

**A HUMAN RIGHTS BASED APPROACH TO THE PSYCHIATRIC
TREATMENT OF MENTAL ILLNESS AMONG PRISONERS IN
UGANDA**

**SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF
THE DEGREE LLM (HUMAN RIGHTS AND DEMOCRATISATION IN
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Dedication

This work is written in memory of my best uncle ever Mr Mark Clement Zulu and to all mentally ill prisoners in Uganda, Zambia and the world over.

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Acronyms

AHSPR	Annual Health Sector Performance Report
HSSIP	Health Sector Strategic & Investment Plan
HSSP I	Health Sector Strategic Plan
HSSP II	Second Health Sector Strategic Plan
HSSP III	Third Health Sector Strategic Plan
NDP	National Development Plan
NHP I	First National Policy
NHP II	Second National Policy
MOH	Ministry of Health
UNMHCP	Uganda National Minimum Health Care Package
WHO	World Health Organisation

Table of contents

Plagiarism declaration.....	ii
Dedication.....	iii
Acknowledgment.....	iv
Acronyms.....	v
Chapter one.....	1
1 Introduction.....	1
1.1 Background.....	1
1.2 Mental health services in Uganda.....	1
1.3 Mental health services within prisons in Uganda.....	2
1.4 Problem statement.....	3
1.5 Focus and objective of the study.....	3
1.7 Significance of the study.....	4
1.8 Assumptions.....	4
1.9 Justification.....	4
1.10 Research methodology.....	5
1.11 Limitations of the study.....	5
1.12 Overview of chapters.....	5
1.13 Ethical considerations.....	5
1.14 Literature review.....	6
1.14.1 Are prisons suited to cater for mentally ill prisoners?.....	6
1.14.2 Treatment needs of mentally ill prisoners.....	8
1.15 Conceptual framework.....	10
1.15.1 Mental illness explored.....	10
1.15.2 Mental illness through the lens of psychiatry and culture.....	11
1.15.3 A multi-disciplinary approach to mental health care.....	12
1.15.4 Contours of the right to health and the ‘neglected diseases’ approach.....	13

Chapter two	15
2 International regional and national human rights framework on the right to health	15
2.1 Introduction.....	15
2.2 Background	15
2.3 International human rights framework.....	17
2.3.1 The Universal Declaration	17
2.3.2 General Comment Number 14 (General Comment No 14) and the import of Article 12 of the ICESCR	17
2.3.3 The ICCPR.....	20
2.3.4 The UN CRPD	23
2.4 Other international human rights standards	24
2.4.1 The UN Body of Principles	24
2.4.2 The UN Standard Minimum Rules.....	24
2.4.3 The MI Principles	25
2.4.4 The UN Standard Rules	26
2.5 Regional human rights framework	27
2.5.1 The African Charter.....	27
2.5.2 The right to health under the African Charter.....	27
2.6 National human rights framework	28
2.6.1 The Constitution of the Republic of Uganda	28
2.6.2 The MTA	29
2.6.3 The PWD Act	29
2.6.4 The Prisons Act.....	30
Chapter three.....	32
3 Introduction	32
3.1 Background	32
3.1.2 An overview of Uganda's health policy framework.....	32
3.2 International and national standards on the health policy implementation.....	33

3.2.2 Domestic standards on the implementation of health policy under the Ugandan Patient's Charter	35
3.3 NHPII objectives on mental health services and their extent of compliance with international standards	36
3.4 Uganda's draft mental health policy and prisoners' right to mental health	38
3.5 Mental health legislation	39
3.5.1 Critical assessment of the MTA.....	39
3.5.2 The Mental Treatment Amendment Bill 2010 (MTA Bill) and the protection accorded to prisoners	40
3.6 Research findings.....	42
3.6.1 The position in Uganda's Prisons	42
3.6.2 Challenges in prison management	44
Chapter Four.....	47
4 Conclusion	47
5 Recommendations	47
5.1 Mental health legislation	47
5.2 Mental health policy and services	48
5.3 Legislative procedures relating to the arrest, detention and trial of mentally ill offenders	48
5.4 Prison conditions	48
Bibliography	50

Chapter One

1 Introduction

Reports of people with mental disorders without access to treatment are a major occurrence in prisons outside and within Africa.¹ An estimated 450 000 000 people worldwide suffer from mental or behavioural disorders.² The disproportionately high rate of mental disorders in prisons is due to several factors.³ The factors include the widespread misconception that all persons with mental disorders are a danger to the public; the general intolerance of many societies to difficult or disturbing behaviour, the failure to promote treatment, care and rehabilitation, and above all the lack of or poor access to mental health services in many countries.⁴

Many of these disorders may be present before admission to prison and may be further exacerbated by the stress of imprisonment.⁵ However mental disorders may develop during imprisonment itself as a consequence of prevailing conditions.⁶

1.1 Background

1.2 Mental health services in Uganda

In Uganda all persons suffering from mental illness are referred to the national mental referral hospital called Butabika.⁷ The mental health facilities were decentralised in the 1960's with the aim of enhancing access to treatment. Uganda has only ten mental health units built at regional level notwithstanding the fact that mental health contributes 13 percent to the disease burden.⁸ The most common illnesses are identified as post traumatic stress disorders, schizophrenia and depression.⁹

¹ International Committee of the Red Cross (ICRC) 'Report on Health and Prisons' (2010):<http://www.icrc.org> (accessed on 12 September 2011).

² WHO 'Mental health and prisons' :<http://www.who.int/mentalhealth> (accessed on 7 September 2011).

³ RC Bland et al 'Prevalence of psychiatric disorders in the population and in prisoners' (1998) 21 *International Journal of Law & Psychiatry* 273 - 279.

⁴ WHO 'Mental health and prisons' (n 3 above).

⁵ As above.

⁶ See report of the Former Special Rapporteur on the Right to the Highest Standard of Physical and Mental Health submitted at the 59th session of the UN Human Rights Commission on 13 February 2003 E/CN.4/2003/58 22 & 93.

⁷ MR Kavuma 'Changing perceptions of mental health in Uganda':<http://www.guardian.co.uk> (accessed on 19 September 2011).

⁸ See 'Uganda's Annual Health Sector Performance Report' (Uganda Annual Health Report) (2009 – 2010) 109.

⁹ WHO 'Report on mental policy and service provision' (WHO Report on mental policy) (2010).

However, these recently established centres catering for 11 500 000 mentally ill persons out of a population of 33 000 000 Ugandans prisoners included are not evenly spread, manned by unqualified staff and poorly stocked with required medicines; rendering them as good as useless.¹⁰ There are a total of 28 psychiatrists catering for the preceding population with a patient ratio of 1: 1 142 857.¹¹ This makes access to health services difficult as mental cases are projected to reach 15 percent by the year 2020.¹²

The Government of Uganda recognises mental health as a public health concern and has recently implemented a number of reforms aimed at strengthening the country's mental health system.¹³ Notwithstanding these developments in mental health policy, there are challenges with regard to resources and service provision.¹⁴ Services are still significantly under funded with only one percent of the health expenditure going to mental health and skewed towards urban areas.¹⁵ Inadequate financing of mental health services has rendered well meaning policies and government programmes redundant, making the delivery and access to the services problematic.¹⁶

1.3 Mental health services within prisons in Uganda

Uganda like other developing countries has inadequate psychiatric services in prisons and general hospitals.¹⁷ Therefore, the mental health needs of prisoners are unlikely to be identified, assessed and treated with the immediacy and efficacy they require. Resultantly, affected prisoners' abnormal behaviour may be judged unfairly by prison staff and worse more, prisoners may be prone to suicidal attempts whilst in prison.¹⁸

Furthermore, an assessment of the magnitude and nature of psychological distress among the prison population in Uganda revealed that a significant number of the affected prison population exhibited psychological distress with depression, anxiety and post traumatic stress disorder being the most common psychiatrist presentations.¹⁹ The lives and health of the 50 000 inmates who pass through Uganda's 223 prisons each year are

¹⁰ Ministry of Health Uganda Health Sector Strategic Plan HSSP (III) (2010 - 2014) 27.

¹¹ Uganda Annual Health Report (n 9 above) 109.

¹² WHO Report on mental policy (n 10 above).

¹³ Uganda Annual Health Report (n 9 above) 109.

¹⁴ F Kigozi et al 'An overview of Uganda's mental health care system: results from an assessment using the WHO assessment instrument for mental health systems (WHO-AIMS)' *International Journal of Mental Health Systems* 2010 1.

¹⁵ Kigozi et al (n 14 above) 8.

