

**RESTRAINT AND SECLUSION IN MENTAL HEALTH CARE: UNCOVERING
HUMAN RIGHTS ABUSES AND ADVOCATING FOR REFORMS**

SUBMITTED

BY

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**BEING A PROJECT SUBMITTED TO THE FACULTY OF LAW, ALEX EKWUEME
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DECLARATION

I, ESTHER CHINECHEREM OKERE, Student of the Faculty of Law, Alex Ekwueme Federal University, Ebonyi State, do hereby declare on my honour, that this project has not been previously presented, either wholly or in part for the award of any other Degree, Diploma, Certificate or Publication in any University, other Higher Institutions or elsewhere.

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(2020/LW/13651)

CERTIFICATION

This is to certify that this long essay titled “Restraint and Seclusion in Mental Health Care: Uncovering Human Rights Abuses and Advocating for Reforms” has been assessed and approved by the Undergraduate Studies Committee of the Faculty of Law, Alex Ekwueme Federal University, as an original work carried out by Esther Chinecherem Okere with registration number 2020/LW/13651 in the Faculty of Law, Alex Ekwueme Federal University, under the guidance and supervision of Prof. Eseni Azu Udu.

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DEDICATION

To the Almighty God, Jesus Christ, and the Holy Spirit.

To my amiable lecturers who have walked with me, imparting wisdom, inspiration, guidance and support. May this work honour your sovereignty and celebrate the gift of knowledge and mentorship that have shaped my journey.

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LIST OF ABBREVIATIONS

A.B.U.T.H.	Ahmadu Bello University Teaching Hospital
C.R.A.	Child Rights Act
C.F.R.N.	Constitution of the Federal Republic of Nigeria
C.R.P.D	United Nations Convention on the Rights of Persons with Disabilities
C.E.D.A.W.	Convention on the Elimination of All Forms of Discrimination against Women
C.C.B.D.	Council for Children with Behavioral Disorders
M.N.S.	Mental, Neurological and Substance Abuse
N.H.A.	National Health Act
N.I.P.R.D.	National Institute for Pharmaceutical Research and Development
N.H.R.C.	National Human Right Commission
N.M.A.	Nigeria Medical Association
N.G.O.	Non-Governmental Organization
P.T.S.D.	Post-traumatic stress disorder
U.K	United Kingdom
U.N.	United Nations
U.S.A.	United States of America
W.H.O	World Health Organization

ABSTRACT

The stability of mental health has been a pivotal ingredient and a key determinant factor of the overall well-being of individuals. This has been geared towards the preservation of human dignity, the maintenance of a favorable environment for mental health care, ensuring the protection of human rights without compromising the need for individualized care, and the overall goal of promoting a humane and effective mental health care system. The main objective of this research is to critically examine the use of restraint and seclusion in mental health care, uncover human rights abuses, and advocate for reforms to promote human rights. The research adopted the Doctrinal research method to explore the legal frameworks and policies governing mental health care and human rights. Through a thorough analysis of relevant laws, regulations, and case studies, the study provided valuable insights into the use of restraint and seclusion in mental health care. This comparative study contributed to the existing literature on mental health care reform and human rights. The findings in relation to this research boil down to the internal defects of restraint and seclusion that pose a threat to human dignity and well-being, which can be corrected through restructuring and revitalizing of the agencies saddled with the responsibility of enforcement, amendment of some laws in existence, implementation of those Laws related to the protection of mental health Patient and also proffer alternatives to restraint and seclusion in mental health. In the overall, the study contributed to the ongoing discourse on mental health care reform, the negative effect of the use of restraint and seclusion mental health care settings, advocated for a policy and practice reforms that promote human rights and dignity.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Mental health is a fundamental aspect of human well-being. As stated by Mahatma Gandhi, *“health is the real wealth, and not pieces of gold and silver”*. Despite its significance, mental health is frequently neglected and ignored by individuals and the Society as a whole.

The term Mental health is the totality of wellness a person experiences relating to his emotional and psychological state. The World Health Organization(WHO) aided the definition of mental health and also provided that mental health includes the “subjective wellbeing, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one’s intellectual and emotional potential, among others.”¹

The use of restraint and seclusion in mental health care setting has been a long standing and contentious issue. Despite efforts to reduce and eliminate this practice, they persist in various States, resulting in significant human right concerns. Restraint and seclusion are often perceived and used as reputable measures of last resort to manage behaviour perceived as threatening or disruptive. However, these practices can have devastating consequences, including physical harm, emotional trauma, and even death. the term “restraint and seclusion in mental health care” is not limited to individual dignity and autonomy, it extends its scope and raises broader questions about the adequacy of mental health care systems and the protection of human rights. It investigates the national human rights law as well as the international human rights law, especially, the United

¹ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 93.

Nations Convention on the Rights of Persons with Disabilities(CRPD), which emphasizes on the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disabilities.²

Despite these legal protections, the use of restraint and seclusion in mental health care settings remains widespread. Studies reveals that these practices are often used disproportionately against marginalized groups. the World Health Organization (WHO) has emphasized the need to reduce and eliminate the use of restraint and seclusion in Mental health care settings, highlighting the importance of promoting a culture that respects the dignity and autonomy of all individuals.

1.2 Statement of the Problem

In the contemporary World, the issue of restraint and seclusion in mental health care settings has gained substantial attention. Despite the establishment of comprehensive human right frameworks, including the United Nations Convention on the Rights of Persons with Disabilities(CRPD), restraint and seclusion has stood out often times as it is widely used in the mental health care settings, resulting in alarming rates of human rights abuses. This problem is further compounded by inadequate laws, policies as well as implementation mechanisms governing the mental health care setting. The use of restraint and seclusion can have long-term consequences including decreased self-esteem, reduced opportunities for social inclusion, increased stigmatization.

The story of *Adebola Rayo*, a legal practitioner who suffered from mental health challenges, she tells her story of having a success in her career, but having to struggle with various issues relating to her mental health.

² United Nations Convention on the Rights of Persons with Disabilities 2006, article 25.

On the stigma she experienced, she laments:

Living in a society where mental illness is an unspoken thing is tough, when you are dealing with such illness. There are derogatory labels flying about, and I was scared of being labelled. I was scared that if I went to a psychiatric hospital, if I got diagnosed, someone would say: 'Oh Rayo? She's mad' or 'she has a mental problem..... Mad' and mental problem; I hate both the word and the phrase, but it is what Nigerians commonly term mental illness, and the words would usually be said derisively and I didn't want that.

Her story shows the urgent need to pay attention to the apathetic growth in the rate of mental health related issues especially in Nigeria.³

This study seeks to address the aforementioned problem by examining the existing legal framework and proposing necessary alternative approaches, reforms, recommendations to restraint and seclusion in the mental health care settings.

Research Questions

- (i) What constitutes restraint and seclusion in mental health care and what are the human rights implications of these practices?
- (ii) What are the challenges bedeviling the prevention of the use of restraint and seclusion in mental health care and propose recommendations?
- (iii) How effective are the existing human rights frameworks in preventing the use of restraint and seclusion in mental health care?
- (iv) What reforms are to be implemented to prevent human rights abuses resulting from the use of restraint and seclusion in mental health care?

³ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 107.

1.3 Aim and Objectives of Research

The aim of this research is to critically examine the use of restraint and seclusion in mental health care, uncover human rights abuses, and advocate for reforms to promote human rights, dignity and well-being.

The Specific Objectives are:

- (i) To examine restraint and seclusion in mental health care as well as their implications for human rights.
- (ii) To analyze the prevalence and consequences of restraint and seclusion in mental health care settings.
- (iii) To propose recommendations for reforms to prevent human rights abuses resulting from the use of restraint and seclusion in mental health care.

1.4 Scope and Limitations of the Study

The study will focus on several key areas to provide a thorough understanding of restraint and seclusion in mental health care and relevant laws. It will begin with an examination of the definition and classification of restraint and seclusion in mental health care. The study will then analyze the effectiveness of relevant international and national human rights frameworks, laws, policies and implementations mechanisms governing the use of restraint and seclusion in mental health care including the Mental Health Act and the United Nations Convention on the Rights of Persons with Disabilities. Detailed case studies of facilities that have successfully reduced or eliminated the use of restraint and seclusion in mental health care, highlighting best and alternative approaches. The study will also explore contemporary issues the use of restraint and seclusion in

mental health care and the bedeviling challenges to the prevention of these practices. Finally, the study will offer recommendations for reforms to prevent human rights abuses resulting from the use of restraint and seclusion in mental health care.

Limitation of the Study

While the study aims to provide a comprehensive analysis, it is subject to certain limitations:

(i) Scope of case studies: The study will select specific case studies of mental health care facilities for detailed analysis, which may not cover all instances of restraint and seclusion.

(ii) Availability of Data: Access to detailed and reliable data on restraint and seclusion practices, particularly in low-resource settings, may be limited.

(iii) Complexity of Mental Health Care Systems: The study may not capture the full complexity of mental health care systems, including variations in Policies, procedures, and practices across different settings.

Other limiting factors that curtailed the smooth flow of the study include; time constraints due to different activities juggling both research time, examinations and attendance to lecture. Also, lack of adequate network reception to access online material.

1.5 Significance of the Study

The study contributes significantly to the field of mental health care and human rights by offering a comprehensive analysis of current legal frameworks, effectiveness and their implications for human rights abuses. Its findings and recommendations are valuable for policy makers and law makers, providing insights on how to develop and implement policies and laws that prevent human rights abuses in mental health and the protection of these mental Patients from discrimination. The

research holds practical relevance, as it identifies challenges bedeviling the prevention of the use of restraint and seclusion in mental health care and propose recommendations relating to alternative approaches to mental health care. By shedding light on the complex issues surrounding restraint and seclusion, the study supports the broader humanitarian goal of achieving justice, dignity, and well-being for individuals with mental health conditions, and promoting a human rights-based approach to mental health care.

1.6 Research Methodology

The research methodology for the study will employ doctrinal research methodology and a multi-faceted approach to provide a critical analysis of restraint and seclusion in mental health care. The methodology will include a combination of literature review, case study analysis, qualitative analysis to examine legal texts, court judgements, and academic commentaries, internet documents and comparative analysis. This approach will ensure a thorough examination of legal frameworks, challenges, effectiveness of preventing the use of restraint and seclusion in mental health care settings. By employing these methodologies, the study aims to provide a comprehensive and critical analysis of restraint and seclusion in mental health care, and to contribute to the ongoing discourse on human rights, dignity and well-being in mental health care.

1.7 Chapter Analysis

Chapter One: Chapter one of this work started with the introduction to the study of restraint and seclusion in mental health, providing an overview of the practices, challenges and human rights abuses. The statement of the problem highlights the prevalence of this restrictive practices as well as human rights concerns despite the existence of legal frameworks. The objectives of this research outlines the specific goals, while the scope and limitation clarify the boundaries of the research.

The significance of the study underscores implications of restrictive practices, highlights the need to enhance justice, human dignity and well-being. The research methodology provides the approach used in the research.

Chapter Two: Chapter two provides an overview of the concepts related to this research and theoretical foundations, it also reviews literatures related to this topic, identifies gaps that the study aims to address.

Chapter Three: Chapter three examines the legal and institutional frameworks addressing the use of restraint and seclusion in mental health care. It discusses national, regional and international laws regulating the use of restraint and seclusion in mental health.

Chapter Four: Chapter four presents a historical overview of mental health, overview of the use of restraint and seclusion as well as its implications. It also provides alternatives to the use of restraint and seclusion in mental health.

Chapter Five: this is the final chapter, it summarizes the key findings, provides recommendations and reforms. It emphasizes on the safety of human person, dignity as well as the well-being of mental health patients. Prioritizing human rights and suggesting areas for further research in order to provide an understanding and improvement in mental health care settings.

CHAPTER TWO

CONCEPTUAL CLARIFICATIONS, THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

The purpose of this section is to examine academic commentary on the use of restraint and seclusion in mental health care, with a focus on human rights abuses and the need for reform. It outlines the conceptual framework for understanding the complex issues surrounding these practices and identifies the main themes that will be explored in this thesis. The existing research on restraint and seclusion has been used as a foundation for framing the research questions that will guide this investigation into promoting more humane and rights-based approaches to mental health care.

2.1 Conceptual Clarifications

2.1.1 Mental Health

Mental health is the totality of wellness a person experiences relating to his emotional and psychological state. In simpler terms, it refers to the emotional and psychological well-being of a person. The World Health Organization (WHO) defines mental health to include the "subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others. The WHO further states that "the wellbeing of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community.¹ Mental health encompasses an individual's overall psychological well-being, influencing their cognitive function, emotional stability and social interactions. It extends beyond the mere absence of mental illness,

¹ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 93.

incorporating the capacity to navigate life's challenges effectively, foster meaningful relationships and engage productively in the society. The Surgeon General of the U.K. IN 1999, Vice Admiral David Satcher, defined mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and providing the ability to adapt to change and cope with adversity. While mental illness refers to collectively, all diagnosable mental disorders and health conditions characterized by alterations in thinking, mood, or behavior associated with distress or impaired functioning.² Jahoda subdivided mental health into three domains: self-realization, in that individuals are able to fully exploit their potential; sense of mastery over the environment; and sense of autonomy, i.e. ability to identify, confront, and solve problems.³ The concept of mental health is not merely the absence of mental illness. The proposed definition of mental health is reported therewith:

Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of equilibrium.⁴

Isaac Ray, a founder of the American Psychiatric Association and its fourth President, defined mental hygiene as "the art of preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements.⁵ Doctor Brock Chisholm,

² National Institute of Mental Health, *Mental Health, A Report of the Surgeon General* (Office of the Surgeon General, Center for Mental Health Services, National Institute for Mental Health, US 1999).

