



Forensic mental health service implications of COVID-19 infection in Nigeria



A. Ogunwale^{a,b,*}, O.E. Majekodunmi^a, S.O. Ajayi^c, J. Abdulmalik^d

^a Forensic Unit, Dept. of Clinical Services, Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria

^b Forensic Research Group, Institute of Psychiatry, Psychology & Neuroscience, King's College, London, United Kingdom

^c Dept. of Nursing Services, Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria

^d WHO Collaborating Centre for Research and Training in Mental Health and Neuroscience, Dept. of Psychiatry, University of Ibadan, Nigeria

ARTICLE INFO

Keywords:

Forensic
Mental health
Service
COVID-19
Nigeria

ABSTRACT

Forensic mental health services are fledgling in most African countries including Nigeria. The current formulation of such services in Nigeria is correctional psychiatry in addition to some hospital-based services. The COVID-19 pandemic presents significant challenges to the already fragile state of forensic mental health services within the country. Its impact includes limitation of access to and continuity of mental healthcare in prison as well as reduction in referrals from other services within the criminal justice system such as the police and the courts. Further tapering of previously less prominent aspects of forensic mental health service in the country such as the preparation of psychiatric court reports has also been observed. Forensic psychiatry training and research have equally been hampered by the pandemic. The lessons learnt from these challenges should offer practitioners and policy makers insight into strategic developmental objectives for the post-COVID era within services and training programmes.

Forensic mental health services are quite nascent in many African countries including Nigeria (Ogunlesi et al., 2012). The current formulation of forensic mental health services in Nigeria is correctional psychiatry being run along three models involving prison in-reach mental health teams as well as integration of mental health nurse roles into the general medical services within the prison (Ogunlesi & Ogunwale, 2018). There are 61,787 prisoners in 244 holding facilities in the country and overall prison population is rising (44,450 in 2000 to 60,360 as at 20th July 2020) while the prison population rate/100,000 of national population appears to be marginally reduced (36 in 2000 to 30 as at June 2020) (Institute for Crime & Justice Policy Research, 2020; Nigerian Correctional Service, 2020). Unfortunately, occupancy levels are at 146.8% of official capacity leading to severe overcrowding in many cases (Institute for Crime & Justice Policy Research, 2020; Obioha, 2011).

In terms of mental health resources, there are few trained psychiatric nurses and psychiatrists in the Nigerian Correctional Service (NCS). Nonetheless, general medical rounds conducted by medical officers employed by the NCS are available in some prison clinics. In others, only trained nurses or other health workers deliver some level of healthcare. Mental health complement is usually provided by few nurses employed by the NCS (some of whom have psychiatric training) as well as prison in-

reach teams from psychiatric hospitals in the city within which the prison is located. In most cases, there is only one visiting psychiatrist to a prison; so all cases are assigned to them. Our service has two visiting psychiatrists but all patients are seen by either of the two during alternate visits. There appears to be only one prison in the country that has a stationed mental health nurse within the general medical team of the prison. This nurse runs only a morning shift five days a week (Ogunlesi & Ogunwale, 2018). This has significant implication for medication administration for very ill inmates who frequently have to be catered for in their cells by fellow prisoners within an established prison sub-culture that demonstrates a hierarchical order among the inmates. While the NCS makes effort to provide basic psychotropic medication in some prisons in line with its mandate by law (Nigerian Correctional Service Act, 2019, sections 23 and 24), significant human and material resource constraints still exist within the system. Additionally, the coverage of prisoners as vulnerable persons under the National Health Insurance Scheme (NHIS) is more in principle than in practice.

Against this backdrop, the spread of COVID-19 infection to Nigeria in February 2020 represented a most undesirable perturbation of the already fragile health systems (Ebenso & Otu, 2020). Amidst a lack of publicly available information on whether COVID-19 tests are being run

* Corresponding author. Forensic Unit, Dept. of Clinical Services, Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria.

