best interest of patients while avoiding harm, which raises critical considerations regarding coercive interventions¹⁹

¹⁶ African Charter on Human and peoples right (1981) Article 2

¹⁷ CRPD 2006, Article 12

¹⁸ International covenant on Economic, Social and Cultural Rights (ICESCR) 1966; Article 12

¹⁹ Beauchamp, T.L.. & Childress, J.F., Principles of Biomedical Ethics, 8th Edition(New York: Oxford University Press, 2019)

Justice and fairness: Ethical practice demands for distribution of mental health resources and addressing structural inequalities, including stigma and discrimination.²⁰

Dignity and respect: Treatment and policies must uphold the inherent dignity of persons with psychosocial disabilities, ensuring they are recognized as holders rather than objects of charity.

Participation and empowerment: The ethical principles of empowerment reinforce the necessity for meaningful involvement of persons with psychosocial disabilities in treatment, research and policy." Nothing about us without us".²¹

2.1.3. Relationship between Mental Health and Human Rights

The link between human rights and mental health is very important; it is not just about laws, it's about helping people with mental health issues get better. According to the International Convention on Economic, Social and Cultural Rights (ICESCR), "Mental health is a human right and the realization of this right is essential for the full enjoyment of all the human rights"²²

By standing up for human rights and helping those with mental health issues, we can build a fairer world, a world where everyone's mental health is valued and supported. Ignoring human rights can really hurt someone's mental health, but respecting those rights can help people feel better and included.²³ Mental health illness has been misunderstood by society, leading to stigma, and this can harm a person's human rights. Persons with mental health conditions might face job loss, housing problems and lack of access to services; hence, a human rights approach fights these stereotypes, ensuring equal treatment for all.²⁴ The relationship between human

²⁰ Ibid

²¹ Charlton , J.I., Nothing about us without us: Disability oppression and Empowerment(Berkeley: University of California Press 1998).

²²Lawrence O. Gostin and Benjamin. M.Meier, "Human Right and Global Mental Health: Essential linkages" (2002); 9 The lancet psychiatric 300

²³ n 15

²⁴ World Health Organisation, Mental Health and Human Right (WHO, 2018)

rights and mental health is a smooth one. By linking human rights and mental health, we aim for a more caring society, a society that supports everyone and respects their dignity.

2.2. LITERATURE REVIEW

This study examines the delicate and often contested balance between treatment need, human rights and autonomy for persons with psychosocial disabilities in Nigeria and South Africa. This balance is not merely a clinical or service delivery issue; it is anchored in evolving international human rights, law, national legislation, and policy framework works that seek to respect individual autonomy.²⁵

In legal capacity and supported decision making, CRPD General Comment No 1 interprets article 12 to require recognition of universal legal capacity, replacement of substitute decision making with supported decision making, and aligning will and preferences. Any "balance" that defaults to guardianship or compulsory treatment conflicts with this standard, liberty, security and non-discrimination.²⁶ Article 14 guidance rejects deprivation of liberty based on actual or perceived disability, including psychosocial disability- specific detention regimes are discriminatory. This refrains the household from involuntary admission. The general comment No 5 in article 19 (community living) and WHO community guidance (2021) emphasizes non-institutional, rights-aligned supports as the practical route to honour both treatment needs and autonomy.

Until 2023, Nigeria operated under colonial-era rules (lunacy ordinance/law), widely criticized as anachronistic and rights-eroding. In January 2023, the Natural Mental Health Act was assented to align care with contemporary rights standards. Peer-reviewed and policy analysis agree it is a landmark, but flag clarity and implementation challenges. Despite legal reforms,

²⁵ n 1

²⁶ Committee on the Rights of Persons with Disabilities, General comments No 1: Article 12- Equal Recognition before the Law, U.N. Doc. CRPD/C/GC/1(2014)

Nigeria continue to face grave human rights and service delivery gaps. Human Rights Watch has documented chaining and abusive confinement in faith-based, traditional and even some state facilities, such as practices starkly conflict with CRPD norms and the new Act's aspirations.^{27,28} System capacity remains thin, with few specialized facilities relative to population under investment and weak community alternatives. These conditions make supported decision-making and informed consent hard to operationalize without system investment and oversight.

Balancing analysis in Nigeria, a new statutory framework offers a platform to prohibit abusive practices, regulate facilities, set up oversight (e.g review bodies) and mainstream rights.²⁹ Public debates and scholarship provide implementable critiques and recommendations. Enforcement lag, entrenched shackling and coercion in non-state and some state settings, scarcity of community services, and stigma without resourcing and enforcement, rights and autonomy remain paper guarantees.

The African disability protocol (2018), now in force, strengthens the continental rights framework, complementing the African Charter and CRPD by addressing specific barriers. It bolsters arguments for community-based care, accessibility and freedom from violence and abuse for persons with psychosocial disabilities.^{30,31} Autonomy Vs safety in crisis, rights literature rejects disability based detention and forced care; instead, it proposes non-coercive crisis alternatives. Evidence from WHO and CRPD practice notes suggests these are clinically effective and rights-compatible when properly resourced.

²⁷ Human Right Watch, "Nigeria: People with Mental Health Conditions Chained, Abused". (11 November 2019)

²⁸ Nigeria, Mental health Act, No 28 of 2021

²⁹ n 28

³⁰ African Union, Protocol to African Charter on Human and Peoples Rights on the Rights of Persons with Disabilities in Africa, adopted 29 Jan 2018, entered into force 5 July. 2024.

³¹ n 25

Moving from "competency threshold" towards supported decision making requires legal tools and practice change. CRPD general comment issued (GCI) is the interpretive anchor; natural statutes should operationalize it. Esidimeni shows that deinstitutionalization can be done badly or rightly; it went further to show that deinstitutionalization without rights-centred planning can be catastrophic, and as such, the lesson learnt is to invest first in community support, workforce, co-design transition with users and families, then close institutions.³²

South Africa now has post post-colonial mental health status. South Africa is older with established review mechanisms, while Nigeria is new and still bedding down. Both must interrogate compatibility with CRPD GCI and progressively remove substitute decision-making and disability based detention.^{33,34} South Africa has updated its national policy (2023 to 2030) with explicit rights language, Nigeria's priority is to issue or align regulations, fund community services, and enforce prohibitions on abuse across state/non-state settings. Concerning accountability, South Africa's Esidimeni arbitration illustrates remedies for systemic failure, NHRC and strategic litigation/ inspection powers to drive compliance.

The literature demonstrates that balancing treatment, rights and autonomy for persons with psychosocial disabilities remains one of the most complex challenges in contemporary mental health law and policy. International human rights instruments, particularly the United Nations Convention on the Rights of Persons with disabilities (CRPD), emphasis autonomy, informed consent and freedom from coercion.

³² Freeman, M.C.(2018). Global lesson for Deinstitutionalisation from the ill-fated transfer of mental health care user in Gauteng, South Africa. *Lancet Psychiatry*, 5(9) , 765-708

³³ n 28

³⁴ South Africa, Mental Health Care Act, 17 of 2022

2.2.1: Analyzes of international and regional legal standards on the rights of persons with psychosocial disabilities.

The analysis of international and regional legal standards concerning the rights of persons with psychosocial disabilities reveals a complex interplay between various legal frameworks and the need for harmonisation. Internationally, the UN Convention on the Rights of Persons with Disabilities (CRPD) serves as a cornerstone, emphasizing the importance of recognizing the rights of individuals with psychosocial disabilities. However, discrepancies between international standards and national laws often hinder effective implementation.

The International Legal Frameworks, such as the CRPD outlines civil, political, social, and specialized rights for persons with disabilities, advocating for their inclusion in society.³⁵ Moreso, the key documents such as the International Bill of Human Rights and the Universal Declaration of Human Rights reinforce the protection of these rights globally.

In Regional Approaches, regional systems, particularly in Europe, Africa, and the Americas, have developed distinct human rights instruments that address mental health and psychosocial disabilities, often achieving significant advancements in legal protections.³⁶ The European Convention on Human Rights (ECHR) emphasizes the right to fair treatment in mental health settings, highlighting the need for humane conditions and legal representation.³⁷ A lack of harmonization between international standards and national laws remains a significant barrier, necessitating model legislation and capacity-building initiatives to promote inclusivity.³⁸ The

³⁵ Sarpekov, Ramazan Kumarbeckovich. "International Legal Standards for the Protection of the Rights of Persons with Disabilities: Some Aspects of Implementation in Kazakhstan and Foreign Countries." *Vestnik Instituta Zakonodatel'stva Respubliki Kazahstan*, June 2023, doi:10.52026/2788-5291_2023_73_2_137.

³⁶ Gostin, Lawrence O., and Lance Gable. "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health." *Social Science Research Network*, May 2009, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1435443&.

³⁷ *ibid*

³⁸ Abduvalieva, Mumtozkhan Asilbekovna. "Comparative Analysis of International Standards for the Protection of Persons with Disabilities and National Legal Norms." *International Journal of Law and Policy*, July 2023, doi:10.59022/ijlp.96.

need for a holistic approach in assessing disabilities, as suggested for Kazakhstan, could enhance the understanding and support for psychosocial disabilities.³⁹

While international and regional frameworks provide a robust foundation for the rights of persons with psychosocial disabilities, the challenge lies in their effective implementation and alignment with national laws. This gap underscores the necessity for ongoing advocacy and reform to ensure that these rights are fully realized in practice.

2.2.2: Evaluation on how domestic laws (e.g, Nigeria and South Mental Health Acts) align with international human rights principles.

The alignment of Nigeria's Mental Health Act 2021 with international human rights principles reflects a significant step towards enhancing the rights of individuals with mental health conditions. This legislation aims to protect and promote the rights of people with mental disorders, aligning with the standards set by international frameworks such as the Convention on the Rights of Persons with Disabilities (CRPD) and the UN Principles for the Protection of Persons with Mental Illness.^{40,41} The key aspects of alignments include: Right to Health, the Act emphasizes the right to the highest attainable standard of mental health, echoing international commitments to health rights.⁴² Protection of Rights it incorporates provisions that safeguard the rights of individuals with mental health issues, ensuring access to care and community-based treatment.⁴³ Legal Capacity: The Act aligns with Article 12 of the CRPD,

³⁹ Sarpekov, Ramazan Kumarbeckovich. "International Legal Standards for the Protection of the Rights of Persons with Disabilities: Some Aspects of Implementation in Kazakhstan and Foreign Countries." *Vestnik Instituta Zakonodatel'stva Respubliki Kazahstan*, June 2023, doi:10.52026/2788-5291_2023_73_2_137.

⁴⁰ Weller, Penelope June. "The Convention on the Rights of Persons with Disabilities and the Social Model of Health: New Perspectives." *International Journal of Mental Health and Capacity Law*, no. 21, Sept. 2014, pp. 74–83, doi:10.19164/IJMHCL.V0121.234.

⁴¹ Kelly, Brendan D. *Human Rights and Mental Illness*. June 2016, pp. 1–34, <https://www.cambridge.org/core/books/mental-illness-human-rights-and-the-law/human-rights-and-mental-illness/A502C36CDC4F94634F66060C61159108>.

⁴² Giwa, David Christopher. "An Appraisal of the Right to Health in Nigeria." *Social Science Research Network*, Jan. 2023, doi:10.2139/ssrn.4581522.

⁴³ Ogunwale, A. (2023). Implementation of the Nigerian Mental Health Act 2021. *The Lancet Psychiatry*. [https://doi.org/10.1016/s2215-0366\(23\)00261-4](https://doi.org/10.1016/s2215-0366(23)00261-4)

promoting the legal capacity of individuals with mental disabilities, thus supporting their autonomy.⁴⁴

Despite these advancements, challenges remain in the practical implementation of the Act, which may hinder its effectiveness in fully realizing these rights. Critics argue that while the legislation is progressive, the socio-economic context and resource limitations in Nigeria may impede its successful application.⁴⁵

The alignment of domestic laws, such as the South African Mental Health Act, with international human rights principles is a critical area of evaluation. The South African Mental Health Care Act 17 of 2002, in conjunction with the Bill of Rights, emphasizes the protection of rights for involuntary mental health care users, demonstrating compliance with international standards, particularly those outlined in the Convention on the Rights of Persons with Disabilities (CRPD).^{46,47} This alignment is essential for ensuring that mental health laws are not only protective but also promote dignity and equality.

In Compliance with International Standards, the South African Mental Health Care Act incorporates rights that align with international human rights principles, such as the right to receive appropriate mental health care and live in the community.⁴⁸ The CRPD serves as a benchmark for assessing domestic laws, ensuring they reflect contemporary human rights discourse.⁴⁹

⁴⁴ McGuire, Magdalena. "Dignity, Equality, Freedom and Respect: A Human Rights-Based Approach to Mental Health." *Health Issues*, no. 101, Dec. 2009, p. 13, <https://search.informit.com.au/documentSummary;dn=655365532897565;res=IELHEA>.

⁴⁵ Stavert, Jill, and Rebecca McGregor. "Domestic Legislation and International Human Rights Standards: The Case of Mental Health and Incapacity." *The International Journal of Human Rights*, vol. 22, no. 1, Jan. 2018, pp. 70–89, doi:10.1080/13642987.2017.1390307.

⁴⁶ Ndou, Moffat Maitele. *A Critical Evaluation of the Human Rights of Involuntary Mental Health Care Users*. Jan. 2015, <https://repository.nwu.ac.za/handle/10394/36894>.

⁴⁷ n 40

⁴⁸ n 41

⁴⁹ n 40

In the evolution of Mental Health Laws in South Africa, the historical context shows a shift from punitive measures to a rights-based approach, emphasizing the need for reforms in mental health institutions.⁵⁰ The international principles, such as those from the UN, advocate for the protection of individuals with mental illness, influencing domestic legislation. In the interpretation and implementation, domestic laws must be interpreted in light of international standards to ensure effective human rights protection,⁵¹ and the ongoing evolution of mental health laws is influenced by international human rights jurisprudence, promoting a holistic approach to mental health care.⁵²

Conversely, while the South African Mental Health Care Act aligns with international standards, challenges remain in its implementation and the need for continuous reforms to address systemic issues within mental health care institutions. This highlights the ongoing struggle to fully realize the rights of individuals with mental illness in practice.

2.2.3: Identifying legal gaps and inconsistencies in mental health or psychosocial disabilities in Nigeria and South Africa.

Identifying legal gaps and inconsistencies in mental health or psychosocial disabilities in Nigeria reveals significant challenges within the legislative framework. Despite recent reforms, such as the enactment of the Mental Health Act 2021, the legal landscape remains fraught with outdated terminology and insufficient protections for individuals with mental health disorders. The following sections outline key issues contributing to these legal gaps.

Outdated Legislation was the Lunacy Ordinance of 1916, which was replaced by the Mental Health Act, because it perpetuated discriminatory language and failed to address modern

⁵⁰ n 46

⁵¹ Morostes, Anca Florina. "Correlation between International Regulations and Domestic Regulations in the Field of Human Rights and Freedoms." *Beobhag Yeon 'gu (Gyeongsang Daehag 'gyo Beobhag Yeon 'guso)*, May 2024, doi:10.2478/jles-2024-0009.

⁵² n 44

mental health challenges.^{53,54} The new Mental Health Act, while a step forward, still contains ambiguities that may hinder effective implementation.^{55,56}

Insufficient Coverage of Mental Health in Disability Laws include the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 which primarily focuses on physical disabilities, neglecting mental health issues.⁵⁷

Moreso, Mental health disorders affect approximately 20-30% of Nigeria's population, yet the legal framework does not adequately reflect this reality.⁵⁸ The implementation Challenges abound because despite the existence of contemporary laws, practical challenges in implementation persist, including lack of resources and public awareness.⁵⁹ The rights of individuals with mental health disorders continue to be violated due to insufficient enforcement of existing laws.⁶⁰

Conversely, some argue that the recent legislative changes represent a significant improvement over previous laws, suggesting a potential for future reforms to address these gaps effectively. However, without robust implementation and public education, these laws may remain largely symbolic. Identifying legal gaps and inconsistencies in mental health or psychosocial disabilities in South Africa reveals significant challenges within the criminal justice and healthcare systems. The existing legal framework often fails to align with international standards, particularly the Convention on the Rights of Persons with Disabilities (CRPD). This

⁵³ Mental Health and Disability Law in Nigeria: A Call for Affirmative Interpretation, *Journal of Law, Policy and Globalization*, from <https://doi.org/10.7176/jlpg/124-04>, September 1, 2022. DOI: 10.7176/jlpg/124-04

⁵⁴ Akanni, Oluyemi O., and Leroy C. Edozien. *The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely?* no. 6, July 2024, pp. 838–45, doi:10.60787/nmj-64-6-351.

⁵⁵ *ibid*

⁵⁶ n 43

⁵⁷ n 53

⁵⁸ *ibid*

⁵⁹ n 43

⁶⁰ Afolaranmi, Esther. *The Legal Framework on the Rights of Persons Living with Disabilities in Nigeria*. doi:10.2139/ssrn.4217495.

situation necessitates a comprehensive examination of various aspects, including legal capacity, access to justice, and systemic inequities.

In Legal Capacity and Recognition, the CRPD mandates equal legal recognition for individuals with disabilities, yet South African law often denies this right, particularly in traditional courts where individuals with disabilities are treated as minors.⁶¹ The current insanity defense framework does not adequately reflect the CRPD's emphasis on universal legal capacity, leading to potential injustices for those with psychosocial disabilities.⁶²

Systemic Inequities exist because the forensic mental health system is marred by colonial legacies, resulting in inequitable treatment of marginalized groups, particularly Black Africans.⁶³ Language barriers further complicate access to justice, as many defendants are not fluent in English, the official court language.⁶⁴

Whereas the Mental Health Care Legislation like the Mental Health Care Act provides some protections, it lacks comprehensive oversight and fails to address the needs of individuals with psychosocial disabilities adequately.⁶⁵ There is a pressing need for reform to ensure that mental health assessments and legal processes are consistent and equitable.⁶⁶

⁶¹ Holness, Willene, and Sarah Rule. *Legal Capacity of Parties with Intellectual, Psycho-Social and Communication Disabilities in Traditional Courts in Kwazulu-Natal*. doi:10.29053/2413-7138/2018/v6a2.

⁶² Combrinck, Heléne. "Rather Bad than Mad? A Reconsideration of Criminal Incapacity and Psychosocial Disability in South African Law in Light of the Convention on the Rights of Persons with Disabilities." *African Disability Rights Yearbook*, vol. 6, Apr. 2021, doi:10.29053/2413-7138/2018/v6a1.

⁶³ Pillay, Anthony L., et al. "Inequities in Forensic Mental Health in South Africa and Recommendations for Service Development." *International Journal of Forensic Mental Health*, vol. 22, Aug. 2023, pp. 326–39, doi:10.1080/14999013.2023.2243856.

⁶⁴ *ibid*

⁶⁵ Swanepoel, M. (2021). *The Constitutional Imperative, Common Law Position and Domestic Legislation in the Context of Mental Health Care Law in South Africa*. 149–167. https://doi.org/10.1007/978-3-030-71024-8_7

⁶⁶ Van Hout, Marie Claire, and Jakkie Wessels. *Navigating the Complexities of the Mentally Ill and Mentally Incapacitated in the Criminal Justice System in South Africa*. Nov. 2021, p. 100068, doi:10.1016/J.FSIML.2021.100068.

Conversely, some argue that the existing frameworks, while flawed, provide a foundation for reform. Incremental changes could enhance the legal recognition and rights of individuals with mental health issues, fostering a more inclusive system.

2.2.4: Investigating the extent to which treatment frameworks respect the autonomy and legal capacity of persons with psychosocial disabilities

The treatment frameworks for persons with psychosocial disabilities in Nigeria reveal significant shortcomings in respecting their autonomy and legal capacity. Despite existing legal frameworks, such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the Discrimination Against Persons with Disabilities (Prohibition) Act, implementation remains inadequate, leading to continued marginalization and discrimination against individuals with disabilities.^{67,68}

As regard the Legal Framework and Autonomy, the UNCRPD emphasizes the recognition of legal capacity for all individuals, mandating support for decision-making rather than substituted decision-making.⁶⁹ However, many individuals with psychosocial disabilities face restrictions based on perceived "functional capacity," which undermines their autonomy and can lead to forced interventions.⁷⁰ Challenges in Implementation exist because the Nigerian government has been slow to enact and enforce laws that protect the rights of persons with disabilities, resulting in a lack of access to justice and legal support.⁷¹ Moreso, cultural attitudes and societal prejudices further exacerbate the challenges faced by these individuals, limiting

⁶⁷ n 60

⁶⁸ Arimoro, Augustine Edobor. "Persons with Intellectual Disability and Access to Justice in Nigeria: Challenges and the Way Forward." *Hasanuddin Law Review*, vol. 5, no. 2, Aug. 2019, pp. 180–98, doi:10.20956/HALREV.V5I2.1561.