³ Available at <https://ueaeprints.uae.ac.uk/id/eprint/65104/1/Final_Galderisi_Mental_Health_Definition.pdf> accessed on 20 April 2025.

⁴ Ibid

⁵ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 93.

the first Director-General of the World Health Organization(WHO) also stated that “without mental health there can be no true physical health”.

Mental Health Disorder

Mental health disorder refers to conditions that affect the brain, leading to significant disturbances in thought, emotion, and behavior. These conditions can severely impact an individual’s ability to cope with daily life, manifesting in various forms such as; bipolar disorder, paranoia, dementia, autism and other form of behavioral disorder among others. These conditions can significantly affect a person’s quality of life, relationships, and overall wellbeing. Mental health is an essential part of the overall health and wellbeing of a person. It's best to begin with the observation of a Medical Doctor, Dr Aliyu Abubakar Ahmadu Bello University Teaching Hospital (ABUTH), Zaria;

According to a recent study, 85 per cent of mad people in Nigeria are youths within the age bracket of 18-38 years. The major cause of mental challenge in Nigeria has gone beyond drug-abuse as the youths now inhale lizard feces, putting their noses into pit toilets, smoking matches, smoking dried horse feces and mixing lizard feces with dye powder.

This describes the worrisome situation of mentally challenged individuals in Nigeria. Most important is that individuals with mental illness are stigmatized as they are commonly referred to as 'mad people.'⁶

Mental illnesses are more prevalent than cancer, diabetes, or heart disease, with a **Hopkins** research showing that over 26 percent of all Americans over the age of 18 suffer from a diagnosable mental disorder in one given year (about 1 in 4 adults).The WHO in 2010 in a report estimates that the global cost of mental illness is nearly \$2.5 trillion (which is about two-thirds in

⁶ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 91.

indirect costs) — it projects an increase to over \$6 trillion by 2030.⁷ There is a link between mental health disorders and other illnesses, as patients with intense medical conditions as diabetes, asthma, and cardiovascular disorders, particularly in primary care facilities have a higher probability of having a mental health disorder as depression and anxiety. The co-existence of these health disorders with general medical conditions is undeniable, as persons with more severe behavioral health challenges commonly develop illnesses as diabetes and heart diseases which makes them die early.⁸ The growing rate in mental health illnesses have been described as the fifth leading cause of death and disease in the world.⁹ Also, it is the top five sources of disability in individuals aged 18-44 years, four result from behavioral health issues.¹⁰ Under India's Mental Health Act of 1987, a mentally ill person was defined as someone requiring treatment for mental disorders excluding intellectual disability (previously termed mental retardation). However, this Act was criticized for neglecting the rights and dignity of individuals with mental illnesses, potentially leading to their isolation.

The Mental Health Care Act of 2017 has since replaced the 1987 Act, aiming to address these concerns and promote a more rights-based approach to mental health care.

The most common types of mental health disorders include:

(i) Depression: is the most common form of mental health challenges in recent times. it is a mental health disorder that affects the mind and has noticeable effects on the physical and social behavior of the individual. Effects of depression include slow body movement and thinking, severe weight

⁷ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 97.

⁸ Ibid

⁹ Ibid

¹⁰ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 97.

loss, and feeling of hopelessness.¹¹ The WHO has stated that depression is the main cause of suicide globally. It also estimates that about 10% of Nigerians suffer from depression. The Nigeria Medical Association (NMA) has disclosed that 90% of reported cases of suicide have been traced to depression.¹²

Depression is a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world. Nearly three in ten adults(29%) have been diagnosed with depression at some point in their lives and about 18% are currently expressing depression, according to the national survey.¹³ Depression can occur at any time and age. Symptoms can vary from mild to severe and can appear differently in each person. These symptoms include: feeling sad, empty and/or hopeless, losing interest, loss of appetite, decreased energy amongst others. Depression can affect anyone—even those who seemingly have it all. Several factors can play a role in depression:

(a). Biochemical: Differences in certain chemicals in the brain (such as the neurotransmitters serotonin, dopamine and norepinephrine) may contribute to symptoms of depression.

(b). Genetic: Depression can run in families. For example, if one identical twin has depression, the other has a 70 percent chance of having the illness sometime in life.

(c) Personality: People with low self-esteem, who are easily overwhelmed by stress, or who are generally pessimistic may be more likely to experience depression.

¹¹ O Antonius, 'Summary of Depression'(30 October 2015), available at <www.livestrong.com/article/111209-summarydepression/>accessed 23 April 2025.

¹² Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd,2019) 94.

¹³ American Psychiatric Association available at <<https://www.psychiatry.org/patients-families/depression/what-is-depression>> accessed 23 April 2025.

(d). Environmental: Continuous exposure to violence, neglect, abuse or poverty can also pose risks for developing depression.¹⁴

(ii) Bipolar Disorder: Also referred to as manic-depressive illness. This disorder makes a person suffer from extreme feeling of happiness), insomnia (lack of sleep), irritability, unusual behavior, feelings of guilt and hopelessness, loss of appetite which could lead to suicidal thoughts and a host of other negative behavior. It makes an individual lose relationships with relatives, family and colleagues. The disorder occurs in various forms including: Bipolar 1 Disorder, Bipolar 11 Disorder, and Cyclothymic Disorder amongst others.¹⁵ Bipolar disorder, formerly known as manic-depressive illness is a mental health condition characterized by extreme mood swings. These mood swings ranges from emotional highs (mania) to lows (depression). Symptoms include: Manic Episodes, Depressive Episodes.

(iii) Schizophrenia: This is a mental health disorder that generally affects people of late adolescence or early adulthood. Is It is associated with a dysfunctional expression or perceptions of reality. The Merriam-Webster dictionary defines it as a mental disorder characterized by delusions, hallucinations, catatonic behavior, and deterioration in the ASA functioning of the everyday life. Its symptoms include delusions, loss of personality, social withdrawal, psychosis and bizarre behavior.¹⁶

(iv) Dementia: This is a severe mental disorder formed by a deterioration of mental capabilities, especially at the stage of full development. Its symptoms include memory loss, and a plunge in

¹⁴ American Psychiatric Association, available at <<https://www.psychiatry.org/patients-families/depression/what-is-depression>. > accessed 23 April 2025.

¹⁵ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 95.

¹⁶ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 95.

personal hygiene. It begins with memory loss and leads to other effects such as inactivity and ultimately depression and suicidal thoughts.¹⁷

Mental health disorder has a varied misconception in Nigeria and by Nigerians. It is often viewed in the context of preternatural forces, witches, and evil spirits and many others. In Nigeria, various terms have been used to describe mental health disorders, with some attributing their causes to supernatural factors such as 'juju' and spiritual influences. However, it is crucial to acknowledge that effective management of mental health conditions requires professional medical intervention. Unfortunately, in Nigeria, many individuals experiencing mental health issues are often taken to traditional healers or confined to institutions, rather than receiving evidence-based treatment from qualified mental health professionals.

2.1.2 Restraint and Seclusion in Mental Health Care

Restraint and seclusion are behavioral management interventions that should be used as a last resort to control a behavioral emergency. Restraint involves the use of physical force or mechanical devices to immobilize a person as well as chemical restraints. Seclusion, a type of restraint, which involves confining a person in a room or a place from which the person cannot exit.¹⁸

Restraint:

This involves the act of holding someone back or limiting their movement or freedom.

¹⁷ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 95.

¹⁸ Available at <<https://era.library.ualberta.ca/items/1f8210e1-d99b-47a2-ada3-4df6e8e4c4eb/view/c72bc7cd-6ec6-4566-8899-373fe0d44f15/Module%2013d%20Seclusion%20and%20Restraint.pdf>. > accessed 24 April 2025.

Seclusion:

This involves isolating an individual from others, usually in a separate room or a place with the intention of reducing stimulation or preventing harm to themselves or others. Seclusion may also be referred to as environmental restraint.

In mental health context, Restraint and seclusion involves the use of physical or chemical methods to manage severe behavioral disturbances or aggression. However, the use of restraint and seclusion is subject to strict guidelines and regulations, prioritizing the dignity and safety of humanity.

The European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment defines the different forms of restraint and seclusion as follows:

- (a) Physical restraint (i.e. staff holding or immobilizing a patient by using physical force- “manual control”)
- (b) mechanical restraint (i.e. applying instruments of restraint, such as straps, to immobilize a patient);
- (c) chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient’s behavior);
- (d) seclusion (i.e. involuntary placement of a patient alone in a locked room).¹⁹

The confinement of patients in an area without their consent to prevent them from leaving a particular place is called “seclusion”, on the other hand, the act of using mechanical or physical

¹⁹ B McSherry, ‘Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities’ *International Journal of Law and Psychiatry* [2017] (53) 39.

intervention to restrict the movement of a patient and bring their behavior under control is called “restraint”.²⁰

2.1.3 Prevalence of Restraint and Seclusion in Mental Health Care

There is much controversy regarding the use of restraint and seclusion in mental health care settings. the use of seclusion and restraint varies considerably across psychiatric hospital level, in 1992, Brown and Tooke observed and concluded that patients who were restrained and secluded has varied from 0-66% and the average duration of the measures ranged from 1.5 hours to 50.6 hours.²¹ In 1994, Fisher reviewed the literature and concluded that restraint and seclusion were useful for preventing injury and reducing agitation and that it was impossible to run a program that dealt with seriously ill individuals without the use of restrictive interventions.²² A review by Mohr et al’ concluded that the use of restraints put patients at risk for physical injury and death and can be traumatic even without physical injury.²³

The rate of mental health issues has been unprecedented and this has led to continuous discrimination and stigmatization experienced by patients using inflicted by the Public,²⁴ organizations/institutions,²⁵ and self-stigmatization.²⁶

²⁰ A Okanli, E Yilmaz and F Kavak, ‘Patients Perspectives on and Nurses Attitude toward the Use of Restraint/Seclusion in a Turkish Population’ *International Journal of Caring Service* [2016] (9) (3) 932.

²¹ A Keski, ‘*The Use of Seclusion and Mechanical Restraint in Psychiatry*’ (Multi print Oy Vaasa 2010) 10.

²² D Knox and G Holloman ‘Use and Avoidance of Seclusion and Restraint’ *Western Journal of Emergency Medicine* [2012] (13) (1) 36.

²³ D Knox and G Holloman, ‘Use and Avoidance of Seclusion and Restraint’ *Western Journal of Emergency Medicine* [2012] (13) (1) 36.

²⁴ An experience where the public shows disgust and detest including seclusion from persons suffering from this illness.

²⁵ Many institutions implement policies, regulations that shows stigma for persons with mental illness.

²⁶ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 100.

A survey carried out in Karfi village in Northern Nigeria reveals that 34% are more inclined to spiritual healing while 46% prefer orthodox medicine, almost half the respondent harbored negative feeling for the mentally ill. The study by Gureje et al reveals that 96.5% believe that people with mental illness are dangerous people because of their violent behavior. A report by Audu et al, shows that only 0.9% attribute mental illness to brain disease, the others attributed mental illness to spiritual attack, punishment for evil doing and illicit psychoactive substance use, among other things.²⁷

Below is a selection of prevalence rates for different types of restraint in various care settings:

(i) Research carried out in Ireland and published in 2012 looked at conflicts and interactions between staff and residents of nursing homes. A total of 1,316 nursing home staff participated in the research by responding to questionnaires anonymously. The research found that the use of restraint beyond what was needed at the time constituted the most frequent form of physical abuse:

- 8.5% of staff said they observed this happening on one or more occasion

- 2.4% of staff said that they had committed such an act on one or more occasion.

(ii) A German study involving eight nursing homes found that approximately 10% of

staff reported using physical restraints and 7% used chemical restraints to reduce

workloads.

²⁷ A Armiyau, 'A Review of Stigma and Mental Illness' *Journal of Clinical Case Reports* [2015] (5) (1) 1.

(iii) A study of a psycho-geriatric unit in Germany found that 30.3% of patients had experienced physical restraint within three weeks of first admission. The rate of use was higher in patients with severe cognitive impairments.

(iv) A 12-month study in Victoria, Australia examined the use of three forms of restraint (chemical, mechanical and seclusion) in people with an intellectual disability and/or acquired brain injury. It found that approximately 9% of those studied had been subjected to one or more of these forms of restraint. The instance of chemical restraint far outweighed the other two forms of restraint, accounting for 83% of all reported incidents. Chemical restraint was found to be administered on a routine basis.

(v) Data gathered from three nursing care settings in the Netherlands found that 49% of residents were subjected to one or more forms of physical restraint. The most common types of physical restraint were bed rails, waist belts and chairs with a table.

(vi) Two separate studies that looked at the prevalence of the use of mechanical restraints found that 7% and 17% of adults with intellectual disabilities were subjected to mechanical restraint in order to prevent self-injurious behaviour.

(vii) An analysis of 30 nursing homes in Hamburg, Germany found that approximately 25% of the nearly 2,400 residents were the subject of a physical restraint, most commonly bed rails. In addition, the researchers found that more than 50% of the residents had a prescription for at least one psychoactive medication, despite their assertion that these medications have been shown to be ineffective in geriatric populations

(viii) A Norwegian study of 1,501 nursing home residents found that 36.7% of those in 'regular units' were subjected to a form of restraint within a seven day period. The equivalent figure for

‘special care units for persons with dementia’ was 45%. Mechanical restraint (primarily bedrails) had the highest prevalence in both settings, followed by ‘use of force or pressure in activities of daily living’.

(ix) A comparative analysis of care quality indicators in nursing facilities across the 50 states in the USA from the 2000 OSCAR† found a large degree of variance in the use of physical restraints. The average percentage (non-risk adjusted) of residents physically restrained ranged from 2.3% in Iowa to 23.1% in Louisiana.

