Policy Gaps in Mental Healthcare Delivery in Nigeria: The Implication for Patient Outcome

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Abstract

Nigeria's mental healthcare system faces persistent challenges despite the National Mental Health Act 2023. This study examines policy gaps in mental healthcare delivery and their implications for patient outcomes. Using a descriptive survey design, data were drawn from indexed scholarly publications and peer-reviewed articles on mental health policy and service delivery in Nigeria from 2010 to 2025. Thematic analysis revealed key gaps such as limited state-level domestication of the Act, inadequate funding and non-operational mental health fund, severe shortage of mental health professionals, and poor integration of services into primary care. These gaps contribute to delayed treatment, high rates of untreated cases, and poor service delivery. The study concludes that bridging policy-implementation gaps through state adoption, ring-fenced funding, strengthening institutions and primary care integration is critical to improving patient outcomes.

KEYWORDS: Mental Health policy, policy implementation gaps, patient outcome, bpolicy coherence

Introduction

The prevalence of mental health has become an increasing visible public health concern across the globe, yet in Nigeria, the disparities between the magnititude of need as well as adequacy of institutional responses has remained stark. According to the World Health Organisation (2022), one out of four Nigerians which represent over seventy million people experiences a diagnosable mental disorder in their lifetime. Despite this burden, mental health has continued to occupy a formidable merged health position in Nigeria's larger health policy architecture. The study interrogates the marginalisation by examining the policy gaps that limits effective mental healthcare delivery in Nigeria.

Historically, Nigeria's approach to mental health has been characterised by fragmentation, negligence and underfunding. The Lunacy Act of 1958 as a colonial era legislature remained the principal legal framework for mental health in Nigeria for over six decades. This provision of this Act stressed on custodial care and involuntary confinement instead of right-based, community-oriented treatment for mentally health challenges. Adeosun (2019) argued that

the Act's archaic orientation entrenched stigma and failed to provide a statutory basis for integration of mental health into primary care. Adeosu (2019) further noted that the legislation has only criminalised mental illness by association and offered no significant pathway for prevention, rehabilitation or patient autonomy.

The passage of the National Mental Health Act in January, 2023 was to widely herald a watershed moment. The Act guarantees a right to mental healthcare that prohibits discrimination and mandates the establishment of the Mental Health Service Department within the Federal Ministry of Health (Federal Republic of Nigeria, 2023). Ugochukwu et al (2024) observed that the legislation was without operationalisation as it is merely aspiration text. He holds this position because study revealed that the Act remained not implemented almost a year after its enactment. In collaboration, Onyemelukwe (2023) opined that the Act has not been able to manifest its full purpose as underinvestment is still acutely an infrastructure deficit. With the larger population of Nigeria, the facilities concentrated in psychiatric hospitals are more in urban centres leaving rural population underserved (Gureje, et al, 2023). Additionally, Adewuya et al (2025) revealed that the National Policy for Mental Health Service Delivery (2013) which envisioned the integration of mental health into primary healthcare has received lesser human resources in some parts of Nigeria. More so, Nigeria lacks a functional mental health information system because most states in Nigeria do not collect disaggregated data on service utilisation, medication availability, and without accurate data, policy makers cannot track progress or allocate resources rationally (Labinjo, 2024).

The consequences of policy gaps in Nigeria mental health administration has driven many Nigerians and families into seeking care from traditional or religious healers, which sometimes results into human rights abuses such as chaining (Jidda, 2023). The WHO (2022) noted that the Nigeria mental health situational analysis revealed that documented cases of prolonged shackling and state-run facilities as then practice but now explicitly prohibited by the new Act but still prevalent due to weak enforcement. The World Bank (2024) estimated that the Nigeria's mental disorders cost 2.5% of GDP annually through lost of productivity, prior studies have documented individuals aspect of Nigeria's mental health system, whereby few have synthesised how legislative, financial and administrative gaps interact to produce systemic failure. Thus, there is a dearth of National Health Act and Mental Health Delivery, which this study seeks to provide a comprehensive, evidence-based diagnosis of policy gaps in mental healthcare delivery in Nigeria.