¹⁶ Uganda Human Rights Commission 13th Annual Report (UHRC 13th Annual Report) (2010) 122.

¹⁷ FN Kigozi 'Psychosis and Crime' unpublished Master of Medicine in Psychiatric thesis, University of Makerere, 1979.

¹⁸ As above.

¹⁹ M Mungherera 'Mental health as a basic human right for prisoners' (2003) 3 *Journal of African Health Sciences* 3.

threatened with inadequate medical care.²⁰ This scenario is worsened by poor sanitation and overcrowding.²¹

At upcountry facilities, mental healthcare is inexistent and treatment consists only of medication prescribed by a visiting psychiatrist and dispensed by other inmates, with no attempt at psychotherapy or other forms of alternative mental healthcare.²² Inmates with mental disabilities at some prisons are simply isolated in punishment cells with no treatment. Further there is a backlog of prisoners with psychosocial disabilities, who remain incarcerated years after being found not guilty by reason of insanity, without receiving proper mental health treatment.²³

1.4 Problem statement

Uganda has made significant strides in health policy and legislation. However, there are still many mentally ill prisoners within Uganda's prison system living under poor conditions without access to the basic psychiatric services and mental health care. This brings into question why a country which has implemented policy and legislation protecting the rights of prisoners has many of such prisoners living without access to wholesome mental health services. It is probable that the policies are either inadequate, not properly implemented or that the approach taken in providing such services is devoid of human rights standards. There is therefore need to determine whether the current policy and legislation on mental health service provision meet national and international human rights standards. This study also examines whether the current policy and legislation in Uganda are responsive to the current mental health needs of prisoners in Uganda.

1.5 Focus and objective of the study

The focus of the study is on the current status of provision of access of psychiatric treatment to prisoners with mental illness in Uganda. The objectives of this paper are to identify the relationship between prison conditions and prisoners with mental illness in Uganda. Secondly to ascertain whether psychiatric treatment is availed to prisoners with mental illness in an adequate and sufficient manner. Thirdly to ascertain whether there is a deliberate government policy, and whether there are legal safeguards to ensure provision of such treatment to the prisoners affected. Finally, to identify the best possible and most

²⁰ Human Rights Watch (HRW) 'Even dead bodies must work health, hard labour and abuse in Ugandan Prisons' (2010):<http://www.hrw.org> (accessed on 20 July 2011).

²¹ Foundation for Human Rights Initiative (FHRI) 'Disability is not inability' (2009) 77.

²² HRW (n 20 above).

²³ See letter to the Ugandan Minister of Justice Kiddhu Makubuya from HRW Africa Director Daniel Bekele dated 28 April 2011, on the indefinite detention of prisoners with psychosocial disabilities in prisons of Uganda: <http://www.hrw.org> (accessed on 1 June 2011).

feasible way that Uganda can provide access to psychiatric treatment to prisoners with mental illness.

1.6 Research questions

In light of the preceding background, the questions that this paper seeks to ask are as follows:

1. What are the prevalent conditions that prisoners with mental illness live under in Ugandan Prisons?
2. Is there adequate provision of psychiatric treatment to prisoners with mental illness within Uganda's national health institutions in conformity with international and national human rights standards?
3. Is there an existing policy and legislation which can be used to provide prisoners with mental illness with such treatment? How does the policy and legislation in question conform to international standards?

1.7 Significance of the study

The findings of this study will serve as an informative tool to policy makers, legislators, academics and researchers in this field. The findings will identify alternative solutions that Uganda can pursue in the provision of psychiatric treatment to prisoners with mental illness and contribute to the body of knowledge already in existence in this field.

1.8 Assumptions

The nature of mental health services given to prisoners with mental illness largely focuses on the provision of psychotherapeutic drugs and injections, this mode of treatment alone is inadequate. Resultantly prisoners do not recover in a wholesome manner. In order to ensure a wholesome treatment regiment for them, there is need to use a multi-disciplinary approach to mental health care. Overall, such an approach could improve the quality and quantity of mental health care within and outside prisons.

1.9 Justification

This study informs the development of mental health services for prisoners within Prisons in Uganda. The study further justifies the adoption of policies which include psychiatric screening of all prisoners on entry influence the adoption of a multi-disciplinary approach in the management of mentally ill prisoners. Consequently, it would enhance measures for effective and efficient disposal of cases involving mentally ill offenders.

1.10 Research methodology

This research is a single case study of Uganda. It combines both quantitative and qualitative aspects of research. In this vein data was collected through informal discussions. The discussants comprise psychiatrists, health workers, prisons officials, mentally ill prisoners and non-governmental organisations dealing with prisoners' rights. As it provides an analytical, descriptive and evaluative approach to the problem, internet resources, desk top research and document analysis are utilised.

1.11 Limitations of the study

This study focuses on prisoners with mental illness in Uganda. It does not focus on mental patients outside prisons within the Ugandan community. Further, research was conducted in three main prisons, Luzira Upper, Murchinson Bay and Luzira Womens'. The researcher was unable to secure an interview with the only Forensic Psychiatrist in Uganda whose input would have been invaluable. Further, the researcher was unable to visit a prison upcountry due to technical difficulties.

1.12 Overview of chapters

Chapter one introduces the subject by providing a background to the study. The focus is on prisoners with mental illness and the impact that prison conditions have on such illness as well as a descriptive analysis of the situation in Uganda. Chapter two provides the legal framework on access to health for prisoners with mental illness. International, regional and national human rights instruments are discussed. Chapter three addresses the question whether there is adequate provision of psychiatric treatment to prisoners with mental illness within Uganda's health institutions and whether there is existing policy and legislation which can be used to provide such treatment. It also highlights the findings of the study. Chapter four concludes with relevant recommendations.

1.13 Ethical considerations

Permission to carry out the research was obtained from the faculty of law at the University of Makerere, the Commissioner of Uganda Prisons, the Regional Prisons Commander Kampala Extra and the officers in-charge (oc) of the individual prisons all allowed access in to the prisons to conduct informal discussions with the prisoners.

Informed consent was obtained from the discussants. To ensure confidentiality and protection of the rights of mentally ill prisoners involved in the discussions, their names and

statuses remain anonymous and are accessible only to the author. In this vein seeing that only three prisoners were spoken to, they are referred to as Mr X, Mr Y and Mr Z where they appear.

1.14 Literature review

1.14.1 Are prisons suited to cater for mentally ill prisoners?

There is a plethora of literature on provision of psychiatric treatment to prisoners with mental illness whose central observation is that prison conditions are hard on mental health in general because of several factors; overcrowding, violence, lack of meaningful activities, isolation from family and friends, uncertainty about life after prison and inadequate health services.²⁴ Consequently, mentally ill prisoners receive inadequate mental services that leave them undertreated or mistreated.²⁵

In the same regard, Lamb (1998) observes that such persons present formidable challenges to treatment because of their treatment resistance, poor compliance with antipsychotic medications, potential dangerousness, high rate of substance abuse, and need for structure.²⁶ Lamb asserts further that to a large extent, the public mental health system has given up on them and allowed them to become the responsibility of the criminal justice system.²⁷ Fellner (2006) further observes that the failure of mental health systems has led to what is termed the criminalization of the mentally ill. Truth is told however that prisons are ill equipped to provide the necessary quantity and quality of mental health services to prisoners. Consequently the conditions of the mentally ill inmates deteriorate.²⁸

Whilst it can be argued that admission to prison offers a unique opportunity for the assessment and treatment of a population, with high physical and psychiatric health needs, many of whom rarely come into contact with the national health services when not in prison, Prisons are not hospitals.²⁹ Therefore, many prisoners with mental illnesses requiring health services in-care patient treatment remain in prison.³⁰ As a matter of fact, in most instances, it is quite odd that a person in prison suffering from a medical emergency can be in a nearby

²⁴ J Fellner 'A corrections quandary and prison rules' (2006) 41 *Harvard Civil Rights Civil Liberties Law Review* 391.

²⁵ Fellner(n 25 above) 404.

²⁶ HR Lamb & LE Weinberger 'Persons with severe mental illness in jails & prisons: a review' (1998) American Psychiatric Association: <http://www.americanpsychiatricassociation.org> (accessed on 10 June 2011).

²⁷ As above.

²⁸ Fellner (n 25 above) 394.

²⁹ J Reed 'Mental Health Care in Prisons' (2003) *British Journal of Psychiatry* 288.

