many specialist psychiatrists and professors of psychiatry raised the issue that there could be abuse of the legislation, with attempts by the regime to admit people accused of political crimes, especially those from religious groups, into psychiatric hospitals. A young female psychiatrist working in El Abbassia Hospital (a major psychiatric mental hospital in the centre of Cairo) refused to write a medical report after she was asked to assess the mental condition of one of the leading protesters, Alaa Abdel Fattah, who was subsequently imprisoned by the regime (en.wikipedia.org/wiki/Alaa_Abd_El-Fattah).

Conclusion

The Egyptian revolution, which was enacted on the basis of non-violent resistance, provides a model for how peaceful protest, with people expressing their hopes through the internet and other media channels, can lead to change.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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Just mental health law is a vital priority in an era of increasing international economic hardship, social inequalities and authoritarianism in some countries and neglect in others. It is essential for human rights but also for psychiatric professionalism and reputation. In this issue *International Psychiatry* begins publication of a regular series on mental health law across the world. In the first two articles, Ogunlesi and Ogunwale and, separately, Loza and El Nawawi report on the history and evolving legislation in two key countries, Nigeria and Egypt. They report some progress but also the considerable distance from a fair outcome for people with psychiatric disorder and those who care for them. In the guest editorial in this issue, Tony Zigmond crucially highlights issues of principle that necessarily form the foundation of law.

MENTAL HEALTH LAW PROFILE

Mental health legislation in Nigeria: current leanings and future yearnings

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Nigeria's current mental health legislation stems from a lunacy ordinance enacted in 1916 that assumed the status of a law in 1958. The most recent attempt to reform the law was with an unsuccessful Mental Health Bill in 2003. Currently, though, efforts are being made to re-present it as an executive Bill sponsored by the Federal Ministry of Health. The present paper reviews this Bill, in particular in light of the World Health Organization's recommendations on mental health legislation.

Nigeria, the most populous country in Africa, has a multi-ethnic and poly-religious population totalling about 167 million. Recent data suggest that, of this population, about 20 million have suffered from mental health problems in their lifetime, although few current sufferers have any form of effective treatment (Gureje *et al*, 2006). Despite the large population and the significant social burden of mental disorders, resources for mental health remain scarce and overconcentrated in urban areas. Indeed, there appears to be roughly

1 psychiatrist per million citizens in Nigeria, a situation that mirrors the state of things in many African countries (Ogunlesi *et al*, 2012).

Apart from the obvious low priority accorded to mental health in terms of policy, funding and personnel, the legal framework for the provision of mental healthcare in Nigeria remains a major concern to psychiatrists as well as other stakeholders. The World Health Organization (WHO) has estimated that only 50% of countries in the African region have mental health policies, while about 79.5% (compared with 91.8% in Europe) have mental health legislation (WHO, 2003). Only about 30% of these laws were enacted after 1990, with some dating back to the colonial era of the early 1900s (Morakinyo, 1977; WHO, 2003; Ogunlesi *et al*, 2012).

Evolution of existing legislation

Historically, the lunacy ordinance enacted in 1916 (see *Laws of Nigeria*, 1948) was drafted about four and a half decades before Nigeria's independence from British rule. The colonial influences in its terminology and expectations are thus quite obvious. Enacted two years after the amalgamation of the northern and southern protectorates into a single entity in 1914, it became the source of regional laws that appeared as the country evolved into regions thereafter. It assumed the status of a law rather than an ordinance in 1958. It is the current legislation in the country and has been etched into state laws within the Federation. The latest versions of these laws have some minor alterations in terms of language and certain stipulations (e.g. size of fine), in order to reflect current realities, but the principles of the ordinance have remained unchanged (*Laws of Ogun State*, 2006). While the existing mental health legislation, derisively called the 'lunacy law', has been able to address certain basic issues relating to mental healthcare, its age (at almost a century) clearly suggests that it must suffer from some anachronism and indeed it does so, in four principal areas:

- the altered political and social climate
- antiquated definitions and terminologies
- non-application of later developments in psychopharmacology, which clearly provided alternatives to custodial care
- non-incorporation of certain human rights charters (United Nations, 1948, 1991).

A more fundamental issue that is clearly related to the foregoing is the recent WHO document on recommendations for drafting acceptable and effective mental health legislation (WHO, 2005). The areas of deficiency in the existing law include its failure to define 'mental disorder' or 'mental disability' and its overwhelming emphasis on custodial care without adequate provision for treatment in the community. Its use of highly derogatory terms such as 'asylum', 'lunatic', 'idiot' and 'unsound mind' demonstrates its antiquity. The law does not accord specific recognition to the human rights of persons with mental disorders as recommended by the WHO. It also has no provisions for vulnerable groups who may fall within its ambit.