Statement of the problem

The enactment of the National Mental Health Act 2022 was a decision policy milestone that signaled Nigeria's intent to align its mental health governance with global human right standards and World Health Organisation comprehensive of the Mental Health Action Plan of 2013 -2030. Despite this passage of the Act, the dissonance between legislative aspiration and operational reality remains profound. The study is intended to address the persistence of systemic policy gaps that continue to undermine the delivery of accessible, equitable and right-based mental healthcare in Nigeria, despite this existence of a new legal framework. Jidda, (2023) and Owolabi et al (2025) observed that despite this Act prevalence, the country's mental health treatment gap of the proportion of individuals who require care but do not receive it remains among the highest globally. This gap is not merely a function of poverty or

cultural preference; it is structurally produced by policy failures that shape service availability, affordability and acceptability. A critical evidence of the policy gap lies mainly in underfunding of mental health in Nigeria. Although, the National Health Act of 2014 makes it mandatory that every Nigerian is entitled to a basic minimum package of health services, mental health has not been meaningfully integrated into the Basic Health Care Provision Fund (Onyemelukwu, 2023). The fiscal policy gap produces cascading effects such as dilapidated facilities, extinction of community-based rehabilitation services amongst other (Gureje, et al, 2023).

From another perspective, problem of the mental health policy gap is due to weak institutionalisation of the National Mental Health Act, 2023. The Act provides for the creation of mental health service department in every state mental health facilities, yet, its implementation has been fragmented and unnoticed. In fact, Ugochukwu, et al (2024) undertook a multi-state policy tracking study and find out that as at December, 2023, only six states out of the 36 states commenced the operationalisation of the policy, this position has not change (Adewuya, et al, 2025). This implies that prohibitions against chaining, forced treatment, and discrimination is in practice. This has made the problem compounded as failure to integrate mental health into primary healthcare despite successive polices advocacy for effective global mental disorder remains invisible, leading to delayed care, worsening prognosis, and increased reliance on unregulated traditional and faith-based providers.

The cultivating effect of these policy gaps is both clinical and economic. It is clinical when untreated mental illness contributes to increased mortality and it is economical when there is lost of productivity as a result of depression and anxiety. Therefore, the problem this study confronts is both the absence of policy text and the presence of implementation voids that affects the finance, governances, human resources, and data systems that prevent policy from translating into service delivery. Existing studies revealed that there has been examination of these dimensions in isolation – the legal analysis of the Act, facility audits, or epidemiological surveys – but rarely interrogate how their interaction produces the persistent treatment gap. Without a systematic diagnosis of these interlocking policy failure, interventions risk being piecemeal and unsustainable. The study therefore seeks to fill that analytical void by mapping specific point at which policy intent dissipates, thereby provide an evidence base for targeted reforms.

Aim and Objectives of the study

The main aim of the study is to examine policy gaps in mental healthcare delivery in Nigeria. The specific objectives are to:

1. examine the extent of National Mental Health Act 2023 across the country;
2. assess the pattern of financing mental healthcare in relation to interaction bench mark;
3. analyse the functionality of mental health information systems and their role in policy monitoring; and
4. identify leverage points for strengthening policy coherence in mental healthcare delivery

Significance of the study

The relevance of interrogating policy gaps in mental health delivery in Nigeria extends beyond academic interest to encompass pressing imperatives in public health, human rights, and economic development by systematically diagnosing the structural, fiscal, and institutional fissures that have prevented implementation of health policies. By identifying specific policy bottlenecks and address them. The study provides the ministry of finance, budget and national planning and state legislatures with investment cases necessary for funding basic healthcare. More so, the study will advanced Nigeria's compliance with international human rights obligations, thereby exposing the gap between de jure protection and de facto practices. The study significance lies in its capacity to convert diagnosis into action, offer governmental actors a coherent map of where policy dissipates; provide development basis for alignment of technical assistance; and to contribute to global discourse on translating mental health legislation into population health gain.

Methodology

The method adopted for the study is the descriptive survey and qualitative research design where data were obtained from indexes of scholars' work on relevant literature through textbooks, journal articles, publication papers presented in seminars and conferences. The Nigeria mental healthcare system is the scope of this study with focus on policy gaps in mental administration.