³⁰ As above.

general hospital within 30 minutes, whereas it would take 30 days to find an appropriate disposal if the prisoner is floridly psychotic.³¹

The assertion that prisons as institutions are not tailored to meet the mental health needs of mentally ill inmates finds support on account of the likely tension between the mission of prison and the need to successfully provide mental health services.³² Mentally ill inmates are required to comply with prison rules in the same manner as inmates not mentally ill.³³ However, the former do not have the same capacity to comply with the rules as do other prisoners. Such prisoners may exhibit their illness through disruptive behaviour which prison systems consider punishable misconduct.³⁴

Disruptive behaviour is rewarded with solitary confinement or seclusion.³⁵ For mentally ill inmates, once in seclusion a continued manifestation of bizarre behaviour could prolong their stay in confinement, despite the likely negative mental health impacts.³⁶ Isolation can be particularly harmful to any prisoner. More so with the mentally ill prisoner who can decompensate in isolation requiring increased crisis care or psychiatric hospitalisation.³⁷ Segregation of the mentally ill inmate reflects a penal philosophy and the conscious decision of prison officials about whom to isolate for how long and under what conditions.³⁸

Prisons officials most commonest fears are that recognising disruptive behaviour on account of mental illness could open up a Pandora's box where even those inmates not mentally ill will fake such illness to evade punishment. However, placing the mentally ill in such an environment greatly impedes any prospects of wholesome recovery of the concerned inmate.

The key adverse factor of solitary confinement is that socially and psychologically meaningful contact is reduced to the absolute minimum to a point that is insufficient for most

³¹ Lamb & Weinberger (n 27 above).

³² S Abramsky & J Fellner 'Ill equipped US prisons and offenders with mental illnesses (2003)' Human Rights Watch Report 145-268.

³³ JL Metzner & J Fellner 'Solitary confinement and mental illness in US prisons: A challenge for medical ethics' (2010) 38 *Journal of the American Academy of Psychiatry and the Law* 105.

³⁴ As above.

³⁵ JL Metzner & J Fellner (n 33 above) 105.

³⁶ HRW 'Mental illness human rights and United States prisons' (2009) 3: <http://www.hrw.org> (accessed on 30 September 2011).

³⁷ J Metzner & J Dvoskin 'An overview of correctional psychiatry' (2006) 29 *Psychiatric Clinics of North America* 761-772 as cited in HRW 'Mental Illness Human Rights and US Prisons' 761-772.

³⁸ As above.

detainees to remain mentally well functioning.³⁹ Therefore, it should be used in very exceptional circumstances and as a last resort because holding persons with mental illness in solitary confinement cannot be justified as a form of punishment or for therapeutic reasons.⁴⁰

As a matter of ethics, health professionals who are aware of the inherent dangers of seclusion may be the only hope for prisoners in such instances. It remains to be seen whether these professionals will not be complicit, but assume a more active role beyond the treatment of mentally ill prisoners.⁴¹

1.14.2 Treatment needs of mentally ill prisoners

The primary focus of health services in prisons is medical treatment when more often than not mental illness requires a wholesome health service regiment.⁴² This comprises detection of the illness, identification of treatment needs, and provision of the appropriate medication and or form of treatment, continuous monitoring, counselling and psychological therapy.

In the same regard, the African Commission on Human and Peoples' Rights in its communication involving Purohit and Moore v the Gambia, has posited that 'mental health care for persons with mental illness includes analysis and diagnosis of a person's mental condition and treatment, care and rehabilitation for a mental illness or suspected mental illness.'⁴³ It is not merely a question of providing momentary relief to the patient as proper treatment assessment and medication could probably be the only way to full recovery.

Clearly, most though by no means all mental health treatment and rehabilitation resources are insufficient to serve the very large numbers of mentally ill persons in the community observes Draine (1995).⁴⁴ Draine submits further that community mental health resources may be inappropriate for the population to be served. Draine asserts that mentally ill persons may be expected to come to outpatient clinics when the real need for a large proportion of this population is outreach services. However, according to Draine, some

³⁹ UN General Assembly, Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Interim Report of the Special Rapporteur on Torture) A63/175 (July 28 2008) 10-11.

⁴⁰ As above.

⁴¹ World Medical Association: Declaration concerning medical doctors refusing to participate in or to condone the use of torture or other forms of cruel inhuman and degrading treatment. Adopted by the 49 th WMA Assembly. Hamburg Germany November 1997: http://www.wma.net/en/30publications/10_policies/c19/index.html. (accessed on 26 September 2011).

⁴² M Slade 'Mental illness and well-being: The central importance of positive psychology and recovery approaches' (2010) *Bio Medical Central Health Services Research* 2-14.

⁴³ Purohit v Gambia (2003) AHRLR 105 96 (ACHPR 2003) para 82.

⁴⁴ J Draine et al 'Clinical Studies in Case Management' (1987) 65 *New Directions for Mental Health Services* 1-114.

service providers may lack the ability to provide the degree of structure required by many mentally ill offenders.

A large proportion of mentally ill persons who commit criminal offenses tend to be highly resistant to psychiatric treatment.⁴⁵ They may refuse referral, may not keep appointments, may not be compliant with psychoactive medications, may not abstain from substance abuse, and may refuse appropriate housing placements.⁴⁶

Other studies confirm that it can be hard for prisoners with mental disorders to obtain the psychiatric treatment they require because the response of the system is slow and cumbersome.⁴⁷ Consequently, prisoners who are potential candidates for hospital treatment may be rejected by psychiatric services because they are perceived as too disturbed or dangerous, or seen as criminals who are unsuitable for treatment.⁴⁸

Thus the mental health system finds these mentally ill offenders extremely difficult to treat and resists serving them.⁴⁹ Moreover, many mentally ill offenders are intimidating because of previous violent and fear-inspiring behaviour. Treating this group is very different from helping passive, formerly institutionalized patients adapt quietly to life in the community.⁵⁰ Community mental health professionals are not only reluctant but may also be afraid to treat them, especially when measures are not adopted to ensure staff safety.⁵¹ Then these mentally ill persons are left for the criminal justice system to manage.⁵² On the other hand, outpatient facilities in which structure is provided, staff are protected, and mental health and criminal justice staff closely collaborate; enhance the successful treatment of prisoners with mental illness.⁵³

All in all, poor communication between the prison, court and hospital systems hinders the assessment and management of the mentally disordered offender.⁵⁴ The result can be the sudden and unpredicted release of someone with acute psychosis who is then lost to follow-up in the community.⁵⁵ More often mentally ill prisoners receive no treatment or after-care when they are released because their treatment needs are not properly

⁴⁵ As above.

⁴⁶ As above.

⁴⁷ Lamb & Weinberger (n 26 above).

⁴⁸ As above.

⁴⁹ LL Bachrach et al 'The chronic psychiatric patient as a 'difficult' patient: a conceptual analysis' (1987) 33 *New Directions for Mental Health Services* 35-51.

⁵⁰ As above.

⁵¹ HR Lamb 'Incompetency to stand trial: appropriateness and outcome' (1987) 44 *Archives of General Psychiatry* 754 - 758.

⁵² As above.

⁵³ Lamb (n 51 above) 756.

⁵⁴ Lamb (n 51 above) 757.

⁵⁵ Bachrach et al (n 49 above) 35 - 51.

recognised.⁵⁶ Notwithstanding the preceding what mentally ill inmates require are adequately equipped and staffed hospital facilities whether inside or outside of prison the prison walls.⁵⁷

1.15 Conceptual framework

1.15.1 Mental illness explored

Scholars are divided on the precise definition of mental illness. A very extreme view mostly associated with psychiatrist Thomas Szasz is that there is no such thing as mental illness because the notion is based entirely on a fundamental set of mistakes.⁵⁸ According to the Szaszian theory, a disease by definition means bodily disease and given the fact that the mind is not part of the body, disease should literally not be applied to the mind as that would be tantamount to equating medicine with morals.⁵⁹

Contrary to the Szaszian theory however, modern psychiatry has primarily embraced a scientific approach, looking for causes such as traumatic experiences or genetic vulnerabilities; establishing the typical course of different illnesses, gaining an understanding of the changes in the brain and nervous system that underlie the illnesses, and investigating which treatments are effective at alleviating symptoms and ending the illness.⁶⁰

While there is debate over how to define mental illness, it is generally accepted that mental illnesses are real and there are different ways of understanding them.⁶¹ Even though the terms mental illness, disorder and disability are often invoked in reference to a mental condition, they do not bear the same meaning.