E-mail address: monalapo@yahoo.co.uk (A. Ogunwale).

within the Nigerian prison systems, there has been no report of COVID-19 infections in any Nigerian prison as of 17th July 2020 (NCDC Coronavirus COVID-19 Microsite, 2020). However, the global health community is aware of the possibility of such outbreaks as well as the attendant prevention strategies required to control them which have grave implications for general and mental health services within such confined spaces as prisons or secure forensic services (Simpson et al., 2020; World Health Organization, 2020). Liebrez et al. (2020) have helpfully identified key areas of emphasis in healthcare delivery in prison settings during the COVID-19 pandemic. These include considerations of access to and continuity of care as well as the need for early co-ordination by prison authorities, general medical staff, mental health teams along with the judiciary. The need for training and provision of accurate information in order to avoid undue panic as well as handling of staff shortage and infection control are also crucial.

1. Access to service & continuity of care

Some prison in-reach services have stopped running clinics on account of blanket restriction of visitors to the prison. However, in one of the services, a mental health nurse from a visiting psychiatric team had been integrated into the general medical clinic at the prison thus representing intra-mural service provision. Although psychiatrists from the partner hospital are unable to conduct routine visits as originally structured pre-COVID 19, this service is currently nurse-driven and still runs clinics with previously enrolled patients being seen. New presentations from inmates who had been in prison prior to the outbreak of the infection are also being attended based on primary care guidelines. No reduction in work hours has been necessary. In this nurse-driven service, the current patient load is about 22. The prison within which it is operational has an official capacity of about 510 but occupancy is typically in excess of this (Orunbon, 2020). From the services contacted, there were no upsurge of mental health referrals. In those services where prison in-reach clinics were no longer being permitted, arrangements were in place for the correctional services to contact the mental health team lead on emergency basis usually via telephone. The role of tele-psychiatry as a viable service option in African settings has been highlighted in previous research (Adjorlolo & Chan, 2015; Mars et al., 2012) but the extent to which this has been adopted given the current crisis remains to be seen.

There are some important implications of not having visiting psychiatrists in the nurse-driven in-reach service due to the pandemic. First, mental health assessments are not comprehensive with only nursing assessment documented. Usually, clear psychiatric diagnoses are to be made by medically qualified personnel. Consequently, the nurse-driven service essentially initiates emergency/preliminary provisional treatment based on symptom profile pending psychiatrists' review. Second, full psycho-legal assessments such as documenting the mental state of the accused person closer to the period of arrest and determining defendants' fitness to plead are not being conducted because they are the preserve of psychiatrists under Nigerian law. This has significant implications for the reliability of the expert opinion in situations in which the insanity plea is eventually raised. Third, given the presence of only one nurse, there is no multi-disciplinary team input into assessment and treatment. Fourth, most antipsychotic medications in the prison health system are first-generation types and when atypical medication is required, it is usually initiated and prescribed by the psychiatrist since nurses have no such prescribing rights. At the moment, patients requiring such medication may not be able to have them. Lastly, under normal circumstances, no depot medication (usually fluphenazine decanoate) can be given to patients newly enrolled by the mental health nurse until it is initiated and prescribed by psychiatrists. Long-acting fluphenazine and second-generation depot antipsychotics have been observed to reduce relapse rates (Kim et al., 2020; Kishimoto et al., 2014) and this consideration is even more crucial in our prison settings where adherence to oral medication may be sometimes doubtful.

Apart from the routine clinic reviews and emergency consultations,

other previously less prominent aspects of forensic mental health service in the country such as the preparation of psychiatric court reports appear to have been further tapered. Referrals from other services within the criminal justice system such as the police and the courts are less frequent given the fact that the most courts were not sitting during the early lockdown response to the outbreak. Some of the courts have gradually recommenced face-to-face sessions with some relaxation of the lockdown while a few of the courts are considering virtual trials and it remains to be seen how this might affect our forensic services.