Theoretical framework

Top-Down Policy Implementation Theory:

The top-down policy implementation theory was propounded by Sabatier and Mazmanian in 1980. The theory postulated that the successful implementation of policy depends on certain conditions which include clear policy objectives, adequate causal theory; legal authority committed implementing officials, supportive interest groups, and supportive socio-economic conditions. These conditions determine policy implementation failure or success. The theory assumption also was that policy can be perceived from top –down perspectives, because policy is made by central actors and implementation is about translating that policy into practice with lesser distortion. Effective implementation of policy occurs once when the implementation conditions are met. The theory further buttressed that a policy must provide clear, consistent and measurable objectives, so as to avoid ambiguity that hinders implementation; policy must be based on a valid theory linking interventions to outcome; give implementation agencies adequate resources authority and power to control target group; policy should be implemented by skilled manpower with sufficient backing from stakeholders.

The application of the theory to the study according to Erasmus (2024) is that the integration of mental health policy into primary care is vague because primary health workers would only deliver the task if they are trained and supervised. The mental health act 2021 authority provision has not been domesticated because the state has weak authority to do so; stigmatisation reduces public demand. The theory focuses more on policy gap and not healthcare delivery, hence, the consolidated framework for implementation research theory.

Consolidated framework for implementation research theory

This theory was propounded by Damschroder in 2009 and it states that policy implementation effectiveness is determined by the interaction between an intervention and its domains which included outer setting or the environment that shapes implementation; inner setting or organisation feature; characteristics of individual who is the implementer of the policy, the belief, knowledge and behaviour as well as implementation process. The application of the theory to the study revealed weak domestication of mental health act 2021, underfunding, high staff turnover, poor infrastructure, stigmatisation of mentally challenge persons, low self-efficacy of primary healthcare workers, poor planning and supervision process amongst others that has hinder the implementation of mental health policy in Nigeria.

Literature review

Policy gaps in mental health

It is trite to say that the Lunacy Act of 1958 which was enacted over sixty years ago by the colonial laws focused on detention and control of the mentally challenges persons rather than focusing on treatment and rights. The Act also criminalise suicide, permitted indefinite detentions without due process; and did not recognise community-based care or informed consent. In fact, Ola, et al (2025) opined that this Act created barriers to human rights; and in addition, the Act also foster barriers to modern mental health practices, because it was inconsistent with international standards of patient right, dignity and autonomy. This was perceived as the rationale why Agboola, et al (2024) opined that some Nigerian mental health policies did not provide for integration of mental health into primary healthcare.

In a bid to rectify this observed gaps in the Lunacy Act of 1958, Nigeria adopted its first indigenous National Mental Health Policy in 1991 which was reviewed and revised in 2013. The policy objective was to promote prevention, treatment, and rehabilitation of the mentally challenged persons in Nigeria, and to achieve this, the policy integrated mental health services into primary healthcare at all levels, trained primary care workers and reduced stigmatisation. Upon the adoption of this policy and its improved packages, it then face other waterlog of implementation challenges; underfunding, and workforce gap. Ola, et al, (2025) observed that Nigeria mental health policy of 2013 was not well implemented in many states of the federation due to poor training, supervision and support. In addition, Onyemelukwe, et al (2023) observed that the policy implementation was cumbersome due to infrastructural deficiency and qualified personnel. In another perception, Labinjo (2024) opined that the policy suffered financial attention of insignificant budget or funding; this resulted into irregular medication supply, weak infrastructural facilities and inability to bring the policy to limelight (Owolabi, et al, 2025).

Advancing globally, Nigeria replaced the Lunacy Act with the Mental Health Act of 2021 so as to align Nigeria with the United Nation Convention on the rights of persons with disabilities. The new policy provision prohibited discrimination against all persons; provided for confidentiality, informed consent and decentralisation of service to primary and secondary levels of healthcare systems. Despites these observed provisions, the Act did not capture mental health services in the National Health Insurance Authority of 2022 benefit packages, because the out-of pocket payment packages still remains the main financing mechanism, thereby limiting accessibility for low- income population, and it results into poor patient

outcomes. Ola, et al (2025) pinpointed that implementation of the policy would depend on resources available and accessible at state level, because up till 2026, most state have not domesticated the Act or allocated budget for it. This is worrisome because of its effects on patient outcome; one is worried at the alarming rate of increasing number of mentally challenge persons in Nigeria. Indeed, it calls for urgent attention. In addition, Ugochukwu, et al (2023) and Agboola, et al (2024) added that there have been referral and coordination gaps in the Act, because the Act mandates referral pathways, but there has been observed uncoordinated referral system and poor linkage or synergy between primary healthcare, secondary and tertiary cares.