⁶⁹ Vivanti, Donata Pagetti, and Luisa Bosisio Fazzi. *Legal Capacity of Persons with Intellectual Disabilities*. no. 6, Jan. 2019, pp. 219–50, <https://universitypress.unisob.na.it/ojs/index.php/minorityreports/article/view/657>.

⁷⁰ Minkowitz, Tina. "CRPD Article 12 and the Alternative to Functional Capacity: Preliminary Thoughts Towards Transformation." *Social Science Research Network*, Dec. 2013, doi:10.2139/SSRN.2371939.

⁷¹ n 68

their ability to exercise their rights fully.⁷² While the legal framework theoretically supports the autonomy of persons with psychosocial disabilities, the practical application often falls short, reflecting broader societal issues that need to be addressed for true empowerment and respect for their rights.

The treatment frameworks in South Africa regarding persons with psychosocial disabilities often fail to respect their autonomy and legal capacity, as mandated by the Convention on the Rights of Persons with Disabilities (CRPD). The current legal landscape reveals significant gaps in recognizing the equal legal capacity of these individuals, particularly in traditional and formal court settings.

As regards the Legal Capacity and Autonomy, Article 12 of the CRPD emphasizes that all individuals, including those with psychosocial disabilities, should enjoy legal capacity equally. However, South African law still reflects a paternalistic approach, often denying autonomy based on perceived incapacity.^{73,74} The Assisted Decision-making Bill aims to provide support for decision-making but lacks adequate safeguards to ensure that support does not undermine autonomy.⁷⁵ Moreso, Traditional Courts Discriminate. A typical example is in KwaZulu-Natal, where traditional courts often treat individuals with disabilities as minors, requiring representation by family members, which further erodes their autonomy.⁷⁶ Negative attitudes and a lack of training among traditional leaders contribute to the systemic denial of legal capacity for persons with psychosocial disabilities

Need for reform cannot be overemphasized, as there is a pressing need for legal reform to align South African laws with the CRPD, particularly in abolishing the functional capacity doctrine

⁷² Ndoni, Erebi. *Reproductive Health Rights of Persons with Disabilities in Nigeria: A Legal or Cultural Flaw?* Springer International Publishing, 2023, pp. 49–69, doi: 10.1007/978-981-99-2411-0_4.

⁷³ n 61

⁷⁴ n 62

⁷⁵ n 61

⁷⁶ *ibid*

that justifies forced interventions.⁷⁷ As such, the current frameworks must shift towards recognizing the inherent legal capacity of individuals with psychosocial disabilities, ensuring their voices are heard in legal matters.

Conversely, some argue that the complexities of mental health may necessitate certain protective measures, which could be perceived as limiting autonomy. However, these measures must be carefully balanced to avoid infringing on the rights and dignity of individuals with psychosocial disabilities.

2.2.5: Recommendation of reforms that enhance legal protection and promote supported decision-making.

Enhancing legal protection and promoting supported decision-making for persons with psychosocial disabilities in Nigeria requires a multifaceted approach. This involves strengthening existing legal frameworks, ensuring effective implementation, and fostering societal change to support the rights of individuals with disabilities.

In respect to strengthening legal frameworks, there is a need to implement the existing laws: The Discrimination Against Persons with Disabilities (Prohibition) Act, 2018, needs robust enforcement mechanisms to ensure compliance and protect the rights of persons with disabilities.⁷⁸ The Rights-Based Approach is necessary, such as transitioning from a charity-based to a rights-based approach is essential. This includes aligning national laws with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to ensure that individuals with disabilities can exercise their rights fully.⁷⁹

Promoting Supported Decision-Making is essential by Legal Capacity Reforms, to advocate for reforms that recognize the decision-making rights of individuals with psychosocial

⁷⁷ n 70

⁷⁸ n 68

⁷⁹ n 60

disabilities. This includes moving away from guardianship models towards supported decision-making frameworks.⁸⁰ In addition to awareness and training, which will no doubt increase the legal awareness and providing training for legal professionals on the rights of persons with disabilities can enhance access to justice and empower individuals to make informed decisions.⁸¹

The Societal Change and Advocacy through Public Awareness Campaigns Initiatives, aimed at changing societal attitudes towards disabilities can reduce stigma and promote inclusion, thereby creating a more supportive environment for individuals with psychosocial disabilities. The involvement of the Civil Society organizations in monitoring and advocating for the rights of persons with disabilities can ensure accountability and promote effective legal protections.⁸² While these reforms are essential, challenges remain, including entrenched societal attitudes and insufficient political will to implement changes. Addressing these issues requires a concerted effort from all stakeholders to create a more inclusive society for persons with psychosocial disabilities in Nigeria.

In South Africa, in order to enhance legal protection and promote supported decision-making for persons with psychosocial disabilities, several reforms are recommended. These reforms should align with the principles outlined in the Convention on the Rights of Persons with Disabilities (CRPD), emphasizing equal legal capacity and the necessity of support in decision-making processes.

In the Recognition of Legal Capacity, South African law must recognize that persons with psychosocial disabilities have full legal capacity on par with others, as mandated by the CRPD

⁸⁰ Finn, Chester A., et al. "How Persons with Intellectual Disabilities Are Fighting for Decision-Making Rights." *Current History: A Journal of Contemporary World Affairs*, vol. 121, no. 831, Jan. 2022, pp. 30–35, doi:10.1525/curh.2022.121.831.30.

⁸¹ n 68

⁸² *ibid*

and needs to implement a supported decision-making model that can provide individuals with the necessary assistance while preserving their autonomy, moving away from substituted decision-making practices.⁸³

Legislative Reforms by way of Assisted Decision-Making Bill should be revised to incorporate the principle of proportionality, ensuring that support measures are tailored to individual needs without undermining autonomy.⁸⁴ Broader Legal Reforms should extend beyond guardianship systems to include various sectors, such as healthcare and social services, to create a comprehensive support network.⁸⁵

Any legal framework must include robust safeguards to prevent abuse and ensure that decisions made on behalf of individuals are in their best interests.⁸⁶ Independent bodies should be established to oversee decision-making processes can enhance accountability and protect the rights of individuals with psychosocial disabilities.⁸⁷ While these reforms are crucial, there is a concern that overly stringent regulations may inadvertently limit the autonomy of individuals with psychosocial disabilities. Balancing support with respect for personal agency remains a critical challenge in the reform process.

⁸³ Gooding, Piers Michael. *Supported Decision-Making: A Disability and Human Rights-Based Concept for Mental Health Law*. Jan. 2014, doi:10.4225/03/58A51788C955F.

⁸⁴n 61

⁸⁵ Then, Shih-Ning, and Christine Bigby. "Supported Decision-Making and the Disability Royal Commission." *Research and Practice in Intellectual and Developmental Disabilities*, Mar. 2024, doi:10.1080/23297018.2024.2330961.

⁸⁶ Dawson, John. "A Realistic Approach to Assessing Mental Health Laws' Compliance with the UN Convention on the Rights of Persons with Disabilities." *Social Science Research Network*, Jan. 2015, <https://ourarchive.otago.ac.nz/handle/10523/8919>.

⁸⁷ *ibid*

CHAPTER THREE

LEGAL AND POLICY ON PSYCHOSOCIAL DISABILITIES IN NIGERIA AND SOUTH AFRICA

3.1 OVERVIEW OF MENTAL HEALTH IN NIGERIA

Mental health is a component part of general health and well-being, and yet it has not received attention in this part of the world. According to the WHO, mental health is: “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community”.⁸⁸ In 2019, a survey on mental health in Nigeria shows how awareness of mental health is low in Nigeria, with most respondents being aware that they have a mental health disorder, recognising it and commonly caused by drug abuse, and sickness of the brain and the majority of the patients are taken to a prayer house for spiritual interventions.⁸⁹ The burden of mental health disorders is very high, with limited access to available and affordable mental health services in the country.⁹⁰

In Nigeria, many cases of mental health problems are being managed by psychiatrists and other mental health workers, including religious clerics and traditional care attendants, leading to the diagnosis, treatment and rehabilitation of patients with mental health disorders. Patients receive care (inpatient/outpatient) and treatment in hospitals and primarily in their communities. The psychiatrists and other mental health specialists are mainly available at tertiary healthcare

⁸⁸ World Health Organization. Mental Health: a State of Well-Being. Available @ http://www.who.int/features/factfiles/mental_health/en/. (2014) accessed 6th August 2025

⁸⁹ Mental Health in Nigeria in Nigeria Survey Africa Polling Institute and EpiAFRIC (2019) accessed 8th August 2025. <https://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/2020/01/MENTAL-HEALTH-IN-NIGERIA-SURVEY-Conducted-by-Africa-Polling-Institute-and-EpiAFRIC-January-2020-REPORT.pdf>

⁹⁰ *ibid*

centers to review and treat complex cases.⁹¹ Most mental health physicians are urban-based, and in view of poor knowledge of mental disorders at the primary health-care level, caring for people with mental illness is typically left to family members.⁹² Furthermore, nine out of every ten doctors in Nigeria are seeking to leave the country, and few neuropsychiatric hospitals are available in the entire country, responsible for the professional training of mental health physicians as well as managing patients with psychiatric disorders.⁹³

The WHO has set a global target for 50 % of countries to update their mental health laws in line with regional and international human rights instruments by 2020 through the WHO mental health action plan 2013–2020.⁹⁴ For Nigeria to have an efficient and effective integration of mental health services, there is a need for reform of the outdated existing laws and formulation of new policies that will see the establishment of a commission for mental health with a mission to protect and support persons with mental health needs in Nigeria.

Although awareness has been created by various NGOs, associations, philanthropists and international agencies, giving public education on mental health in Nigeria most especially on media and urban places. Nonetheless, there is need for the National Orientation Agency (NOA) to collaborate with the Federal Ministry of Health (FMOH) to create more strategic communication and coordinate the public education and awareness campaigns on mental health and mental disorders especially within educational institutions, communities and rural areas. These awareness campaigns and public education should be targeted on violence victims, healthcare workers, military and law enforcement officers, prisoners and minority groups like

⁹¹ G.M. Khalid, U.I. Idris, A.I. Jatau, Y.H. Wada, Y. Adamu, M.A. Ungogo. Assessment of occupational violence towards pharmacists at practice settings in Nigeria 2020 Oct-Dec Pharm. Pract., 18 (4) (2020), p. 2080, 10.18549/PharmPract.2020.4.2080

⁹² The Lancet Global Health. The Time Is Now: Reforming Nigeria's Outdated Mental Laws (2020), 10.1016/S2214-109X(20)30302-8

⁹³ Mercy Abang. Nigeria's Medical Brain Drain; Healthcare Woes as Doctors Flee. Aljazeera (2019) accessed 8th August 2025. <https://www.aljazeera.com/amp/features/2019/8/nigerias-medical-brain-drain-healthcare-woes-as-doctors-flee>

⁹⁴World Health Organisation (WHO). Mental health action plan 2013–2020 available @ https://www.who.int/mental_health/publications/action_plan/en/ accessed 9th August 2025

the homeless and social deviants, drug addicts and drug abusers, children/adolescents and students.⁹⁵

The need, therefore, for a concerted effort between the government, policy makers and international organizations to provide good reforms for a better, accessible, and affordable mental health service for the mental well-being of the populace, cannot be overemphasized

3.1.1 Lunatic Act

There was concern in the United Kingdom in the 19th century about wrongful confinement in private madhouses, or asylums, and the mistreatment of patients, with tales of such abuses appearing in newspapers. The term "Lunatic Act" primarily refers to legislation like the Lunacy Act of 1845, which significantly reformed the treatment of individuals with mental health issues in England and Wales. The Lunacy Act of 1845 was a pivotal piece of legislation in the history of mental health law in England and Wales. It marked a significant shift in how individuals deemed mentally ill were treated, transitioning from viewing them as social outcasts to recognizing them as patients deserving of care and treatment.⁹⁶

This became applicable to Nigeria as a Statute of General Application. In 1906, the Lunacy Ordinance was passed in the then Southern Province. The Ordinance among other things, authorized the government to establish a Lunatic asylum. This led to the building of the asylums in Yaba (Lagos), Lantoro (Abeokuta) and Calabar in 1907.⁹⁷ The Lunacy Ordinance assumed the status of law rather than an Ordinance in 1958, herein referred to as the lunacy Act of 1958. The Act seeks to change perception and understanding of mental health, while

⁹⁵ A.I. Jatau, A. Sha'aban, K.A. Gulma, Z. Shiyu, G.M. Khalid, A. Isa, A.S. Wada, M. Mustapha The burden of drug abuse in Nigeria: a scoping review of epidemiological studies and drug laws *Publ. Health Rev.*, 42 (2021), Article 1603960, 10.3389/phrs.. 2021.1603960 accessed 11th August 2025

⁹⁶ The Lunacy Act 1845 or the Lunatics Act 1845 (8 & 9 Vict. c. 100) and the County Asylums Act 1845 (8 & 9 Vict. c. 126). Available @ https://en.wikipedia.org/wiki/Lunacy_Act_1845 accessed on the 30th Aug, 2025

⁹⁷ Mulikat Hassan, Revisiting Nigeria's Mental Health Legislation. *The Law Industry Trends. News & Insights.* available @ <https://libralawoffice.com/wp-content/uploads/2021/05/Revisiting-Nigerias-Mental-Health-Legislati> accessed 28 Aug,2025

also addressing access to ‘a better quality of life’ and better quality mental health services for people with mental health conditions.⁹⁸ The Lunacy Act faced widespread criticism from medical professionals, human rights advocates and legal experts.⁹⁹ This is because the tone of the Act continued to use derogatory terms like “lunatic”, “idiot,” and “insane,” contributing to stigmatization and ignoring the rights and dignity of mentally ill individuals. The Act was then repealed and replaced with the Mental Health Act 1983, the Mental Health Act 2007 and currently the National Mental Health Act 2021.

3.1.2 Mental Health Act 2021

In January 2023, a little over six decades after the Lunacy Act of 1958 was established, giving medical practitioners the power to detain people suffering from mental illnesses, President Muhammadu Buhari signed into law Nigeria’s Mental Health Bill, the National Mental Health Act, 2021.^{100,101} The Nigeria Mental Health Act 2021 represents a significant advancement in mental health legislation, replacing the outdated Lunacy Ordinance of 1958. This new law aims to protect the rights of individuals with mental disorders and enhance access to mental health services across various healthcare settings.¹⁰² Right to Humane Treatment (s.14–18) – Outlaws chaining, isolation without review, or cruel treatment; Right to Participation in Care (s.19–21) – Patients have the right to be informed, give consent, and participate in treatment planning; Right to Confidentiality (s.20) – Health records must remain private except in lawful

⁹⁸ *ibid*

⁹⁹ Chioma Obinna, Mental Health: Experts call for repeal of Lunacy Act. Vanguard. November 11, 2019. Available @ https://www.vanguardngr.com/2019/11/mental-health-experts-call-for-repeal-of-lunacy-act/?utm_source=chatgpt.com. accessed 25th Aug, 2025

¹⁰⁰ Aloysius Ugwu, Beti Baiye, From the Lunacy Act to the First Mental Health Act in Nigeria: Five Takeaways. Nigeria Health Watch. 2023. Available @ <https://articles.nigeriahealthwatch.com/from-the-lunacy-act-to-the-first-mental-health-act-in-nigeria-five-takeaways/>. Accessed 29th Aug, 2025

¹⁰¹ National Mental Health Act, § 46 (Nigeria), Act No. 46 (2021). Official Gazette No. 229, Vol. 109 (December 30, 2022).

¹⁰² Ozota, G. O., Sabastine, R. N., Uduji, F. C., & Okonkwo, V. C. (2024). Nigeria mental health law: Challenges and implications for mental health services. *South African Journal of Psychiatry*. <https://doi.org/10.4102/sajpsycho.v30i0.2134>

circumstances; Right to Freedom from Discrimination (s.15–17) – Protects against discrimination in education, employment, housing, healthcare; Right to Community Living (s.22–23) – Promotes integration into community care instead of long-term institutionalization; Oversight and Redress (s.30–32) – Provides appeal mechanisms and review tribunals for involuntary admissions.

3.1.3 Constitutional and human rights provisions

It is of note that Nigeria’s 1999 Constitution (as amended),¹⁰³ does not contain a specific section dedicated solely to “mental health”. Rather, the legal framework for protecting the rights of persons with mental health conditions is derived from general constitutional rights, particularly within Chapter IV: Fundamental Rights. Section 33: Right to Life, 34: Right of Dignity of Human Person, 43: Right of freedom from discrimination among others. These rights provide the constitutional foundation for mental health legislation such as the National Mental Health Act, 2021.

Other Nigerian Human Rights Provisions Relevant to Mental Health include the National Health Act, 2014.¹⁰⁴ In this Act, section 1: guarantees the right of all Nigerians to access basic minimum health services, while section 23 provides for patient rights, including informed consent, confidentiality, and non-discrimination. Moreso, the Disability Rights Legislation referred to as the Discrimination against Persons with Disabilities (Prohibition) Act, 2018,¹⁰⁵ explicitly prohibits discrimination against persons with disabilities (which includes

¹⁰³ Federal Republic of Nigeria. Constitution of the Federal Republic of Nigeria. 1999 (as amended)

¹⁰⁴ National Health Act, 2014, Act No. 8 of the Federal Republic of Nigeria, *Official Gazette* 145(101) (27 October 2014)

¹⁰⁵ Federal Republic of Nigeria. Discrimination against Persons with Disabilities (Prohibition) Act, 2018. Available @ <https://lawnigeria.com/2019/11/13/discrimination-against-persons-with-disabilities-prohibition-act-2019/>. Accessed on the 25th of Aug, 2025

psychosocial/mental disabilities). and aligns with the UN Convention on the Rights of Persons with Disabilities (CRPD).

The Child Rights Act, 2003, also protects children from neglect, abuse, and harmful practices (sections 11–14), and in section 13 grants the right to health and medical services. In essence, children with mental health conditions have both access to care and protection against stigma or harmful cultural practices.¹⁰⁶

3.2 OVERVIEW OF MENTAL HEALTH LAW IN SOUTH AFRICA

Mental health law in South Africa is underpinned by the Constitution and operationalised through the Mental Health Care Act 17 of 2002, which enshrines a rights-based, community-centred approach.^{107,108} South Africa's approach to mental health law is grounded in the Constitution of the Republic of South Africa, 1996, which is the supreme law of the country. The Bill of Rights guarantees dignity (section 10), equality (section 9), freedom and security of the person (section 12), access to health care (section 27), and children's rights (section 28). These provisions collectively provide a human-rights framework for the treatment and care of persons with mental illness. The Constitution aligns with South Africa's international obligations under instruments such as the UN Convention on the Rights of Persons with Disabilities (CRPD).

The Mental Health Care Act 17 of 2002 (MHCA), which came into force in 2004, is the primary legislation governing mental health care in South Africa.¹⁰⁹ It replaced the outdated Mental Health Act 18 of 1973, shifting the legal paradigm from custodial institutionalisation to a rights-based, community-oriented model. The key objectives of the MHCA include: Protecting

¹⁰⁶ Federal Government of Nigeria, *Child's Rights Act 2003* (Act No. 26), *The Federal Government*, Abuja.

¹⁰⁷ Republic of South Africa. 1996. Constitution of the Republic of South Africa. Act No. 108. Pretoria: SA Government

¹⁰⁸ Republic of South Africa. 2002. Mental Health Care Act. Act No. 17 of 2002. Pretoria: SA Government

¹⁰⁹ *ibid*

the rights of mental health care users; Regulating the care, treatment, and rehabilitation of persons with mental illness; Promoting integration of mental health services into general health services at primary, secondary, and tertiary levels; Establishing clear procedures for voluntary, assisted, and involuntary care, balancing individual rights with public safety and Providing for Mental Health Review Boards, which function as independent bodies overseeing decisions regarding involuntary admission, treatment, and patients' complaints.

The National Mental Health Policy Framework and Strategic Plan 2013–2020 (MHPF-SP 2013–2020) was officially introduced in 2013 as South Africa's first comprehensive mental health policy, aligning with the WHO Mental Health Action Plan and reflecting a strong rights-based approach.¹¹⁰ It was designed to operationalise the Mental Health Care Act of 2002, emphasising task-sharing and integration of mental health into primary health care.