In spite of these shortcomings, it has managed to ensure some degree of compliance with the WHO recommendations in the areas of provisions for emergency and involuntary admissions (although not separate from treatment), general reference to the level of competence required for the determination of mental disorder, provision of oversight and review mechanisms (by way of 'visiting committees') as well as a section dealing with offences committed by asylum officials and the appropriate sanctions.

An aborted attempt at revision – the Mental Health Bill (2003)

The most recent attempt to reform the lunacy law was undertaken in the democratic dispensation of the 4th republic (1999–2003). During that republic, the Mental Health Bill was sponsored as a legislative bill in the Nigerian Senate. This task was undertaken by two serving senators who were also medical practitioners and of whom one was a psychiatrist (now deceased). Happily enough, the bill passed its first reading on the floor of the Senate. In Nigeria, bills for new laws or amendments must pass through three readings and obtain presidential assent before they become law. Unfortunately, in the interval between the first and second reading, the bill suffered a setback with the expiration of the life of that Senate and the death of the lead sponsor. Currently, efforts are on stream to re-present it as an executive bill sponsored by the Federal Ministry of Health.

Notwithstanding this, it is equally necessary to assess the level of compliance of this proposed bill with the recommendations of the WHO (2005) (although these were made 2 years after this proposed law was drafted). It must be understood that while these recommendations are not inviolable, they represent adaptable schema upon which contemporary draft legislation can be based. Broadly speaking, the current proposal seems to contain fairly satisfactory provisions in the following areas of the WHO Checklist on Mental Health Legislation (WHO, 2005): definitions of mental disorders, with proper coverage of dissocial personality disorder and substance use disorders; rights of families or other carers of patients; mental capacity issues (although there is in fact no clear definition of capacity in the draft Nigerian legislation); voluntary admission and treatment; involuntary admission (not clearly separated from treatment); proxy consent for treatment; emergency situations; specification of competence required for determination of mental disorders; oversight and review mechanisms (mental health tribunals, judicial review at the level of a state high court); some mention of police responsibilities; provisions for minors within the mental health and justice systems; and a description of offences under the act with appropriate sanctions outlined.

However, it is worrisome to note that the proposed bill falls short in some vital areas. It failed to provide a clear statement on the promotion of fundamental rights of people who are mentally ill and does not specifically guarantee the rights of users of mental health services in relation to issues like confidentiality. It is silent on provisions regarding 'non-protesting' patients and involuntary treatment in community settings. The proposed law does not regulate special treatments such as electroconvulsive therapy (ECT), the use of seclusion and restraint, issues related to clinical and experimental research (consent in particular), and socio-political issues such as discrimination, housing, employment, social security, civil issues (e.g. voting rights, parental rights) as well as protection of other vulnerable groups, like women and ethnic minorities. When all these areas are further distilled into component parts, the overall level of compliance with WHO recommendations may be far lower than is superficially suggested by this overview.

In spite of the foregoing, the prospects for a successful revision of the existing law are brightened by a variety of local factors. Currently, the Association of Psychiatrists in Nigeria (APN), a major stakeholder in mental healthcare, is at the vanguard of the mental health law reform and mental health advocacy is gaining momentum. In recent times, a desk officer for mental health had been appointed at the Federal Ministry of Health, partly with a mandate to work with stakeholders towards collating inputs for the bill to be sponsored as an executive bill. Furthermore, the National Human Rights Commission subscribes to existing charters that strengthen human rights and thus constitutes a potential ally and stakeholder in the current effort to revise the existing legislation.

The WHO recommendations of developing country-specific mental health legislation that is needs-based, driven by human rights, collaborative in orientation and culturally sensitive offer practical guidelines for the construction of a new law. Coupled with these are the abundant legislation-related resources which the WHO has made widely available and which afford the opportunity to learn from more recent legislation in other countries. Furthermore, current epidemiological data with which to identify mental health needs are available (Gureje *et al*, 2006) and provide a basis for the needs-based approach of the WHO.

In addition, the recommended technical competence required to draft new legislation is obtainable in the country. In line with the WHO recommendation, major stakeholders (including the medical directors of existing federal psychiatric hospitals in the country) are currently brainstorming and engaging the Federal Ministry of Health with a view to accelerating the passage of the bill.

Conclusion

It is important to state that to achieve the desired target of the passage of the proposed legislation, advocacy driven by all stakeholders must be given serious attention. This certainly will bring pressure to bear on the government and ensure speedy enactment of a new law that will meet contemporary benchmarks, improve mental healthcare delivery and provide a better basis for later legislative revisions that must come with time.

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MENTAL HEALTH LAW PROFILE

Mental health legislation in Egypt

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This paper first briefly reviews the history of psychiatric services in Egypt. It then details the legislation in place during the last years of the Mubarak regime and goes on to set out recent developments, in particular the Code of Practice introduced for the Mental Health Act of 2009.

Historical background

The earliest reference to the care in specialised institutions of people with a mental illness dates back to Fatimid Egypt and the establishment of the Bimaristan in the 13th century, which still stands today in central Cairo. Throughout the Islamic