In attempt to bridge some of these identified policy gaps, Nigeria government adopted the World Health Organisation Mental Health Gap Action Programme (MhGAP) integration so as to scale up services through non specialist health workers, by rolling out training programmes for physicians and Primary healthcare workers, while awareness exists, participation in MhGAP implementation is low due to irregular drug supply, lack of supervision and absence of formal discussions with higher level or expertise. Although, it is suffice to say that the policy document recognises MhGAP, but it did not back it with substantial funding, monitoring or integration into health information systems (WHO, 2025). Ola, et al (2025) observed that despite strong technological readiness by the Lagos State government with digital mental health policy environment, the readiness is never matched with implementation, thereby using the digital health architecture to under-prioritise mental health. These implies that Nigeria government mental health policies have luxury of gaps ranging from underfunding; workforce shortage, and mal-distribution to urban centres mobility; stigmatisations and community support deficiency; and weak monitoring as well as evaluative system. These policy gaps directly have adverse effects on patients, thereby increasing mortality rate, amongst other effects.

Nigeria mental healthcare Financing and global benchmark

Mental healthcare financing in Nigeria is characterised by severe underinvestment, minimal public budget allocation and heavy reliance on out-of-pocket payments. The Nigeria government budgetary allocation have been observed to have been capturing less than 1% of its total health budget to mental health, despites the provisions of the National Mental health Policy of 2013 and Mental Health Act of 2021 mandating integration and decentralisation of service, yet low attention has resulted into irregular supply of psychotropic medication, poor infrastructure, and limited training for primary healthcare workers. Ugochukwu, et al (2023) observed that the exclusion of mental health from the NHIA benefit packages, patients and families would bear the cost directly thereby creating huge financial barrier particularly for rural household and poor citizens. Ola, et al (2023) noted that despite the present of external funding and non-government organisation support, to fill some of these gaps. Although, they are fragmented, short term and not aligned with national plans. There has not been any tangible dedicated mental health fund at the federal or state levels.

The international benchmarks for mental health funding as recommended by the World Health Organisation is that low and middle-income countries should allocate 5-10% of the health budget to mental health to attain minimum service coverage, while high-income countries are enjoined to allocate 5-15%; integration of mental health services into national

health insurance schemes to reduce financial burdens or dedicated budget line for mental health to prevent diversion to other health prioritise; and equitable distribution of fund to primary care and rural areas not only urban and tertiary certres. These global standards were observed by scholars as been compromised in Nigeria (Premium Time, 2024). Onyemelukwu, et al (2023), Labinja, (2024) and Ugochukwu, et al (2024) observed that Nigeria budgetary allocation for mental health has been less than 1% which falls far below the global benchmark. This underfunding result into chronic shortage of drugs, staff and facilities; Ugochukwu, et al (2023) observation that mental health Act of 2021 exclusion of mental health in the NHIA benefits packages has created a policy lacuna, whereof insurance coverage and financial protection are absent as well as catastrophe health expenditure are created. These gaps themselves did not comply with world benchmark. Also, Ola, et al (2025) observed that the mental health workforce faces several challenges inclusive of inadequate recruitment and retention of mental health professionals; estimating one psychiatrist to over one hundred population with most concentration in the urban areas. It is another shortcoming when compare to universal standard. Gureje, et al (2023) noted that there is not transparent system in Nigeria to monitor these policy gaps so as to track mental health expenditure and its outcomes.

The implication of these policy gaps directly undermines patient outcomes in several ways. Ola, et al (2025) identified increasability to mental health facilities which results into high out-of-pocket cost for patient, delay in seeking help and treatment as well as late presentation of mentally challenge persons for medical attention. In addition, resulting into difficulty in managing patients. Gureje, et al (2023) perceived irregular medication supply and lack of follow up in most cases as outcomes of mental policy gaps in Nigeria, thereby preventing continuity of care for patients. In Ugochukwu, et al (2023) opinion, the implication of policy gap entails inability of primary healthcare facilities to provide avoidance-based interventions, reduce recovery rates and quality. It is trite to add that rural and low-income populations are affected disproportionately thereby widening their health challenges and inequalities. Thus, it is germane to close financial gaps, improve on mental health policy without any negligent; improve on mental health resources and build a stronger standard for global acceptance.