Other complementary Legislation and Policies in South Africa that influence mental health care are the National Health Act 61 of 2003,¹¹¹ which provides the broader framework for health service delivery, including mental health; the Children's Act 38 of 2005,¹¹² which governs mental health care of minors; and the Criminal Procedure Act 51 of 1977 that provides for forensic psychiatric observation and treatment of mentally ill offenders.¹¹³

3.3 REGIONAL AND INTERNATIONAL FRAMEWORK

Both Nigeria and South Africa are bound by a shared set of regional and international frameworks that recognize and protect the rights of persons with psychosocial disabilities. Regional instruments include, among others, the African Charter on Human and Peoples' Rights

¹¹⁰ Republic of South Africa. Department of Health. 2013. National Mental Health Policy Framework and Strategic Plan 2013–2020. Pretoria: Department of Health.

¹¹¹ Republic of South Africa. 2003. National Health Act. Act No. 61 of 2003. Pretoria: SA Government.

¹¹² Republic of South Africa. 2005. Children's Act. Act No. 38 of 2005. Pretoria: SA Government.

¹¹³ Republic of South Africa. 1977. Criminal Procedure Act. Act No. 51 of 1977. Pretoria: SA Government

(ACHPR, 1981), and Protocol on the Rights of Persons with Disabilities in Africa (2018) among others.

The International framework includes, United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006), Universal Declaration of Human Rights (UDHR,1948), International convention on Economic, Social and Cultural Rights (ICESCR,1966), International Covenant On Civil and Political Rights (ICCPR,1966), World Health Organization (WHO) Guidance. These frameworks place obligations on both countries to ensure non-discrimination, dignity, access to mental health care, and inclusion for persons with psychosocial disabilities.

3.3.1. African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights (ACHPR, 1981),¹¹⁴ also known as Banjul charter, is an international human rights instrument that was created specifically for the African context, and it's intended to promote and protect human and peoples' rights as well as basic freedom across the African continent. It was adopted in 1981 by the organization of African Union, and established the African Commission on Human and people's rights (ACHPR) to monitor State compliance, interpret provisions and consider complaints from individuals and NGOs.

Both Nigeria and South Africa are signatories and state parties to the charter, meaning they are bound to implement its provisions in domestic law. The charter has been particularly important in the following ways.

Dignity and Equality: Article 2 guarantees freedom from discrimination based on "race, ethnic groups, colour, sex, language, religion, political or any other opinion, national and social

¹¹⁴ African Charter on Human and Peoples' Rights (Adopted 27 June 1981, entered into force 21 October 1986) OAU Doc. CAB/LEG/67/3 rev. 5; 21 I.L.M. 58 (1982).

origin, fortune, birth or other status" This interpretation covers disability as part of " other status" which is significant for psychosocial disabilities. Article 3, recognizes the right to equality before the law and equal protection.

Right to Health and well-being: Article 16 states that "every individual shall have the right to enjoy the best attainable state of physical and mental health". This is directly relevant to psychosocial disability, it obliges the state to protect health rights, established medical services and ensure access to care without discrimination.

Dignity, integrity and protection from exploitation: Article 5 protects dignity and prohibits torture, cruel, inhuman or degrading punishment/ treatment. This provision has been invoked against abusive practices in mental health institutions

Right to participate and inclusion: Article 13 provides that every citizen has the right to participate freely in government and public affairs, and Article 18(4) explicitly calls for " the aged and disabled" to receive special measures of protection.

However, on application, Nigeria ratified the charter in 1983, and under section 12 of the Nigerian constitution, treaties must be domesticated by an Act of the National Assembly to have force in Law. The African charter (Ratification and Enforcement) Act, cap A9, laws of the federation of Nigeria 2004 gives the charter direct applicability in Nigerian courts, especially the supreme Court and court of appeal, having relied on the charter to expand fundamental rights,¹¹⁵ particularly in where the constitution is silent¹¹⁶ as seen in the case of *Abacha v Fawehimi* where the supreme Court held that the charter, being domesticated, has the force of law in Nigeria and it's enforceable by citizens. This provides a legal pathway for

¹¹⁵ African Charter on Human and Peoples' Rights (Ratification and Enforcement)Act, Cap A9, Laws of the Federation of Nigeria 2004

¹¹⁶ n 52

persons with psychosocial disabilities to challenge discrimination or lack of access to mental health services as violations of Article 2,3, and 16.¹¹⁷

South Africa ratified the charter in 1996 after the end of apartheid. Unlike Nigeria, South Africa follows a monist approach where ratified treaties can influence constitutional law, provided they align with the Bill of Rights under the 1996 constitution. South Africa's constitution is already one of the most progressive in the world, with section 9 (equality), section 10 (dignity) and section 27 (health care) echoing the charter's provisions.¹¹⁸

For psychosocial disability, this framework strengthens claims for equal access to health care, non-discrimination and social inclusion. The (ACHPR) provides a regional normative doctrine that both Nigeria and South Africa are bound to respect; it serves as a binding regional framework for both countries, shaping their human rights obligations in relation to psychosocial disability.¹¹⁹ The uniqueness of the charter is remarkable because it integrates civil, economic, political, social, cultural and people's rights into one binding instrument, unlike the UN system, which separates them.¹²⁰

3.3.2. Protocol on the Rights of Persons with Disabilities in Africa (2018)

The protocol to the African charter on Human and People's Rights on the rights of persons with disabilities in Africa (2018) is the first binding regional treaty in Africa specialty dedicated to disability rights. It builds on the African charter on human and people's Rights (1981) and UN convention on the rights of persons with disabilities (CRPD), but adopts them to Africa's socio cultural context.¹²¹ The protocol emphasizes equality, dignity, non-discrimination, accessibility, inclusive education, healthy political participation and protection from harmful

¹¹⁷ Abacha v Fawehimi (2000) 6 NWLR(PT 600) 228 (SC)

¹¹⁸ n 56

¹¹⁹ n 63

¹²⁰ Odinkalu CA. Implementing Economic, Social and Cultural [rights] in the African Charter on Human and Peoples' Rights. Human Rights Law Journal. 2001;10:105.

¹²¹ African union, protocol to the African charter on Human and People's Rights on the Rights of Persons With disabilities in Africa, adopted 29 January 2018 (not yet in force)

practices, while requiring states to take legislative, policy and budgetary measures to promote and protect the rights of persons with disabilities, including those with psychosocial disabilities.¹²²

The African commission on Human and people's Rights (ACHPR) has also advanced disability rights through resolutions and guidelines, which serves as normative frameworks. Notably, it's resolution on the rights of persons with Disabilities in Africa (2013) urges member states to adopt stronger protection,¹²³ and the commission's role in drafting and promoting protocol underscore it's function as a key guardian of disability rights in Africa.¹²⁴

Together, the protocol and ACHPR resolution provide a regional framework that complements international standard while addressing African specific challenges such as poverty, stigma, harmful cultural practices and weak health systems in realization of rights of persons with disabilities.

3.3.3. United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006),

The United nations convention on the Rights of Persons With Disabilities,(UN CRPD) is an international human rights treaty, which exists to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all disabled persons.¹²⁵ It was adopted on 13 December 2006 the United Nations Headquarters in New York, and opened for signature on 30 March 2007.

The convention applies established human rights principles from the UN Declaration on Human Rights to the situation of persons with disabilities.¹²⁶ It covers civil and political rights to equal treatment and freedom from discrimination, social and economic rights in areas with

¹²² Viljoen F. and Biejon J, The protocol to African charter on Human and People's Rights on the Rights of Persons With Disabilities in Africa: A Commentary (Pretoria University Law Press 2021)

¹²³ African commission on Human and People's Rights (ACHPR), Resolution on the Rights of Persons With Disabilities in Africa (ACHPR/Res.275 (LV) 2014) adopted May 12 2014

¹²⁴ Odinkalu CA," The Role of the African Commission On Human and People's Rights in the development of International Human Rights Law in Africa (2001) 35 journal of African Law 182.

¹²⁵ n 1

¹²⁶ Universal Declaration of Human Rights, GA RES 217A (III), UN GAOR, 3rd Session, UN Doc A/810 (1948)

education, health care, employment and transport.¹²⁷ As of November 2024, the convention has been ratified by 191 parties (190 States and the European Union).¹²⁸ The convention is monitored by the committee on the Rights of Persons With Disabilities for which annual conference of states parties to CRPD have set guidelines since 2008.¹²⁹

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006 is the most important global framework for protecting and monitoring the rights of persons with psychosocial disabilities. It marked a paradigm shift from a charity or medical approach to disability towards a human rights based model. Psychosocial disability refers to disabilities arising from mental health conditions that affects a person's ability to participate fully in the society. The CRPD is particularly relevant because it recognizes psychosocial disability as part of the broad definition of disability and provides a binding framework for state parties to ensure equality, dignity and non-discrimination.¹³⁰ Recognition of psychosocial Disability under the CRPD is seen in Article 1, which defines persons with disabilities as including those with "long term physical, mental, intellectual or sensory impairment" This explicitly includes persons with psychosocial disabilities. The CRPD requires state parties to recognize that disability results not only from an impairment but also from barriers in society that hinder full participation. This social model is crucial for psychosocial disability since stigma, exclusion and lack of reasonable accommodation often worsen the situation more than the condition itself.

Key Rights Relevant to Psychosocial Disability include Article 5: Equality and non-discrimination guarantees equal protection under the law and prohibits discrimination on the bases of disability.

¹²⁷ Degener T, " A Human Rights Model of Disability" in Quinn G (ed) Disability and Human Rights (Oxford University Press 2020) 45

¹²⁸ United Nations Treaty Collection," Convention on the Rights of Persons with Disabilities" (Status as at November 2024)

¹²⁹ United Nations," Committee on the Rights of Persons With Disabilities (CRPD)" (UN OHCHR 2024)

¹³⁰ n 1

Article 12: Equal recognition before the law: This article affirms that persons with psychosocial disabilities have legal capacity.¹³¹ This challenges substituted decision making and promotes supported decision making.¹³² in Article 14, Liberty and security of persons, this article prohibits deprivation of liberty based solely on disabilities. This is particularly relevant given widespread practice of institutionalization or forced psychiatric detention. Article 19 mandates that persons with disabilities including those with psychosocial disabilities have the right to live in country with necessary support. Article 25 recognizes the right to the highest attainable standard of health without discrimination including access to mental health services that are respectful of autonomy and consent.¹³³ Article 26 is on Habilitation and Rehabilitation, this article calls for holistic rehabilitation programs that supports independence and participation, not only medical treatment.

Before CRPD, psychosocial disabilities were mainly addressed through mental health Law, emphasizing treatment, often coercive rather than rights. The CRPD reframed this by emphasizing, autonomy, participation and non-discrimination.

In monitoring and implementation, states that ratified the CRPD including Nigeria and South Africa are obliged to align domestic Laws and policies with its standards. The committee on Rights of Persons with Disabilities oversees compliance and provide General comments, such as General comment No 1 on article 12, which clarifies that denial of legal capacity on grounds of psychosocial disability is discriminatory.¹³⁴

However, UN CRPD has its principles in which it operates. Respect for inherent dignity, include autonomy and freedom to make one's own choice, and Non-discrimination, full and

¹³¹ Committee on the Rights of Persons With Disabilities, General comments No 1: Article 12-Equal Recognition before the Law, UN Doc CRPD /C/GC/I (19 May 2014)

¹³² G. Quinn, " personhood and legal capacity: Perspectives on the paradigm shift of Article 12 CRPD" (2010) 11 European Yearbook of Disability Law 3

¹³³ D.Kanter," The United Nations Convention on the Rights of Persons With Disabilities and it's implications for the Rights of Persons With Mental Disabilities in Africa" (2009) 27 Law in context 147

¹³⁴ A. Dhanda, " Legal capacity in the Disability Right Convention I: Strange ahold of the Past or Lodestar for the Future" (2006-07)34 Syracuse journal of international Law and commerce 429

effective participation and inclusion in the society, respect and acceptance of persons with disabilities as part of human diversity and humanity. Accessibility and equality are part of the principles.¹³⁵

3.3.4. Other International frameworks

The Universal Declaration of Human Rights (UDHR, 1948). The UDHR is the foundational international human rights instrument that guarantees the inherent dignity and equal rights of all persons.¹³⁶ For persons with disabilities, it provides a base for protection against discrimination and affirms right to equality, education, health, work and social security. Although not legally binding, it has inspired subsequent treaties and national constitutions that secure disability rights

Furthermore, the International Convention on Economic, Social and Cultural Rights (ICESCR) recognizes the right attainable standard of physical and mental health, education, work and social protection.¹³⁷ These provisions are particularly relevant for persons with disabilities, ensuring inclusion, rehabilitation and non-discrimination in accessing socio-economic rights. States are obliged to take progressive measures to guarantee these rights equally for persons with psychosocial and other disabilities.

3.4. RELEVANT CONSTITUTIONAL AND BILL OF RIGHTS PROVISION

Others are the Convention on the Rights of the Child (CRC), 1989, ratified by both. This recognises children's right to the highest attainable standard of health (Article 24), including mental health.

¹³⁵ T. Minkowitz, "The United Nations Convention on the Rights of Persons With Disabilities and the Rights to be free from non-Consensual Psychiatric Intervention" (2007) 34 Syracuse Journal of International Law and Commerce 405

¹³⁶ United Nations, Universal Declaration of Human Rights, G.A. Res. 217 A(III), UN Doc. A/ 810 (1948)

¹³⁷ United Nations, International Covenant on Civil and Political Rights, 999 U.N.T.S 171 (adopted 16 Dec 1966, entered into force 23 Mar. 1976)

It protects children with mental and psychosocial disabilities, ensuring non-discrimination, survival, development, and special assistance.

Both countries are also bound by African Union (AU) regional human rights treaties:

3.5. COMPARATIVE ANALYSIS ON THE IMPLEMENTATION OF PROTECTION FOR PERSONS WITH PSYCHOSOCIAL DISABILITIES

International framework (shared obligations)

Both South Africa and Nigeria are parties to the UN Convention on the Rights of Persons with Disabilities (CRPD) and so are bound by its rights-based approach to persons with disabilities, including psychosocial disabilities. South Africa ratified the CRPD on 30 November 2007; Nigeria signed on 30th of March 2007 and ratified on 24th of September 2010. The Practical implication is such that ratification creates international obligations (non-discrimination, legal capacity, liberty, health, community inclusion) that must be reflected in domestic law, policy, and practice, but ratification alone does not guarantee effective implementation.

According to the 2006 population and housing census, Nigeria's population was 140 431 790 and the methodology used to obtain statistical data on the prevalence of disability in Nigeria was through field interviews (National census). The total number of women with disabilities in Nigeria was 1,544,418 while children were 1.002 062.¹³⁸ The most prevalent form of disability in Nigeria includes Visual impairment, Hearing impairment, Physical impairment, Intellectual impairment, and Communication impairment.¹³⁹

¹³⁸ National Population Commission. (2010). Census priority table: 2006 population distribution by sex and class size of household, state and local government area table HH (ADD 1) (Vol. IX). Federal Republic of Nigeria Official Gazette, No 2, Vol 96, Abuja. (Original work published in gazette on February 2, 2009)

¹³⁹ Interview source from Mrs Comfort Nnaji, principal planning officer, ministry of Women Affairs and Social Development Imo State Nigeria': CC Opara, Principal Assistant Social Welfare Officer I, Ministry of Women Affairs and Social Development Imo State.

Similarly, according to the 2022 population census, South Africa's population was 62,027,503, and the methodology used to obtain statistical data on the prevalence of disability in South Africa was through a multi-mode data collection, with the total number of people with disabilities aged 5 years and above being 3,299,714. The most prevalent forms of disability in South Africa include Visual impairment, Physical impairment, Intellectual impairment, Hearing impairment, and Communication impairment.¹⁴⁰

3.5.1: An overview of Domestic legislative frameworks

In South Africa, the Mental Health Care Act 17 of 2002 remains the primary statutory instrument regulating mental health care, involuntary admission, treatment, review boards, and patients' rights. The Act uses a "user-centered" vocabulary but retains procedures for involuntary treatment and review mechanisms.¹⁴¹

Constitutional protections (sections on equality, dignity, freedom and security of the person, and fair trial rights) and Constitutional Court jurisprudence strongly shape the interpretation and constitutional compliance of mental health law.¹⁴²

Historically in Nigeria, it was governed by colonial-era Lunacy statutes and criminal law provisions that reflect an older medical/forensic model, the National Mental Health Act (the "National Mental Health Act 2021" which was assented in 2023 into practice, replaces the Lunacy Act framework and is explicitly framed to protect the rights of persons with intellectual, psychosocial and cognitive disabilities, create institutional structures, and modernize standards. The Act aims to promote rights, regulate services, and establish oversight.¹⁴³ The Practical implication is such that South Africa's legal architecture is older but heavily shaped by

¹⁴⁰ *ibid*

¹⁴¹ Szabo CP, Kaliski SZ. Mental health and the law: a South African perspective. *BJPsych Int.* 2017 Aug 1;14(3):69-71. doi: 10.1192/s2056474000001951.

¹⁴² De Vos NO and Others v Minister of Justice And Constitutional Development and Others [2015] ZACC 21 (26 June 2015)

¹⁴³ Akanni OO, Edozien LC. The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely? *Niger Med J.* 2024 Feb 22;64(6):838-845. doi: 10.60787/nmj-64-6-351. PMID: 38979056; PMCID: PMC11227633

constitutional litigation and a rights discourse; Nigeria's new Act is a major statutory reform but faces implementation and capacity challenges (laws without equivalent resources/administration).¹⁴⁴, ¹⁴⁵

Substantive areas (statutory design vs real-world practice)

Involuntary admission, review, and liberty safeguards

- **South Africa:** The Mental Health Care Act provides stepwise procedures for assessment and temporary admission, and establishes Mental Health Review Boards to review involuntary admissions. The Constitutional Court in *Makana* (ZACC, 2023) scrutinized whether the Review Boards' design and the Act's scheme sufficiently protect liberty and require independent review; the Court confirmed the high importance of prompt and independent oversight while engaging with resource realities. *Makana* shows the Court's willingness to require procedural safeguards consistent with constitutional rights.¹⁴⁶
- **Nigeria:** The National Mental Health Act formalizes rights and contains provisions on involuntary admission and safeguards, but implementation is in early stages, and the historic practice has been that detention/placement decisions often reflect medical/administrative discretion with weak independent review. Reports and academic reviews emphasize gaps between statutory protections and practice (limited review mechanisms, overcrowding, and few community alternatives).¹⁴⁷ In effect, South Africa has more established review mechanisms and an active constitutional jurisprudence enforcing procedural safeguards; Nigeria has an improved legal framework on paper, but faces larger implementation bottlenecks.

¹⁴⁴ Makana People's Centre v Minister of Health & Others (CCT 125/22) [2023] ZACC 15; 2023 (8) BCLR 963 (CC); 2023 (5) SA 1 (CC) (9 June 2023)

¹⁴⁵ Yesiru A, KareemYesiru A, KareemUmar B, et al, An x-ray of the National mental health act 2021 of Nigeria: opportunities, limitations and the way forward. West African Journal of Medicine. 2023; 40(12 Suppl 1):S43

¹⁴⁶ *ibid*

¹⁴⁷ n 92

Legal capacity, supported decision-making and criminal procedure

CRPD standard emphasizes equal legal capacity and the need for supported decision-making rather than substituted decision-making. States are expected to eliminate discriminatory practices that deny legal capacity to persons with psychosocial disabilities.

South Africa (cases & practice): *De Vos N.O. v Minister of Justice and Constitutional Development* (De Vos, 2015, CCT 150/14) tackled detention of persons unfit to stand trial and declared parts of the Criminal Procedure Act unconstitutional where they led to automatic detention without individualized consideration; the Constitutional Court reformed the approach to ensure that detention is not automatic and that less-restrictive measures must be considered. This case shaped the balance between fair trial needs and the liberty of persons with psychosocial or intellectual disabilities.

Nigeria (criminal law): The Nigerian criminal jurisprudence continues to rely on common-law formulations (insanity/unsoundness of mind). The Supreme Court's decision in *Madjemu v The State* (2001) remains authoritative on the burden and proof of insanity: Nigerian courts tend to treat claims of insanity with caution and apply evidentiary standards that often disadvantage accused persons with psychosocial disabilities. Recent scholarship documents the forensic emphasis and limited use of alternatives to prosecution or diversion. This affects the protection of persons with psychosocial disabilities in the criminal justice system.¹⁴⁸ The net effect is that South African courts have moved toward a rights-conscious balancing (De Vos), whereas Nigerian courts remain largely within traditional criminal law paradigms—though the new Mental Health Act opens room for reform in practice.¹⁴⁹

¹⁴⁸ Daniel Madjemu v The State, (2001) 9 NWLR (Pt. 718) 349

¹⁴⁹ Ogunwale A, Pienaar L, Oluwaranti O. Plausible subjective experience versus fallible corroborative evidence: The formulation of insanity in Nigerian criminal courts. *Front Psychiatry*. 2023; 9;14:1084773. doi: 10.3389/fpsy.2023.1084773.