(x) A review of incident forms in two service divisions operated by a provider of services to adults with intellectual disabilities in the USA found a prevalence of physical restraint of 5.2% in one division and 7.9% in the other. The use of this form of restraint was reserved for three categories of behavior: self-injurious behavior, aggressive behavior and environmentally disruptive behavior.

(xi) Research published in 2000 analyzed the treatment and management of behaviors that challenge in 500 adults with intellectual disabilities in residential services in the UK. The most commonly-used management strategies for people that had behaviors that challenge were “...physical restraint (used with 44% of people showing challenging behavior), sedation (35%), seclusion (20%) and mechanical restraint (3%)”.²⁸

The use of physical restraint on patients has rightly undergone great analysis and it is important to record how upsetting it is as those who observed incidence of physical restraint reported feelings of distress and hopelessness and its traumatizing effect on the patient and they recommended that

²⁸ Health Information and Quality Authority, available at <https://www.hiqa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature-Review.pdf. >accessed 30 April 2025.

restraint should be the last option.²⁹ The use of restraint and seclusion is not therapeutic, it is incompatible with a recovery approach and it is contrary to the purpose of care,³⁰ evidence has it that restraint and seclusion has many adverse effects including psychological and emotional effects and even death.³¹

Factors Influencing the Prevalence of Restraint and Seclusion in Mental Health

The prevalence of restraint and seclusion in mental health care settings can be associated with the following

- (a) Younger Age
- (b) Borderline personality disorder
- (c) Bipolar disorder
- (d) Involuntary treatment disorder
- (e) Patients earlier on hospitalization
- (f) Environmental factors
- (g) Organizational policies and guidelines

Several reviews have concluded that the absence of standardized definitions and measurement approaches challenges the global effort for the reduction of the use of restraint and seclusion.³²A

²⁹ M Chris and L Brian, *The Lived Experience of Coercion* (Springer Nature Switzerland AG 2024) 11.

³⁰ Geneva: World Health Organization 'Strategies to end seclusion and restraint'. WHO Quality Rights Specialized Training. Course guide 2019.

³¹ Ibid

³² Z Belayneh, J Chavulak, D Lee, M Petrakis and T Haines, 'Methodological issues in measuring restrictive care practices' *Journal of Clinical Nursing* [2025] (34) (5) 1629-1647.

1998 study in Zimbabwe revealed that 8.5% of psychiatric patients were secluded and restrained during their hospitalization, a large majority of the individuals were 35 years of age and younger. A 2013 South Africa study showed that male patients were secluded than female patients.³³ Restraints and seclusion are widely used in psychiatric hospitals to manage challenging behaviors in patients experiencing psychosis.³⁴ The prevalence of restraint and seclusion in mental health care is a concerning issue, as these practices can cause physical and emotional harm to individuals and patient may experience the feeling of shame, humiliation and loss of self-respect.³⁵ However, recognizing the need for a change, health care providers can adopt alternative measures and approaches in order to promote a safer and more respectful mental health care environment. Restraint and seclusion should be employed as a last resort when there is immediate threat to physical safety as propounded by the Council for Children with Behavioral Disorders(CCBD).³⁶

2.1.3 Human Rights

The notion ‘rights’ defy any exclusive definition, as it is a subject of vigorous jurisprudential polemics.³⁷ Rights could be defined as any claims that are morally just and legally granted as due to a person.³⁸ Human rights therefore could be defined as those rights or claims that are inherent in man. They are associated with the nature of Man.³⁹ Human rights are fundamental rights and freedoms inherent to individuals regardless of nationality, gender, religion or any other status. The

³³ Available at <<https://pmc.ncbi.nlm.nih.gov/articles/PMC6307050/>> accessed 25 April 2025.

³⁴ R kontio, G Joffe, H Putkonen, L Kuosmanen, K Hane, M Holi, M Valimaki, ‘Seclusion and Restraint in Psychiatry: Patients’ Experiences and Practical Suggestions on How to Improve Practices and Use Alternatives’ *Articles in Perspectives in Psychiatry care* [2012] (24) (16) 16.

³⁵ M Zboun and M Marzouq, ‘The Use of Restraint in Mental Health Facilities’ *Archives of Psychiatry and Behavioral Sciences* [2020] (3) (12) 4.

³⁶ N Bartlett and T Ellis, ‘Policies Matter: Closing the Reporting and Transparency Gaps in the use of Restraint, Seclusion, and Time-Out Rooms in Schools’ *Canadian Journal of Educational Administration and Policy* [2021] (15) (2) 2.

³⁷ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 1.

³⁸ Ibid

³⁹ Ibid, 4

concept of Human Right is subject to various definition. In this wise, Eze defines human rights thus:

Demands or claims which individuals or groups make on society, some of which are protected by Law and have become part of the *Lex Lata* while others remain aspirations to be attained in the future.⁴⁰

The Nigerian Supreme Court, by way of definition, declared thus:

Human right is a right which stands above the ordinary laws of the land and which is in fact, antecedent of the political society itself. It is a primary condition to a civilized existence, and what has been done by our Constitution since independence is to have these rights enshrined in the constitution so that the right could be ‘immutable’ to the extent of the non-immutability of the Constitution itself.⁴¹

Human rights include civil, political, economic, social, and cultural rights, such as: Right to life and liberty, freedom from torture and discrimination, Right to equality and justice, Right to education and healthcare, freedom of expression and discrimination among others. Human rights serve as a foundation for dignity, justice, peace, and are enshrined in the Nigerian Constitution as well as International law and frameworks governing human rights.

2.1.4 Legal Right of a Mental Patient

A legal right of a mental patient refers to legally protected rights of individuals with mental illness. These rights are essential for the purpose of safeguarding their dignity, ensuring fair treatment and respect for their autonomy. Mental health patients’ rights are an integral part of human rights, emphasizing the importance of dignity, non-discrimination, and access to quality health care. A mental patient can be regarded as having protected rights. These rights can be summarily categorized as follows;

⁴⁰ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 5.

⁴¹ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 5.

(a) Fundamental Rights

(i) Equal fundamental rights as fellow citizens⁴²

(ii) Protection from discrimination⁴³

(b) Specific Rights

(i) Access to medical, social, and legal services⁴⁴

(ii) Protection from physical and mental abuse, exploitation, and violence⁴⁵

(iii) Right to education, vocational training, leisure, and recreational activities⁴⁶

(iv) Humane and dignified treatment with respect to personal dignity and privacy⁴⁷

(v) Freedom of expression and opinion, access to information.⁴⁸

(vi) Reasonable care, assistance, and protection from family, legal representatives, careers, and government⁴⁹

(c) Employment and Housing Rights

(i) Equal access to employment opportunities and fair remuneration⁵⁰

(ii) Protection from employment termination due to mental health conditions⁵¹

⁴² National Mental Health Act, 2021 s 12(1)(a).

⁴³ Ibid, s 12(1)(b).

⁴⁴ Ibid, s 12(2)(a).

⁴⁵ National Mental Health Act 2021, s 12(2)(b).

⁴⁶ National Mental Health Act 2021, s 12(2)(c) and (d).

⁴⁷ Ibid, s 12(2)(f).

⁴⁸ Ibid, s 12(2)(g).

⁴⁹ National Mental Health Act 2021, s 12.

⁵⁰ National Mental Health Act 2021, s 13.

⁵¹ Ibid, s 13.

(iii) Right to housing without eviction solely due to mental health conditions⁵²

(d) Right to Mental Health Services

(i) Access to appropriate, affordable, and accessible mental health services⁵³

(ii) Physical and mental health care, counseling, rehabilitation, and after-care support⁵⁴

(e) Right to Quality Treatment

(i) Same standard of care as physical health problems⁵⁵

(ii) Treatment in the least restrictive environment and manner⁵⁶

(iii) Access to psychotropic drugs, essential medicines, and biopsychosocial interventions⁵⁷

(iv) Participation in treatment plan formulation⁵⁸

Other Rights includes;

(a). Right to appoint a legal representative⁵⁹

(b). Right to participate in treatment planning⁶⁰

(c). Right to privacy and visitation⁶¹

⁵² Ibid, s 14.

⁵³ Ibid, s 15.

⁵⁴ Ibid, s 15.

⁵⁵ National Mental Health Act 2021, s 16.

⁵⁶ National Mental Health Act 2021, s 16.

⁵⁷ Ibid

⁵⁸ National Mental Health Act 2021, s 16.

⁵⁹ National Mental Health Act 2021, s 17.

⁶⁰ National Mental Health Act, 2021, s 18.

⁶¹ Ibid, s 19.

(d). Right to access information regarding mental and other health status⁶²

These rights vary by jurisdictions, however, the main aim is for the promotion of patient well-being, respect and dignity of human person.

2.2 Theoretical Framework

2.2.1 Human Rights Theory

Human rights theory has been shaped by numerous philosophers, theorist and activists. This theory views restraint and seclusion as controversial practices in mental that have raised significant concern. The theory believes and uphold the dignity of humanity while advocating for a reform in mental care. This theory argues that the use of restraint and seclusion can violate individual rights to dignity, autonomy and freedom from abuse as it has been observed that widespread human rights violations are caused by mental health systems and enabled by mental health laws which has led to a legacy of trauma in the lives of mental patients.⁶³ The human rights theory postulates that the mental health setting is safer when there are alternatives to the use of restraint and seclusion which includes patient-centered care, de-escalation technique and others that will be provided in this work. Human rights theory recognizes the consequences of these practices and advocates for a reform. Reports and guidelines from the UN Special Rapporteur on the Right to Health have emphasized on the need to protect human rights in mental health care. This theory posits that laws on mental health often fail to address the issue of discrimination and human right violation in

⁶² National Mental Health Act, 2021, s 20.

⁶³ Geneva: World Health Organization and United Nations (represented by the Office of the United Nations High Commissioner for Human Rights) 'Mental health, human rights and legislation: guidance and practice' 2023.

human right settings.⁶⁴ human rights theory emphasizes on alternatives to restraint and seclusion in mental health care.

2.2.2 Social Control Theory

The social control theory was pioneered by Travis Hirschi, this theory proposes that people are inherently inclined to deviance, and that bonds to society deter criminal activity. The concept contends that a person connection to the society prevents deviant behavior. The use of restraint and seclusion can perpetuate stigma and marginalization, thereby weakening societal bonds and exacerbating human rights issues. A study involving nursing home residents with dementia concluded that the use of physical restraints may lead to cognitive and functional impairment.⁶⁵ The more weakened the groups are, the less willingness to commit crime, for Hirschi, is the social bond, which gives us something to lose through crime.⁶⁶ The foregoing implies that the use of restraint and seclusion is a setback to the social control in reduction of crime rates. The social control theory argues that social bonding influences crime rates by reduction. With this, the consumption of illegal substances and drugs which affect the lives and mental health of individuals would be eliminated. This theory emphasizes on the fact that become more productive when they bond with the society, this will prevent brain drain, depression among others and promote healthy living of the individuals and society at large.

⁶⁴ Available at <<https://www.who.int/publications/i/item/9789240080737>. >accessed 28 April 2025.

⁶⁵ Available at <https://www.hiqa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature-Review.pdf. >accessed 28 April 2025.

⁶⁶ B Costello and J Laub 'Social Control Theory: The Legacy of Travis Hirschi's Causes of Delinquency' *Annual Review of Criminology* 3 (2020).

2.2.3 Labeling Theory

This theory was primarily developed by Howard Becker, this theory posit that society assigning labels to people usually affect their behavior and reduces their self-esteem. A reasonable man would say thus; when you walk into a place for the first time and individuals therein whom you have never spoken to behave unseemly towards you, it is because of what they heard about you.

The labeling theory contends that the use of labels on a person goes a long way affecting their self-identity and self-esteem. This concept believes that the use of label affects mental patients as people tend to avoid them. The use of labels on mental patients can have several negative effects including; Stigmatization, self-perception-affecting their self-esteem, social isolation- people with mental illness will be treated differently, limited opportunities-affecting opportunities for education, employments, scholarship program among others. Let us consider the reasonable Man's reaction to a defamatory statement- the reasonable Man is always willing to file a suit, to do everything to regain his reputation. Tracing this to the labeling theory, a person who is labeled 'A mad Person' will have no option than to isolate himself, or embrace suicidal thoughts even if he is just suffering depression and his outburst earlier was as a result of frustration not because he is actually 'mad'.

The labeling theory contends that the use of labels on mental patients is not an option for the treatment of mentally deranged patients. The theory argues that there are other alternatives to labeling which includes; empowerment, prioritizing patient experiences and perspectives- with the acknowledgement that every patient is different and can respond to treatment differently, empathy around people with mental illness- this

reduces stigma. The popular story of Adebola Rayo speaks volume as regards this labeling theory-

On the stigma she experienced, she laments:

Living in a society where mental illness is an unspoken thing is tough, when you are dealing with such illness. There are derogatory labels flying about, and I was scared of being labelled. I was scared that if I went to a psychiatric hospital, if I got diagnosed, someone would say: 'Oh Rayo? She's mad' or 'she has a mental problem.....

Mad' and mental problem; I hate both the word and the phrase, but it is what Nigerians commonly term mental illness, and the words would usually be said derisively and I didn't want that.⁶⁷

She was scared of being labelled 'a mad person'. Through a serene approach, the story of Adebola Rayo explains the labeling theory, insisting that it is a wrong approach to the treatment of mentally disabled Patients.

2.2.4 Trauma- Informed Care Theory

Trauma-informed care is a therapeutic framework that considers the pervasive nature of trauma and promotes healing and recovery of patients rather than practices that will re-traumatized them. The theory recognizes that each person is unique in perspective and in life experience.⁶⁸ The theory emphasizes on the need for professionals and organization to understand the pervasive impact of trauma in the lives of people they serve and develop trauma-sensitive or trauma-responsive services.⁶⁹ The theory contends that the use of restraint and seclusion in the treatment of people with mental illness will re-traumatize them, exacerbating feelings of powerlessness, distress and fear.