Functionality of mental health information systems in policy monitoring

The Nigeria's National Mental Health Policy 2013 and the Mental Health Act 2022 recognise the need for data –driven planning. The policies demanded for integration of mental health indicators into the National Health Management Information System (NHMIS) so as to monitor and evaluate the mechanisms to track service coverage, workforce and health outcomes. Also, MhGAP process equally identifies integration of mental health issues into health information system. The Nigeria's mental health information system remains fragmented and underdeveloped. The policy gap in mental health is largely exclusion of key mental information system; this is as a result of weak institutional mechanisms for data collection in the health sector (Adeosun, et al, 2021 and Odejimi, et al, 2025). Makanjuola, et al (2021) added that the Nigeria ecosystem with several digital health projects has low portfolios for mental health with no dedicated platforms for mental health data as well as weak monitoring and evaluation mechanism in place.

The role and function of mental health information system is to track policy implementation, resources allocation, and patient outcomes to inform adjustments as a technical means to close mental health policy gaps. Ola, et al (2025) observed that in some states, where policy is adequately captured, readiness for implementation is misaligned due to lack of data systems to track actual service delivery. Without routine mental health data in NHMIS, policy makers cannot monitor coverage and identify bottlenecks like medications stocks-outs or link financing to outcomes, it is an absence of routine data which affect decision-making. Where there is lack of formal supervision and data feedback, it reduces the impact of training and mental health information cannot thrive. Jidda,(2023) observed that the role of mental health information system was to add value to existing policy and enhance commitment of data tools for effective healthcare delivery in Nigeria. More so, to ensure that available resources are judiciously utilised for quality result, reduce waste of resources and maximise it tracking quality data for policy reformation and health outcomes.

The implication of mental health information system functionality is to help bridge policy gaps by accurately tracking and preserving health information for transformation purposes. Onyemelukwu (2023) added that without data, funds would be directed to high-need areas of interventions that would bridge policy gaps and results in quality patient outcome. Also, lack of information prevents learning and adaptation of clinical practices which reduces quality of service delivery. Policy makers according to Adewuya, et al (2025) cannot be held accountable for policy promises when there is not data on implementation. Ola, et al (2025) emphasis on the need for integration of real time data systems, with when supported supervision and data feedback to review mental health policy gaps and possible reformation.

Strengthening policy coherence: the leverage points

Policy coherence refers to the coverage adequacy or alignment of policies, laws, budgets, work plans and service delivery mechanisms towards a collective goal. The Nigerian mental health policies were quite incoherent, especially the observed policy incoherence between the National Mental Health Policy 2013 and Mental Health Act 2021, financing framework, and primary healthcare strategy that has limited translation of policy into improved patient outcomes. These gaps identified in the existing policies on mental health in Nigeria can be leverage upon through several interventions that would strengthen policy coherence as follows:

1. **Government and institutional alignment:** One gap identified in the study is that mental health issues are excluded from the activities and benefit packages of NHIA (Ugochukwu, 2023); with key health sector documents, this is apportioned to weak institutional mechanisms from the government, be it tertiary, secondary or primary sector. The Mental Health Act, 2021 created a legal framework for decentralisation which was not domesticated by most states as it was. Agboola, et al (2024) noted that the absence of a dedicated mental health unit with authority and budget at any level of governance leads to fragmented accountability. Ola, et al (2025) proposed that there should be an establishment and funding of state mental health units under the ministry of health to help coordinate policy implementation, budgeting and monitoring as leverage point for policy gaps necessitated due to weak institutions.
2. **Insurance and financial integration:** It is fundamental to recap what Agboola, et al (2024) reported that policy gap manifests as a result of inadequate funding and

irregular medication supply at the primary healthcare. Most of the issues surrounding Mental Health Act 2021 which were excluded from the NHIA 2022 benefit packages left patients to foot their medical bills out of their pocket which is far below the global set benchmark for patient, as a leverage point, it is pivotal to include mental health service into the NHIA benefit packages and create a ring-fenced budget line for mental health as federal and state healthcare service delivery. Makajuola, et al (2021) noted that inculcation of mental health service into NHIA benefit packages will help bridge mental health policy gap and foster quality healthcare delivery.