Community-based care, non-discrimination and access to services

The South Africa policy documents and the MHC Act emphasise community care and parity in standards, but health system resource constraints, uneven provincial implementation, and service gaps (especially in rural areas) persist. The Constitutional Court and academic literature repeatedly flag implementation shortfalls despite good legislative design.¹⁵⁰

In Nigeria, the National Mental Health Act explicitly requires the development of community mental health services, rights education, and anti-discrimination measures, a big normative advance. However, practical problems include a limited mental health workforce, funding, stigma, weak enforcement, and slow institutionalisation of oversight structures (bodies, guidelines, budgets). Scholarly reviews stress that law reform is necessary but not sufficient.¹⁵¹

Leading cases (short summaries with legal significance)

- *Makana People’s Centre v Minister of Health & Others* [ZACC 15/2023] (Constitutional Court, South Africa, 2023) — critical review of Chapter IV of the Mental Health Care Act (Review Boards and procedures for involuntary detention). The Court examined whether automatic or insufficiently independent review undermines liberty rights and confirmed the need for timely, independent oversight and proportionality in involuntary treatment.
- *De Vos N.O. & Others v Minister of Justice and Constitutional Development* [2015] ZACC 21 (South Africa) — addressed detention of accused persons unfit to stand trial and limited automatic detention orders; the Court required individualized decisions and alternatives to automatic imprisonment consistent with constitutional rights to liberty and fair trial.

¹⁵⁰ Meghan Hussey, Malcolm MacLachlan, Gubela Mji, Barriers to the Implementation of the Health and Rehabilitation Articles of the United Nations Convention on the Rights of Persons with Disabilities in South Africa. *international Journal of Health Policy and Management*. 2017;6(4): 207-21

¹⁵¹ n 94

- Daniel Madjemu v The State (2001) (Supreme Court of Nigeria) — leading Nigerian authority on the insanity defence (proof and evidentiary requirements). The decision shows how Nigerian criminal courts have historically approached claims of insanity/unsoundness, often requiring robust evidence and sometimes discounting the accused’s own account absent expert corroboration. This has implications for persons with psychosocial disabilities in the criminal justice system.¹⁵²

Conclusion on the Implementation Gaps

As regards Law vs practice gap, South Africa: relatively mature rights discourse plus her active constitutional jurisprudence results in stronger legal remedies, yet implementation is inconsistent across provinces (resources, service coverage, staffing) while Nigeria’s has substantial recent statutory reform (National Mental Health Act) but low administrative capacity, weak oversight mechanisms in practice, funding and human resources constraints make implementation slow.

As regards Detention and review safeguards, South Africa: judicial decisions (Makana; De Vos) have pressed for stronger safeguards and individualized review, while Nigeria’s statutory safeguards exist on paper, but independent review bodies and timely judicial oversight are less entrenched in practice

In terms of Criminal justice responses, South Africa’s courts have moved to guard against automatic detention, require fair procedure and consider less-restrictive options. Nigerian courts still apply common law frameworks that may inadequately protect persons with psychosocial disabilities; the need for stronger diversion, supported decision-making and mental health diversion programmes is highlighted in the literature.

¹⁵² n 98

As regards Community care and resources, both countries require major investment in community mental health services; South Africa has better policy continuity but faces resource strains; Nigeria must operationalize new institutional mandates and allocate budgets.

CHAPTER FOUR

BALANCING RIGHTS, AUTONOMY, AND TREATMENT IN PRACTICE

4.1. TENSION BETWEEN INVOLUNTARY TREATMENT AND AUTONOMY

Involuntary treatment in mental health remains one of the most contentious aspects of modern health care law, raising complex questions about personal liberty, autonomy, and societal protection.¹⁵³ Involuntary treatment generally refers to the use of psychiatric interventions, including hospitalization and medication, without the consent of the individual. Such interventions are typically authorized under a mental health status when individuals are assessed as posing a serious risk to themselves or others or are deemed incapable of making informed decisions due to severe mental disorders.¹⁵⁴ Autonomy is the right of individuals to make informed, uncoerced decisions about their own lives and bodies, in health care ethics. Antinomy is central, often expressed in the need for informed consent.¹⁵⁵

The tension between these two concepts can be seen in different ways. The legal foundation of involuntary mental health treatment is deeply rooted in the evolution of psychiatric care and social control mechanisms. The emergence of mental health legislation in the 19th century to protect the individual and society from dangers associated with mental health conditions was a guide.¹⁵⁶ Statutes like UK's Lunacy Acts and similar laws in other jurisdictions authorized confinement in an asylum based on medical certificates with minimal procedural safeguards. These ancient laws reflected some approaches, like a paternalistic approach, prioritizing containment and custodian care over individual autonomy and due process.

¹⁵³ Callaghan Sascha, Ryan Christopher James. Is There a Future for Involuntary Treatment in Rights-based Mental Health Law? *Psychiatry, Psychology and Law*/ 2014 25(5):744-766

¹⁵⁴ Saya, A., Brugnoli, C., Piazzini, G., et al.(2019). Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry around the World: A Narrative Review. *Frontiers in Psychiatry*, 10, 271. <https://doi.org/10.3389/fpsy.2019.00271>

¹⁵⁵ Laureano CD, Laranjeira C, Querido A, Dixe MA, Rego F. Ethical Issues in Clinical Decision-Making about Involuntary Psychiatric Treatment: A Scoping Review. *Healthcare (Basel)*. 2024;12(4):445. doi:10.3390/healthcare12040445

¹⁵⁶ Nolan Peter. Approaches to mental health care in 19th and early 20th-century England. *British Journal of Mental Health Nursing*. 2022; 11(4):1-7. DOI: 10.12968/bjmh.2022.0033

In consent and capacity, consent given under coercion isn't true consent and if a patient has decision-making capacity, forcing treatment violates his right to decision. Involuntary treatment is justified when sometimes patients are assessed to lack capacity due to psychosis, severe mental conditions, and so, are considered unable to make informed decisions. Meaning that involuntary treatment is seen as necessary for their protection.

At the heart of the ongoing debates on involuntary treatment lies a fundamental tension between patients' autonomy and public safety. On one hand, autonomy is a cornerstone of medical ethics and legal systems entitling individuals to make decisions about their own bodies and health care.¹⁵⁷ Autonomy requires that treatment be based on informed consent, even in cases of severe illness. On the other hand, it has been justified by the government that involuntary treatment is a means of protecting individuals from self-harm or deterioration and safeguarding others from the results in the restrictions of liberty for individuals diagnosed with psychosocial conditions as lacking decision making capacity.¹⁵⁸ The tension is further compounded by concerns regarding the effectiveness, fairness and discriminatory impact of involuntary treatment laws. Critics argue that such laws disproportionately target people with psychological disability, perpetuate social stigma, and fail to provide adequate therapeutic benefit.¹⁵⁹ Furthermore, there are concerns about the overuse of coercive measures, such as physical restraints, forced medication, and prolonged institutionalization, which can cause psychological harm and undermine trust in health care systems. Over the years, the international human rights standards have been calling for reforms. The notable international instrument, the United Nations Convention on the Rights of Persons with disability, has been particularly influential in challenging traditional mental health laws. It recognizes legal

¹⁵⁷ Varelius J. The value of autonomy in medical ethics. *Med Health Care Philos.* 2006;9(3):377-388. doi:10.1007/s11019-006-9000-z

¹⁵⁸ Carney T, Yager J, Maguire S, Touyz SW. Involuntary Treatment and Quality of Life. *Psychiatr Clin North Am.* 2019;42(2):299-307. doi:10.1016/j.psc.2019.01.011

¹⁵⁹ Wickremsinhe MN. Emergency involuntary treatment law for people with mental disorders: A comparative analysis of legislation in LMICs. *Int J Law Psychiatry.* 2018;56:1-9. doi:10.1016/j.ijlp.2017.09.003

capacity, autonomy, and rights to equal recognition before the Law, explicitly questioning the legitimacy of involuntary treatment based on disabilities related grounds. CRPD advocates for supported decision-making as an alternative to substitute decision-making, promoting a global reassessment of mental health legislation.

Risk of harm to self or others is another tension seen in involuntary treatment and autonomy as regards persons living with psychosocial disabilities. Among others, one of the primary groups for involuntary hospitalization is the presence of an imminent risk that the person will cause serious harm to themselves or others. These risks may include suicidal behavior, threats or acts of violence, or inability to care for oneself to the point of physical deterioration. Generally, these risks must be substantial or immediate, not speculative, to justify deprivation of liberty. This "dangerousness" criterion aims to protect both the individual and society while providing a threshold for intervention that is neither arbitrary nor overly broad.

In capacity and consent, severe Mental Disorder Impairing decision making in many jurisdictions, most especially Nigeria and South Africa, requires that the individual suffer from a recognized mental disorder or Psychosocial disability that impairs their capacity to make informed decisions regarding treatment. Notably, this criterion acknowledges that some individuals may lack the cognitive ability or insight necessary to understand the consequences of refusing treatment. For it to be acceptable, the diagnosis must be clinically confirmed by a qualified mental health professional, ensuring that involuntary treatment is targeted towards persons genuinely in need of care, rather than used as a tool of social control.¹⁶⁰ This criterion seeks to create a balance between respecting personal autonomy and addressing the realities of severe mental or psychosocial illness that may temporarily diminish one's ability to make safe

¹⁶⁰ Cave E. Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships, and Risk. *Med Law Rev.* 2017;25(4):527-553. doi: 10.1093/medlaw/fww046.

choices. The process of initiating involuntary treatment is governed by detailed statutory procedures designed to ensure that the decision to override consent is legally justified and subject to periodic review. Notification of the Right information upon initiation of involuntary treatment, the patient must be informed of the reasons for their detention, their rights, and the avenue for appeal. These requirements ensure transparency and allow patients to understand the legal basis for deprivation of liberty. Generally, patients have the sole right to appeal involuntary treatment decisions to higher courts or specialized mental health tribunals. Mental health commission or independent bodies may be empowered to investigate complaints about coercion, treatment conditions or rights violations. The protection of patients from excessive or unnecessary coercion is the safeguard against abuse, and legal frameworks. These include the outright requirement for treatment to be proportionate and in the patient's best interests, restrictions on the application of physical restraints, mandates for regular re-evaluation, and forced medication. In care delivery, the need for respect and dignity is reinforced as ethical guidelines and professional codes.

Confidentiality and privacy, to protect patients or persons living with mental health or psychosocial disabilities, is another tension. Involuntary treatment statutes also address the sensitive nature of mental health information, while balancing the need for clinical communication with the protection of patients' privacy. Safeguards can be seen to regulate who can access a psychosocial or mental health patient's records and under what circumstances. To reconcile competing imperatives, respecting individuals' autonomy while ensuring health and safety in the context of severe psychosocial disabilities, the reflection lies on the legal framework governing involuntary treatment. The common criteria of risk of harm and impaired decision-making capacity provide the substantive basis for intervention, while statutory

procedures and judicial oversight established procedural rigor and accountability.¹⁶¹ Despite these safeguards, involuntary treatment remains ethically and legally challenging, requiring continuous assurance that the rights and dignity of patients are upheld without compromising the necessary care and protection that mental health or psychosocial disability crises may demand.

In the international human rights standard, the global discussion on mental health Law has witnessed a notable transformation in recent decades, driven largely by evolving human rights standards that challenge traditional practices of involuntary treatment known before now.¹⁶² Central to this shift is the United Nations Convention on the Rights of Persons with disability (CRPD), a landmark international treaty that fundamentally reframes disability issues from welfare and charity concerns to matters of human rights and dignity. However, involuntary treatment in mental health care or psychosocial disability carriers' critical intersection of clinical protection, ethics, and laws, and raises profound questions about individuals' autonomy and justice. With the intention of protecting both the individuals and the society, involuntary treatment challenges fundamental human rights principles, particularly those related to liberty and informed consent. The debate on involuntary treatment lies in the tension between respecting a person's autonomy and ensuring their safety and that of others.

Balancing these competing values is inherently complex, too much emphasis on autonomy may lead to neglect of vulnerable individuals unable to seek help or redress, and excessive focus on protection risks paternalism, loss of liberty, and erosion of trust in mental health. Consent and legal capacity in autonomy is ascertained when a patient has decision-making capacity; forcing treatment violates their rights to make decisions. Also, consent given under coercion isn't

¹⁶¹ Bingham SL. Refusal of treatment and decision-making capacity. *Nurs Ethics*. 2012;19(1):167-172. doi:10.1177/0969733011431925

¹⁶² Macgregor A, Brown M, Stavert J. Are mental health tribunals operating in accordance with international human rights standards? A systematic review of the international literature. *Health Soc Care Community*. 2019;27(4):e494-e513. doi:10.1111/hsc.12749

consent. Considering the risk to self or others, a psychosocial disability patient may want to refuse treatment even if there is a serious risk. Respecting autonomy means allowing harm if that is their choice but within limit

Beneficent with autonomy is respecting autonomy and sometimes allowing a patient to refuse treatment, even when health care providers believe treatment would prevent suffering. Using voluntary treatment is often paternalistic, assuring the patient cannot decide for themselves and substituting the health worker's judgement. Coerced treatment can damage trust, leading to feelings of violation, trauma, stigma, and possibly reducing engagement with care in the long run. International human rights has increasingly emphasized that involuntary treatment should be minimized, consent should be central, and coercion should be tightly regulated. However, there are arguments for and against this tension.

To argue for, in certain mental health or psychosocial disability crises, patients may be unable to understand or appreciate the consequences of refusing treatment due to impaired capacity. To prevent harm to the patient or others is also an important point to argue for. Sometimes the harm of not treating physical deterioration, self-neglect, and risk of suicide is seen as outweighing the infringement on autonomy, and lastly, social responsibility and public safety. Conversely, to argue against, the following points will be considered. Violation of the person's right to self-determination, potential for abuse or misuse, as in wrongful commitment, stigma, forced treatment that the patient finds harmful. Coercion can also damage trust with health care providers, discourage help seeking, and lastly, legal and moral requirements, even among individuals with impaired capacity, forced treatment must meet stringent ethical and legal standards.

Furthermore, autonomy and involuntary treatment can be well balanced in the following ways: Having advance directions or prior expression of wishes about treatment in anticipation of

times when a patient might lose capacity; ensuring capacity assessments are rigorous, transparent, and fair; and using coercion as a last resort and minimizing the duration and severity of coercion. Others are involving patients as much as possible, even when involuntary treatment is being considered; establishing a regular review mechanism, oversight with the possibility to appeal, and providing post-treatment debrief and psychological support to mitigate trauma.

Bringing it down to South Africa, the Mental Health Care Act 17 of 2002 (SA) establishes procedures for voluntary and involuntary admission, criteria for involuntary care, and the use of review boards and safeguards. It adopts a large functional approach to capacity, different procedures and safeguards exist, and involuntary admission requires formally prescribed criteria and review. South African courts have been called upon to reconcile statutory schemes, human rights, including the constitution, and CRPD obligations. The Makana People Centre/Life Esidimeni litigation and related constitutional court material highlights how failures of statutory safeguards and poor implementation can produce catastrophic violations of autonomy and life. The court has emphasized the need for compliance with statutory procedural safeguards and scrutiny where deprivation of liberty and involuntary treatment occur. South African Law highlights its evolution from a custodial status-based model towards more rights-respecting, functional approaches, but there are implementation gaps and contested interpretations of autonomy in practice.

Historically, Nigeria long operated under colonial era laws, eg, the lunatic Act 1958, which were status-based and often failed to protect autonomy or provide adequate safeguards. That regime made both involuntary confinement and treatment easier and gave rise to human rights concerns. The Nigeria Mental Health Act 2021 is a major statutory overhaul. It lays out criteria for involuntary treatment/ admission, requires safeguards, and contains express provisions on

informed consent and involuntary care, indicating movement towards functional criteria and improved protection.

4.2 INSTITUTIONAL PRACTICES IN NIGERIA AND SOUTH AFRICA

By institutional practices, it means the structures, law facilities, norms, and routines used by state and quasi-state actors to provide care, admit, detain, or treat persons with psychosocial disabilities. These facilities and structures include Psychiatric hospitals, general hospitals, faith and traditional healing centers, NGOs, and regulatory or oversight mechanisms.

In Nigeria, the relevant statute was the colonial era Lunatic Act (1958) and the earlier ordinances, which focused on detention and custodial care. In January 2023, the National Mental Health Act was introduced to replace the old provisions and to provide an explicit rights, service delivery, and governance framework. The Discrimination against Persons with Disabilities (Prohibition) Act provides anti-discrimination protection for persons with disabilities. The change from Lunacy's "custodial" orientation to an Act focused on rights, community care, and governance is a legal turning point, but enactments, full implementation, and gaps remain at the facility and community levels.

Psychiatric Hospitals in Nigeria.

Federal Neuro Psychiatric Hospital

Is it located at Yaba, Lagos state, commonly known as "Yaba Left". was established in 1907 as the Yaba asylum during the colonial era, and is the oldest refined psychiatric institution, and remains a principal federal neuropsychiatric referral centre in Lagos. Over time, its name was changed from Yaba Lunatic Asylum to Yaba Mental Home, and then finally to Yaba Psychiatric Hospital. ^{163,164,165}

¹⁶³ Wikipedia contributors, Federal Neuropsychiatric, Yaba (Wikipedia last edited 26 June 2025)

¹⁶⁴ Afolabi SO, From Asyto Psychiatric Hospital: 113 Year Journey of "Yaba Left Daily Trust ",14 June 2025

¹⁶⁵ Ogunlesi AO et al, Yaba psychiatric Hospital: 110 Years of Restoring Hope To Mentally ill Persons(Vanguard News,18 March 2018)

Yaba psychiatric provides both outpatient and inpatient care, emergency services for both old and children. It also hosts continuing professional education programs and collaborates with academic centres in Lagos for training. As an old federal psychiatric hospital in a major urban place in Lagos City, it has historically been a training ground for psychiatric nurses, medical officers, and other mental health workers. It also collaborates with the university around the state for service development. However, Yaba has been notable for efficiency as regards psychosocial disorders.

Yaba custodial history means institutional practices must be read against a legacy of containment. Although service at Yaba has become more clinical and rights-oriented, resource and governance gaps create conditions where involuntary admissions, long stays, and limited community alternatives remain issues to address.¹⁶⁶

Neuropsychiatric Hospital. Aro, Abeokuta. Ogun state.

The origin of Aro dates back to 1944, and it was developed into a purpose-built psychiatric hospital. It rose to international prominence through Professor Thomas Adeoya Lambo's leadership and the development of "Aro Village." Aro is known for its influential community-oriented system that combines inpatient day hospital care with foster family and village-based after care. Aro also operates as a federal institution with a tripartite mandate, clinical service delivery, training of mental health cadres, and research.¹⁶⁷ Aro most significant contribution to psychiatric institutional practice is the Aro Village system, a hybrid model that decentralized convalescent care to community and foster settings, reduced long stay institutionalization, and strengthened social reintegration. The model influenced WHO, thinking on community mental health and remains a key historic example when arguing for deinstitutionalization and community-based alternatives in Nigeria. Aro also has a centre for Psychiatric nursing training

¹⁶⁶ n164

¹⁶⁷ Federal Neuropsychiatric Hospital, Aro Abeokuta. Ogun, Official Website: History and Service Overview (2023). Available @ <https://portal.neuroaro.gov.ng/>

and operational research on community care models. The capacity of Aro is a large one with over 700 beds, and as for institutional practice, it can be recognized towards community care, yet the Aro Village model also shows limits when institutional support, supervision, and adequate community resources are absent.¹⁶⁸

Federal Neuro Psychiatric Hospital, Enugu.

Enugu psychiatric hospital was founded in the Early 60s as an outpatient unit associated with the general hospital in Enugu and later expanded to a full federal neuro-psychiatric hospital in the 70s. It is the principal federal psychiatric resource for the South East geographical zone and functions as a referral, training, and specialist treatment centre for those with mental and psychosocial disorders. Enugu provides inpatient and outpatient psychiatric services, emergency care, and specialist clinics for psychosocial disband serious mental cases. Like other federal psychiatric hospitals, Enugu also has a training center for nurses and other mental health workers. In institutional practices, Enugu practice shapes access to specialist care in the southeast. Following up can increase the length of stay and pressure on the patients in the wards, reinforcing an international practice that must be countered through investment in primary health care.¹⁶⁹

South Africa aimed for large custodial psychiatric institutions from the colonial and apartheid era. Valkenberg Hospital, Cape Town, Sterkfontein Hospital, Johannesburg, Weskoppies Hospital, Pretoria, and many others are psychiatric hospitals found in South Africa. They were designed primarily for segregation and long-term confinement rather than rehabilitation.