Trauma –informed theory further recognizes that lived experience may have been

⁶⁷ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 107.

⁶⁸ Available at <<https://era.library.ualberta.ca/items/1f8210e1-d99b-47a2-ada3-4df6e8e4c4eb/view/c72bc7cd-6ec6-4566-8899-373fe0d44f15/Module%2013d%20Seclusion%20and%20Restraint.pdf>. >accessed 29 April 2025.

⁶⁹ Available at <https://www.ncbi.nlm.nih.gov/books/NBK207201/pdf/Bookshelf_NBK207201.pdf#page106. > accessed 29 April 2025.

traumatic and this shapes the way the person copes or respond to functions.⁷⁰ Trauma-informed theory acknowledges that the delivery of care may unwittingly reduce patient stress and ensure that there is no adverse effect on the person as the person works through the recovery process.⁷¹ Studies have showed that the trauma-informed care reduces restraint and seclusion, it improves patient engagement, satisfaction and wellbeing, it reduces staff stress among others.

2.2.5 Recovery-Oriented Care Theory

Recovery is the achievement of an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from a mental issue.⁷² The recovery-oriented care theory include understanding that everyone is different and should be supported in making life choices. In recovery-oriented approach it is important to note the following;

- (i) Support each person to have control over life regardless of their emotional experiences,
- (ii) Acknowledge individual differences,
- (iii) See each person as an individual and not just focus on their mental health condition,
- (iv) Be optimistic and support each other achieve their goals,

⁷⁰ Available at <<https://era.library.ualberta.ca/items/1f8210e1-d99b-47a2-ada3-4df6e8e4c4eb/view/c72bc7cd-6ec6-4566-8899-373fe0d44f15/Module%2013d%20Seclusion%20and%20Restraint.pdf>. > accessed 29 April 2025.

⁷¹ Available at <<https://era.library.ualberta.ca/items/1f8210e1-d99b-47a2-ada3-4df6e8e4c4eb/view/c72bc7cd-6ec6-4566-8899-373fe0d44f15/Module%2013d%20Seclusion%20and%20Restraint.pdf>. > accessed 29 April 2025.

⁷² Available at <<https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/recovery.aspx#:~:text=The%20principles%20of%20a%20recovery,treated%20with%20dignity%20and%20respect.> > accessed 29 April 2025.

(v) Understand that mental condition vary significantly from person to person.⁷³

(vi) Recovery-oriented theory emphasizes the need for supporting individuals with mental health conditions through their recovery process. The theory contends that patients who are restrained or secluded are often in a non-recovery state, i.e. their lives are in turmoil or in a state of breakdown leading to the need for hospitalization.⁷⁴ The recovery-oriented delves into the importance of assisting people with mental condition, elucidating some key steps to reducing restraint and seclusion. These includes;

Instituting practices and procedures based on the recovery oriented care concepts;

(a) Allowing flexibility in practice and procedures to meet individual needs;

(b) Implementing person-centered approaches to care;

(c) Instituting guidelines that are user-friendly, easy to understand and easy to remember.⁷⁵

2.2.6 Psychological Theory

Psychological theory is a set of statements that summarizes and explains mental and behavioural patterns within the context of society and culture.⁷⁶ During the first half of 20th century, three theories emerged that shaped the foundation of psychology: psychoanalysis- believes that internal

⁷³ Available at

<<https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/recovery.aspx#:~:text=The%20principles%20of%20a%20recovery,treated%20with%20dignity%20and%20respect.>> accessed 29 April 2025.

⁷⁴ Available at <<https://era.library.ualberta.ca/items/1f8210e1-d99b-47a2-ada3-4df6e8e4c4eb/view/c72bc7cd-6ec6-4566-8899-373fe0d44f15/Module%2013d%20Seclusion%20and%20Restraint.pdf>>accessed 29 April 2025.

⁷⁵ Ibid

⁷⁶ Available at <<https://www.sciencedirect.com/topics/psychology/psychological-theory>>accessed 29 April 2025.

drives(id, ego, superego) and the unconscious determine human behavior, behaviourism-considered environment, reward, and punishment drove behaviours, humanism.⁷⁷

Psychological theory examines the impact of the use of restraint and seclusion in mental health and recommend a more compassionate approach for the purpose of safety and dignity of people with mental illness.

2.3 Literature Review

In a work by Melbourne Social Equity Institute, '*Seclusion and Restraint Project: Overview*',⁷⁸ the project speaks volume on the reduction and elimination of the use of restraint and seclusion in mental health services, the work offered evidence of a consensus that the use of restraint and seclusion in mental health care services is

- (i) Not therapeutic
- (ii) Breaches human rights
- (iii) Compromises the therapeutic relationship/trust
- (iv) Can be reduced

The research submitted by this institute provided that any initiative for a reform in the mental health care setting must be based on the principles of recovery, trauma-informed care and human rights. The research team also stated that the use of restraint and seclusion could be regulated through legislation, policy and accreditation to ensure safety and dignity of humanity. The research

⁷⁷ Available at <<https://www.sciencedirect.com/topics/psychology/psychological-theory>. >accessed 29 April 2025.

⁷⁸ Melbourne Social Equity Institute, '*Seclusion and Restraint Project: Overview*' *University of Melbourne* [2014] 5.

provided six core strategies for the reduction of Seclusion and restraint in mental health care settings. Those six core strategies are:

- (i) Leadership towards organizational change –articulating a philosophy of care that embraces restraint and seclusion
- (ii) Using data to inform practice-using data in an empirical, non-punitive way to examine and monitor patterns of seclusion and restraint use
- (iii) Workforce- developing procedures, practices and training that are based on knowledge and principles of mental health recovery
- (iv) Use of seclusion and restraint reduction tools
- (v) Debriefing techniques- conducting analyses of why restraint and seclusion occurred and its impact on mental patients
- (vi) Consumer roles in inpatients.

The work of the Regulation Directorate on ‘*Restrictive Practices*’⁷⁹ is worth of review as it that in terms of caring for people with intellectual disabilities, successfully identifying the cause of the challenge can assist in devising interventions that will negate the need for restraints. The research also stated that that there are consequences for restraints. Two studies revealed that the use of restraint for older patients will increase their length of stay in the hospital, the use of bedrails or cotsides has been shown to be particularly problematic. Several articles also documented the risks of bedrails. In USA, the Food and Drug Administration and the Joint Commission for the

⁷⁹ Available at <https://www.hiqa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature_Review.pdf. >accessed 30 April 2025.

Accreditation of Health Care Organizations have issued advisories cautioning against the risks associated with bedrails. A study involving nursing home residents also reveals that the use of physical restraint may lead to cognitive and functional impairment. A study also reveal that mechanical restraint is the second highest cause of death in law enforcement and care services in the UK and USA. Some of the negative effect of psychotropic medication used in chemical restraint has also been revealed to include: agitation, functional decline, gait disturbance, increased fall risk, memory impairment among others.

Murphy and Bennington in their work '*Restraint and Seclusion: The Model for Eliminating Their Use in Healthcare*'⁸⁰ emphasizes on the elimination of the use of restraint and seclusion in mental health care. Their work suggests the following interventions which includes; national oversight, cultural changes, independent advocacy, physical changes to the environment.

Fisher, on restraint and seclusion argues that it is nearly impossible to operate a program for severely symptomatic individuals without some form of restraint and that it is basically efficacious in preventing injury and reducing agitation.⁸¹

Raveesh, Gowda, Gowda, in their work 'alternatives to the use of restraint revealed three common alternatives, which includes; Nursing interventions, Multi-professional agreements involving Patients, use of authority/power-either in the form of strength or the presence of a Staff for the Ward.'⁸²

⁸⁰ Available at <<https://sandrabloom.com/wp-content/uploads/2005-Murphy-Bennington-Davis-Engagement-Model-Restraint-and-Seclusion.pdf>. >accessed 30 April 2025.

⁸¹ W Fisher, 'Restraint and seclusion: A review of the Literature' American Journal of Psychiatry [1994] (151) (11).

AI-Maraira and Hayajneh⁸³ in their work ‘Use of Restraint and Seclusion in Psychiatric Settings: A literature Review’ contends that restraint and seclusion in mental health care settings should be used as a last resort. A review by NSW in 2016, revealed that clinicians have justified the use of restraint and seclusion on the grounds that they are therapeutic, however, this stance is not supported by evidence.⁸⁴

David and his research team in their comparative Study on ‘Decreasing the use of restraint and seclusion among psychiatric inpatients’⁸⁵ introduced several interventions which yielded beautiful results as to the decrease in the use of restraint and seclusion in mental health.⁸⁶

Several theories had been propounded which explains the impact of restraint and seclusion in mental health care, these theories revealed that mental health is a crucial aspect of the wellbeing of a Man and when there is disability, there are processes by which he can recover safely without the use of restraint and seclusion, which have been revealed to be accompanied with serious consequences. There are much debates about the effectiveness of restraint and seclusion in mental health settings.⁸⁷

The work of Marie and Clara on ‘Model of Prevention of Seclusion and Restraint Use in Mental Health: An Integrative review’ had revealed that preventing restrictive practices in mental health

⁸³ O AI Maraira and F Hayajneh, ‘Use of Restraint and Seclusion in Psychiatric Settings: A literature Review’ *Journal of Psychosocial Nursing Mental Health Services* [2019] (57) (4) 32-39.

⁸⁴ The Review of Seclusion, Restraint and observation of Consumers with a Mental Illness in NSW Health Facilities. 2017.

⁸⁵ D Hellerstein, A Bennett-Staub and E Lequesne, ‘Decreasing the Use of Restraint and Seclusion Among Psychiatric Inpatients’ *Journal of Psychiatric Practice*. [2007] (13) (5) 308.

⁸⁶ B Raveesh, G Gowda and M Gowda, ‘Alternatives to Restraint’ *Indian Journal of Psychiatry* [2019] (61) (4) 695.

⁸⁷ K Huckshorn, ‘Reducing Seclusion and Restraint use in mental health settings: Core strategies for prevention’ *Journal of psychosocial nursing and mental health services* [2004] (42) (9) 22-33.

will be achieved by developing a shared responsibility and a shift towards a culture of partnership.⁸⁸

Bernadette in her work ‘Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities’ emphasized on the six care categories for mental patients as developed by the National Association of State Mental Health Program Directors in the United States.⁸⁹

In the work of Knox and Holloman ‘Use and Avoidance of Seclusion and Restraint’. They unapologetically reminded us of the words of the National Association of State Mental Health Program Directors in the United States, which goes thus: Every episode of restraint and seclusion is harmful to the individual and humiliating to staff members who understand their job responsibilities.⁹⁰

⁸⁸ M Goulet and C Deschenes, ‘Model of Prevention of Seclusion and Restraint Use in Mental Health: An Integrative review’ *Santè mentale au Québec* [2022] (47) (1) 151-180.

⁸⁹ B McSherry, ‘Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities’ *International Journal of Law and Psychiatry* [2017] (53) 42.

⁹⁰ D Knox and G Holloman ‘Use and Avoidance of Seclusion and Restraint’ *Western Journal of Emergency Medicine* [2012] (13) (1) 36.

CHAPTER THREE

LEGAL AND INSTITUTIONAL FRAMEWORK ON RESTRAINT AND SECLUSION IN MENTAL HEALTH CARE: UNCOVERING HUMAN RIGHTS ABUSES AND ADVOCATING FOR REFORMS.

3.1.1 Domestic Legal Framework

3.1.1.1 Constitution of Nigeria 1999 (as amended)

The *Constitution of the Federal Republic of Nigeria* which is the *fons et origo* of the state does not explicitly or expressly provides for Restraint and Seclusion in mental health care. However, it provides for human rights in general which has a bearing attached to mental health care. The constitution provides a legal framework for human rights and dignity, which can be interpreted to apply to restraint and seclusion in mental health care. while The Constitution does not specifically mention restraint and seclusion in mental health care, it guarantees fundamental human rights-protects dignity of human persons,¹ right to personal liberty,² right to freedom from discrimination,³ right to freedom of movement.⁴ Subject to this Constitution, the High Court shall have original jurisdiction to hear and determine any Application pertaining the above rights.⁵ It vests the National Assembly the powers to confer other powers that may appear necessary or desirable for the purpose of justice, peace and good governance of the State.⁶ Over the years, the

¹ Constitution of the Federal Republic of Nigeria, 1999 (as amended), s 34.

² Ibid, s 35.

³ Ibid, s 42.

⁴ Ibid, s 41.

⁵ Ibid, s 46(1).

⁶ Ibid, s 46(4).

Nigerian Government have realized the importance of mental health and this has prompted the enactment of relevant laws to ensure the protection of those affected with mental illness.⁷

3.1.1.2 The National Health Act 2014

The *National Health Act* is a legal framework which regulates the standard of health services rendered in the health sector. It provides for and emphasizes patient rights among other thing. This legal framework lays emphasis on the quality or standard of services rendered. The National Health Act provides a legal framework for the regulation, development and management of Nigeria's health system. This legal framework also protects and promote the rights of people. It also establishes other bodies like the National Council for health, Federal ministry of health among others.

3.1.1.3 The National Mental Health Act 2021

The *National Mental Health Act* is a legal framework which guarantee that persons living with mental conditions are not subjected to discrimination as it relates to their health rights, property rights, employment , as well as cultural, social and religious rights.⁸ The National Mental Health Act provides for and protect the rights of persons with mental illness. The right includes health rights, freedom from discrimination,⁹ employment rights,¹⁰ right to mental health services upholding the dignity of humans with mental illness,¹¹ right to quality and standard treatment,¹²

⁷ OM Atoyebi 'A Critical Examination of the Rights of Persons with Mental Health Illness in Nigeria', available at <<https://omaplex.com.ng/a-critical-examination-of-the-rights-of-persons-with-mental-health-illness-in-nigeria>> accessed 3 May 2025.