A mental illness is a physical manifestation of disease.⁶² It involves disturbances of thought, experience, and emotion serious enough to cause functional impairment in people, making it more difficult for them to sustain interpersonal relationships and carry on their jobs, and sometimes leading to self-destructive behavior and even suicide.⁶³

⁵⁶ Slade (n 42 above) 2-14.

⁵⁷ S Wilson 'The principle of equivalence and the future of mental health care in prisons' (2004)184 *British Journal of Psychiatry* 5-7.

⁵⁸ C Perring 'Mental Illness' in EN Zalta (ed) *The Stanford Encyclopedia of Philosophy* (2010): <http://plato.stanford.edu/archives/spr2010/entries/mental-illness/> (accessed on 27 October 2011).

⁵⁹ As above.

⁶⁰ Perring 'Mental illness' in Zalta (n 58 above).

⁶¹ Wilson (n 57 above) 5-7.

⁶² Metzner & Dvoskin (n 37 above) 761-772.

⁶³ Perring 'Mental illness' in Zalta (n 58 above).

A mental disorder refers to a specific disease for example, depression or alcoholism.⁶⁴ It implies mental illness, arrested or incomplete development of the mind and any other disability of the mind, and includes severe mental impairment, mental impairment and psychopathic disorder.⁶⁵

Mental disability arises when a person has already been affected by a mental disorder and is consequently disabled by that disorder.⁶⁶ Mental disability refers to a mental health condition which is either acute or chronic.⁶⁷ Some examples of the former include stress, substance abuse, manic disorders and psychosis.⁶⁸ Examples of the latter include schizophrenia, schizoaffective disorders, major depression and bi-polar disease.⁶⁹ Where an acute mental disease is untreated, it could graduate into a chronic mental disease and eventually disability.⁷⁰

1.15.2 Mental illness through the lens of psychiatry and culture

Psychiatry is a medical discipline specialising in the treatment of diseases of the mind from whatever cause.⁷¹ Culture comprises beliefs, values and traditions which are accepted as the way of life of a particular people.⁷²

A more fine-grained understanding of culture is needed to unpack the elements relevant to any specific mental health problem, without which we are left with a one-size-fits-all approach that silences dialogue and exchange.⁷³ There are many culture-related symptoms and syndromes not captured by official diagnostic nosology that may be a focus of concern for patients and contribute to distress and disability.⁷⁴ Most importantly is the fact that the meaning of symptoms, illness and suffering differs according to available cultural models on affliction.⁷⁵ This in turn is a major determinant of the individual and social impact of mental health problems.⁷⁶

⁶⁴ WHO 'The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines,' WHO Geneva 1992.

⁶⁵ As above.

⁶⁶ M Gelder et al (eds) *Shorter Oxford Textbook of Psychiatry* (2001) 897 - 928.

⁶⁷ National Health Strategy (NHS) 'What is mental illness, pamphlet LF001TAS, Commonwealth Department of Health Care' (1999).

⁶⁸ G Cote & S Hodgins 'The prevalence of major mental disorders among homicide offenders' (1992) 15 *International Journal of Law and Psychiatry* 89-99.

⁶⁹ NHS (n 66 above).

⁷⁰ Gelder et al (n 66 above) 897 – 928.

⁷¹ As above.

⁷² T Nhlapo 'Indigenous law and gender in South Africa: Taking cultural diversity and human rights seriously' (1995) *Third World Legal Studies* 2 - 24 & 70.

⁷³ LJ Kirmayer 'Culture and context in human rights' in M Dudley et al (eds) *Mental Health and Human Rights* (2008) 6.

⁷⁴ As above.

⁷⁵ Kirmayer (n 73 above) 7.

⁷⁶ Kirmayer (n 73 above) 8.

The global hegemony of psychiatric knowledge derived from American and European traditions based on individualism and autonomy has infiltrated the African society with psychiatric expertise and its corresponding values.⁷⁷ However, in order to champion the cause of vulnerable persons within society, psychiatry must see beyond its complicity with pharmaceutical companies and other eco-political interests that encourage us to frame problems in ways that exclude the social origins of life.⁷⁸ A potentially effective strategy for change is evident using psychiatry as a mouth piece for the voiceless and marginalised by promoting their human rights.⁷⁹

However insisting on a mental illness interpretation of a problem understood in religious or social-moral terms can have negative or positive outcomes, depending on the cultural meaning and social circumstances.⁸⁰ Mental illness is caused by physical, psychological and social impact of structural inequalities and injustices evident to all.⁸¹ Therefore in order for psychiatry to assume centre stage, address inequalities in the access to mental health care service provision and effectively play its role in treating mental illness, a range of other complementary social and psychological interventions must be applied.

1.15.3 A multi-disciplinary approach to mental health care

Mental health refers to the balance between all aspects of life be they social, physical, spiritual and emotional.⁸² Mental health forms an integral part of our overall well-being by impacting the manner in which we live our lives on a daily basis.⁸³

Therefore, mental health means much more than the absence of mental illness. It informs both the positive and negative aspects of individual interactions, and how we respond to those interactions. Owing to its varying manifestations, medicine alone may not be the most suitable form of treatment. It is imperative to consider other useful treatment alternatives.

The bio-psycho-social model asserts that mental, neurological and substance abuse problems cannot be limited to a single domain of human experience.⁸⁴ Rather, most mental health problems are influenced by multiple domains of human experience, including the

⁷⁷ As above.

⁷⁸ Kirmayer (n 73 above) 8.

⁷⁹ Kirmayer (n 73 above) 9.

⁸⁰ Kirmayer (n 73 above) 10.

⁸¹ Kirmayer (n 73 above) 6.

⁸² See WHO definition on mental health: <http://www.who.org> (accessed 1 October 2011).

⁸³ UHRC 13th Annual Report (n 16 above).

⁸⁴ Ministry of Health Uganda Draft National Policy on Mental health, neurological and substance abuse services (MOH draft policy) (June 2010).

biological, psychological and social/spiritual factors.⁸⁵ Therefore no single intervention is likely to achieve good outcomes for all people with mental health problems.⁸⁶ It is therefore essential that services are provided in a multifaceted and multidisciplinary manner to ensure the relevant skills mix required at all levels of care.⁸⁷ Relevant staff cadres include among others psychiatrists, clinical and counselling psychologists, psychiatric social workers, psychiatric clinical officers, psychiatric nurses and occupational therapists.⁸⁸

1.15.4 Contours of the right to health and the ‘neglected diseases’ approach

The Former Special Rapporteur on the Right to the Highest Standard of Physical and Mental Health (Former Special Rapporteur) has identified a health framework within which to tackle the treatment of neglected diseases in Uganda.⁸⁹ Although these interventions focus primarily on neglected diseases, they could equally inform the effective provision of mental health service provision.⁹⁰ In this light, the Former Special Rapporteur has identified key interventions. The key interventions include access to information, public participation, human resource and infrastructure development and research respectively.

Primarily, access to information and education on preventive and health promoting behaviour is crucial to the right to health.⁹¹ Government has a legal duty to disseminate accessible educational information to the entire population in order to dispel myths and misconceptions on mental illness through mass media, health professionals, prisons officials, schools and other organisations, as a means of raising awareness.⁹²

Secondly, community participation through free, prior and informed consent is essential in the effective treatment of mental illness amongst the individuals themselves and their respective communities.⁹³ When the process is owned by the communities themselves, mental health needs of those affected are likely to be identified more promptly and treated effectively.⁹⁴

Thirdly, the mental health budget needs to be increased to adequately cater to the training of human resources, building of necessary infrastructure and purchase of relevant

⁸⁵ MOH draft policy (n 84 above).

⁸⁶ As above.

⁸⁷ As above.

⁸⁸ As above.

⁸⁹ See the report of the Former Special Rapporteur on the Right to the Highest Standard of Physical and Mental Health Doc No. E/CN.4/2006/48/Add.2 :<http://www.ohchr.org> (accessed on 12 September 2011).

⁹⁰ As above.

⁹¹ See art 9(1) of the African Charter on Human and Peoples’ Rights. See also *Constitutional Rights Project and Others v Nigeria* (2000) AHRLR 227 (ACHPR 1999).

⁹² Report of the former Special Rapporteur on the Right to Health (n 88 above) para 12 & 35.

⁹³ Report of the former Special Rapporteur on the Right to Health (n 88 above) para 36 & 37.