2. Infection control

Steps taken to prevent possible outbreak of COVID-19 infections have included the use of infra-red thermometers in the prison clinic to avoid undue physical contact. Regular hand hygiene and use of face masks have been implemented within the prison system. The masks are mandatory for prison staff and visitors (where they are permitted). Since the courts started operations, prisoners attending court hearings also use face masks. The United Nations Office on Drugs and Crime (UNODC) had supported the NCS in providing face masks, gloves, sanitizers and infra-red thermometers (<https://www.unodc.org/nigeria/en/nigerian-correctional-service-partners-with-unodc-unaid-and-eu-to-prevent-the-spread-of-covid-19-in-custodial-centres.html>; accessed July 15, 2020) although it is not certain if the face masks provided are sufficient for the entire correctional service. Social distancing during clinic visits has been given priority based on the practice of seeing one patient at a time. This had been standard practice in one of the prison clinics prior to the COVID-19 outbreak and could have been based on a procedural security point of view rather than disease prevention. Some prison authorities have issued a 'no-visitor' directive for the time being. Nonetheless, individuals' perception of further restriction while being incarcerated during the pandemic is still a focus of investigation (Tomlin, 2020). In one of the prison services, a holding area had been set up in a medium security prison where newly admitted prison in-mates are held for a period of fourteen days before they are transferred to the maximum security prison to which they had been originally remanded. This is to prevent the spread of the infection into the prison by new inmates.

3. Inter-sectoral co-ordination

An institutional response to overcrowding in the prisons has been the collaborative effort of the National Judicial Council, Federal Ministry of Justice, correctional services, and state attorneys-general to decongest prisons based on the recommendations of the Presidential Committee for the decongestion of correctional centres. This has been achieved through early releases of certain categories of prisoners as well as the invocation of the presidential prerogative of mercy (Federal Ministry of Justice, 2020). In one of such cases, a patient of the prison in-reach service was released. However, it presents its own challenge because the continuity of that patient's care may be hampered by lack of appropriate referral given the skeletal mental health services being offered in different parts of the country due to the stretching of health resources by the outbreak. Typically, prisoners are released to their family members or other supportive parties. It is the responsibility of the family members, NGOs or the released prisoners themselves to seek continuity of mental health care in the community. Such individuals may attend government tertiary mental health hospitals or primary health care centres at their own cost where such are available. In Nigeria, only a few states of the federation (Lagos and Ogun) have demonstrated sustained success in integrating mental health into primary healthcare.

Furthermore, the Nigerian Correctional Service Act (2019; section 24) had envisaged the establishment of a mental health review board in all states of the federation in order to ensure more equitable mental healthcare for prison inmates. It is highly probable that the disease outbreak had shifted administrative priority to physical health objectives and delayed the take-off of this important oversight mechanism.

4. Staff training in handling COVID-19 cases

In one of the services, the general medical staff in the prison clinic were trained by the state government on the handling of COVID-19 cases and this training was stepped down to the mental health nurse stationed at the clinic.

5. Forensic mental health training for psychiatry trainees and research

Due to the 'lock down' in the correctional system and the suspension of regular trials by the courts, the forensic psychiatry rotations of residents cannot be completed satisfactorily. Ideally, they are expected to be exposed to prison psychiatry as well as some level of court work. These requirements unfortunately cannot be met under the current circumstances. Mental health research among prisoners is also likely to have been severely constrained due to blanket restriction of visitors to the prison. Typically, psychiatry residents spend 3 months or less in forensic psychiatry rotation prior to taking the membership examination of the West African College of Physicians and/or the National Postgraduate Medical College of Nigeria although the rotation is not a strict requirement for sitting the examinations. Post-membership trainees with subspecialty interest in forensic psychiatry usually spend 6–12 months in the rotation where forensic psychiatric training is available. Thus, for a lock-down commencing since March 2020, at least 2 residents in our own training programme have been unable to gain the expected experience in prison psychiatry and court work. This is comparable with the experience of other services contacted within the country.