⁸ Ibid,

⁹ National Mental Health Act 2021, s 12.

¹⁰ Ibid, s 13.

¹¹ Ibid, s 15.

¹² Ibid, s 16

housing,¹³ right to privacy and dignity,¹⁴ right to appoint legal representative among others.¹⁵ Particularly, this legal framework views any derogation from this right as an offence.¹⁶ The National Mental Health Act provides that persons with mental health conditions are protected from the use of forced treatment, seclusion and any other method of restraint in facilities. To this effect, no person shall be subjected to any form of restrain or seclusion unless he has received medical care for at least 48 hours and upon expiration, two medical officers examines the person and certify in writing that it is the only means to prevent immediate or imminent harm to the person .¹⁷ The *National Mental Health Act* also provides that these persons subjected to this restraint or seclusion shall at all times be kept in a human and hygienic condition and in a least restrictive environment.¹⁸ Interestingly, the law does not provide for consent as a defence with regards to sexual intercourse with persons with mental health conditions.¹⁹ Succintly, it is apposite to state that this legal framework also provides that any person who restrains or secludes a person is guilty of an offence and is liable for a fine of N2,000,000.00 or imprisonment for a term not more than five years or both.²⁰

3.1.1.4 Child Rights Act 2003

The *Child Right Act* as a legal framework provides for the protection and welfare of Children. While it does not specifically provide for restraint and seclusion in mental health care, it guarantees children's right to dignity, protection from abuse, access to health care, freedom from neglect,

¹³ National Mental Health Act 2021, s 14.

¹⁴ Ibid, s 19.

¹⁵ Ibid, s 17.

¹⁶ Ibid, s 23.

¹⁷ OM Atoyebi 'A Critical Examination of the Rights of Persons with Mental Health Illness in Nigeria' available at <<https://omaplex.com.ng/a-critical-examination-of-the-rights-of-persons-with-mental-health-illness-in-nigeria>> accessed 4 May 2025.

¹⁸ National Mental Health Act 2021, s 34(6).

¹⁹ Ibid,

²⁰ Ibid, s 34.

abuse, violence among others thereby protecting their rights as human beings. Specifically, it provides for the right of a child in need of special protection of Nature including the provision of their mental needs.²¹ This legal framework protects and safeguard the rights of children. however, it has a peculiar problem which is implementation as the rights of children around the World are neglected.

3.1.1.5 The National Mental Health Policy 2013

The legal framework reaffirmed the health, including the mental wellbeing of Nigeria, it recognizes that health is an inalienable right and that mental, neurological and substance abuse(MNS) care should be available to all citizens. Summarily, it provides for the following reforms;

- (i) Mainstreaming mental and neurological health within national health, social welfare, education and criminal justice policy.
- (ii) Integrating mental and neurological health into the primary care system.
- (iii) Strengthening and developing existing systems for human resource development, information and communication.
- (iv) Decentralization of specialist mental and neurological health services
- (v) Strengthening management of mental and neurological health services
- (vi) Encouraging inter-sectoral partnerships with other key Governmental Organizations (GOs) and NGOs.

²¹ Child Rights Act 2003, article 16.

(vii) Linking to educational programs in schools, workplaces, the community and the media.²²

3.1.1.6 The Discrimination Against Persons with Disabilities (Prohibition) Act 2018

This comprehensive legal framework focuses on prohibition of discrimination, accessibility, equal opportunities and combating disability. The Act prohibits discrimination on the basis of disabilities and also provides penalty for the breach of such rights.²³ The Act also provides that the Federal Ministry of Information has a responsibility of creating awareness as per the rights, respect, and dignity of persons with disability, including their contributions, capabilities and achievements in the Society.²⁴ The Act speaks volume in the aspect of the right of persons with disability in relation to access to public premises²⁵ and accessibility aids in public buildings.²⁶ The Act also prohibits the use of persons with disability in soliciting for alms and also provides penalty for the breach of such rights.²⁷ Right to education without discrimination or segregation in any form,²⁸ right to free health care,²⁹ equal rights to work,³⁰ participation in politics³¹ among others are provided therein. The Act also provides for the establishment of the National Commission for persons with disabilities.³² The Act also provides for the procurement of a permanent certificate of disability.³³ One major problem of this Act is the implementation, the government lags behind in the

²² WHO 'National Policy for Mental Health Service Delivery (2013)', available at <<https://extranet.who.int/mindbank/item/3580>> Accessed 4 May 2025.

²³ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 1.

²⁴ Ibid, s 2.

²⁵ Ibid, s 3.

²⁶ Ibid, s 4.

²⁷ Ibid, s 16.

²⁸ Ibid, s 17.

²⁹ Ibid, s 21.

³⁰ Ibid, s 28.

³¹ Ibid, s 30.

³² Ibid, s 31.

³³ Ibid, s 22.

implementation of this rights. While the Act guarantees these rights, Discrimination is at its highest peak in the State.

3.1.1.7 National Human Right Commission (NHRC) Act 1995 (as amended).

This legal framework establishes the National Human Rights Commission empowering it and creating its responsibilities for the sole purpose of enforcement and protection of human rights. It creates a funding system for the commission and also the power to accept gifts. The main aim of the Act is for the establishment of the commission as a responsibility imposed on state parties by the United Nations for the purpose of upholding justice, respect for human dignity, protection and enforcement of human rights.

3.1.1.8 Violence against Persons Prohibition Act (VAPP) 2015

This legal framework addresses various forms of violence, especially domestic and gender-based violence. The Act does not comprehensively address mental health as a standalone subject, several sections of the Act supports mental health in terms of preventing; Emotional, verbal and psychological abuse,³⁴ stalking,³⁵ harmful widowhood practices,³⁶political violence. The VAPP Act focuses heavily on the rights and protection of individuals, especially Women and vulnerable persons and also plays a vital role mental health recovery.

³⁴ Violence against Persons Prohibition Act (VAPP) 2015, s 14.

³⁵ Ibid, s 17.

³⁶ Ibid, s 16.

3.1.1.9 African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 2004

The African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 2004 is not the same enactment with the African Charter on Human and Peoples' Rights. Whereas the former is a domestic legislation, the latter is an international treaty. The striking effect is that domestic courts cannot enforce treaties for the reason that Nigeria adopts the dualist view of international law whereby treaty obligations do not gain automatic ingress into our domestic law and in the event of conflict, the domestic law assumes superiority.³⁷ The Supreme court has held that treaties do not form part of our law merely by their conclusion in the country.³⁸ It must be noted that The Nigerian court has held that the court's jurisdiction to give full recognition and effect to the provisions of African Charter on Human and Peoples' Rights(Ratification and Enforcement) Act remains unimpaired. The charter seems to be a reproduction of the African Charter on Human and Peoples' Rights, it provides for the civil and political rights as well as the economic, social and cultural rights. It is safe to say that a person can enforce his or her rights entrenched in this legal framework.

3.1.2 Regional Legal Framework

3.1.2.1 African Charter on Human and Peoples' Rights 1981

This legal framework was adopted in 1981 and came into force October 21 1986. This framework recognizes human rights and hinges on the principle of cultural relativity.³⁹ This charter recognizes the civil and political rights and also the economic, social and cultural rights which are often

³⁷ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 223.

³⁸ *Reinsurance Corporation v Abate Fantaye* [1986] 3 NWLR (pt 811) at 834.

³⁹ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 84.

referred to as first and second generation respectively. In relation to this topic, it guarantees the right to the enjoyment of rights listed in the charter without any form of discrimination.⁴⁰ It also provides for respect for other human beings without discrimination.⁴¹ This charter also imposes duty on state parties to ensure the promotion and protection of this rights.⁴² The following concepts have been established from the foregoing principles and laws viz:

- (a) the African Charter is a special genius of law in the Nigeria legal and political system;
- (b) The Charter has some international flavours and in that sense cannot be amended or watered down or sidetracked by any Nigeria law and
- (c) The effect of the Charter in Nigeria maybe completely obliterated by any express repeal by an express repeal of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act.⁴³

3.1.2.2 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

The rights of Women have, since the internalization of human rights laws, been brought into the mainstream of human rights discourse. This flows from the vulnerability of Women owing to certain discriminatory laws, cultural orientations and harmful practices. In repositioning women to enjoy equal rights and streamline the human rights regime to the enjoyment of all individuals without discriminations, the African Union enacted the 'Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' otherwise referred to as the Moputo

⁴⁰ African Charter on Human and Peoples' Rights 1981, article 2.

⁴¹ Ibid, article 28.

⁴² Ibid, article 25.

⁴³ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 266.

Protocol.⁴⁴ The Protocol guarantees that every woman shall have a right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.⁴⁵ All States Parties to the Protocol shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards.⁴⁶ In alignment with this provision, the Nigerian Court has noted that the Nrachi ceremony which encourages promiscuity and prostitution which was condemned in Article 6 of the Convention on the *Elimination of All Forms of Discrimination against Women (CEDAW)*.⁴⁷ The Protocol also guarantee and ensure that women with disabilities are protected from sexual abuse, discrimination based on disability and the right to be treated with dignity.⁴⁸ States Parties shall also ensure the rights of pregnant or nursing women or women in detention by providing them with environment which is suitable for their condition.⁴⁹

3.1.3 International Legal Framework

3.1.3.1 United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006

United Nations Convention on the Rights of Persons with Disabilities (CRPD) Act is a landmark international human rights treaty that protect the rights of persons with disability, recognizing that persons with disabilities are subjects with rights and not object of charity. persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in

⁴⁴ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022)131.

⁴⁵ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, article 3(1)-(4).

⁴⁶ Ibid, article 5.

⁴⁷ *Mojekwu v Ejikeme* [2000] 5 NWLR (pt. 657) 403.

⁴⁸ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, article 23(a)-(b).

⁴⁹ Ibid, article 24.

interactions with various barriers may hinder their full and effective participation in society on an equal basis with others.⁵⁰ The principles introduced by the CPRD include;

- (a) respect for inherent dignity, individual autonomy including the freedom to make one's choices, and independence of persons;
- (b) Non-discrimination; Full and effective participation and inclusion in the society;
- (c) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (d) Equality of opportunity;
- (e) Accessibility
- (f) Equality between men and women;
- (g) Respect for the evolving capacities of children with disabilities to preserve their identity.⁵¹

The CPRD protects the rights of persons with disability by ensuring non-discrimination and imposing obligations on state parties to ensure the full realization of this treaty.⁵²

3.1.3.2 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991

This United Nations Principle provides that its provisions shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex among others. This legal framework recognizes the right to the best available mental care, respect for inherent dignity of persons with

⁵⁰ United Nations Convention on the Rights of Persons with Disabilities 2006, article 1.

⁵¹ United Nations Convention on the Rights of Persons with Disabilities 2006, article 3.

⁵² Ibid, article 4.

mental illness, non-discrimination among others.⁵³ It also recognizes the right of persons with mental illness to live and work,⁵⁴ the right to be cared for,⁵⁵ right to be treated in the least restrictive environment,⁵⁶ prohibition of physical or involuntary seclusion of patient except in accordance with the official procedures,⁵⁷ privacy, religion or belief,⁵⁸ facility for mental health,⁵⁹ prohibition of derogation from these rights.⁶⁰

3.1.3.3 Universal Declaration of Human Rights (1948)

The Universal Declaration of Human Rights spelt out in detailed and specific terms the human rights provided in United Nations Charter.⁶¹ The declaration recognizes the first generation rights-civil and political rights⁶² and the second generation rights⁶³-economic, social and cultural rights.⁶⁴ It specifically provides for freedom from discrimination. The *Universal Declaration of Human Rights* is a response to the cry for recognition of human rights, though it is not a binding instruments, it has by the efflux of time acquired much approval by successive human rights instruments.⁶⁵

⁵³ United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991, Principle 1.

⁵⁴ Ibid, Principle 3.

⁵⁵ Ibid, Principle 7.

⁵⁶ Ibid, Principle 9.

⁵⁷ Ibid, Principle 11.

⁵⁸ Ibid, Principle 13.

⁵⁹ Ibid, Principle 14.

⁶⁰ Ibid, Principle 25.

⁶¹ E.A. Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 45.

⁶² Universal Declaration of Human Rights 1948, Article 1-21.

⁶³ Ibid, article 22-27.

⁶⁴ E.A. Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 47.

⁶⁵ Ibid, 48.

3.1.3.4 The International Covenant On Civil and Political Rights (ICCPR) 1966

The Commission on Human Rights embarked on the development of norms that are legally binding on states that choose to adhere to them.⁶⁶ The covenant recognized various rights including the right to life,⁶⁷ right to freedom from torture or cruel, inhuman or degrading treatment or punishment,⁶⁸ the right to liberty and security of person⁶⁹ including the rights of detained persons to be treated with humanity and with respect for the inherent dignity of human person,⁷⁰ the right of equality before the law and equal protection of the Law.⁷¹

3.1.3.5 The International Covenant on Economic, Social and Cultural Rights(ICESCR)1966

This covenant is a cognate of the *International Covenant on Economic, Social and Cultural Rights* having been unanimously adopted in 1966 by a UN General Assembly Resolution. It also entered into force on January 3, 1976.⁷² There are several rights recognized therein including the right to the highest attainable standard of physical and mental health.⁷³

3.2 Institutional Framework

3.2.1 National Commission for Persons with Disability

The Discrimination against persons with Disabilities(prohibition)Act established the National Commission for Persons with Disabilities.⁷⁴ The Act views this commission as a body corporate with perpetual succession, a common seal, may sue and be sued, acquire, hold and dispose

⁶⁶ EA Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 49.

⁶⁷ International Covenant On Civil and Political Rights (ICCPR) 1966, article 6.

⁶⁸ Ibid, article 7.

⁶⁹ Ibid, article 9.