⁹⁴ As above.

equipment.⁹⁵ In addition human resource should be motivated through adequate and sufficient remuneration, failing which it may negatively impact in the care of mentally ill persons, who present formidable challenges in being taken care of.⁹⁶

Fourthly the Former Special Rapporteur reiterates the need for more research and development in the field of neglected diseases.⁹⁷ This holds true for mental illness where there is required to be more research conducted on the current burden of diseases within the prison community.⁹⁸ Research should not only focus on new interventions but also provide ways of improving and sustaining already existing systems.⁹⁹ Research can be achieved through international co-operation and assistance.¹⁰⁰

The overall goal of a multi-disciplinary approach in the treatment of mental illness is to ensure that prisoners receive access to wholesome mental health services through varied interventions. In this regard, prisoners' mental, social, physical and biological needs are routinely assessed through on entry-screening. In addition factors such as nutrition, living conditions and sanitation, which impact on the mental well being of prisoners are addressed and improved upon.

⁹⁵ Report of the former Special Rapporteur on the right to health (n 88 above) paras 43 - 45.

⁹⁶ As above.

⁹⁷ Report of the former Special Rapporteur on the right (n 88 above) para 62.

⁹⁸ As above.

⁹⁹ Report of the former special Rapporteur on the right to health (n 88 above) para 70.

¹⁰⁰ As above.

Chapter Two

2 International regional and national human rights framework on the right to health

2.1 Introduction

The central theme under this chapter is a discussion on the international, regional and national human rights framework on the right to health and other interrelated rights. This theme is discussed within the context of prisoners with mental illness. The discussion ascertains the mode of protection if any accorded to prisoners with mental illness. The preceding is achieved along three fronts. Primarily, the chapter outlines selected international human rights instruments, standards and principles. Secondly the chapter discusses African regional human rights instruments and standards. The chapter concludes with a discussion of specific Ugandan Legislation on the right to health in relation to prisoners with mental illness respectively.

2.2 Background

A myriad of international human rights standards on the right to health exists.¹⁰¹ The key international instruments for discussion are the Universal Declaration on Human Rights (Universal Declaration)¹⁰² the International Covenant on Economic, Social and Cultural Rights (ICESCR)¹⁰³ the International Covenant on Civil and Political Rights (ICCPR)¹⁰⁴ and the Convention on the Rights of Persons with Disabilities (UN CRPD).¹⁰⁵ Such selection is justified along three fronts. Firstly, the Universal Declaration recognises both Civil and Political Rights and Economic Social and Cultural Rights in one document and establishes a fundamental set of human rights applicable to all nations. Together with the two core human rights conventions, they make up what is known the international bill of rights, which comprises the most authoritative and comprehensive prescription of human rights obligations that governments undertake in joining the United Nations (UN). Secondly, the two Conventions recognise not only the right to health but contain a range of other rights which feed into the right to health. The Conventions promote the implementation and oversight of rights established by the UDHR. Thirdly; the Convention on Disability will be

¹⁰¹ See for example art 5(e) (iv) of ICERD (1965); art 11(1) & 12 of CEDAW (1979), art 24 of CRC (1989): <http://www.ohchr.org> (accessed on 20 September 2011).

¹⁰² UDHR (1948) adopted on the December 10 1948 by General Assembly Resolution 217A (III) UN Document A/810 at 71.

¹⁰³ Adopted on 16 December 1966 by GA Res 2200A (XXI) UN Doc A/6316: <http://www.ohchr.org> (accessed on October 1 2011), acceded to by Uganda on 21 January 1987.

¹⁰⁴ Adopted on 16 December 1966 by GA Res 2200A (XXI) UN Doc A/6316: <http://www.ohchr.org> (accessed on October 1 2011), acceded to by Uganda on 21 June 1995.

¹⁰⁵ Adopted on 24 January 2007 A/Res/61/106: <http://www.unhcr.org> (accessed on 30 September 2011), signed and ratified by Uganda on 30 March 2007 & 25 September 2008 respectively.

discussed because it is the only international human rights treaty which solely protects and promotes the rights of persons with disabilities.

The preceding human rights instruments notwithstanding, reference is made to other relevant human rights standards on the right to health. Namely, the United Nations Body of Principles for the Protection of all Persons under any form of Detention or Imprisonment (Body of Principles)¹⁰⁶ the United Nations Minimum Standard Rules in the Treatment of Prisoners (UN Standard Minimum Rules)¹⁰⁷ Principles for the Protection of persons with Mental Illness and the Improvement of Mental Health (MI Principles)¹⁰⁸ and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (Standard Rules).¹⁰⁹

The regional human rights framework comprises the African Charter on Human and Peoples' Rights¹¹⁰ (the Charter) and selected jurisprudence of the African Commission on Human and Peoples' Rights (the Commission).¹¹¹ These are the main regional bodies mandated to oversee the protection and promotion of human rights in Africa.

At domestic level, the main Ugandan pieces of legislation to be discussed are the Ugandan Constitution,¹¹² Mental Treatment Act (MTA)¹¹³ Convention on Persons with Disabilities Act (PWD Act)¹¹⁴ and the Prisons Act.¹¹⁵

¹⁰⁶ Adopted by UN A/Res/43/173 of 9 December 1998 at its 76 Plenary Meeting. <http://www.un.org> (accessed on 30 September 2011).

¹⁰⁷ Adopted by the First United Nations Congress on the Prevention of Crime & Treatment of Offenders at Geneva in 1995 & approved by the Economic Social Council Resolutions 663(C) XXIV OF July 31 1957 & 2076 (LXII) of 13 May 1977. <http://www.un.org> (accessed on 30 September 2011).

¹⁰⁸ Adopted by the United Nations GA Res 46/119.UN Doc A/46/49(1991). <http://www.un.org> (accessed on 30 September 2011).

¹⁰⁹ Adopted by UN Assembly Resolution 48/96 at its 85th plenary meeting on 20 December 1993. <http://www.un.org> (accessed on 30 September 2011).

¹¹⁰ African Charter on Human & Peoples' Rights (1981/1986).

¹¹¹ Art 30 of the African Charter on Human and Peoples' Rights establishes the African Commission on Human and Peoples' Charter Rights.

¹¹² Act 21 of 1995.

¹¹³ Chapter 279 of the Laws of Uganda.

¹¹⁴ Act of 2006.

¹¹⁵ Chapter 304 of the Laws of Uganda.

2.3 International human rights framework

2.3.1 The Universal Declaration

The Universal Declaration as implicit in the name is a non-binding instrument. Notwithstanding its non-binding nature, it carries a great deal of persuasive moral force brought to life through the ICESCR and the ICCPR, which it preceded.¹¹⁶

The provisions of these two conventions create binding legal obligations upon member states. By this token, the Universal Declaration provides interpretive guidance and guidelines for implementation for states in the realisation of the rights and resultant obligations contained under the international bill of rights.¹¹⁷

As regards health, the Universal Declaration reaffirms the right of everyone to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.¹¹⁸

On the whole, the Universal Declaration emphasises the need for all human being to be treated with dignity.¹¹⁹ This holds true for prisoners with mental illness who are vulnerable on account of their incarceration and mental condition. Therefore for such a vulnerable group, living a dignified life includes access to mental health services. This is a vital determinant to the enjoyment of all other human rights. In this vein, the state owes a duty of care to such persons solely under its care to provide the range of medical services of the same level and at the same standard or even better as that provided within the general community.

2.3.2 General Comment Number 14 (General Comment No 14) and the import of Article 12 of the ICESCR

The ICESCR is an international treaty by the UN, committing states to progressively realise economic, social and cultural rights including the right to health.¹²⁰ The ICESCR provides the most comprehensive article on the right to health in international human rights law under article 12. This article recognises the right of everyone to the highest standard of physical and mental health.¹²¹

¹¹⁶ Art 1 of UDHR.

¹¹⁷ UNHCHR 'International human rights instruments' <http://www.unhchr.org> (accessed on 21 September 2011) (n 101 above).

¹¹⁸ Art 25 of UDHR.

¹¹⁹ UNHCR(n 117 above).

¹²⁰ Art 12 of ICESCR.

¹²¹ As above.