Under the South Africa Mental Health Care Act 2022, these hospitals are classified as specialized psychiatric facilities with the provision of long-term care for severe and chronic mental and Psychosocial disorders, forensic psychiatric services with the assessment of

¹⁶⁸ Asuni T, Aro Mental Hospital in Perspective: A Commemoration Volume in Honor of Professor Adeoye Lambo, ed. O.A. Esan (Ibadan) University Press, 1967; 45-56

¹⁶⁹ Federal Neuropsychiatric Hospital, Enugu, Official Website: History and Service Overview. Available @ <https://fnhe.gov.ng/>

criminal responsibility and state patients, and lastly, specialized services, eg, children and adolescent psychiatric or psychosocial disorders. Furthermore, the institutional role of South Africa in psychosocial disabilities is that the psychiatric hospitals still play a significant role as referral centres for severe cases, but South Africa's policy has transformed them as part of a place of care rather than the dominant form of treatment.¹⁷⁰

General Hospitals

Under the Mental Health Care Act 2002, the integration of mental health into the general health services at the general hospitals is a major reform, stating that in South Africa, mental health services should be available at the district and regional general hospitals, making psychiatric care more accessible. The nature of services in South African general hospitals is as follows:

- 1 Short-term inpatient psychiatric wards or observation units.
2. Most general hospitals in South Africa are known for the provision of integrated care, combining physical health services and psychiatric thereby reducing stigma.
3. Outpatient clinic for diagnosis, treatment, and follow-up

The institutional role is that, in South Africa, the general hospital represents an important step away from custodial psychiatric ensuring that persons with psychosocial disabilities can access mental health care in mainstream health facilities. This helps to reduce stigma, and it also aligns with South Africa's constitutional commitment to equality, dignity, and access to health care.

In South Africa, NGOs are central to mental health service delivery, often contracted by the provincial government to community residential care facilities. Yet, there are lapses like weak regulation, as seen in the life of Esidimeni, exposing the dangers of over-reliance without adequate oversight.¹⁷¹ However, South African's traditional healers, also known as the "Sangomas and herbalists," are legally recognized under the Traditional Health Practitioners

¹⁷⁰ Gillis LS, The Hospital Development of psychiatric interventions in South Africa since 1652. *South Africa Journal of Psychiatry*. 2012; 18(3): 79-85)

¹⁷¹ Patel V et al, *Mental Health Policy and Service Guidance Package: South Africa Case Study* (World Health Organization, 2009)

Act 2007. Many South Africans consult them alongside biomedical services, but their integration into mainstream psychiatric care is still controversial, and harmful practices among them remain a concern.

Comparative analysis of the institutional practices.

According to Law and practice, South Africa has a stronger statutory framework, which is the Mental Health Care Act, and secondly, the explicitly constitutional rights to dignity and equality. While Nigeria has modernized its mental health Laws (2023) recently, but still waits for their implementation to bring systematic changes and continues to contend with entrenched custodial practices and unregulated healing centers.

In Oversight and accountability, South Africa's statutory review/oversight institutions and the Life Esidimeni arbitration, which strengthened accountability discourse, have offered clearer remedial paths than Nigeria's historically fragmented oversight. However, both countries face challenges of enforcement, monitoring of resources allocated.

The role of non-state institutions is a major part of Institutional ecology, and a primary site for human rights violations, like chaining and seclusion, is the unregulated faith/ traditional healing places in Nigeria. While in South Africa, NGO partners are likely to operate regulated frameworks, yet poor contracting and monitoring can still cause harm.

Lastly, there is the movement to community care, where both countries, with the help of WHO guidance, emphasize community-based recovery-oriented services and integration with primary care. Nigeria has promising pilots and Community-Based Rehabilitation (CBR) models, but scale-up is slow, while South Africa has a 2023- 2030 policy that is explicitly aimed at implementing this shift, but resources are the lifeblood.¹⁷²

¹⁷² Peterson I et al. Barrier to the Participation of People with Psychosocial Disabilities In Mental Health Policy Development in South Africa. A Qualitative Study of Perspectives of Policy Makers, Professionals, Religious Leaders, and Academics. BMC International Health and Human Rights:2013; 13(17)::1-12

4.3 CASE LAW ANALYSIS (DOMESTIC AND REGIONAL)

To appreciate the judicial and normative approaches to balancing treatment, autonomy, and rights of persons with psychosocial disabilities, it is crucial to identify some international, regional, and domestic case laws. Internationally, courts have adopted some relevant case laws; the regional courts, such as the African Commission, the European Court of Human Rights, and the Inter American courts, have also adopted transitional positions, permitting compulsory treatment under strict safeguards.¹⁷³

Domestically, South Africa has moved closer to CRPD compliance by constitutionalizing equality, dignity, and freedom from mental health law.¹⁷⁴ In contrast, Nigeria continues to exhibit a treatment-driven orientation with limited judicial oversight.¹⁷⁵

In the Grand Chamber case of *Ilmseher v. Germany*,¹⁷⁶ there were references to the observations of the UN Human Rights Committee (report of Germany), the UN Committee against Torture (CAT); the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment, report of the Commissioner for Human Rights of the CoE. References to these instruments and supervisory bodies have been made in cases on alleged violations of Articles 2 (the right to life), 3 (prohibition of torture and inhuman and degrading treatment) and 5 (right to liberty and security) – classical civil rights, and that is why there were not so many references to the Revised/European Social Charter and reports of the European Committee of Social Rights.

However, in a significant number of cases examined also under Article 3, the Court has referred to the European Social Charter. Thus, in the Grand Chamber case of *Paposhvili v. Belgium*,¹⁷⁷

¹⁷³ Minkowitz, Tina, “The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions,” *Syracuse Journal of International Law and Commerce* 34 (2007): 405–428.

¹⁷⁴ n 107

¹⁷⁵ n 103

¹⁷⁶ *Inseher v Germany* (2017) Application No 11261/11, ECtHR 4 May 2017.

¹⁷⁷ *Paposhvili v Belgium* (2016) Application No 41738/10, ECtHR 13 Dec 2016.

a case involving the proposed deportation of a seriously ill person to Georgia, the Court based its findings, *inter alia*, on the information referred to in the European Committee of Social Rights' conclusions in assessing the conformity of the Georgian health-care system with Article 11 of the European Social Charter (the right to protection of health). In *Paposhvili*, the Court specified that in addition to situations of imminent death, there might be "other very exceptional cases" where the humanitarian considerations weighing against removal were equally compelling (section 183): "situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy.

In many cases where the Court has found a violation of Article 8 (right to private and family life) and Article 1 of Protocol No. 1 (Protection of property), the Court has also made reference to the Revised/European Social Charter and to a certain extent to the case-law of the European Committee for Social Rights. Thus, in the Grand Chamber case of *Béláné Nagy v. Hungary*,¹⁷⁸ the Court made reference not only to Articles 12 and 15 of the European Social Charter, but also to the case-law related to the assessment of compliance with the Charter, as reflected by the conclusions adopted by the European Committee of Social Rights (Hungary has ratified both the ESC and the RESP and declared itself bound by paragraph 1 of Article 12 and by Article 15). It goes without saying that the Court also referred to the UN Convention on the Rights of Persons with Disabilities and ILO Convention no. 102 on Social Security (Minimum Standards) and ILO Convention no. 128 on Invalidity, Old-Age and Survivors' Benefits. The case-law on persons with disabilities from the perspective of health may be divided between

¹⁷⁸ *Belane Nagy v Hungary* (2016) Application No 53080/13, ECtHR 13 Dec 2016

the context of police custody or prison and situations outside that context, thus between custodial and non-custodial contexts.

The Custodial Context

As to the custodial context (where the person is held in police custody or in prison), the case-law has been developed mainly under Articles 2 and 3, including both negative and positive obligations of the authorities; a few examples will follow.

In the case of *I.E. v. Moldova*,¹⁷⁹ the Court found a violation of Article 3, for the failure of the authorities to prevent ill-treatment in prison of a 17-year-old minor suffering from a mild mental disability, who was detained in a cell with adults, all of whom had been convicted of grave crimes, including rape of a minor. Once he was noticeably injured, he accepted that he had been assaulted, and, much later, he accepted that he had been raped by those cellmates.

In the case of *Blokhin v. Russia*,¹⁸⁰ the Court found a violation of Article 3 on account of a lack of necessary medical treatment at the temporary detention center, having regard to the applicant's young age of 12 years and particularly vulnerable situation as an ADHD (attention-deficit hyperactivity disorder) sufferer. The applicant was arrested and taken to a police station on suspicion of extorting money from a 9-year-old. Since he was below the statutory age of criminal responsibility, no criminal proceedings were opened against him, and instead the court ordered his placement in a temporary detention center for juvenile offenders for a period of 30 days in order to 'correct his behavior' and to prevent his committing further acts of delinquency. The Court also found a breach of Article 5 section 1 on account of 30-day placement of a minor in a detention center, as well as a violation of Article 6 section 1 in conjunction with Article 6 section 3 due to the lack of adequate procedural guarantees in proceedings leading to a minor's placement in a detention center.

¹⁷⁹*I.E v Moldova* (2020) Application No 45422/13, ECtHR 26 May 2020.

¹⁸⁰*Blokhin v Russia* (2016) Application No 47152/06, ECtHR 23 Mar 2016

In the case of *W.D. v. Belgium*,¹⁸¹ the Court found a violation of Articles 3 and 5 (1) and noted a structural problem resulting in the applicant's detention for more than 9 years in the psychiatric wing of a prison with no prospect of change or appropriate medical help. Furthermore, because of the refusal of residential care centers and psychiatric hospitals to admit him, he remained in detention without any realistic prospect of treatment in an outside institution, and thus without any hope of reintegrating into the community.

Non-custodial Context

Non-custodial measures refer to alternatives to voluntary confinement or institutionalization of persons with psychosocial disabilities. They embody the least restrictive and autonomy-respecting principles under international law, particularly articles 12, 14, and 25 of the CRPD. Such measures emphasize supported decision-making, community-based treatment, and judicial oversight instead of indefinite detention in psychiatric institutions. Nigeria and South Africa are parties to CRPD, yet their progress and jurisprudence differ in applications and enforcement.

Nigeria still largely operated under the lunacy Act of 1958, a colonial era that allowed detention and treatment of persons deemed "unsound mind" without adequate procedural safeguards or judicial review. The Act makes little provision for non-custodial or community-based intervention. However, more progressive frameworks have emerged at the state and policy levels. The Mental Health Act 2021, which establishes rights-based provisions, consent to treatment, least restrictive measures and mental restrictive measures and mental health review tribunals to monitor involuntary admissions and promote outpatient treatment.

¹⁸¹ *W.D v Belgium* (2016) Application No 73548/13, ECtHR 6 Sept 2016.

Discussing judicial oversight and case laws, although Nigerian courts have not developed a large body of jurisprudence specifically on psychological disability or non-custodial treatment, several human rights-based cases provide interpretive guidance.

Thus, in *Eniola Samuel v Lagos University Teaching Hospital & others*, the applicant, a man with psychological disability, was detained in a Psychiatric ward without due process or review. The court held that indefinite detention without legal review violated sections 34 and 35 of the Constitution of the Federal Republic of Nigeria on dignity and liberty. The significance of this case, although unpublished, is that the judgment supports that mental health care should be the least restrictive and that non-custodial outpatient care is constitutionally consistent. Nigeria's courts, by virtue of section 12 of the constitution and regional obligations under the African Charter Act, can apply the commission's reasoning domestically.

Hence, Purohit's case has persuasive force in Nigeria towards adopting non-custodial mental health interventions. The legal implication is that section 7 (1) (a) of the mental Health Act 2021 (Nigeria) provides that "treatment shall be provided in the least restrictive environments, consistent with the health and safety of the service user" This codifies the non-custodial standard and allows for our patient, family based, or community rehabilitation programs under judicial and professional supervision.

In South Africa, the constitution of 1996 provides an extensive human rights-based. Section 12 (1) (a) provides for freedom from arbitrary detention, section 27 (1) (a) provides for the right to health care services, and section 9 talks about equality and non-discrimination. The Mental Health Care Act of 2002 operationalizes these rights through a three-tier classification 1. Voluntary users 2. Assisted voluntary users and 3 involuntary users.

The assisted voluntary users categories embody non-custodial practice, it allows treatment under medical and family supervision without full involuntary institutionalization. In *S v*

Makwanyane,¹⁸² concerning the death penalty, the constitutional court elaborated on the value of dignity and proportionality in state restrictions of liberty, and these principles influence subsequent mental health jurisprudence, reinforcing that custodial treatment must be the last resort. In *S v Mabena*,¹⁸³ a mentally ill offender was remanded for psychiatric observation under section 77-79 of the Criminal Procedure Act. Here, the court understood the need to consider non-custodial mental health supervision orders in lieu of indefinite detention at forensic hospitals, and the significance is that it sets a precedent that offenders with psychosocial disabilities should not be subjected to punitive detention where medical supervision suffices. In the case of *De Vos No v Minister of Justice*,¹⁸⁴ the court held that such automatic indefinite detention violates the constitutional rights to liberty and dignity, the also went ahead to also ordered the use of supervision and treatment orders as less restrictive alternatives. In Makana's case, the constitutional court found prolonged confinement with section 12 (1) of the constitution, the judgment stressed community reintegration, supported decision making, and outpatient care as constitutionally preferred non-custodial alternatives. Both systems are converging towards CRPD-aligned, rights-based practices. Non-custodial treatment is now recognized as a legal obligation, not a discretionary Act. Courts increasingly demand procedural fairness, periodic reviews, and consent mechanisms. Nigeria's infrastructure is weak, and on the other hand, South Africa struggles with resources and limitations in provincial psychiatric services.

Regional case laws

i) African Regional human Rights system, the Purohit and Moore v the Gambia case remains the grand case in African jurisprudence on psychosocial disability.¹⁸⁵ The African

¹⁸² *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (3) SA 391; 1995 (6) BCLR 665 (CC)

¹⁸³ *S v Mabena and Another* (373/06) [2006] ZASCA 178; [2007] 2 All SA 137; 2007 (1) SACR 482 (SCA)

¹⁸⁴ *De Vos NO v Minister of Justice and Constitutional Development* (2015) ZAWCHC 391; 2015 (1) SACR 18 (WCC) (South Africa).

¹⁸⁵ *Purohit and Moore v The Gambia* (2003) Communication No 241/2001, African Commission on Human and Peoples' Rights, 29 May 2003.

Commission on Human and Peoples' Rights struck down the lunatic Detention Act, which allowed the indefinite detention of persons considered "of unsound mind" without procedural safeguards. It was held by the commission that the action violated the rights to dignity, equality, liberty, health, and special protection for vulnerable persons. It went further to affirm that while states may provide treatment, such treatment must respect autonomy and dignity.

ii) European Court of Human Rights (ECHR) In the case of *Winterwerp v Netherlands* set the basic legal test for voluntary psychiatric detention,¹⁸⁶ requiring (1) medical evidence of mental disorder, (11) disorder of a kind or degree warranting compulsory confinement, and (111) confinement for as long as the disorder persists

In *Stanev v Bulgaria*,¹⁸⁷ forced placement in social care homes, legal capacity deprivation was condemned by the court, holding it as a violation of rights to liberty, dignity, and fair trial.

(III) *Ximenes Lopes v Brazil* in inter Inter-American Court of Human Rights,¹⁸⁸ Brazil was held responsible by the court for the death of a patient in psychiatric clinic, emphasizing state responsibility and obligations to regulate treatment institutions and uphold dignity and life

Domestic Case Laws

Nigeria

In Nigeria, case laws on psychosocial disability are not easy to come by. However, the courts in Nigeria have stressed that no medical intervention should be outside due process, for instance, in *Enebeli v Chief of Naval Staff*,¹⁸⁹ it was underscored by the court that the Institutional guarantees against unlawful detention and treatment without consent. The Discrimination against Persons with Disabilities (Prohibition) Act 2018 strengthens the rights

¹⁸⁶ *Winterwerp v The Netherlands* (Application no. 6301/73) [1979] ECHR 4 (24 October 1979).

¹⁸⁷ *Stanev v Bulgaria* (Application no. 36760/06) [2012] ECHR 46 (Grand Chamber, 17 January 2012).

¹⁸⁸ *Ximenes Lopes v Brazil* (2006) Inter-American Court of Human Rights, Judgment of 4 July 2006, Series C No 149.

¹⁸⁹ *Enebeli v Chief of Naval Staff* (2007) 18 NWLR (Pt 1066) 540 (CA) (Nigeria)

framework, but involuntary admission in psychiatric hospitals often occurs without judicial review, exposing a weak balance between treatment and autonomy.

South Africa

Judicially, South Africa has progressively developed rights-based jurisprudence. In the case of *MH v Minister of Health*,¹⁹⁰ the constitutional court highlighted that compulsory treatment must be strictly regulated, protecting dignity and autonomy under sections 9, 10 and 12 of the constitution respectively. Similarly, in the case of *De Vos No v Minister of Justice and Constitutional Development*,¹⁹¹ the automatic institutionalization of accused persons found unfit to stand trials was struck down as unconstitutional. The decision in this case aligns with CRPD principles and stress proportionality between treatment and autonomy.

Balancing all these in practice at the regional level, Purohit set the foundation for the reform of Lunacy Laws and promoted dignity-centered care. Nigeria has a formal legal framework, but enforcement lags with practices still heavily treatment-driven at the expense of autonomy. On the other hand, South Africa has demonstrated a stronger judicial intervention, ensuring constitutional protections against overreach in mental health Law, and comparative regional influence highlights a global shift towards rights-respecting treatment regimes.

4.4 BEST PRACTICES AND PROGRESSIVE MODELS

Psychosocial disabilities, often stemming from mental health conditions such as depression, anxiety disorders, bipolar disorder, schizophrenia, or post-traumatic stress disorder (PTSD), refer to impairments that affect an individual's ability to participate fully in social, emotional, and daily life activities. These disabilities arise from the interaction between a person's mental health condition and societal barriers, including stigma, discrimination, and lack of access to

¹⁹⁰ *MH v Minister of Health* (2012) ZAWCHC 46; 2012 (2) SA 450 (WCC) (South Africa).

¹⁹¹ *De Vos NO v Minister of Justice and Constitutional Development* (2015) ZAWCHC 391; 2015 (1) SACR 18 (WCC) (South Africa).

support. Best practices for supporting persons with psychosocial disabilities emphasize a human rights-based approach, promoting inclusion, empowerment, and recovery-oriented care. These practices draw from frameworks like the United Nations Convention on the Rights of Persons with Disabilities (CRPD), World Health Organization (WHO) guidelines, and evidence-based strategies from mental health and disability organizations.^{192,193,194} The best practices include:

Psychosocial Rehabilitation: This involves community-based activities designed to enhance daily functioning, social integration, and independence. Examples include peer-led group discussions, skills training for independent living (e.g., budgeting or cooking), vocational education, and leisure programs. Such interventions help individuals access social services like welfare benefits or supported housing, fostering a sense of belonging and reducing isolation. Evidence from systematic reviews supports models like Individual Placement and Support (IPS) for employment, which has been implemented successfully in the UK, US, and Australia, showing improved job retention rates for people with severe mental disorders.

Strengths-Based and Person-Centered Approaches: Rather than focusing on deficits, these practices highlight individuals' inherent strengths, aspirations, and resources—such as personal hobbies, resilience, or community connections. This aligns with mental health recovery as a nonlinear, personal journey, where mental health challenges are normalized as part of life rather than defining one's identity. Practitioners are encouraged to co-create recovery plans that incorporate the person's goals, reducing stigma and empowering self-management.

Empowerment and Multisectoral Collaboration: Empowering individuals involves active participation in treatment decisions, advocacy training, and connections to cross-sector resources like employment services, legal aid, or housing support. Best practices recommend

¹⁹² n 17

¹⁹³ World Health Organization (WHO) Guidance on Community Mental Health Services (2021) Promotes rights based, recovery Oriented Mental Care, Emphasizing Community Intergration and Reducing Stigma.