⁷⁰ Ibid, article 10.

⁷¹ Ibid, article 26.

⁷² E.A. Udu, *Human Rights in Africa* (Mbeyi and Associates (Nig). Ltd 2022) 56.

⁷³ The International Covenant on Economic, Social and Cultural Rights(ICESCR)1966, article 12.

⁷⁴ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 31.

properties⁷⁵. The Head office is located at the Federal Capital Territory Abuja.⁷⁶the commission has a governing council for the conduct of its affairs.⁷⁷ Powers vested upon the commission includes;

(a) The commission shall have power to do any lawful thing that will facilitate the carrying out of its functions and in particular may—

(i) Enter into contract for education and welfare of persons with disabilities;

(ii) Purchase or acquire any assets, business or property considered necessary for the proper conduct of its functions;

(iii) Sell, let, lease or dispose of any of its property;

(iv) Undertake or sponsor research where necessary for the performance of its functions;

(v) Train managerial, technical or other category of staff for the purpose of running the affairs of the Commission.⁷⁸

(vi) It should be noted that these powers are exercisable by their employees or agents as authorized by the Commission.⁷⁹ The Commission also have powers to accept gifts⁸⁰ and the Act also provides a funding system for the Commission.⁸¹

⁷⁵ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 31(2).

⁷⁶ Ibid, s 31(3).

⁷⁷ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 32.

⁷⁸ Ibid, s 39.

⁷⁹ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 39(2).

⁸⁰ Ibid, s 46.

⁸¹ Ibid, s 45.

3.2.2 National Institute for Pharmaceutical Research and Development (NIPRD)

The inclusion of this institutional framework is vital as drugs and medications are very essential in mental health care. Some of their Roles includes;

- (a) Research and development on pharmaceuticals, herbal medicines and other health product
- (b) Developments and improvements of new and existing drugs
- (c) Policy and regulatory decisions
- (d) Ensure quality and safe drugs.

An overview from the health sector revealed that Nigeria as a state lags behind in quality drugs and individuals are left with no options than the sub-standard medications.

3.2.3 Federal Ministry of Health

This is a world-class government institution that ensures a healthy Nigeria by the provision of effective healthcare facilities. It is one of the federal ministries of Nigeria concerned with the formulation and implementation of policies related to health. It has several departments including the Nigeria Centre for Disease Control, its functions and objectives includes; development of plans, conduct of research, routine collection and processing data, planning and coordinating human resources for health, mobilizations, coordination of National health management information system among others,⁸² annual reports of health condition in the country, guidelines for planning.⁸³ Importantly, there are also state ministries of health responsible to the states in Nigeria.

⁸² Origin of Federal Ministry of Health. site.health.gov.ng/about%20us. >Accessed 7th May 2025.

⁸³ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019)63.

3.2.4 National Human Right Commission (NHRC)

The Commission serves as an extra judicial mechanism for the respect and enjoyment of human rights.⁸⁴ This commission was established by the National human rights Commission Act 1995 as amended which enjoined all states to establish a national independence commission for the enforcement of human rights.⁸⁵ The commission has a governing council which comprises of 16 members. Its functions and powers include;

Functions:

- (a) Deal with all matters relating to the protection of human rights;
- (b) Monitor and investigate all alleged cases of human rights;
- (c) Assist victims of human rights violations;
- (d) Undertake studies on all matters relating to human rights;
- (e) Publish regularly reports on the state of human rights protection in Nigeria and so on.⁸⁶

Powers:

- (a) Power to do all things which by the Act or any other enactment are required or permitted to be done
- (b) Do such things necessary and expedient to the performance of its functions under the Act.⁸⁷

⁸⁴ Available at <<https://www.nigeriarights.gov.ng>. >accessed 7th May 2025.

⁸⁵ N Amalu and M Adetu, 'The Role of the National Human Rights Commission(NHRC) in Post Conflict Situations in Nigeria' *International Journal of Arts and Humanities* [2019] (8) (1) 135.

⁸⁶ National Human Right Commission (NHRC) Act 1995 (as amended), s 5.

⁸⁷ National Human Right Commission (NHRC) Act 1995 (as amended), s 6.

3.2.2 Regional Institutional Framework

3.2.2.1 African Commission on Human and Peoples' Rights.

The African Charter on Human and Peoples' Rights established this Commission,⁸⁸ it was inaugurated on 2 November 1987 in Addis Ababa, Ethiopia. The Commission's Secretariat is located at Banjul, The Gambia.⁸⁹ The Commission is made up of eleven members serving in their personal capacity.⁹⁰ The Mandate of the Commission include;

- (a) To promote Human and Peoples' Rights,
- (b) Ensure the protection of human and peoples' rights under conditions laid down in the Charter,
- (c) Interpret all the provisions of the Charter,
- (d) Perform any task which may be entrusted to it by the Assembly Heads of State and Government.⁹¹

3.2.2.2 African Court on Human and Peoples' Rights

The Protocol to the African Charter on Human and Peoples' Rights on the establishment of the African Court on was adopted on June 9, 1998 by the Summit of Heads of State and Government in Ouagadougou, Burkina Faso.⁹² The court is empowered to act in both adjudicatory and advisory capacities in the protection and enforcement of human rights.

⁸⁸ African Charter on Human and Peoples' Rights 1981, article 30.

⁸⁹ Available at <<https://achpr.au.int/en>> accessed 10 May 2025.

⁹⁰ African Charter on Human and Peoples' Rights 1981, article 31.

⁹¹ Ibid, article 45.

⁹² EA Udu Human Rights in Africa (Mbeyi and Associates (Nig). Ltd 2022)117.

3.2.3 International institutional Framework

3.2.3.1 World Health Organization (WHO)

World Health Organization(WHO) is a specialized agency of the United States (UN) established in 1948 to further improve public health conditions.⁹³ Although it inherited specific tasks relating to epidemic control, quarantine measures, and drug standardization from the health organization of the League of Nations (set up in 1923) and the International Office of Public Health (established in 1907), WHO was given a broad mandate under its Constitution to promote the highest possible level of health by all people.⁹⁴ WHO defines health positively as “a state of complete physical, mental, and social wellbeing not merely the absence of disease.”⁹⁵ Each year WHO celebrates its date of establishment, April 7, 1948, as World Health Day, with its administrative headquarters in Geneva.⁹⁶

For universal coverage, they-

- (a) Focus on primary health care to improve access to quality essential services;
- (b) Work towards sustainable financing and financial protection;
- (c) Improve access to essential medicines and health product;
- (d) Support participation in national health policies;
- (e) Improve monitoring, data and information.⁹⁷

⁹³ Available at <<https://www.britannica.com/topic/World-Health-Organization>. > accessed 9 May 2025.

⁹⁴ Ibid

⁹⁵ Ibid

⁹⁶ Ibid

⁹⁷ Available at <<https://www.who.int/about/what-we-do>. >accessed 9 May 2025.

For health emergencies;

- (a) Prepare for emergencies by identifying, mitigating, and managing risks;
- (b) Prevent emergencies and support development for tools needed for outbreak;
- (c) Detect and respond to acute health emergencies;
- (d) Support delivery of essential health services in fragile settings.⁹⁸

Through their work, they address;

- (a) Human capital across the life-course;
- (b) Non-communicable diseases;
- (c) Mental health promotion among others.⁹⁹

3.2.3.2 United Nations Committee on the Rights of Persons with Disabilities (CRPD)

The United Nations Committee on the Rights of Persons with Disabilities establishes a framework and a guide for the organization of persons with Disabilities. It is the institutional framework charged with the responsibility of monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities(CPRD) by states who have ratified it. The expert Committee is composed of 18 independent Experts elected by the States.¹⁰⁰ The members of the committee

⁹⁸ Available at <<https://www.who.int/about/what-we-do>. >accessed 9 May 2025.

⁹⁹ Ibid

¹⁰⁰ United Nations Committee Convention on the Rights of Persons with Disabilities, article 34.

serve in their individual capacity not as government representatives. The Committee meets in Geneva, Switzerland and holds two sessions per year.¹⁰¹

ROLES:

- (i) Review the implementation of the Convention by the States who ratified the convention and adopt concluding observations;
- (ii) Examine individual complaints and conduct an inquiry concerning the violation of disability rights;
- (iii) Discuss the interpretation of articles of the Convention and adopt General comments to guide States in ensuring the rights of persons with Disabilities.¹⁰²

¹⁰¹ United Nations Committee on the Rights of Persons with Disabilities. available at <<https://www.edf-feph.org/content/uploads/2021/05/The-United-Nations-CPRD-Committee-guide-for-DPO-for-upload.pdf>> accessed 10 May 2025.

¹⁰² United Nations Committee on the Rights of Persons with Disabilities. available at <<https://www.edf-feph.org/content/uploads/2021/05/The-United-Nations-CPRD-Committee-guide-for-DPO-for-upload.pdf>> accessed 10 May 2025.

CHAPTER FOUR

ANALYSIS OF THE LEGAL CHALLENGES ON THE APPLICATION ON THE RIGHTS OF MENTAL HEALTH PATIENTS IN NIGERIA

4.1 Historical Overview of Mental health

The concept of mental health can have origin traced back to development in public health, in clinical psychiatry and in other branches of knowledge. Although, references to mental health as a state can be found in the English language well before the 20th century, technical references to mental health as a field or discipline are not found before 1946. During that year, the International Health Conference, held in New York, decided to establish the World Health Organization (WHO) and a Mental Health Association was founded in London. Before that date, found are references to the corresponding concept of “mental hygiene”, which first appeared in the English literature in 1843, in a book entitled *Mental hygiene or an examination of the intellect and passions designed to illustrate their influence on health and duration of life*. Moreover, in 1849, “healthy mental and physical development of the citizen” had already been included as the first objective of public health in a draft law submitted to the Berlin Society of Physicians and Surgeons. In 1948, the WHO was created and in the same year the first International Congress on Mental Health took place in London. At the second session of the WHO’s Expert Committee on Mental Health (September 11-16, 1950), “mental health” and “mental hygiene” were defined as “Mental hygiene” refers to all the activities and techniques which encourage and maintain mental health.

4.1.1 Overview of Restraint and Seclusion in Mental Care

Restraint is defined as any manual method, physical, material, or equipment that immobilizes or reduces the ability of a patient to freely move his arms, legs, body or head.¹ Recall that chapter two of this work explains the different types of restraints, namely; physical, chemical, seclusion and environmental. Seclusion is the locking or confining of a person to a space or room alone.² The reason for the use of restraint is for the protection of staff from injuries especially with patients who are violent, the frequent reason for the use of coercive measure is patient aggression.³ Restraint and seclusion in mental health has been the method for the treatment of mental health care. However, restraint and seclusion in mental health care have been widely criticized as ineffective and potentially harmful approaches in mental health care. Even if restraint and seclusion can prevent injury to patients and staff, a physical altercation with a patient can result in a variety of injuries to both and these injuries could be avoided if effective ways are available to manage the patient without their use,⁴ the use of restraint and seclusion in mental health has resulted in shame, humiliation, traumatic experience, loss of self-respect among others. A study on patients perspectives of their hospital treatment measured after seclusion and restraint revealed that they 90 patients, although, they received enough attention, their opinions were not heard.⁵ Stigmatization of mental patients deprives them of their right of human dignity and participation in the wider society, the mental health of a person is essential for the purpose of carrying on his

¹ B Raveesh, G Gowda and M Gowda, 'Alternatives to use of restraint: A path toward humanistic care' *Indian Journal of Psychiatry* [2019] (64) (4) 693.

² World Psychiatric Association, 'Towards eliminating seclusion and restraint from mental health systems in Australia and New Zealand [2023] 3.

³ M Zboun and M Marzouq, 'The Use of Restraint in Mental Health Facilities' *Archives of Psychiatry and Behavioral Sciences* [2020] (3) (12) 5.

⁴ D Knox and G Holloman, 'Use and Avoidance of Seclusion and Restraint' *Western Journal of Emergency Medicine* [2012] (13) (1) 37.

⁵ M Zboun and M Marzouq, 'The Use of Restraint in Mental Health Facilities' *Archives of Psychiatry and Behavioral Sciences* [2020] (3) (12) 5.

daily activities.⁶ Issues of mental health are of great concern to the public in several parts of the World as many as 450 million people at any given time worldwide are estimated to be suffering from some of brain or mental disorder which includes substance abuse and behavioral disorders. Despite these prevalence, more than 30% of countries in the world do not have mental health policies and programs, the first mental health policy in Nigeria was formulated in Lagos 1991.⁷ Studies about the use of Restraint and seclusion in mental health settings have revealed various consequences and also recommended alternatives to its use. Summarily, the use of restraint and seclusion in mental health have overwhelming consequences which can be avoided through other various approaches to the treatment of mental health.

4.1.2 Earlier Works on Human Rights Abuses in Mental Health Care

There is no unanimity as regards abuses in mental health care. This lack of consensus reflects the complex interplay between psychiatric authority, legal frameworks, and societal attitudes towards mental illness. As a result of these, three principal perspectives on human right abuses as it relates to mental health care has emerged.

The first perspective supports their use stating the reasons why it is efficacious in treating mental patients. One of the reasons it is used for the protection of staff from injuries especially with patients who are violent, the frequent reason for the use of coercive measure is patient aggression.⁸ This is a fair consideration in the secular world as ensuring the safety of staff and nurses is paramount. Others under this school of thought believe that restraint and seclusion in mental health

⁶ A Armiyau, 'A Review of Stigma and Mental Illness' *Journal of Clinical Case Reports* [2015] (5) (1) 1.

⁷ Ibid, 2.

⁸ M Zboun and M Marzouq, 'The Use of Restraint in Mental Health Facilities' *Archives of Psychiatry and Behavioral Sciences* [2020] (3) (12) 5.

should be encouraged because there are limited staff or resources, restraint and seclusion may serve as alternative interventions.