The UN Committee on Economic, Social and Cultural Rights (Committee on ESCR), a treaty body overseeing states implementation of the rights under the ICESCR is instrumental in providing interpretive guidance on article 12.¹²² It has adopted General Comment No 14 which elaborates on the content of article 12.¹²³ General comments are one of the most important sources of interpretation of human rights conventions.¹²⁴

General Comment No 14 interprets article 12 as a right to the enjoyment of a range of facilities, goods, services and conditions essential for the optimum realisation of the highest attainable standard of health.¹²⁵ To this end, it imposes an obligation on governments to take specific steps to promote and protect the right to health.¹²⁶

The right to health as expressed under article 12 is both a positive right to government action or services necessary to maximise health and a negative right to protection against dangerous or unhealthy conditions.¹²⁷ It is for this reason that General Comment No 14 in its description of the right to health states that this right contains both ‘freedoms and entitlements’.¹²⁸ Whilst the former includes the right to control ones’ health and body, the latter includes the right to a system of health protection based on equality. It is important to note that, unlike many of the positive rights created by the ICESCR, which are subject to progressive realization, non-discrimination on the basis of disability is an obligation that is effective immediately.¹²⁹

In order to achieve the maximisation of the right to health and protection against dangerous or unhealthy conditions, states must provide access to the underlying determinants of the right to health care.¹³⁰ These are aspects of livelihood which make it possible for the right to health to thrive. They include access to adequate sanitation, an adequate supply of food, healthy occupational and environmental conditions and access to health related information.¹³¹ The realisation of governments’ obligations with regards to the

¹²² The Committee on ESCR General Comment No. 14 (The Right to the Highest Standard of Health) Art. 12 Doc E/C 12/2000/4: <http://www.ohchr.org> (accessed on 28 September 2011).

¹²³ As above.

¹²⁴ WHO Mental Health & Policy Service Development Team, ‘The role of international human rights in national mental health legislation’ (2004) 13:<http://www.who.org> (accessed on 20 August 2011).

¹²⁵ General Comment No. 14 (n 122 above) para 9.

¹²⁶ Art 12(2) of ICESCR.

¹²⁷ General Comment No. 14(n 122 above) para 8.

¹²⁸ General Comment No. 14 (n 122 above) para 8.

¹²⁹ As above.

¹³⁰ General Comment No. 14 (n 122 above) para 11.

¹³¹ As above.

right to health also entails the free and informed participation of all citizens, in all decisions associated with health decision making at community, national and international levels.¹³²

The Committee on ESCR recognises that the right to health services must be available, accessible, acceptable and of appropriate and good quality.¹³³ This implies that governments should provide functioning public health-care facilities, goods and services, including essential drugs and programmes.¹³⁴ These should be available in sufficient quantity within the state programmes which should be made accessible to all especially the vulnerable and marginalised groups.¹³⁵ These services should be of the quality and quantity that is appropriate for and relevant to the various health needs of a given population.¹³⁶ Skilled personnel scientifically approved and unexpired drugs and equipment and safe sanitation amongst others should be availed to the population.¹³⁷

The spirit of article 12 envisaged in the preceding discussion is reflective of the need for all humanity to have in the minimum access to the core aspects of the right to health.¹³⁸ The right to the highest attainable level of mental health under article 12 entails a right on the part of prisoners with mental disabilities to receive services that are available, accessible, and acceptable and of appropriate good quality in a sustainable manner. In order to ensure sustainability in the manner in which mental health services are delivered to prisoners with mental illness, states should primarily address the need for a range of community services required to serve persons with mental disabilities; in both planning and budget development processes.¹³⁹ Over all, states should refrain from denying or limiting equal access for all persons including prisoners or detainees to preventative, curative and palliative health care services.¹⁴⁰

¹³² General Comment No. 14 (n 122 above) para 11.

¹³³ As above.

¹³⁴ General Comment No. 14(n 122 above) para 12a.

¹³⁵ General Comment No. 14 (n 122 above) 12(b).

¹³⁶ General Comment No. 14 (n 122 above).

¹³⁷ Resolution on Access to Health and Essential Medicines in Africa (2008), adopted by the ACHPR Resolution 141 (XXXXVIII).

¹³⁸ See *The Government of the Republic of South Africa & Others v Grootboom & Others* BCLR 1169 (CC) para 36 where the court explores the meaning of minimum core.

¹³⁹ General Comment No. 14 (n 122 above) para 30.

¹⁴⁰ General Comment No. 14 (n 122 above) para 34.

2.3.3 The ICCPR

A fundamental human rights obligation that cuts across all areas of mental health legislation is the protection against discrimination.¹⁴¹ The thematic concentration of article 2(1) of the ICCPR is the prohibition against discrimination.¹⁴² Non-discrimination as a concept is closely linked with the notion of equality.¹⁴³ The concept is significant to prisoners with mental disabilities. Such prisoners are held at the mercy of the state and have to cope with the stress inherent in isolation and the stigma associated with imprisonment. As part of the right to access health services, the principle of non-discrimination presupposes that “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, without discrimination of any sort.

By virtue of article 2(1) of the ICCPR states are not only obligated to respect the rights under the covenant but also to make them a practical reality. In this regard, states are mandated to adopt legislative and other measures as a means of enforcement of the rights in question.¹⁴⁴ Enforceability in this sense means ensuring the availability and accessibility of appropriate remedies of redressing the alleged violations.¹⁴⁵

a. The right to health within the context of specific rights under the ICCPR

There is a varying range of rights within the covenant of particular relevance to the right to health. These are the rights to life, freedom from cruel inhuman and degrading treatment and dignity.¹⁴⁶

b. The right to life

There is a fine link between the right to life and health.¹⁴⁷ In the absence of requisite medical care and treatment, death is a glaring reality. When the health of prisoners with mental illness deteriorates or due to lack of such treatment, they are deprived in the enjoyment of their rights to health and life respectively.

In given situations, the underlying determinants of the right to health such as safe and clean water and sanitation, adequate food, clean and a healthy environments are

¹⁴¹ Arts 55 & 56 of the UN Charter & arts 2(1) & 26 of the ICCPR.

¹⁴² UN Human Rights Committee (UN HRC) General Comment No. 18: Non-discrimination paras 173 – 175 UN Doc HR1/GEN/1/Rev.9 (Vol 1).

¹⁴³ Art 1 of the UDHR.

¹⁴⁴ Art 2(2) of the ICCPR.

¹⁴⁵ Art 3(3) of the ICCPR.

¹⁴⁶ Arts 6, 7 & 10 of the ICCPR.

¹⁴⁷ Prisoners Abroad ‘Health & medical treatment’: <http://www.prisonersabroad.org.uk> (accessed on 3 September 2011).

difficult to attain within the prison ambiance thereby increasingly inhibiting prisoners in the enjoyment and exercise of the right to life.

For prisoners with mental illness, the interface between the right to health and the right to life is that a clean, safe and healthy environment could ameliorate their mental health statuses, and hence safeguard their right to life. Prisons should therefore generally aspire to provide the underlying conditions for the well being of all prisoners.

c. Prohibition from torture and freedom from cruel inhuman and degrading treatment

Article 7 of the ICCPR proscribes torture, cruel, inhuman and degrading treatment.¹⁴⁸ In providing interpretive guidance on the normative content of article 7, the UN Human Rights Committee (UN HRC) observes that it relates not only to acts which cause unnecessary physical pain but extends also to those causing mental suffering.¹⁴⁹

The vast majority of mental health professionals, staff or administrative authorities would not intentionally cause harm or great suffering to an individual, but a broad range of practices may cause suffering or an affront to an individual's dignity. Mistreatment as a result of neglect or failure to take precautions to prevent or stop abuse is common. Often neglect may be due to a lack of resources or staff.¹⁵⁰

The denial of a prisoner with mental illness life saving medicines, services and goods could be considered a breach of article 7. The UN HRC has confirmed that no justification or extenuating circumstances may be invoked to excuse a violation of article 7.¹⁵¹ Neglecting to provide needed treatment to alleviate mental suffering may violate article 7.¹⁵² The prohibition should be interpreted to extend to the widest possible forms of abuse whether physical or mental.¹⁵³ Therefore, if prisoners' mental health deteriorates and they endure serious psychological suffering because they have not been provided the mental health treatment that is needed, their right to be free of cruel or inhuman treatment is violated.

Their rights may also be violated if they are confined under conditions that put them at high risk of psychological harm, such as solitary confinement.¹⁵⁴ The UN HRC under its

¹⁴⁸ See the Convention against Torture (CAT) adopted on by the UN General Assembly 39/46 of December 1984.

¹⁴⁹ UN HRC General Comment No. 20: Prohibition from Torture & Cruel Treatment or Punishment para 44 UN Doc HR1/GEN/1/Rev.9 (Vol1).

¹⁵⁰ As above.

¹⁵¹ As above.

¹⁵² Interim Report of the Special Rapporteur on Torture (n 40 above) 10 - 11.

¹⁵³ General Comment No. 20 (n 149 above) para 44.

¹⁵⁴ H Reyes 'The worst scars are in the mind: psychological torture' (2007) 89 *The International Review of the Red Cross* 867.