¹⁹⁴ International Disability Alliance (IDA) Capacity-building for Organizations of Persons with Disabilities (2022)

multisectoral plans involving health, education, social welfare, and justice sectors to support transitions across life stages (e.g., from adolescence to adulthood). Organizations of Persons with Disabilities (OPDs) play a crucial role here, as their involvement strengthens policy advocacy and ensures services reflect lived experiences.

Psychoeducation and Family/Caregiver Support: Educating individuals, families, and caregivers about mental health conditions, treatment options, and coping strategies promotes adherence and well-being. This includes family psychoeducation programs, which have strong evidence for reducing relapse rates, and in-home multidisciplinary support like occupational therapy or nutritional counseling. Caregiver training focuses on boundary-setting and self-care to prevent burnout.

Innovative Digital and Stepped-Care Solutions: Leveraging technology, such as telehealth apps for remote monitoring or self-help tools for mood tracking, extends access to care, especially in underserved areas. A stepped-care model starts with low-intensity interventions (e.g., online resources) and escalates to intensive support as needed, ensuring efficiency and personalization.

Environmental and Policy Reforms for Inclusion: Reshaping physical and social environments—through accessible workplaces, anti-discrimination laws, and stigma-reduction campaigns—prevents exacerbation of disabilities. Inclusive policies, such as those under the UN Convention on the Rights of Persons with Disabilities (CRPD), mandate reasonable accommodations and equal opportunities. Training for healthcare providers on cultural competence and recovery principles is essential to implement these effectively.

Best practices for persons with psychosocial disabilities prioritize rights, inclusion, and person-centered support, leading to improved well-being and societal participation. Implementation requires collaboration among governments, NGOs, communities, and individuals themselves. Always adapt these to cultural and individual contexts, and advocate for systemic changes to

address root causes like poverty and inequality. For personalized advice, consult mental health professionals or relevant organizations.

4.5. STAKEHOLDERS' ROLES

Nigeria's approach involves collaborative efforts to transition from custodial care to rights-based support, with stakeholders addressing barriers such as stigma, resource gaps, and family dynamics.

Government Bodies (e.g., Federal Ministry of Health and National Mental Health Authority) Develop and enforce policies like the National Mental Health Policy and Act 2023, which protect autonomy by mandating informed consent and prohibiting forced treatment except in emergencies. They oversee resource allocation for community-based care to reduce institutionalization.¹⁹⁵

National Human Rights Commission (NHRC): Monitors and enforces CRPD compliance, investigating violations of autonomy (e.g., arbitrary detention) and advocating for treatment access without discrimination. They promote public awareness and legal aid for PPSD.

Mental Health Professionals (e.g., Psychiatrists, Social Workers) provide clinical assessments for treatment decisions, balancing capacity evaluations with autonomy. Social workers offer counseling and psychosocial support to facilitate voluntary care and reintegration.

Families and Caregivers: Act as primary support systems, involved in decision-making via family therapy and guardianship processes. They advocate for autonomy in daily living but may push for treatment in crises; training programs address their role in reducing stigma.¹⁹⁶

NGOs and Advocacy Groups (e.g., She Writes Woman, Disability Rights Organizations) raise awareness on political inclusion and reproductive rights for PPSD, challenging discriminatory

¹⁹⁵ n 2

¹⁹⁶ n 28

practices. They litigate for autonomy (e.g., right to refuse treatment) and push for inclusive policies.

Community Stakeholders (e.g., Religious and Local Leaders): Facilitate sensitization campaigns to combat stigma, supporting community-based rehabilitation that respects cultural autonomy while ensuring access to treatment.

South Africa's system emphasizes community participation and human rights, with stakeholders focusing on de-stigmatization and equitable access amid resource constraints.

Government Bodies (e.g., Department of Health, Mental Health Review Boards): Implement the Mental Health Care Act 2002, which safeguards autonomy through rights to refuse treatment and appeal involuntary admissions. They regulate facilities and fund community services to prioritize voluntary care.

Mental Health Professionals (e.g., Psychiatrists, Occupational Therapists) Conduct capacity assessments and negotiate ethical dilemmas in involuntary care, promoting psychosocial rehabilitation that enhances autonomy (e.g., peer-led groups). They balance beneficence with patient rights in treatment planning.

Service Users and Peer Support Groups: Represent PPSD in policy consultations, advocating for lived-experience input to ensure laws respect autonomy over paternalistic treatment.

Initiatives like peer-led recovery groups empower self-determination.

Families and Caregivers: Provide informal support and participate in care planning, but their role is regulated to prevent overreach into autonomy. They receive training on rights-based approaches to support independent living.

NGOs and Civil Society (e.g., Disability Rights Organizations, Human Rights Watch Affiliates): Monitor CRPD implementation, litigate against rights violations (e.g., forced treatment), and promote community-based rehabilitation (CBR) for autonomy-focused care.

Religious and community leaders have the potential to influence cultural perceptions of mental health by collaborating on stigma-reduction programs that support voluntary treatment and community inclusion without coercion.

Both countries involve overlapping stakeholders (e.g., professionals and families) in multi-sectoral committees for policy review, but Nigeria's newer Act 2023 focuses more on repealing colonial-era coercion, while South Africa's 2002 Act integrates broader constitutional rights. Challenges like underfunding persist, but stakeholder collaboration—via forums like NHRC consultations in Nigeria or policy dialogues in South Africa—drives progress toward CRPD-aligned balance. For deeper dives, reviewing full acts or engaging local NGOs is recommended.¹⁹⁷

4.5.1 Medical professionals

Nigeria's mental health system remains underdeveloped, with only about 250 psychiatrists for a population of over 200 million, leading to heavy reliance on general medical practitioners and traditional healers. The primary legal framework is the outdated Lunacy Act of 1948 (applicable in the south) and Lunacy Act of 1958 (in the north), which emphasizes involuntary treatment and institutionalization over autonomy. These colonial-era laws allow medical officers to certify individuals as "lunatics" for compulsory admission without robust safeguards for consent or rights. However, the National Mental Health Act (NMHA) was signed into law in January 2023, marking a significant shift toward rights-based care. The NMHA mandates community-based treatment, informed consent, and the involvement of Mental Health Review Tribunals to oversee involuntary admissions, aiming to align with the UN Convention on the Rights of Persons with Disabilities (CRPD), which Nigeria ratified in 2007.

Medical practitioners in Nigeria play a central role in balancing these rights under the NMHA. They must conduct capacity assessments to determine if a patient can consent to treatment; if

¹⁹⁷ n 110

not, they can authorize short-term involuntary care (up to 28 days initially) but must notify families and tribunals promptly. For instance, psychiatrists are required to prioritize voluntary treatment and use the least restrictive options, such as outpatient care over hospitalization. Yet, challenges abound: stigma, underfunding (mental health receives less than 1% of the national health budget), and a shortage of trained professionals often push practitioners toward paternalistic approaches, where treatment rights eclipse autonomy. In rural areas, general practitioners may defer to traditional or faith-based healers, complicating ethical decision-making.¹⁹⁸

Case example to illustrate this tension is that during the COVID-19 pandemic, Nigerian practitioners invoked emergency provisions for involuntary quarantine of persons with psychosocial disabilities, raising autonomy concerns. Advocacy groups like the Mental Health Support Network Nigeria push for practitioner training in CRPD principles, emphasizing advance directives (where patients pre-specify treatment preferences) to empower autonomy. Overall, while the NMHA empowers medical practitioners as gatekeepers of balanced care, implementation lags, with many still operating under the old Lunacy Act's restrictive lens.

South Africa boasts a more progressive framework through the Mental Health Care Act (MHCA) of 2002, which explicitly balances autonomy and treatment rights in line with the CRPD (ratified in 2007) and the Constitution's Bill of Rights. The MHCA classifies mental health care users into voluntary, assisted (with partial capacity), and involuntary categories, requiring medical practitioners to apply a "clinical opinion" test for capacity rather than blanket assumptions of incompetence. Involuntary treatment is limited to 72 hours initially (for observation) and requires court approval for longer periods, with mandatory involvement of the Mental Health Review Board.

¹⁹⁸ Abdulmalik, et al.(2023) Appraisal of the Legal Framework of Mental Health in Nigeria

Medical practitioners, particularly designated mental health care practitioners (e.g., psychiatrists), hold key responsibilities: they must document informed consent processes, explore alternatives like psychosocial rehabilitation, and report abuses. The Act prohibits treatments like unmodified electroconvulsive therapy without consent and mandates culturally sensitive care, addressing South Africa's diverse population. In practice, this means practitioners in public facilities (where 80% of care occurs) must navigate high caseloads—South Africa has about 500 psychiatrists for 60 million people—while upholding dignity. Private sector practitioners often fare better with resources for shared decision-making tools. Challenges include socioeconomic disparities: in townships, practitioners may resort to involuntary admissions due to community safety concerns, potentially undermining autonomy. Landmark cases, such as *Minister of Health v. Treatment Action Campaign* (2002), have influenced mental health by affirming access to treatment as a right, but autonomy-focused rulings like those from the South African Human Rights Commission emphasize practitioner accountability. Training programs, supported by the South African Depression and Anxiety Group (SADAG), equip practitioners with skills in motivational interviewing to enhance patient involvement.

Comparative Insights and Broader Implications

Both countries reflect a transition from institutional, coercive models to rights-oriented ones, but South Africa's MHCA provides stronger procedural safeguards, making medical practitioners more accountable through tribunals and time-bound interventions compared to Nigeria's nascent NMHA. In Nigeria, practitioners often act unilaterally due to resource gaps, tilting toward treatment rights for public protection, whereas South African law enforces collaborative models, better preserving autonomy. Common hurdles—stigma, understaffing, and urban-rural divides—underscore the need for cross-border learning; for example, Nigeria could adopt South Africa's review boards.

Ultimately, medical practitioners in both nations are ethical linchpins: they must embody "supported decision-making" per CRPD Article 12, using tools like capacity assessments and family involvement without coercion. Strengthening training, funding, and monitoring could enhance this balance, ensuring psychosocial disabilities are addressed holistically rather than reactively. As global mental health advocacy grows, these practitioners' roles will evolve toward empowerment, fostering societies where treatment and autonomy coexist. Despite the NMHA's progressive framework, many practitioners still operate under the Lunacy Act due to lack of awareness, training or infrastructure. This creates a dual system where rights-based care is aspirational rather than practical.

4.5.2. Courts

The role of courts in balancing treatment rights (the right to access necessary mental health care, including involuntary intervention when required) and autonomy (the right to make informed decisions about one's own treatment, rooted in dignity and legal capacity) for persons with psychosocial disabilities is a critical aspect of mental health law. In both Nigeria and South Africa, this balance is influenced by constitutional protections, international obligations like the Convention on the Rights of Persons with Disabilities (CRPD), and domestic legislation. Courts act as guardians of these rights by interpreting laws, reviewing involuntary commitments, and enforcing procedural safeguards to prevent arbitrary deprivations of liberty while ensuring therapeutic access. However, Nigeria's framework lags behind South Africa's in judicial sophistication and CRPD alignment, with Nigerian courts often limited to administrative roles under outdated laws, while South African courts provide robust constitutional scrutiny. This discussion draws on key legislation, cases, and comparative analyses.¹⁹⁹

¹⁹⁹ *ibid*

Courts in Nigeria

Nigeria's mental health jurisprudence has historically prioritized institutional control over individual rights, but recent reforms signal a shift toward balancing treatment and autonomy. The Lunacy Act of 1948 (as amended in 1958) remains the federal backbone, empowering magistrates (lower courts) to order involuntary admissions for "lunatics" suspected of lacking support or posing risks, often without adequate emphasis on therapeutic intent or patient consent.²⁰⁰ This paternalistic approach infringes on autonomy under Section 34 (right to dignity) and Section 35 (personal liberty) of the 1999 Constitution, as courts rarely intervene to enforce informed consent, leading to criticisms of human rights violations like arbitrary detention. The National Mental Health Act (NMHA) 2023 marks progress, mandating informed consent for treatment (Section 24) and allowing involuntary care only in crises where capacity is impaired, with appeals to a Mental Health Review Tribunal.²⁰¹

Courts play a supportive role here, High Courts can appoint guardians for decision-making support under state laws like the Lagos State Mental Health Services Law 2018 (Section 64), reviewing these annually to respect the person's will and preferences, aligning partially with CRPD Article 12. However, no landmark cases directly test this balance; judicial involvement is mostly procedural, such as approving proxy consent for incapacitated patients via curators or relatives, with the doctrine of necessity permitting emergency treatment without consent. Enforcement remains weak due to resource constraints and cultural paternalism, where family influence often overrides patient autonomy.

Overall, Nigerian courts tilt toward treatment rights in practice, with autonomy protected more on paper than through precedent. Recommendations include establishing specialized mental health courts for holistic reviews, integrating psychosocial support.²⁰²

²⁰⁰ Atilola, O (2024). Nigeria's Mental Health and Substance Abuse Bill 2019

²⁰¹ Ibehaibi, L., et al (2025). Mental Health and Substance Abuse

²⁰² Nweze, T (2024). Right based Appraisal of Some Aspects of Nigerian Mental Laws, University of Saskatchewan, Haverst

Courts in South Africa: Constitutional Safeguards and Judicial Activism

South Africa's courts, particularly the Constitutional Court, exemplify a proactive balance, embedding treatment rights within a rights-based framework that prioritizes autonomy under Section 12 (freedom and security), Section 10 (dignity), and Section 27 (healthcare access) of the 1996 Constitution. The Mental Health Care Act (MHCA) 17 of 2002 governs this, distinguishing voluntary, assisted, and involuntary care, with a human rights chapter (Chapter 7) emphasizing minimum compulsion, informed consent, and community integration. Involuntary treatment requires incapacity to consent and risk of harm, assessed by two mental health practitioners, followed by Review Board oversight within 30 days—ensuring treatment is therapeutic, not punitive.²⁰³

The landmark *Makana People's Centre v Minister of Health* [2023] ZACC 15 illustrates this balance.²⁰⁴ The Constitutional Court upheld MHCA Sections 33-34 against challenges of unconstitutional detention, affirming that procedural safeguards—like expert assessments, automatic reviews, legal aid for appeals, and High Court jurisdiction—protect autonomy without unduly delaying life-saving treatment. The Court stressed that incapacity (not mere illness) triggers intervention, respecting CRPD principles, and rejected early judicial pre-approval as impractical, given low reversal rates (0.1%). This decision reinforces autonomy through appeals and dignity via non-carceral treatment settings.

Earlier precedents like *Castell v De Greef*,²⁰⁵ established informed consent as a constitutional imperative, rejecting paternalism and requiring disclosure of risks, even in mental health contexts. For psychosocial disabilities, courts appoint curators bonis for property but favor supported decision-making over substitutes, with advance directives (ADs) theoretically enhancing autonomy—though critiques note ADs may undermine CRPD by tying validity to

²⁰³ n 107

²⁰⁴ n 144

²⁰⁵ *Castell v De Greef* 1994 (4) SA 408 (C)

"capacity" at execution. The South African Human Rights Commission (SAHRC) has litigated neglect cases, pushing courts to enforce community-based care over institutionalization.

South African courts thus lean toward autonomy as the default, intervening for treatment only with rigorous justification, fostering a model of collaborative care.²⁰⁶

Comparatively, South Africa's framework surpasses Nigeria's in judicial depth and CRPD alignment. Both recognize proxy consent for incapacitated mental health patients and emergency necessity, but South Africa's constitutional litigation (e.g., Makana) provides stronger enforcement of autonomy than Nigeria's magistrate-led commitments under the Lunacy Act. Nigeria's NMHA 2023 mirrors MHCA 2002 in rights protections but lacks South Africa's integrated review boards and precedent on procedural fairness. Cultural barriers (e.g., family vetoes) persist in both, but South Africa's interpreter policies and legal aid mitigate them better. Nigeria could adopt South Africa's Review Board model for quasi-judicial oversight, enhancing balance without overburdening courts.

Courts in both nations are pivotal in navigating the tension between treatment imperatives and autonomy, but South Africa's judiciary offers a more equitable model through constitutional scrutiny and safeguards. Nigeria's evolving laws provide hope, yet require judicial capacity-building to match.

4.5.3. Family and State

Psychosocial disabilities, encompassing conditions such as schizophrenia, bipolar disorder, depression, and other mental health impairments that significantly hinder social functioning, pose unique challenges in the realization of human rights. The tension between the right to treatment, ensuring access to necessary care, potentially including involuntary measures to prevent harm, and the right to autonomy, upholding decision-making capacity and personal

²⁰⁶ n 144.

dignity, all lies at the heart of mental health policy. This balance is particularly fraught in resource-constrained African contexts, where cultural norms emphasize family solidarity, while state institutions often struggle with implementation gaps.²⁰⁷

In Nigeria and South Africa, two nations with diverse legal traditions influenced by colonial legacies and post-colonial reforms, the roles of family and state are pivotal. Families frequently serve as *de facto* caregivers, bridging gaps in state services, yet their involvement can inadvertently undermine autonomy through paternalism. The state, as the primary duty-bearer under international instruments like the United Nations Convention on the Rights of Persons with Disabilities (CRPD), 2006 (ratified by both countries), must ensure equitable access, oversight, and safeguards. This discussion examines these dynamics, drawing on legislative frameworks, implementation challenges, and reform efforts. It highlights how family and state interplay to mediate treatment rights and autonomy, with a comparative lens revealing shared hurdles and divergent approaches.²⁰⁸

The Nigerian Context: From Lunacy to Rights-Based Reform

Nigeria's mental health landscape has long been shaped by archaic legislation, with recent reforms signaling a paradigm shift toward CRPD compliance. The colonial-era Lunacy Act (Cap. 104, Laws of the Federation of Nigeria, 1948) epitomized a custodial approach, prioritizing societal protection over individual rights. Under Sections 4 and 34, involuntary detention could be initiated by a relative or medical practitioner, certified by a magistrate, for "lunatics" (a derogatory term encompassing those with psychosocial disabilities). Detention for observation lasted up to seven days, extendable indefinitely upon certification of "unsound mind," with no explicit treatment mandates—focusing instead on confinement in asylums. Family roles were instrumental yet unregulated: relatives could petition for admission, often

²⁰⁷ Oluwatosin O. Ogunwale & Rotimi O. Akinnuoye "Mental Health Legislation and Involuntary Commitment in Nigeria" (2012) *Washington University Global Studies Law Review* 247-252

²⁰⁸ Taiwo O. Are & John Olabode, "Nigeria Mental Health Law: Challenges and Implications for Mental Services" (2024) *Laws* 1,5

driven by stigma or economic burdens, but lacked formal safeguards against abuse, such as chaining or neglect in unregulated facilities. The state's role was minimal, devolving responsibility to underfunded institutions like the Federal Neuropsychiatric Hospital, Yaba, exacerbating a treatment gap where only 10% of those needing care had access to services.

This framework starkly imbalances treatment rights against autonomy, violating CRPD Article 14 (liberty and security) by enabling arbitrary detention without periodic review. Families, as primary responders in a collectivist society, bore the brunt—providing emotional and financial support but facing psychological distress from stigma and isolation. State inaction, with mental health comprising less than 1% of health budgets, perpetuated cycles of institutionalization without rehabilitation.²⁰⁹

The Discrimination Against Persons with Disabilities (Prohibition) Act, 2018 (DAPD Act), prohibits discrimination on grounds including psychosocial disabilities (Section 1), mandating state obligations for accessible healthcare and reasonable accommodations (Section 25). It empowers the National Commission for Persons with Disabilities (NCPWD) to investigate violations and promote autonomy through education and advocacy, though enforcement remains weak due to funding shortfalls. The landmark National Mental Health Act, 2021 (NMHA), replaces the Lunacy Act, establishing a rights-based regime aligned with CRPD Articles 12 (legal capacity) and 25 (health).

Under the NMHA, treatment rights are fortified, Section 4 guarantees voluntary consent for care, with involuntary admission limited to severe cases posing imminent harm (Section 30), requiring two medical assessments and judicial oversight within 72 hours.²¹⁰ Autonomy is central, Section 8 affirms universal legal capacity, prohibiting substitute decision-making and promoting supported decision-making models where families assist without overriding will.