The second perspective tilts towards the reduction of restraint and seclusion in mental health care services. Allan had recalled that at a particular time in the mid-2000s reducing restraint and seclusion became one of the four new national focus areas in mental health.⁹ reducing restraint and seclusion entails reducing restrictive practices by using restraint and seclusion where it is required based on the prevalent situation while adhering the rules and guidelines for the use of restraint and seclusion in mental health care.

The third perspective vehemently opposes restraint and seclusion in mental health care as they declare that every episode of restraint and seclusion is harmful to the individual and humiliating to staff members who understand their job responsibilities.¹⁰ The school of thought vehemently proposes that there are alternatives to restraint and seclusion in mental health care treatment.¹¹ It has been recorded that in 2013, the National Mental Health Commission commissioned the project on the avoidance of restraint and seclusion in mental health care.¹² This third perspective strives in this discourse as it provides for the avoidance of restraint and seclusion in mental health while proposing some alternatives to restrictive practices.

⁹ World Psychiatric Association, 'Toward Eliminating Seclusion and Restraint from Mental Health Systems in Australia and New Zealand' [2023] 5. available at <https://www.researchgate.net/publication/377968163_Towards_Eliminating_Seclusion_and_Restraint_from_Mental_Health_Systems_in_Australia_and_New_Zealand_A_Case_Study_of_Alternatives_to_Coercion_in_Mental_Health_Care> accessed 6 May 2025.

¹⁰ D Knox and G Holloman, 'Use and Avoidance of Seclusion and Restraint' *Western Journal of Emergency Medicine* [2012] (13) (1) 36.

¹¹ B Raveesh, G Gowda and M Gowda, 'Alternatives to Restraint' *Indian Journal of Psychiatry* [2019] 61 (4) 695.

¹² World Psychiatric Association 'Toward Eliminating Seclusion and Restraint from Mental Health Systems In Australia And New Zealand' [2023] 5. available at <https://www.researchgate.net/publication/377968163_Towards_Eliminating_Seclusion_and_Restraint_from_Mental_Health_Systems_in_Australia_and_New_Zealand_A_Case_Study_of_Alternatives_to_Coercion_in_Mental_Health_Care> accessed 5 May 2025.

4.1.3 Economic and Social Implications of Human Rights Abuses in Mental Health Care

As earlier stated, The *Constitution of the Federal Republic of Nigeria* which is the *fons et origo* of the state does not explicitly or expressly provides for Restraint and Seclusion in mental health care. However, it provides for rights relating to restrictive practices, for instance, protects dignity of human persons,¹³ right to personal liberty,¹⁴ right to freedom from discrimination,¹⁵ right to freedom of movement.¹⁶ These rights negate the use of restraint and seclusion in mental health care treatment. The *National Mental Health Act* provides for and protect the rights of persons with mental illness. The right includes health rights, freedom from discrimination,¹⁷ employment rights,¹⁸ right to mental health services upholding the dignity of humans with mental illness.¹⁹ The *Discrimination Against Persons with Disabilities (Prohibition) Act 2018* prohibits discrimination on the basis of disabilities and also provides penalty for the breach of such rights.²⁰ Both legal and institutional frameworks on human rights and mental health frowns at the use of restrictive practices as it is harmful and unhealthy and could lead to undesired consequences.

These consequences are capable of resulting into social consequences as people who are target of restrictive practices are often forced to believe it is the best treatment. However, as observed by different scholars, the use of restrictive practices in mental health care treatment has resulted in shame, humiliation, traumatic experience, loss of self-respect among others. Evidence of the

¹³ Constitution of the Federal Republic of Nigeria, 1999 (as amended), s 34.

¹⁴ *Ibid*, s 35.

¹⁵ *Ibid*, s 42.

¹⁶ *Ibid*, s 41.

¹⁷ National Mental Health Act, s 12.

¹⁸ *Ibid*, s 13.

¹⁹ *Ibid*, s 15.

²⁰ Discrimination Against Persons with Disabilities (Prohibition) Act 2018, s 1.

adverse effect have consistently been found across studies to include; PTSD, increased length of stay, deep vein thrombosis and so on.²¹

The second aspect of this discourse which is economic implication emphasis on the effect of restrictive practices in mental health care. It provides that if the elimination of restraint and seclusion is achieved, it will prevent long stay in the hospital and people will recover and resume their daily activities which will increase economic participation in the state.

In the overall sense, restrictive practice will cause more harm to the patient, therefore the emphasis on person-centered care is essential.²²

4.2 Status of Mental Health Care Regulation and Reform

4.2.1 Overview of Mental Health Care Regulation and Reform

Nigeria's mental health regulation has evolved significantly, shaped by its colonial and post-independence era. The first mental health legislation was the Lunacy Act 1958. However, in January 2023, a little over six decades, President Muhammadu Buhari signed into law the National Mental Health Act 2021.²³ The Act is a significant step forward for mental health in Nigeria as it seeks to protect the lives of persons suffering from mental illness, addressed the flaws of the Lunacy Act and emphasizing the need for government commitment towards mental health care.²⁴

In recent years, the Nigerian government has realized the importance of mental health as a pivotal

²¹ M Chieze, S Hurst, S Kaiser, O Sentissi, 'Effects of Seclusion and Restraint in Adult Psychiatry' *Frontiers in Psychiatry* [2019] (10) 11.

²² E Cochrane, D O'kane and C Oster, 'Fear and Blame in Mental Health Nurses' Accounts of Restrictive Practices: Implications for the Elimination of Seclusion and Restraint *International Journal of Mental Health Nursing* [2018] (27) (5) 1511-1521.

²³ A Ugwu and B Baiye, 'From the Lunacy Act to the First Mental Health Act in Nigeria: Five Takeaways' available at <<https://articles.nigeriahealthwatch.com/from-the-lunacy-act-to-the-first-mental-health-act-in-nigeria-five-takeaways/?amp=1>> accessed 11 May 2025.

²⁴ Ibid

ingredient for the wellbeing of an individual and this has prompted the enactment of relevant laws to ensure the protection of the rights of persons living with mental health.²⁵ The Mental Health Act 2021 which came into force 5th January 2023 has several provisions which guarantee that persons with mental health conditions are not subjected to discrimination as it relates to their health rights, property/housing rights, employment rights, as well as cultural, social, and religious rights.²⁶

4.2.2 Structural and Institutional Factors Influencing Mental Health Care

Structural and institutional factors play a significant role in defining the mental health care system - access, quality and outcomes. These factors can either enhance or hinder effective mental health care delivery.

(i) Funding and Resource Allocation; funding for the treatment of mental health is essential; the need to improve budgets assigned for programs on mental health and to improve institutions with mental health goals must also be addressed.²⁷ Underfunding of mental health services, unavailability of professionals, facilities and treatments often limit the treatment of health care services.

(ii) Fragmentation of Services: lack of integration between mental health and primary care can lead to gaps in treatment. Bringing mental health services into the primary healthcare framework is critical for augmenting the overall quality of healthcare delivery systems given that numerous studies have convincingly demonstrated that an estimated 80% of individuals who experience mental health challenges primarily receive necessary care in the context of primary care

²⁵ O Atoyebi, 'A Critical Examination of the Rights of Persons with Mental Health Illness in Nigeria. available at <<https://omaplex.com.ng/a-critical-examination-of-the-rights-of-persons-with-mental-health-illness-in-nigeria/>> accessed 9 May 2025.

²⁶ Ibid

²⁷ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 106.

environments.²⁸ By thoughtfully weaving extensive mental healthcare resources into the structure of primary care, healthcare system can adopt and execute a more comprehensive and unified method that recognizes the complex relationships and mutual reliance between mental health and physical health.²⁹

(a) Mental Health Policies: the establishment of an all-inclusive national policy is also essential; initiating programs and enacting legislations are necessary steps for significant and sustained actions.³⁰ The presence of national mental health strategies influences the quality and access to treatment.

(b) Availability of Medications: it is important that essential medications and drugs for treatment of mental health disorder as the treatment can help ameliorate symptoms, reduce disability, shorten the course of many disorders and prevent relapses.³¹

(c) Stigma and Discrimination: attitudes towards mental health patients can deter them from seeking help or disclosing symptoms.

(d) Hospital and Facilities Improvement: institutional settings should prioritize trauma-informed approaches or therapy and should not focus on medications only.

²⁸ F Mohammed, G Ghazi, H Aziz and A Taher, 'Overview of Mental Health in Primary Care' *African Journal of Biomedical Research* [2024] (27) (4) 7192.

²⁹ Ibid

³⁰ Y Olomjobi, *Medical and Health Law* (Princeton & Associates Publishing Co. Ltd 2019) 106.

³¹ Ibid, 105.

4.2.3 Review of the Current Practices and Policies Surrounding Restraint and Seclusion in Mental Health Care

Restraint and seclusion are restrictive interventions used in psychiatric settings to manage patients behavior especially those who are victims of mental illness. It is usually imputed to be the last resort or measures, however, it has raised several significant ethical, clinical and human rights concerns. Several guidelines have emphasized that it should be used as a last-resort, however, incorporating a trauma-informed care and person-centered approaches is crucial as it is often said that communication is key. Communication reduces the need for restrictive practices. Some forms of restraint include confinement of a person within a particular place. As observed by some scholars, comprehensive training of staff and professionals on de-escalation techniques and ethical decision making is essential. In addition, emphasizing the need for consistent data collection and regulatory framework to support elimination of restraint and seclusion is essential.

4.2.4 Analysis of the Human Rights Implications of these Practices

Restrictive practices have been argued by some to be a form of abuse and violation of human rights and considered a sign of a mental health crisis arising from a lack of adequate number of staff or other conditions, all indicating poor quality of care.³² The physical and psychological harms of restraint and seclusion have been well documented.³³ These practices though often justified has raised human rights concerns especially when it is not applied appropriately.

³² Z Belayneh, J Chavulak, D Lee, M Petrakis and T Haines, 'Prevalence and variability of restrictive care practical use in adult mental health inpatient settings: A systematic review and meta-analysis' *Journal of Clinical Nursing* [2024] (33) (4) 1256-1281.

³³ *Ibid*

Rights violations:

(i) Right to Life:

Restrictive practices when used improperly or applied excessively can lead to death which violates right to life.³⁴

(ii) Right to freedom from inhumane or degrading treatment.³⁵

Restrictive practices are capable of inflicting physical pain, harm, discomfort, shame and so on, obviously constituting a breach on their right to freedom from inhumane or degrading treatment.

(iii) Rights to personal liberty : Restrictive practices usually involves the confinement of individuals in a particular place and this is against their will which violates their right to personal liberty and freedom of movement.³⁶

(iv) Right to human dignity: restrictive practices on mental health patients are usually demeaning, diminishing or reducing the patient's self-esteem and dignity which violates a person right to human dignity.³⁷

(v) Right to freedom from discrimination: mental health patients are victims of discrimination due to their ailments and this breaches their fundamental right to freedom from discrimination.³⁸

Restrictive practices are often coercive measures which violates human rights and there are several alternatives which are effective and can render a perfect duty in mental health treatment.

³⁴ Constitution of the Federal Republic of Nigeria, 1999 (as amended), s 33.

³⁵ International Covenant on Civil and Political Rights, 1966 article 7.

³⁶ Constitution of the Federal Republic of Nigeria, 1999 (as amended), s 35.

³⁷ Ibid, s 34.

³⁸ Ibid, s 42.

4.2.5 Challenges and prospects of eliminating seclusion practices in mental health care.

Challenges:

(i) Inadequate funding:

funding is a significant challenge towards the elimination of restraint and seclusion practices in mental health. monitoring the elimination of these practices require funding, the absence of which will result in the support of restrictive practices. Adequate funding is essential for staff support, development of alternative measures to restraint.

(ii) Lack of standardized guidelines and oversight: laws regulating mental health treatment vary widely by jurisdiction. One can conclude that the guidelines for regulation of the practices are not the same. Some jurisdictions may uphold restrictive practices for safety concerns.

(iii) Ethical considerations: there is a struggle in balancing the rights of mental patients and the need for safety. Some patients with severe mental health issues could be restricted to protect the safety of staff and other individuals.

(iv) Infrastructural and facility Design: many infrastructures and facilities are not design to eliminate restraint and seclusion in mental health.

(v) Lack of training and professional development: many mental health professionals are not adequately trained in de-escalation techniques or alternative strategies.

Prospects:

(i) Ethical and human rights advocacy: legal and institutional frameworks regulating human rights and mental health should advocate for the eliminating restrictive practices in mental health care treatment.

(ii) Innovative Clinical Practices: several alternatives to restrictive practices recognize that many patients experience trauma after the use of these methods.

(iii) Training and workforce development: staff should be enlightened on alternatives to restraint and seclusion and the negative impact of restrictive practices.

(iv) Peer-support integration: involving peer-support workers has shown to reduce restrictive practices for enhancing empathy, trust and patient engagement.

(v) Technological innovations: therapeutic environment serves as alternatives to restrictive practices. Calm and sensory spaces should replace sterile, control-oriented settings.

4.2.6 Alternatives to restraint and seclusion in mental Health Care

The implementation of restrictive practices in acute mental health care services has conventionally focused on managing aggressive behaviors in order to promote individual and practitioner safety.³⁹ However, the problems arising from the use of these practices such as injuries caused, and the significant costs associated with their implementation has led to an international drive towards reducing and ultimately eliminating restrictive practices.⁴⁰ A tilt towards the elimination of

³⁹ SL Bennetts, G Pepin, S Moylan, R Carolin and J Lucas, 'Elimination of Restrictive Practices from Acute Adult Mental Health Care Services: A Qualitative Evidence Synthesis of the Lived Experience Literature' [2024] (5) *SSM* 1.