General Comment No 18 specifies that the protection against torture and cruel or inhuman and degrading treatment applies to medical institutions, whether public or private.¹⁵⁵ Further that in order to demonstrate compliance with article 7, all governments that have ratified the ICCPR should further address the conditions and procedures for providing medical and particularly psychiatric care.¹⁵⁶ Information should be provided on detention in psychiatric hospitals, on measures taken to prevent abuses in this field, on appeals available to persons interned in a psychiatric institution and on any complaints registered during the reporting period.¹⁵⁷

The UN HRC has also taken a stance with regard to all persons in detention and psychiatric facilities. The UN HRC under the aegis of General Comment No 20(44) affirms in this regard that Article 7 “is complemented by the positive requirements of Article 10, paragraph 1 of the Covenant, which requires all persons deprived of their liberty to be treated with humanity and dignity.”¹⁵⁸ The UN HRC makes particular emphasis on the need for states to report on conditions in psychiatric facilities, appeals processes, and complaint procedures.¹⁵⁹ In this regard the UN HRC calls upon states to put in place legislation needed to define the expected standard of care and to protect against mistreatment.¹⁶⁰ It avers that states should not merely enact legislation and remain idle, but they should move a step further to ensure enforcement under domestic law.¹⁶¹

d. The right to dignity

The right to respect for a persons’ dignity is provided for under article 10 of the ICCPR.¹⁶² Under this article all prisoners should be treated, by all officials and anyone else, ‘with humanity and with respect for the inherent dignity of the human person.’¹⁶³ Compliance with article 10 requires prison management to ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement.¹⁶⁴ The UN HRC has

¹⁵⁵ As above.

¹⁵⁶ As above.

¹⁵⁷ General Comment No. 18 (n 142 above) paras 173 – 175.

¹⁵⁸ *Price v The United Kingdom* ECHRJ, (10 July 2001) Application No 33394/96. <http://www.echr.org> (accessed on 12 August 2011).

¹⁵⁹ General Comment No. 20 (n 149 above) para 44.

¹⁶⁰ As above.

¹⁶¹ As above.

¹⁶² Art 1 of the UDHR.

¹⁶³ The Committee on ESCR General Comment No. 5: on the Rights of Persons with Disabilities UN Doc E/1995/22, para 34.

¹⁶⁴ UN HRC General Comment No. 21: the Right to Humane Treatment of Persons Deprived of their Liberty HR1/GEN/1/Rev.9 (Vol 1).

affirmed that the application of article 10, promoting the right to humane treatment, cannot be dependent on the material resources available.¹⁶⁵

Respect for the human dignity of prisoners also requires operating prisons in ways that will enhance the likelihood of their successful re-entry into the community upon release. To this end, the UN HRC notes the importance of article 10 of the ICCPR in mandating a positive goal for corrections, something beyond mere punishment through deprivation of liberty, by advocating for reformation and social rehabilitation of prisoners.¹⁶⁶

2.3.4 The UN CRPD

The purpose of the UN CRPD is to promote, protect and ensure the complete enjoyment of all human rights by all persons with disabilities on an equal basis and promote respect for the inherent dignity of such persons.¹⁶⁷ Inclusive in the term persons with disabilities are those with long term physical, mental, intellectual or sensory impairments.¹⁶⁸ The UN CRPD is premised on providing reasonable accommodation to all persons with disabilities by eliminating societal barriers which may inhibit them in the enjoyment of their human rights.

Article 26 of the UN CRPD provides for the enjoyment of the right to health by all persons with disabilities. To this end states should provide the same range, quality and standard of free and affordable health care, as provided to other persons, without discrimination.¹⁶⁹ These health care services should be relevant to the peculiar needs of persons with disabilities.¹⁷⁰ Thus all mentally disabled persons should be provided with health care services tailored to meet their various mental health needs.¹⁷¹ The services should include early identification of mental illness and necessary intervention.¹⁷² Such services should be designed to reduce and prevent further recurrence of any such illness.¹⁷³ All health care facilities and services should be provided within reach of persons with mental disabilities and by qualified staff, who must be aware of the rights of persons with disabilities and knowledgeable about their mental health needs.¹⁷⁴

The overall goal in the provision of mental health services should therefore be to fully maximize the inherent potential ability of persons with mental disabilities in a manner

¹⁶⁵ As above.

¹⁶⁶ As above.

¹⁶⁷ Art 1 of UN CRPD.

¹⁶⁸ As above.

¹⁶⁹ Art 25(a) of UN CRPD.

¹⁷⁰ Art 25(b) of UN CRPD.

¹⁷¹ As above.

¹⁷² As above.

¹⁷³ As above.

¹⁷⁴ Art 25(c) & (d) of UN CRPD.

enabling them to integrate into society more meaningfully.¹⁷⁵ The implications of this goal are telling particularly for prisoners with mental disabilities, who require access to mental health services primarily to accelerate rehabilitation, reformation and to promote steady integration into society. Therefore, prisoners with mental illness have the right to an equal enjoyment of the rights under the CPRD as other inmates without discrimination and should be provided with reasonable accommodation in prison¹⁷⁶

2.4 Other international human rights standards

In addition to the binding international human rights instruments, there are some non-binding international standards and principles setting out guidelines for the provision of health care to prisoners. In spite of their non-binding nature, they possess a moral legal force which provides guidelines to states, in the implementation of the rights and corresponding state obligations under the various instruments.

2.4.1 The UN Body of Principles

The Body of Principles has established guidelines pertaining to the access of mental health services for all persons under any form of detention or imprisonment. Accordingly, the key provision under these guidelines is principle 24, which requires medical care and treatment to be provided whenever necessary and without charge. By this token states are obligated to bear all costs incidental to the incarceration including the identification, assessment, treatment and monitoring of mental illness.

2.4.2 The UN Standard Minimum Rules

These rules outline the minimum conditions acceptable under international human rights law in the treatment of prisoners.¹⁷⁷ The text of the rules covers medical services in prison including mental health services.¹⁷⁸ The rules require that medical services provided to prisoners should include the services of at least a medical officer trained in psychiatry.¹⁷⁹ In addition the psychiatric service to be offered must include diagnosis, treatment and prevention of psychiatric disorders.¹⁸⁰ The rules further require specialised services outside prisons be made available to prisoners.¹⁸¹ The medical officer at the institution is required to examine the physical and mental statuses of the prisoners and provide the appropriate

¹⁷⁵ Art 26(1) of UN CPRD.

¹⁷⁶ Interim Report of the Special Rapporteur on Torture (n 40 above) 10-11.

¹⁷⁷ UN Standard Minimum Rules (n 107 above).

¹⁷⁸ Rules 22-25.

¹⁷⁹ Rule 22(1).

¹⁸⁰ As above.

¹⁸¹ Rule 21(2).

treatment.¹⁸² Further all sick prisoners should be attended to on a daily basis so as to monitor their conditions.¹⁸³ Lastly and most important of all is that the medical officer has an obligation to advise on whether continued detention or any condition of detention could be detrimental to the physical and mental well being of a prisoner.¹⁸⁴

2.4.3 The MI Principles

The MI Principles establishing minimum human rights standards of practice in mental health, are recognized as the most complete standards for the protection of the rights of persons with mental disability internationally.¹⁸⁵

The Principles recognise the inherent dignity of mentally ill persons and proscribe any treatment that dehumanises or degrades such persons.¹⁸⁶ Further they recognise the right of mentally ill persons to the best available mental care, to be provided without discrimination of any kind.¹⁸⁷

Principle 4 requires the determination of the existence of mental illness to be done in accordance with internationally accepted standards. In this regard the Principles prohibit determination of the existence of mental illness by compulsion and recognise the right of all mentally ill persons to be treated in a least restrictive and intrusive environment, in line with the patients' health needs.¹⁸⁸ Further that the treatment shall be done in accordance with internationally accepted standards and services are to be given by qualified professional staff.¹⁸⁹ Where the treatment is given in the form of medication, the Principles require that it be administered by a mental health practitioner for its specific and relevant need; and never for punitive purposes.¹⁹⁰ The treatment referred to above should be given with the full and informed consent of a patient.¹⁹¹

Not only do the Principles require that the mentally ill be attended by qualified professionals but also that the mental health facility should have access to the same level of resources as any other health establishment, but also provide guidelines on procedures for involuntary admission.¹⁹² Further a review body and other procedural safeguards, including

¹⁸² Rule 24.

¹⁸³ Rule 25(1).

¹⁸⁴ Rule 25(2).