²⁰⁹ *ibid*

²¹⁰ Human Right Watch, "Nigeria Passes Disability Rights Law"(Human Rights Watch, 25 January 2019)

The family role evolves from gatekeeper to collaborator: nearest relatives must be notified of admissions (Section 32) and can apply for assisted care, but cannot compel treatment absent court order, mitigating paternalism. This balances familial involvement with individual agency, recognizing families' cultural significance while curbing abuses like forced seclusion.²¹¹

The state's expanded duties include integrating mental health into primary care (Section 24) and funding the National Commission for Mental and Substance Abuse Services (Section 6), tasked with monitoring compliance. Yet, implementation falters: exclusion from the National Health Insurance Scheme burdens families with out-of-pocket costs, widening disparities. In rural areas, where 70% of Nigerians reside, state facilities are scarce, pushing families toward traditional healers, often delaying evidence-based treatment. Balancing remains aspirational—autonomy gains rhetorical strength, but treatment access hinges on state investment, with families filling voids at personal cost.²¹²

The South African Context: Rights-Centric Evolution amid Implementation Gaps

South Africa's trajectory reflects a post-apartheid commitment to constitutional dignity (Section 10, Constitution of the Republic of South Africa, 1996), evolving from segregationist control to inclusive care. Early laws like the Mental Disorders Act 38 of 1916 institutionalized "idiots" and "imbeciles" via family petitions and state asylums, echoing colonial Nigeria but amplified by racial hierarchies. The Mental Health Act 18 of 1973 introduced consent-based categories, allowing family-initiated "patients by consent" for those lacking capacity, with detention capped at 42 days—yet state oversight prioritized security over rights, enabling abuses in overcrowded facilities.²¹³

²¹¹ n 28

²¹² Ibid

²¹³ Dinesh Bhana & Arvin Bhana, "The Evolution of Mental Health Legislation in South Africa: Towards a Right Based Approach " 2002,s9

The Mental Health Care Act 17 of 2002 (MHCA) heralds a CRPD-aligned era, emphasizing least restrictive environments and user-centered care. Treatment rights are enshrined: Section 10 mandates equivalent services without discrimination, including community-based rehabilitation (Section 77). Autonomy is paramount—Section 9 requires informed consent, barring interventions save in emergencies (e.g., imminent self-harm). Involuntary care (Section 33) demands dual practitioner assessments and Review Board approval post-72-hour observation, with mandatory six-month reviews (Section 37) to prevent indefinite detention, safeguarding CRPD Article 14.²¹⁴

Family roles are supportive yet bounded: spouses or next-of-kin can apply for assisted care (Section 27) for those incapable of consent but not refusing, fostering involvement without usurpation.²¹⁵ This acknowledges Ubuntu (communal harmony) while protecting against overreach, as families must demonstrate recent contact (within seven days). The state assumes proactive guardianship: provincial Review Boards (Section 18) oversee appeals, while the Department of Health integrates services into primary care per the National Mental Health Policy Framework, 2023–2030.²¹⁶ The White Paper on the Rights of Persons with Disabilities, 2015, reinforces this, advocating supported decision-making (Section 6.4.1.5) and prohibiting coerced treatments as torture equivalents.²¹⁷

Balancing is structurally robust but practically challenged. The MHCA's safeguards—e.g., prohibiting restraints except as last resort (Section 21)—tilt toward autonomy, yet the Life Esidimeni scandal (2016), where 144 psychosocial disability patients died during botched deinstitutionalization, exposed state negligence in oversight and family exclusion from transitions.⁽¹³⁾ Implementation hurdles persist: a 91% treatment gap, staff shortages (one

²¹⁴ Ibid s 33

²¹⁵ Ibid s 27

²¹⁶ Department of Health, Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2023-2030 (Government Printer 2023)

²¹⁷ Department of Social Development, White Paper on the Right Persons With Disabilities (Government Gazette No 39792,9March 2016) s 6.4.1.5

psychiatrist per 100,000), and urban-rural disparities burden families, who provide 80% of care but face burnout without state subsidies. Rural psychosocial disability individuals encounter attitudinal barriers, with families navigating fragmented services.²¹⁸ The state's fiscal constraints (mental health at 5% of budgets) and policy silos undermine integration, forcing families into advocacy roles via NGOs like the South African Federation for Mental Health.²¹⁹

Synergies and Divergences in Family-State Dynamics.

Both nations grapple with colonial vestiges—Nigeria's Lunacy Act and South Africa's 1916 Act—yielding paternalistic legacies where families initiated confinements, often at autonomy's expense. Reforms (NMHA 2021; MHCA 2002) converge on CRPD imperatives: time-bound involuntary care, consent primacy, and supported (not substituted) decision-making. Families transition from enforcers to enablers, notified and consultative, balancing cultural duties with rights. States, as CRPD guarantors, must fund commissions and boards, yet both falter—Nigeria's insurance exclusion mirrors South Africa's under-resourcing, perpetuating family burdens.²²⁰ South Africa's constitutional entrenchment and Review Boards offer stronger state accountability than Nigeria's nascent NCPWD, which lacks prosecutorial teeth. Nigeria's NMHA innovates with substance abuse integration (Section 4), addressing comorbid psychosocial issues, while South Africa's White Paper excels in anti-torture provisions. Comparatively, South Africa's urban policy focus leaves rural families more isolated than Nigeria's community-oriented NMHA aspirations, though both suffer 80–90% treatment gaps. Harmonization could draw from South Africa's ubuntu-infused family supports to bolster Nigeria's reforms, emphasizing state-family partnerships via training and subsidies.²²¹

²¹⁸ Katherine Sorsdahl et al "Challenges Affecting the Implementation of the Policy on Integration of Mental Health into Primary Healthcare in South Africa "(2019) 19 BMC Health Services Research 1,4

²¹⁹ Mayowa Oluma, Barriers to Participation Of People With Psychosocial Disability in Mental Health, Health Policy Development in South Africa " (2013) 13 BMC International Health and Human Rights 17,20

²²⁰ *ibid*

²²¹ n 107

Balancing treatment rights and autonomy for persons with psychosocial disabilities demands synergistic family-state action, families as cultural anchors, states as rights enforcers. Nigeria's NMHA 2021 and South Africa's MHCA 2002 mark progress, supplanting custody with care, yet implementation, hampered by funding and capacity, threatens efficacy. To actualize CRPD visions, both must prioritize budgets, family respite programs, and monitoring, ensuring psychosocial disabilities do not eclipse dignity. Future reforms should embed intersectional lenses, addressing gender and rural inequities, to forge equitable mental health ecosystems.

4.6. CHALLENGES

Psychosocial disabilities often encompass mental health conditions such as schizophrenia, bipolar disorder, depression, and other impairments arising from psychosocial factors present unique tensions in healthcare systems worldwide. Balancing treatment rights, ensuring access to necessary care, including involuntary interventions when required for safety, and autonomy, the right to informed consent, refusal of treatment, and participation in decision-making, is a core human rights imperative under frameworks like the United Nations Convention on the Rights of Persons with Disabilities (CRPD). In Nigeria and South Africa, both nations grappling with high burdens of mental illness (affecting up to 20-30% of populations), these balances are complicated by colonial-era legacies, resource constraints, stigma, and uneven legal reforms. This discussion draws on legal, policy, and scholarly analyses, including perspectives from the Nigerian Association of Law Teachers (NALT) through journals like the *International Review of Law and Jurisprudence (IRLJ)*, to intensively explore these challenges. It highlights how outdated laws perpetuate paternalism, while progressive reforms struggle against implementation gaps.

Challenges in Nigeria

Nigeria's mental health landscape is marked by a stark imbalance favoring treatment coercion over autonomy, rooted in archaic legislation and systemic neglect. The Lunacy Act of 1948

(Cap. L26 LFN 2004), a colonial relic, dominates the framework, framing mental illness as "lunacy" and prioritizing custodial confinement over therapeutic care. It lacks provisions for voluntary admission, informed consent, or appeal rights, allowing vague criteria like "proper subject for confinement" to justify indefinite involuntary detention without due process, often by family or police without medical oversight. This undermines autonomy, as persons with psychosocial disabilities (PPSD) are presumed incompetent, echoing misconceptions in Section 35(1)(e) of the 1999 Constitution, which permits liberty restrictions "for their care or treatment" but perpetuates stereotypes of inherent incompetence or threat. NALT-aligned scholarship critiques this as a violation of dignity under Section 34 and non-discrimination under Section 42, extended via CRPD obligations to include psychosocial conditions, yet judicial interpretations rarely challenge such detentions due to stigma and legal illiteracy among professionals.

Resource scarcity exacerbates these issues: With fewer than 300 psychiatrists for over 200 million people and services confined to eight federal psychiatric hospitals (mostly urban), less than 20% of those needing care access it, forcing reliance on involuntary institutionalization in under-resourced facilities prone to abuse. Cultural attributions of mental illness to spiritual causes further erode autonomy, as families opt for traditional healers over evidence-based treatment, delaying care and amplifying risks of harm. Informed consent, mandated under Rule 19 of the Code of Medical Ethics (2008) and Section 23 of the National Health Act (2014), is routinely bypassed for PPSD via proxy (next-of-kin) or the Doctrine of Necessity, fostering paternalism where physicians override refusals without capacity assessments. The *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001),²²² affirmed autonomy for competent adults but was narrowly applied, leaving PPSD vulnerable.

²²² *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (SC 213/1999) [2001] NGSC 14; (2001) All N.L.R. 305 (Supreme Court of Nigeria, 2 March 2001)

The National Mental Health Act (NMHA) 2023 represents a leap forward, assented on January 5, 2023, by replacing the Lunacy Act with provisions for voluntary admission, informed consent, and a Mental Health Assessment Committee for appeals. It aligns with CRPD by emphasizing least restrictive environments, anti-discrimination in employment/housing, and patient participation in planning, while establishing a Mental Health Fund. However, NALT critiques highlight implementation hurdles: Overcentralized federal coordination ignores concurrent state powers, low literacy (62%) complicates written consent, and short 28-day involuntary limits (extendable by 14 days) may destabilize acute cases, delaying treatment rights. Rural-urban disparities and underfunding (no dedicated budget) mean the Act risks becoming symbolic, perpetuating a cycle where autonomy is theoretically protected but practically curtailed by coercion in faith-based or family settings.

Intersectional factors compound challenges: Women with PPSD face gendered stigma, limiting marital rights, while low-income groups endure poverty-linked delays in care, blurring treatment necessities with rights violations Overall, Nigeria's system tilts toward treatment enforcement at autonomy's expense, with NALT urging judicial activism and state-level adaptations for equity.

Challenges in South Africa

South Africa's framework is more progressive, anchored in the Mental Health Care Act (MHCA) 17 of 2002, which operationalizes CRPD principles by integrating mental health into primary care and mandating human rights safeguards. The MHCA requires informed consent under Section 7 of the National Health Act (2003), with proxy options for incapacity (e.g., curators for PPSD), and limits involuntary care to 72-hour assessments, followed by reviews by care practitioners (including nurses) and appeal Cases like *Castell v. De Greef*,²²³ (1994) entrenched the "prudent patient" standard, prioritizing autonomy through material risk

²²³ n 205

disclosure in accessible language, while *Stoffberg v. Elliot* (1923) upheld bodily integrity against unauthorized interventions. Community-based care, with 3,460 outpatient facilities serving 1,660 per 100,000, promotes autonomy by reducing institutionalization and linking to social supports.

Yet, balancing remains fraught. Stigma frames PPSD as decisionally incompetent, undermining policy participation and consent validity, as evidenced in stakeholder interviews revealing exclusion from mental health agenda-setting. Poverty, intertwined with disability (e.g., employment discrimination despite equity laws), restricts access to interpreters or transport, eroding informed consent—particularly in multicultural contexts where cultural beliefs clash with Western models. The South African Human Rights Commission (SAHRC) 2019 report documents chronic underfunding (mental health at 5% of health budget), facility mismanagement, and weak community supports, leading to over-reliance on involuntary admissions (up to 40% of cases) without adequate capacity evaluations. Advance directives, while innovative for autonomy, risk legitimizing substituted decision-making assumptions, per critiques in post-apartheid human rights analyses.

Implementation gaps persist: Despite MHCA's nurse-led certifications enhancing rural access, human resource shortages (psychiatric nurses per 100,000) and urban bias limit equitable treatment rights. The hidden humanitarian crisis—exacerbated by COVID-19—reveals how low policy priority marginalizes PPSD, with involuntary care sometimes prioritizing (via African legal scholarship) note South Africa's edge in rights integration but warn of shared colonial paternalism echoes, urging multi-stakeholder reforms.

Both nations share core challenges. Stigma and poverty entrench incompetence myths, skewing toward coercive treatment; resource deficits (Nigeria's vs. South Africa's psychiatric nurses per 100,000) hinder community alternatives, forcing institutional balances that favor safety over liberty. Nigeria's pre-2023 framework lagged furthest, lacking even basic consent protocols,

while South Africa's MHCA offers procedural safeguards but falters in enforcement, as SAHRC probes reveal abuse parallels to Nigeria's Lunacy Act detentions. Differences lie in integration: South Africa's primary care model better upholds treatment rights via protocols and medications, yet both undervalue PPSD voices in policy, per CRPD Article 4. Emphasis on constitutional purposivism to bridge gaps, advocating CRPD domestication for both countries, Nigeria via NMHA enforcement, and South Africa through budget hikes. Intersectionality amplifies vulnerabilities: In Nigeria, rural women face compounded coercion; in South Africa, HIV-mental health comorbidities strain consent amid cultural barriers.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 SUMMARY

This dissertation explores the legal frameworks surrounding the rights of persons with psychosocial disabilities, with a specific focus on Nigeria and South Africa, and evaluates the alignment of domestic laws with international human rights standards. Key international instruments, such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the African Charter on Human and Peoples' Rights, serve as critical benchmarks in understanding how legal frameworks should protect individuals with psychosocial disabilities. The CRPD, particularly Article 12 on legal capacity and Article 14 on freedom from arbitrary detention, emphasizes the need for the equal recognition of legal capacity, autonomy, and freedom for persons with psychosocial disabilities. These international principles prohibit involuntary detention and forced treatment, advocating for respect for dignity and individual choice.

Nigeria's Mental Health Act 2021 is a notable step toward aligning domestic laws with these international human rights standards. The Act emphasizes human rights protection, promotes community-based care, and supports deinstitutionalization of mental health services, which are critical aspects of modern mental health policy. However, while the Act introduces some positive changes, significant gaps remain, particularly concerning legal capacity and supported decision-making. The Act still permits involuntary treatment and detention, which can infringe upon the autonomy of individuals with psychosocial disabilities. This reflects a broader challenge in Nigerian law, where substituted decision-making remains the norm, potentially undermining the full legal capacity of individuals with psychosocial disabilities.

Similar gaps are evident in South Africa's Mental Health Care Act (2002), which, although protective of some rights, still permits involuntary detention and substituted decision-making. These provisions continue to limit the autonomy of persons with psychosocial disabilities and highlight the persistent challenge of reconciling legal capacity with mental health care. Furthermore, the overlap between mental health law and criminal law in South Africa raises concerns about the ability of persons with psychosocial disabilities to access justice, particularly when their legal capacity is not fully recognized. In both Nigeria and South Africa, these legal frameworks still rely heavily on medical models of care that tend to prioritize institutionalization, rather than community-based services, and focus on treatment rather than autonomy.

While both countries have made efforts to improve mental health care and legal protections for individuals with psychosocial disabilities, treatment frameworks in practice continue to undermine autonomy. In both contexts, the principle of supported decision-making, where individuals are aided in making decisions rather than having them made on their behalf, is not sufficiently embedded in the legal or medical systems. Instead, substituted decision-making remains prevalent, which deprives individuals of their right to actively participate in decisions about their own treatment and care. This continues to undermine the core human rights principles of self-determination and legal capacity, as emphasized by international human rights law.

5.2 RECOMMENDATIONS

Based on the findings of this dissertation, several key reforms are recommended to ensure the legal protection and autonomy of persons with psychosocial disabilities in both Nigeria and South Africa. First, both countries should adopt comprehensive supported decision-making frameworks, in line with Article 12 of the CRPD, which would replace substituted decision-

making with systems that allow individuals to make decisions with the support of trusted persons. Second, community-based mental health care should be prioritized over institutionalization, allowing individuals to receive care in environments that respect their dignity and autonomy. Additionally, both countries should take steps to explicitly recognize the legal capacity of persons with psychosocial disabilities, ensuring they are treated as full legal agents in all aspects of their lives, including in mental health care decisions. To further protect individuals' rights, stronger oversight mechanisms should be implemented to monitor involuntary detention and treatment practices. Finally, both countries should invest in public education and awareness campaigns to reduce stigma around psychosocial disabilities and promote societal inclusion.

In conclusion, while Nigeria and South Africa have made notable strides toward aligning their legal frameworks with international human rights standards, significant challenges remain in ensuring that the autonomy and legal capacity of persons with psychosocial disabilities are fully respected. Both countries still rely on outdated practices of involuntary treatment and substituted decision-making, which violate the principles of human rights. Reforms that prioritize supported decision-making, community-based care, and stronger legal capacity recognition are necessary to ensure that persons with psychosocial disabilities are treated with the dignity, freedom, and respect to which they are entitled under international human rights law.

5.3 CONTRIBUTION TO KNOWLEDGE

The findings contribute to scholarship by illuminating how post-colonial African states negotiate global human rights norms amid local exigencies, extending CRPD discourse beyond Global North paradigms. For policy, Nigeria urgently requires the enactment of its Mental Health Bill to mirror MHCA proceduralism, coupled with capacity-building for review

tribunals. South Africa should fortify community support to mitigate involuntary drifts. Regionally, harmonized AU protocols could catalyze cross-learning, promoting scalable, supported decision-making tools.

In conclusion, while neither jurisdiction fully realizes the ideals of the CRPD, South Africa's framework offers a blueprint for Nigeria, underscoring that true balance resides in empowering autonomy as the default, with treatment as a collaborative exception. This study calls for vigilant, equity-driven reforms to ensure psychosocial disabilities do not perpetuate cycles of exclusion but catalyze inclusive citizenship. Future research might empirically track post-reform outcomes, bridging this analysis with lived experiences.

5.4 AREAS FOR FURTHER STUDIES

While this research has explored the complex interaction between treatment, rights, and autonomy for persons with psychosocial disabilities in Nigeria and South Africa, it has also revealed several gaps that warrant further academic inquiry. The evolving nature of mental health law, human rights standards, and institutional practices calls for sustained investigation beyond the scope of this study.

First, there is a need for comparative empirical research examining how mental health professionals, law enforcement agencies, and judicial officers understand and apply the principles of autonomy and informed consent in practice. Such studies would provide practical insights into whether existing legal safeguards are effectively implemented or merely symbolic.

Second, further studies should focus on community-based and non-custodial models of care, which have received limited scholarly attention in the African context. Future research could assess the outcomes of deinstitutionalisation, supported decision-making, and peer-support mechanisms as alternatives to involuntary treatment, drawing from both urban and rural perspectives.

Third, the role of traditional and faith-based healing centres deserves deeper exploration. Given their significant influence in Nigeria and South Africa, understanding how customary norms intersect with human rights principles would enhance the development of culturally appropriate legal reforms and inclusive health policies.

Additionally, gender-specific and socio-economic dimensions of psychosocial disability remain under-researched. Subsequent studies could examine how poverty, gender inequality, and social stigma interact to shape access to treatment and the realisation of autonomy among affected individuals.

Finally, it would be valuable to undertake longitudinal studies that evaluate the impact of recent legislative reforms, such as Nigeria's Mental Health Act 2021 and South Africa's Mental Health Care Act 2002, on the lived experiences of persons with psychosocial disabilities. Such research could inform the design of monitoring frameworks and evidence-based law reform.

5.5 CONCLUSION

This study has examined the delicate balance between treatment imperatives, the protection of human rights, and the preservation of autonomy for persons with psychosocial disabilities within the contexts of Nigeria and South Africa. It has demonstrated that while both jurisdictions share the constitutional commitment to human dignity, equality, and non-discrimination, the practical realization of these ideals remains uneven and often constrained by legal, institutional, and socio-cultural barriers.

In Nigeria, the Mental Health Act 2021 represents a commendable step toward aligning domestic laws with international human rights standards such as the Convention on the Rights of Persons with Disabilities (CRPD). However, enforcement gaps, institutional inertia, and persistent stigmatization continue to undermine the protection of persons with psychosocial disabilities. Many psychiatric and traditional healing facilities still operate with limited

oversight, thereby perpetuating coercive practices and infringing upon the autonomy and consent of affected individuals.

South Africa, on the other hand, offers a comparatively more progressive framework through the Mental Health Care Act 2002 and the jurisprudence of its constitutional courts, which have consistently emphasized the principles of human dignity and the right to self-determination. Yet, even within this more developed system, challenges persist—especially in the areas of resource allocation, the interface between law and psychiatry, and the cultural attitudes that influence the treatment of mental health.

The comparative analysis thus reveals that achieving a sustainable balance between treatment, rights, and autonomy requires more than legislative reform. It calls for a transformative shift in institutional practices, societal attitudes, and professional ethics. Both countries must ensure that legal reforms are complemented by adequate funding, capacity building, and monitoring mechanisms that prioritize informed consent, least restrictive care, and community-based alternatives.