⁴⁰ *Ibid*

restraint and seclusion in the treatment of mental patients often raises a question in the mind of health care workers as to the alternatives to restraint and seclusion in mental health. Don William in his review on recent research in eliminating and reducing physical restraint, mentions five approaches: restraint fading, staff training, assessment and modification of antecedent conditions, modification of release criteria from restraint, and successful behavioral treatment.⁴¹ In a survey conducted by Downey *et al*, it was noted that about 90% of the emergency departments consider using an alternative before actually restraining.⁴² In one of the studies which examined the practice and opinions of practicing physicians and nurses from two psychiatric hospitals in Finland, most of the respondents agreed to using three common alternatives viz,⁴³

- (i) Nursing interventions: The mere presence of the nursing staff round the clock and regular conversations with the patients will make the patients engage and it will decrease the incidents of aggression
- (ii) Multi-professional agreement involving patient: Agreements involving physicians, nursing staff and the patient about medications, dosage, difficulties in the ward, criterias for restraint will make the patient willing to participate in treatment process, and in turn, more co-operative and less aggressive
- (iii) Use of authority/power, either in form of strength of the ward staff or in the form of a person with authority like a senior nurse- their presence or conversation with them will help in controlling the aggression without the need of restraint.

⁴¹ B Raveesh, G Gowda and M Gowda, 'Alternatives to Use of Restraint' *Indian Journal of Psychiatry* [2017] (61) (4) 694.

⁴² B Raveesh, G Gowda and M Gowda, 'Alternatives to Use of Restraint' *Indian Journal of Psychiatry* [2017] (61) (4) 694.

⁴³ Ibid

Other alternatives to restraint and seclusion include;

(a) recovery-oriented support aim at⁴⁴

(i) connectedness;

(ii) hope and optimism about the future;

(iii) rebuilding or redefining a positive identity;

(iv) pursuing a meaningful life;

(v) empowerment through personal responsibility. Ensuring that practice does not result

(b) Trauma-informed approach involves the recognition of the high prevalence of traumatic experiences in people with mental health issues and the approach emphasizes understanding and responding to the effect of all types of trauma as well as ensuring that practice does not result in re-traumatization.⁴⁵ According to the Mental Health Coordinating Council(Australia), there are eight foundational principles of trauma-informed care:⁴⁶

(i) understanding trauma and its impact;

(ii) promoting safety;

(iii) ensuring cultural competence;

⁴⁴ P Gooding, B McSherry, (Melbourne Social Equity Institute, 2018) 34.

⁴⁵ P Gooding, B McSherry, (Melbourne Social Equity Institute, 2018) 34.

⁴⁶ Ibid, 35.

- (iv) supporting service control, choice and autonomy;
 - (v) sharing power and governance;
 - (vi) integrating care;
 - (vii) healing happening in relationships; and recovery being possible.
- (c) De-escalation technique: this method emphasizes on prevention of potential violence. Individuals are encouraged to use the following;
- (i) effective communication
 - (ii) empathy and active listening
 - (iii) negotiation and problem solving
 - (iv) observing and recognizing early signs of escalation and so on.

4.3 Regulatory Approaches and Impact Analysis

The regulatory frameworks governing restraint and seclusion in mental health settings in Nigeria is shaped by various national policies and guidelines. The Federal Ministry of Health emphasizes the need for careful consideration and monitoring when using restraint and seclusion.⁴⁷ The Mental Health Act also emphasizes on the rights of Patients from torture, cruel, inhuman or degrading treatment.⁴⁸ A key challenge in Nigeria is the lack of standardized training and guidelines on restraint and seclusion. The research suggest that effective regulation can reduce the use of restraint

⁴⁷ National Mental Health Act 2021, s 34.

⁴⁸ Ibid, s 12.

and seclusion thereby promoting patient-centered care and other alternatives to restraint and seclusion can minimize the need for restraint and seclusion.

The impact of inadequate regulation is significant as inconsistent practices and potential human rights violations may occur without standardized guidelines and training.

In conclusion, effective regulation can promote patient-centered care, reducing violation of human rights and the use of restraint and seclusion. As mental care improve, regulatory frameworks should adapt to prioritizing the wellbeing and safety of patient.

4.4 Implications of the Use of Restraint and Seclusion in Mental Health

The negative effects of restraint and seclusion in mental health care settings cannot be overemphasized. Restraint and seclusion are practices used in various settings especially hospitals and psychiatric wards to manage individuals/patients who display aggressive, disruptive, violent or self-injurious behavior. These practices are often used to protect other persons including staff, however, it raises significant concerns as per the implication therein. The following are the implications of the use of restraint and seclusion in mental health settings;

(a) Restraint and seclusion are often criticized for violating the human rights and dignity of human person. These practices encourage punishment which are contrary to the provisions of the law. Research and studies have concluded that restraint and seclusion are practices associated with trauma, abuse, violence, which this can hinder and prevent significant progress in the lives of these Patients/individuals.

- (b) The use of restraint and seclusion can have both immediate and long-term consequences. For short term, these practices can cause physical harm (e g bruising, asphyxiation, or even death) and psychological distress. Long term effects may include post-traumatic stress disorder (PTSD).
- (c) Law and regulations regarding restraint and seclusion vary globally, some guidelines promote the use of restraint and seclusion, some are of the view that these practices should be used as last resort coupled with continuous monitoring and documentation. Some vehemently oppose the use of restraint and seclusion in mental health owing to the negative effects.
- (d) Litigation risk: improper use of these practices can lead to lawsuits, especially in the cases of serious injuries and death
- (e) The use of restrictive practices often focus on a punitive and risk-averse effect rather than on trauma-informed, person-centered care.
- (f) The use of restraint and seclusion as interventions can lead to stress, moral injury and staff burnout.
- (g) Restrictive practices can damage therapeutic relationships between the physician and patient.
- (h) Restraint and seclusion can deeply humiliate and degrade the patient dignity leading to lasting emotional scars.
- (i) Research and independent bodies often review that deaths and serious incidents are linked to this intervention.
- (j) People become more vulnerable filled with confusion and fear.

CHAPTER FIVE

CONCLUSION

5.1 Summary of Findings

This study critically analyzed the use of restraint and seclusion in mental health settings, uncovering human rights abuses and advocating for reforms. The key findings from the Nigerian jurisdiction include the *Constitution of the Federal Republic of Nigeria 1999* (as amended) as well as the *National Mental Health Act 2021*. Other key regulatory frameworks include the *National Health Act 2014*, *Child Rights Act 2003*, *The National Mental Health Policy 2013*, *The Discrimination Against Persons with Disabilities (Prohibition) Act 2018*, *National Human Right Commission (NHRC) Act 1995* (as amended), *Violence against Persons Prohibition Act 2015*. On the other hand, other regional and institutional laws regulating this study include: *African Charter on Human and Peoples' Rights Act 1981*, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, *United Nations Convention on the Rights of Persons with Disabilities (CRPD) Act 2006*, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991*, *Universal Declaration of Human Rights (1948)*, *International Covenant On Civil and Political Rights (ICCPR) 1966*, *International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966*.

The critical concerns and gaps identified in the study include the following;

(i) Lack of uniformity in standards: There is a significant disparity in the legal and regulatory frameworks governing the use of restraint and seclusion in mental health care settings, some jurisdiction recognize the use of these restrictive practices as a last resort, some vehemently oppose its use, others provide regulatory framework and guidelines for regulating its use.

(ii) Ouster Clauses and in-built restrictions: The *Constitution of the Federal Republic of Nigeria 1999* (as amended) as well as the *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act* and other legal frameworks are encumbered with myriad of in-built restrictions which impede the realization of the rights imbedded therein.

(iii) Violation of Human Rights: Research and studies reveal that restrictive practices are linked and often associated with negative impact including trauma, reoccurrence of such illness, shame, loss of dignity, lack of personal liberty, and death thereby violating the human rights of individuals.

(iv) Lack of Enforcement mechanisms: Although our National legal frameworks provide for regulatory agencies and institutional frameworks, the regional body also provides for implementation mechanisms, there are several lapses associated with enforcement and implementation of the Law.

(v) Excessive usage: The use of restraint and seclusion are often applied in situations where alternative or non-coercive interventions could have been used.

(vi) Inadequate staff training: Mental health professionals and personnel often lack adequate training in de-escalation techniques and other alternatives to restraint and seclusion.

(vii) Inadequate legal protection: The legal frameworks as well as institutional framework existing in many jurisdictions protects and preserve the institutions rather than protecting and promoting the fundamental human rights of patients.

(viii) Lack of accountability: The lack of accountability in mental health care settings often leaves patient with lasting scares from restrictive practices.

5.2 Recommendations

The research recommends the following;

- (i) Uniformity in standards regulating restraint and seclusion in mental health settings
- (ii) Constitutional amendment: The provisions of *section 17 of the 1999 Constitution of the Federal Republic of Nigeria* (as amended) which provides for the right to health is provided under Chapter two of the same Constitution should be lifted and embedded in the Chapter four of the same Constitution which provides for fundamental human rights which are justiciable, reason being that by virtue of Section 6(6)(c), Chapter two is non-justiciable.
- (iii) Non-governmental organizations should direct its policy towards upholding the rights and advocating for the enforcement of these rights as well as eliminating restrictive practices.
- (iv) Enforcement mechanisms: Measures should be put in place to ensure that the right of disabled persons and mental health patients are secured and protected, there should be a specific body or agency whose responsibilities is to the realization of this rights.
- (v) Regulatory agencies: Although our national laws provide regulatory bodies, the mental health Act should create a specific body for monitoring compliance with restrictive guidelines where it is to be used as a last resort.
- (vi) Lack of Judicial authorities: The non-justiciability of chapter two has led to the non-enforcement of the right to health as well as mental health. Nigeria lags behinds in delivering any judgement on restraint and seclusion in mental health care settings, therefore, the Nigeria government should examine their laws and make it conform to the elimination of these practices.

(vii) Specific body for accountability purposes: There is no specific agency in Nigeria charged with the responsibility of rendering accounts on the usage of restrictive practices in situations where it is used as a last resort following from the failure of other non-coercive practices.

(viii) Alternatives to the use of restraint and seclusion should be explored.

5.3 Contributions to Knowledge

The study contributes significantly to the ongoing discourse on the use of restraint and seclusion in mental health care setting by critically examining its usage within the psychiatric facilities.

The research contributes to the existing literature by;

(i) Providing evidence to the fact that restraint and seclusion violates human rights of mentally disabled patients, especially dignity of human person, personal liberty, torture or cruel, inhuman or degrading treatment.

(ii) Highlighting the inconsistencies between the national laws and international laws, emphasizing on the need of removal of ouster clauses and in-built restrictions in our domestic laws, thereby providing a better understanding of and the need to enact laws which promotes and protect the fundamental human rights of mentally disabled patients.

(iii) Emphasizing on the exploration of other alternatives to restraint and seclusion in mental health care settings and advocating for reforms, discarding the use of these practices as they are harmful.

(iv) Emphasizing on the lifting of right to health provided in chapter two to be embedded in chapter four which provides for the fundamental human rights.

(v) Challenging the global mental health community to provide a standard and centralized guideline for regulating the treatment of mental health Patients.

Ultimately, this research seeks to bridge the knowledge gaps, exposing the negative effect of restraint and seclusion in mental health and provide actionable and practicable alternatives to restraint and seclusion in mental health, providing recommendation and advocating for a reform.

5.4 Areas for Further Studies

This research has laid a ground work for understanding the legal, ethical and societal challenges associated with the use of restraint and seclusion in mental health care settings. However, several areas remain ripe for further explorations. The following outlines key avenues for further research;

(i) Further research on restraint and seclusion in mental health should be encouraged especially human rights abuses linked to its usage.

(ii) Further research should be conducted on how national laws and international laws promoting human rights can be harmonized towards ensuring the protection of the rights of mental health Patients.

(iii) Researchers should explore the economic impact of the use of restrictive practices compared to other alternatives.

(iv) Rigorous studies should be conducted to evaluate the effectiveness or otherwise of alternative approaches to restraint and seclusion in mental health

(v) Qualitative research is recommended for capturing the voices of persons subjected to the use of restrictive practices.

(vi) By venturing into these uncharted territories, scholars can recommend other approaches needed for the protection and promotion of the rights of mentally disabled patients, thereby promoting and ensuring a deep commitment to the protection of human rights and nurturing mental health.

5.5 Conclusion

Mental health is a fundamental aspect of human well-being. The need for mental health awareness and treatment of mental health patient cannot be overemphasized, hence, the mental health awareness day (October 10th). The need for the protection and promotion of the human rights of mentally disabled persons cannot be overemphasized, hence, the provision of laws safeguarding the rights and guidelines for the treatment of these patients.

The use of restrictive practices in mental health care settings, though accepted in some jurisdictions as a means of controlling aggressive behavior of mentally disabled patients and as a means of ensuring safety has been widely recognized as a practice that raises serious human right concerns. Research and studies reveal that these practices are associated with physical trauma, psychological trauma, humiliation, other consequences as well as damaging therapeutic relationships.

In relation to the legal and ethical perspectives, the use of restraint and seclusion conflicts and violates the fundamental human rights provided in the various laws regulating man's existence. The Nigerian government in an attempt to improve its legislation enacted the mental health Act 2021, the Act has shown progress towards the protection of the rights of mentally disabled patients, yet significant challenges still persist, thereby leading to poor output and result in the protection and promotion of these rights.

A shift towards alternatives to the use of restraint and seclusion in mental health care settings should be considered and employed. These alternatives include; de-escalation techniques, recovery-oriented approaches, therapeutic environment and other effective approaches that upholds the dignity of human person.

Ultimately, restraint and seclusion in mental health care settings should be regarded as obsolete and harmful practices which should be discarded in favour of other alternatives strategies in order to protect and preserve human dignity as well as protecting health care professionals.

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