3. **Workforce capacity and task-shift:** As a process of training primary care workers, Agboola, et al (2024) found that low worker engagement is as a result of inadequate supervision, lack of support and coordination from specialist, to tackle this gap. Makajuola, et al (2021) and Adewuya et al (2025) suggested that the MhGAP tools can be adopted and integrated into training workforce, therefore creating a paradigm shift of responsibilities. Furthermore, health institutions should encourage training within pre-service curricula and link it to mandatory supervision and performance indicators in primary healthcare centres.
4. **Data and monitoring system:** The exclusion of mental health from routine health information system is a policy gap (Gureje, et al, 2015) which Ola, et al (2025) also regarded as a strategic implementation gap because of the high policy readiness in digital health projects and there are no other dedicated data platforms. Ugochukwu, et al (2023) added that without routine data on service alignment, drug availability, and accessibility as well as patient outcome, policy makers cannot track policy implementation or any intervention. In attempt to bridge the gap, integration of mental health induction into NHMIS, and reporting quarterly achievement and supervision can then be accounted for.
5. **Alignment of Digital Health and Innovation:** Fundamentally, through concerted efforts, mental health policy gaps can be aligned hence, Ola, et al (2025) argued that policy readiness is not policy match by implementation because mental health is not prioritised in national digital healthcare architecture. The strategic oversight in the areas of digital health resources allocation to mental health is the policy gap that needs to be aligned. With a mandate of digital healthcare investment for mental health and development, an innovative template for telepsychiatry data capturing can be enhanced.
6. **Community Involvement as Anti-stigmatisation:** According to Ugochukwu, et al (2023) stigmatisation and negative social attitudes slow down mentally help-seeking patient thereby leaving them with no option than reliance on informed and orthodox care. Nigeria mental health policy document rarely include concrete funded strategies for community involvement. Lack of operational plans for anti-stigmatisatioon campaign and community involvement was the gap (Libanji, 2024). Jidda, (2023) suggested a leverage point that fund and monitor community engagement components within state mental health plans. These strategic leverage points can strengthen policy gaps so to improve patient outcome.

Conclusion

It is trite to state that Nigeria has made progress in developing a right-based policy and legislative framework on mental health evidenced by the National Mental Health Policy 2013

and the Mental Health Act 2021. However, there has been observed policy gaps between policy formulation and implementation which has consistently undermine mental healthcare delivery and patient outcomes. The evidence indicates a system that is characterised by underfunding with less than 1% of health budget allocated to mental health which is far below global benchmark; weak integration of services into primary healthcare due to inadequate training, supervision, and medication supply; exclusion of mental health from the National Health Insurance Authority benefit packages; and fragmented data system that prevent effective policy monitoring and evaluation in the healthcare sectors. These policy gaps therefore, contributed huge challenges to mentally challenged patients with severe effects such as difficulties in accessing mental health coverage, out-of-pocket payment system and delay in treatment, resulting into leaving patient with no option than to rely on informal or traditional care without adequately addressing these mental health policy gaps. Nigeria will not attain Universal Health Coverage for mental health. In order to leverage these gaps, policy coherence, data monitoring systems, government and institutional alignments amongst others were identified

Recommendations

Based on the findings, the following actionable recommendations were made:

1. The federal government should strengthen governance and healthcare institutions so as to domesticate, implement and monitor Mental Health Act 2021 policy across all states of the federation for quality service delivery.
2. Ministries of health should raise mental health allocation to meet global benchmark and reduce out-of-pocket expenditure for patient.
3. The National Health Management Information System should as a matter of routine, collect, report, utilise data for the purpose of integration and alignment of digital health platforms for telepsychiatry services with extension to underserved rural areas.
4. Community leadership should engage in funding and monitoring support packages for mentally challenged patient with intention to reduce stigmatisation of mental health patient so as to bridge formal and informal gaps existing in the society.
5. Healthcare policy makers should review and reform the National Health Act of 2021 and the National Mental Health Policy 2013 towards bridging mental health policy gap.

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