Overall, forensic mental healthcare in Nigeria with its prominent slant towards correctional psychiatry has experienced significant limitations due to the COVID-19 outbreak. Key areas affected include access to services and continuity of care as well as postgraduate training in forensic psychiatry. Lessons learnt should provide us insight into strategic developmental objectives for the post-COVID era within our services and training programmes.

Declaration of competing interests

The authors have no competing interests to declare.

References

- Adjorlolo, S., & Chan, H. C. (2015). Forensic assessment via videoconferencing: Issues and practice considerations. *Journal of Forensic Psychology Practice*, 15(3), 185–204.
- Ebenso, B., & Otu, A. (2020). Can Nigeria contain the COVID-19 outbreak using lessons from recent epidemics? *The Lancet Global Health*, 8(6), Article e770. [https://doi.org/10.1016/S2214-109X\(20\)30101-7](https://doi.org/10.1016/S2214-109X(20)30101-7)
- Federal Ministry of Justice. (2020). *COVID-19: FG committed to further decongest prisons—Malami*.
- Institute for Crime & Justice Policy Research. (2020). *World prison brief—Nigeria*. <https://prisonstudies.org/country/nigeria>.
- Liebrezn, M., Bhugra, D., Buadze, A., & Schleifer, R. (2020). Caring for persons in detention suffering with mental illness during the Covid-19 outbreak. *Forensic Science International: Mind and Law*, 1, Article 100013. <https://doi.org/10.1016/j.fsimpl.2020.100013>
- Mars, M., Ramlall, S., & Kaliski, S. (2012). Forensic telepsychiatry: A possible solution for South Africa? *African Journal of Psychiatry*, 15(4), 244–247. <https://doi.org/10.4314/ajpsy.v15i4.31>
- NCDC Coronavirus Covid-19 Microsite. (2020). <https://covid19.ncdc.gov.ng/>.
- Nigerian Correctional Service. (2020). *Summary of inmate population by convict and awaiting trial persons as at 13th July, 2020* <http://corrections.gov.ng/statistics>.
- Nigerian Correctional Service Act, (2019).
- Obioha, E. E. (2011). Challenges and reforms in the Nigerian prisons system. *The Journal of Social Sciences*, 27(2), 95–109. <https://doi.org/10.1080/09718923.2011.11892910>
- Ogunlesi, A. O., & Ogunwale, A. (2018). Correctional psychiatry in Nigeria: Dynamics of mental healthcare in the most restrictive alternative. *BJPsych International*, 15(2), 35–38. <https://doi.org/10.1192/bji.2017.13>
- Ogunlesi, A., Ogunwale, A., De Wet, P., Roos, L., & Kaliski, S. (2012). Forensic psychiatry in Africa: Prospects and challenges. *African Journal of Psychiatry*, 15, 3–7. <https://doi.org/10.4314/ajpsy.v15i1.1>
- Orunbon, A. (2020, March 6). *Decongestion of correctional centres: The Ogun example*. Punch Newspapers. <https://punchng.com/decongestion-of-correctional-centres-the-ogun-example/>.
- Simpson, A. I. F., Chatterjee, S., Darby, P., Jones, R. M., Maheandiran, M., Penney, S. R., Saccoccio, T., Stergiopoulos, V., & Wilkie, T. (2020). Management of COVID-19 response in a secure forensic mental health setting. *The Canadian Journal of Psychiatry*, 1–6. <https://doi.org/10.1177/0706743720935648>
- Tomlin, J. (2020). What does social distancing mean for patients in forensic mental health settings? *Forensic Science International: Mind and Law*, 1, Article 100018. <https://doi.org/10.1016/j.fsimpl.2020.100018>
- World Health Organization. (2020). *Preparedness, prevention and control of COVID-19 in prisons and places of detention*. Copenhagen: World Health Organization Regional Office for Europe. https://www.euro.who.int/_data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1