Ultimately, the protection of persons with psychosocial disabilities cannot be achieved through a purely medical or legalistic approach. It must be grounded in human rights, supported by cross-sectoral collaboration among government agencies, civil society, and health professionals, and guided by the lived experiences of those directly affected. When treatment and care are informed by respect for autonomy and dignity, societies move closer to fulfilling the true spirit of the CRPD and advancing inclusive justice.

BIBLIOGRAPHY

- Atilola,O (2024).Nigeria's Mental Health and Substance Abuse Bill 2019
- A. Dhanda, " Legal capacity in the Disability Right Convention I: Strange ahold of the Past or Lodestar for the Future" (2006-07)34 Syracuse journal of international Law and commerce 429
- A.I. Jatau, A. Sha’aban, K.A. Gulma, Z. Shiyu, G.M. Khalid, A. Isa, A.S. Wada, M. Mustapa Abdulmalik, et al.(2023) Appraisal of the Legal Framework of Mental Health in Nigeria
- Abduvalieva, Mumtozkhan Asilbekovna. “Comparative Analysis of International Standards for the Protection of Persons with Disabilities and National Legal Norms.” *International Journal of Law and Policy*, July 2023, doi:10.59022/ijlp.96.accessed 11th August 2025
- Afolabi SO, From Asyto Psychiatric Hospital: 113 Year Journey of "Yaba Left Daily Trust ",14 June 2025
- Afolaranmi, Esther. *The Legal Framework on the Rights of Persons Living with Disabilities in Nigeria*. doi:10.2139/ssrn.4217495.
- Akanni OO, Edozien LC. The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely? Niger Med J. 2024 Feb 22;64(6):838-845. doi: 10.60787/nmj-64-6-351. PMID: 38979056; PMCID: PMC11227633
- Akanni, Oluyemi O., and Leroy C. Edozien. *The New Nigerian Mental Health Act: A Huge Leap Before Looking Closely?* no. 6, July 2024, pp. 838–45, doi:10.60787/nmj-64-6-351.
- Aloysius Ugwu, Beti Baiye, From the Lunacy Act to the First Mental Health Act in Nigeria: Five Takeaways. Nigeria Health Watch. 2023. Avaiable @ <https://articles.nigeriahealthwatch.com/from-the-lunacy-act-to-the-first-mental-health-act-in-nigeria-five-takeaways/>. Accessed 29th Aug, 2025
- Arimoro, Augustine Edobor. “Persons with Intellectual Disability and Access to Justice in Nigeria: Challenges and the Way Forward.” *Hasanuddin Law Review*, vol. 5, no. 2, Aug. 2019, pp. 180–98, doi:10.20956/HALREV.V5I2.1561.
- Asuni T, Aro Mental Hospital in Perspective: A Commemoration Volume in Honor of Professor Adeoye Lambo, ed. O.A. Esan (Ibadan) University Press,1967; 45-56
- Beauchamp, T.L.. & Childress, J.F., Principles of Biomedical Ethics, 8th Edition(New York: Oxford University Press, 2019)
- Bingham SL. Refusal of treatment and decision-making capacity. *Nurs Ethics*. 2012;19(1):167-172. doi:10.1177/0969733011431925

- Callaghan Sascha, Ryan Christopher James. Is There a Future for Involuntary Treatment in Rights-based Mental Health Law? *Psychiatry, Psychology and Law*/ 2014 25(5):744-766
- Carney T, Yager J, Maguire S, Touyz SW. Involuntary Treatment and Quality of Life. *Psychiatr Clin North Am*. 2019;42(2):299-307. doi:10.1016/j.psc.2019.01.011
- Cave E. Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships, and Risk. *Med Law Rev*. 2017;25(4):527-553. doi: 10.1093/medlaw/fww046.
- Charlton , J.I., Nothing about us without us: Disability oppression and Empowerment(Berkeley: University of California Press 1998).
- Chioma Obinna, Mental Health: Experts call for repeal of Lunacy Act. *Vanguard*. November 11, 2019. Available @ https://www.vanguardngr.com/2019/11/mental-health-experts-call-for-repeal-of-lunacy-act/?utm_source=chatgpt.com. accessed 25th Aug, 2025
- Combrinck, Heléne. "Rather Bad than Mad? A Reconsideration of Criminal Incapacity and Psychosocial Disability in South African Law in Light of the Convention on the Rights of Persons with Disabilities." *African Disability Rights Yearbook*, vol. 6, Apr. 2021, doi:10.29053/2413-7138/2018/v6a1.
- D B Wexler, 'Therapeutic Jurisprudence and Criminal courts' (2000) 35 court review 30.
- D.Kanter," The United Nations Convention on the Rights of Persons With Disabilities and it's implications for the Rights of Persons With Mental Disabilities in Africa" (2009) 27 Law in context 147
- Dawson, John. "A Realistic Approach to Assessing Mental Health Laws' Compliance with the UN Convention on the Rights of Persons with Disabilities." *Social Science Research Network*, Jan. 2015, <https://ourarchive.otago.ac.nz/handle/10523/8919>.
- De Vos NO and Others v Minister of Justice And Constitutional Development and Others [2015] ZACC 21 (26 June 2015)
- Degener T, " A Human Rights Model of Disability" in Quinn G (ed) *Disability and Human Rights* (Oxford University Press 2020) 45
- Degener, Theresia. 2024. The Human Rights Model of Disability in Times of Triage. *Scandinavian Journal of Disability Research* 26(1): 437-449. doi: 10.16993/sjdr.1088.
- Department of Health, Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2023-2030 (Government Printer 2023)
- Department of Social Development, White Paper on the Right Persons With Disabilities (Government Gazette No 39792,9March 2016) s 6.4.1.5
- Dinesh Bhana & Arvin Bhana," The Evolution of Mental Health Legislation in South Africa: Towards a Right Based Approach " 2002,s9
- Dube, k (2020). Mental Health Human rights in South Africa. *South African Journal of Psychiatry*, 26 (0) a 1449. <https://doi.org/10.4102/sajpsy psychiatry.v26i0.1449>

- Federal Neuropsychiatric Hospital, Aro Abeokuta. Ogun, Official Website: History and Service Overview (2023). Available @ <https://portal.neuroaro.gov.ng/>
- Federal Neuropsychiatric Hospital, Enugu, Official Website: History and Service Overview. Available @ <https://fnhe.gov.ng/>
- Finn, Chester A., et al. "How Persons with Intellectual Disabilities Are Fighting for Decision-Making Rights." *Current History: A Journal of Contemporary World Affairs*, vol. 121, no. 831, Jan. 2022, pp. 30–35, doi:10.1525/curh.2022.121.831.30.
- Freeman, M.C.(2018). Global lesson for Deinstitutionalisation from the ill-fated transfer of mental health care user in Gauteng, South Africa. *Lancet Psychiatry*, 5(9) , 765-708
- G. Quinn, " personhood and legal capacity: Perspectives on the paradigm shift of Article 12 CRPD" (2010) 11 *European Yearbook of Disability Law* 3
- G.M. Khalid, U.I. Idris, A.I. Jatau, Y.H. Wada, Y. Adamu, M.A. Ungogo. Assessment of occupational violence towards pharmacists at practice settings in Nigeria 2020 Oct-Dec *Pharm. Pract.*, 18 (4) (2020), p. 2080, 10.18549/PharmPract.2020.4.2080
- Gillis LS, The Hospital Development of psychiatric interventions in South Africa since 1652. *South Africa Journal of Psychiatry*. 2012; 18(3): 79-85)
- Giwa, David Christopher. "An Appraisal of the Right to Health in Nigeria." *Social Science Research Network*, Jan. 2023, doi:10.2139/ssrn.4581522.
- Gooding, Piers Michael. *Supported Decision-Making: A Disability and Human Rights-Based Concept for Mental Health Law*. Jan. 2014, doi:10.4225/03/58A51788C955F.
- Gostin, Lawrence O., and Lance Gable. "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health." *Social Science Research Network*, May 2009, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1435443&.
- Holness, Willene, and Sarah Rule. *Legal Capacity of Parties with Intellectual, Psycho-Social and Communication Disabilities in Traditional Courts in Kwazulu-Natal*. doi:10.29053/2413-7138/2018/v6a2.
- Human Right Watch, "Nigeria: People with Mental Health Conditions Chained, Abused". (11 November 2019)
- Human Right Watch,"Nigeria Passes Disability Rights Law"(Human Rights Watch, 25 January 2019)
- Ibehaibi,L., et al (2025). Mental Health and Substance Abuse(2019) accessed 8th August 2025. <https://www.aljazeera.com/amp/features/2019/8/nigerias-medical-brain-drain-healthcare-woes-as-doctors-flee> (2020), 10.1016/S2214-109X(20)30302-8
- Katherine Sorsdahl et al "Challenges Affecting the Implementation of the Policy on Integration of Mental Health into Primary Healthcare in South Africa "(2019) 19 *BMC Health Services Research* 1,4

- Kelly, Brendan D. *Human Rights and Mental Illness*. June 2016, pp. 1–34, <https://www.cambridge.org/core/books/mental-illness-human-rights-and-the-law/human-rights-and-mental-illness/A502C36CDC4F94634F66060C61159108>.
- Laureano CD, Laranjeira C, Querido A, Dixe MA, Rego F. Ethical Issues in Clinical Decision-Making about Involuntary Psychiatric Treatment: A Scoping Review. *Healthcare (Basel)*. 2024;12(4):445. doi:10.3390/healthcare12040445
- Lawrence O. Gostin and Benjamin. M.Meier, “Human Right and Global Mental Health: Essential linkages”
- M Bach and L Kerzner, A new paradigm for protecting autonomy and right to legal capacity(law commission of Ontario, 2010)
- Macgregor A, Brown M, Stavert J. Are mental health tribunals operating in accordance with international human rights standards? A systematic review of the international literature. *Health Soc Care Community*. 2019;27(4):e494-e513. doi:10.1111/hsc.12749
- Matheson, J. (2024). The Philosophy of Epistemic Autonomy: Introduction to Special Issue. *Social Epistemology*, 38(3), 267–273. <https://doi.org/10.1080/02691728.2024.2335623>
- Mayowa Oluma, Barriers to Participation Of People With Psychosocial Disability in Mental Health, Health Policy Development in South Africa " (2013) 13 BMC International Health and Human Rights 17,20
- McGuire, Magdalena. “Dignity, Equality, Freedom and Respect: A Human Rights-Based Approach to Mental Health.” *Health Issues*, no. 101, Dec. 2009, p. 13, <https://search.informit.com.au/documentSummary;dn=655365532897565;res=IELHEA>.
- Meghan Hussey, Malcolm MacLachlan, Gubela Mji, Barriers to the Implementation of the Health and Rehabilitation Articles of the United Nations Convention on the Rights of Persons with Disabilities in South Africa. *international Journal of Health Policy and Management*. 2017;6(4): 207-21
- Mental Health and Disability Law in Nigeria: A Call for Affirmative Interpretation, *Journal of Law, Policy and Globalization*, from <https://doi.org/10.7176/jlpg/124-04>, September 1, 2022. DOI: 10.7176/jlpg/124-04
- Mental Health in Nigeria in Nigeria Survey Africa Polling Institute and EpiAFRIC (2019) accessed 8th August 2025. <https://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/2020/01/MENTAL-HEALTH-IN-NIGERIA-SURVEY-Conducted-by-Africa-Polling-Institute-and-EpiAFRIC-January-2020-REPORT.pdf>
- Mercy Abang. Nigeria's Medical Brain Drain; Healthcare Woes as Doctors Flee. Aljazeera
- Minkowitz, Tina, “The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions,” *Syracuse Journal of International Law and Commerce* 34 (2007): 405–428.

- Minkowitz, Tina. "CRPD Article 12 and the Alternative to Functional Capacity: Preliminary Thoughts Towards Transformation." Social Science Research Network, Dec. 2013, doi:10.2139/SSRN.2371939.
- Morostes, Anca Florina. "Correlation between International Regulations and Domestic Regulations in the Field of Human Rights and Freedoms." *Beobhag Yeon'gu (Gyeongsang Daehag'gyo Beobhag Yeon'guso)*, May 2024, doi:10.2478/jles-2024-0009.
- Mulikat Hassan, Revisiting Nigeria's Mental Health Legislation. The Law Industry Trends. News & Insights. available @ <https://libralawoffice.com/wp-content/uploads/2021/05/Revisiting-Nigerias-Mental-Health-Legislati> accessed 28 Aug,2025
- Ndoni, Erebi. Reproductive Health Rights of Persons with Disabilities in Nigeria: A Legal or Cultural Flaw? Springer International Publishing, 2023, pp. 49–69, doi: 10.1007/978-981-99-2411-0_4.
- Ndou, Moffat Maitele. *A Critical Evaluation of the Human Rights of Involuntary Mental Health Care Users*. Jan. 2015, <https://repository.nwu.ac.za/handle/10394/36894>.
- Nolan Peter. Approaches to mental health care in 19th and early 20th-century England. *British Journal of Mental Health Nursing*. 2022; 11(4):1-7. DOI: 10.12968/bjmh.2022.0033
- Nweze,T (2024).Right based Appraisal of Some Aspects of Nigerian Mental Laws, University of Saskatchewan, Haverst
- Odinkalu CA," The Role of the African Commission On Human and People's Rights in the development of International Human Rights Lawin Africa (2001) 35 journal of African Law 182.
- Odinkalu CA. Implementing Economic, Social and Cultural [rights] in the African Charter on Human and Peoples' Rights. *Human Rights Law Journal*. 2001;10:105.
- Ogunlesi AO et al, Yaba psychiatric Hospital: 110 Years of Restoring Hope To Mentally ill Persons(Vanguard News,18 March 2018)
- Ogunlesi, AO & Ogunwale A (2012) Mental Health Legislation in Nigeria: Current leaning and future needs, *South African Journal of Psychiatry*, 18 (1): 24-28. <https://doi.org/10.4102/sajpsychiatry.v18i1.282>
- Ogunwale A, Pienaar L, Oluwaranti O. Plausible subjective experience versus fallible corroborative evidence: The formulation of insanity in Nigerian criminal courts. *Front Psychiatry*. 2023; 9;14:1084773. doi: 10.3389/fpsy.2023.1084773.
- Ogunwale, A. (2023). Implementation of the Nigerian Mental Health Act 2021. *The Lancet Psychiatry*. [https://doi.org/10.1016/s2215-0366\(23\)00261-4](https://doi.org/10.1016/s2215-0366(23)00261-4)
- Oluwatosin O .Ogunwale & Rotimi O.Akinnnuoye "Mental Health Legislation and Involuntary Commitment in Nigeria " (2012)Washington University Global Studies Law Review 247-252

- Ozota, G. O., Sabastine, R. N., Uduji, F. C., & Okonkwo, V. C. (2024). Nigeria mental health law: Challenges and implications for mental health services. *South African Journal of Psychiatry*. <https://doi.org/10.4102/sajpsychiatry.v30i0.2134>
- Patel V et al, Mental Health Policy and Service Guidance Package: South Africa Case Study (World Health Organization, 2009)
- Peterson I et al. Barrier to the Participation of People with Psychosocial Disabilities In Mental Health Policy Development in South Africa. A Qualitative Study of Perspectives of Policy Makers, Professionals, Religious Leaders, and Academics. *BMC International Health and Human Rights*:2013; 13(17)::1-12
- Pillay, Anthony L., et al. "Inequities in Forensic Mental Health in South Africa and Recommendations for Service Development." *International Journal of Forensic Mental Health*, vol. 22, Aug. 2023, pp. 326–39, doi:10.1080/14999013.2023.2243856.
- Sarpekoy, Ramazan Kumarbeckovich. "International Legal Standards for the Protection of the Rights of Persons with Disabilities: Some Aspects of Implementation in Kazakhstan and Foreign Countries." *Vestnik Instituta Zakonodatel'stva Respubliki Kazahstan*, June 2023, doi:10.52026/2788-5291_2023_73_2_137.
- Sarpekoy, Ramazan Kumarbeckovich. "International Legal Standards for the Protection of the Rights of Persons with Disabilities: Some Aspects of Implementation in Kazakhstan and Foreign Countries." *Vestnik Instituta Zakonodatel'stva Respubliki Kazahstan*, June 2023, doi:10.52026/2788-5291_2023_73_2_137.
- Saya, A., Brugnoli, C., Piazzini, G., et al.(2019). Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry around the World: A Narrative Review. *Frontiers in Psychiatry*, 10, 271. <https://doi.org/10.3389/fpsy.2019.00271>
- Stavert, Jill, and Rebecca McGregor. "Domestic Legislation and International Human Rights Standards: The Case of Mental Health and Incapacity." *The International Journal of Human Rights*, vol. 22, no. 1, Jan. 2018, pp. 70–89, doi:10.1080/13642987.2017.1390307.
- Swanepoel, M. (2021). *The Constitutional Imperative, Common Law Position and Domestic Legislation in the Context of Mental Health Care Law in South Africa*. 149–167. https://doi.org/10.1007/978-3-030-71024-8_7
- Szabo CP, Kaliski SZ. Mental health and the law: a South African perspective. *BJPsych Int*. 2017 Aug 1;14(3):69-71. doi: 10.1192/s2056474000001951.
- T Degener, 'A Human Rights Model of Disability' in P Blanck and E Flynn(eds), *Routledge Handbook of Disability law and human right*(2017)
- T. Minkowitz, "The United Nations Convention on the Rights of Persons With Disabilities and the Rights to be free from non Consensual Psychiatric Intervention"(2007) 34 *Syracuse journal of International Law and Commerce* 405
- Taiwo O. Are & John Olabode, "Nigeria Mental Health Law: Challenges and Implicafor Mental Services "(2024) 14(2) *Laws* 1,5

- The burden of drug abuse in Nigeria: a scoping review of epidemiological studies and drug laws *Publ. Health Rev.*, 42 (2021), Article 1603960, 10.3389/phrs.. 2021.1603960
- The Lancet Global Health. The Time Is Now: Reforming Nigeria's Outdated Mental Laws
- Then, Shih-Ning, and Christine Bigby. “Supported Decision-Making and the Disability Royal Commission.” *Research and Practice in Intellectual and Developmental Disabilities*, Mar. 2024, doi:10.1080/23297018.2024.2330961.
- United Nations General Assembly, Human Right council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc A/HRC/35/21 (2017)
- Van Hout, Marie Claire, and Jakkie Wessels. *Navigating the Complexities of the Mentally Ill and Mentally Incapacitated in the Criminal Justice System in South Africa*. Nov. 2021, p. 100068, doi:10.1016/J.FSIML.2021.100068.
- Varelius J. The value of autonomy in medical ethics. *Med Health Care Philos.* 2006;9(3):377-388. doi:10.1007/s11019-006-9000-z
- Viljoen F. and Biejon J, The protocol to African charter on Human and People's Rights on the Rights of Persons With Disabilities in Africa: A Commentary (Pretoria University Law Press 2021)
- Vivanti, Donata Pagetti, and Luisa Bosisio Fazzi. Legal Capacity of Persons with Intellectual Disabilities. no. 6, Jan. 2019, pp. 219–50, <https://universitypress.unisob.na.it/ojs/index.php/minorityreports/article/view/657>.
- Weller, Penelope June. “The Convention on the Rights of Persons with Disabilities and the Social Model of Health: New Perspectives.” *International Journal of Mental Health and Capacity Law*, no. 21, Sept. 2014, pp. 74–83, doi:10.19164/IJMHCL.V0I21.234.
- Wickremsinhe MN. Emergency involuntary treatment law for people with mental disorders: A comparative analysis of legislation in LMICs. *Int J Law Psychiatry.* 2018;56:1-9. doi:10.1016/j.ijlp.2017.09.003
- Wikipedia contributors, Federal Neuropsychiatric, Yaba (Wikipedia last edited 26 June 2025)
- World Health Organisation (WHO). Mental health action plan 2013–2020 available @ https://www.who.int/mental_health/publications/action_plan/en/ accessed 9th August 2025
- World Health Organization, Mental health: promoting and protecting human rights (2022) <https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights> accessed 26 August 2025.
- World Health Organization. Mental Health: a State of Well-Being. Available @ http://www.who.int/features/factfiles/mental_health/en/. (2014) accessed 6th August 2025

Yesiru A, KareemYesiru A, KareemUmar B, et al, An x-ray of the National mental health act 2021 of Nigeria: opportunities, limitations and the way forward. West African Journal of Medicine. 2023; 40(12 Suppl 1):S43