¹⁸⁵ *Victor Rosario Congo v Ecuador* Inter-American Commission of Human Rights IAm Comm (March 9 1999), OEA/Ser/L/V 11 Doc. 26, 54: <http://www.iachr.org> (accessed on 10 September 2011).

¹⁸⁶ Principle 1 (2) of MI Principles (n 108 above).

¹⁸⁷ Principle 1(1) & (4).

¹⁸⁸ Principles 5 & 9(1).

¹⁸⁹ Principle 9(3).

¹⁹⁰ Principles 10(1) & (2).

¹⁹¹ Principle 11(1).

¹⁹² Principle 14(1).

access to information regarding mental health records and other related matters are provided for.¹⁹³

Finally, the Principles mandate that criminal offenders receive the best available mental health care in a manner consistent with their fundamental human rights,¹⁹⁴ on the basis of informed consent.¹⁹⁵

2.4.4 The UN Standard Rules

The Standard Rules were adopted chiefly to create awareness on the need for adequate knowledge and experience of the diverse conditions and special needs of persons with disabilities, and thereby propose effective machinery for monitoring the process by which states seek to attain the equalization of opportunities for persons with disabilities.¹⁹⁶

Consequently, the Standard Rules have identified preconditions for equal participation for all persons with disabilities, primarily through awareness raising.¹⁹⁷ Of particular relevance to prisoners with mental illness are the conditions regarding medical care and rehabilitation respectively.¹⁹⁸ The Rules oblige states to provide effective and efficient mental health care to persons with mental disabilities.¹⁹⁹ In addition states also have a duty to establish programs run by medical professionals and trained local community workers geared towards the detection, assessment and treatment of impairment.²⁰⁰ The treatment accorded to persons with mental disabilities must be provided at regular intervals in order to enhance and maintain their level of capabilities.²⁰¹

The enhancement and maintenance of capabilities fosters rehabilitation. Rehabilitation programs provided by the state should have due regard to persons with mental disabilities' individual needs, based on the principles of equality and participation.²⁰² Rehabilitation programs should be far reaching and extend towards the promotion of individual autonomy.²⁰³ In this regard, the services should also be made available in the location of persons with disabilities to enable easy access.²⁰⁴

¹⁹³ Principles 16, 17, 18 & 19.

¹⁹⁴ Principle 1.

¹⁹⁵ Principles 11 & 20(2).

¹⁹⁶ Preamble of the UN Standard Rules (n 109 above).

¹⁹⁷ Rule 1.

¹⁹⁸ Rules 2 & 3.

¹⁹⁹ Rule 2.

²⁰⁰ Rules 2(1) & (3).

²⁰¹ Rule 2(6).

²⁰² Rule 3(1).

²⁰³ Rule 3(2).

²⁰⁴ Rule 3(5).

2.5 Regional human rights framework

2.5.1 The African Charter

The Charter recognises that all member states have a duty to promote and protect human and peoples' rights and freedoms taking into account the importance traditionally attached to these rights and freedoms.²⁰⁵ Member states are mandated to undertake and adopt legislative or other measures to give effect to its provisions.²⁰⁶ The Charter further recognises the right of every individual to the full enjoyment of the rights and freedoms without discrimination.²⁰⁷ The preceding prohibition against discrimination implies that human beings are inviolable and have the right to the respect of their inherent dignity.²⁰⁸

2.5.2 The right to health under the African Charter

Article 16 of the Charter provides for the right to health. This article provides every individual the right to the enjoyment of the best attainable state of physical and mental health.²⁰⁹ Additionally, it requires states to safeguard the health of its citizens and ensure they receive medical attention when sick.²¹⁰ In a bid to set guidelines for the interpretation of the rights contained under the Charter, the Commission has developed jurisprudence exploring the meaning of the right to health under the Charter as it relates to prisoners in detention facilities and the obligations that this right imposes upon states. The notable decision of the Commission providing a comprehensive understanding of the preceding aspect is the communication involving *Purohit and Moore v Gambia*, a communication brought in regard to the legal and material conditions of detention in a Gambian Mental Health Institution.²¹¹ The Commission amongst other matters explores the prohibition of discrimination on the basis of disability and the meaning of the right to health as provided for under the Charter.²¹² In its reasoning, the Commission maintains that the notion of non-discrimination and equality are non-derogable and form the basis for the enjoyment by anyone of all the other rights under the Charter. The Commission reiterates the need for persons with disabilities to be accorded special treatment which would enable them attain and sustain their optimum level of independence; whilst recognizing that such persons would, like all other persons, have the right to realise their aspirations in order to live life to its fullest. In the preceding regard, the African Commission opines that mentally disabled persons or persons suffering from a

²⁰⁵ Preamble of the African Charter on Human and Peoples' Rights (ACHPR).

²⁰⁶ Art 1 of ACHPR.

²⁰⁷ Art 2 of ACHPR.

²⁰⁸ Arts 4 & 5 of ACHPR.

²⁰⁹ Art 16(1) of ACHPR.

²¹⁰ Art 16(2) of ACHPR.

²¹¹ *Purohit v Gambia* (n 44 above) paras 1 – 8.

²¹² *Purohit v Gambia* (n 44 above) paras 45, 57, 61 & 79 – 82.

mental illness have the right to a life of decency which must be fervently secured by all state parties to the African Charter.²¹³ By virtue of their disabilities, the health care given to mentally ill persons should entail an analysis and diagnosis of their mental condition, treatment, care and rehabilitation for suspected or diagnosed mental health problems.²¹⁴

2.6 National human rights framework

2.6.1 The Constitution of the Republic of Uganda

The Constitution of Uganda is the supreme law and binds all persons and authorities in Uganda.²¹⁵ The Constitution also recognises and respects the fundamental rights and freedoms of all the persons.²¹⁶

The protection from discrimination underpins all societies founded upon the principles of equality, freedom and social justice. In line with the Preamble, article 21(1) of the Constitution recognises that all persons are equal and hence deserve equal protection before the law. Art 21(2) further prohibits discrimination on several grounds including disability. Prohibition from discrimination is done in recognition of the inherent worth and dignity of all persons. Accordingly, article 24 of the Constitution proscribes torture, cruel, inhuman or degrading treatment or punishment by recognising the respect of human dignity. By necessary inference, prisoners with mental illness therefore have the right to enjoy their constitutionally guaranteed rights. Their disability should not be a ground for discrimination or a bar to the enjoyment of their constitutionally guaranteed rights. They deserve to be treated with the inherent dignity that they possess and not be subjected to inhuman or degrading treatment.²¹⁷

The prohibition against inhuman and degrading treatment is non-derogable under article 44(a) of the Constitution. The protection afforded to prisoners with mental illness is further concretised under articles 35(1) and (2). These two articles recognise the rights of persons with disabilities to dignity and to the realisation of their full mental potential. The Constitution further obliges parliament to enact laws which will protect such persons.

The Constitution recognises that the inherent dignity of prisoners with mental illness can only be upheld when the underlying rights which promote the dignity of a person are also safeguarded. The right to access health services, provided for under section 14 is one such right. Social and economic objective number 14 obliges states to ensure that all

²¹³ *Purohit v Gambia* (n 44 above) para 81.

²¹⁴ *Purohit v Gambia* (n 44 above) paras 81 & 82.

²¹⁵ Art 2 of Act 21 of 1995 (n 112 above).

²¹⁶ Arts 20(1) & (2) (n 112 above).

²¹⁷ Objective 6 (n 112 above).

Ugandans including prisoners with mental illness have access to health services and all underlying determinants of health. In addition, social and economic objective number 20 mandates states to take practical measures in order to ensure the provision of medical services to the population.²¹⁸

As regards access to justice for persons with mental illness, article 23 (1) prohibits the deprivation of personal liberty save in certain situations. Article 22(f) provides for the detention of any person suspected to be of unsound mind for the purpose of care or treatment of that person or protection of the community. Article 23(3) requires any person who is arrested, detained or restricted to be immediately informed of the reasons of such detention and the right to a lawyer of his or her choice.

2.6.2 The MTA

The MTA provides for the care of persons of unsound mind and for the management of mental hospitals in Uganda.²¹⁹The scope of the Act is strictly limited to the magisterial process of conducting an inquiry into the state of mind of a person believed to be of unsound mind; detention, care and treatment of such a person in a mental hospital up to the point of discharge or release.²²⁰

This Act is not particularly sensitive to several concerns faced by persons of unsound mind and those of mentally ill persons. The provisions of the Act do not conform to internationally acceptable human rights standards. For example, the reference to the term person of unsound mind is viewed as derogatory by those suffering from mental disorders.²²¹ It does not put into consideration the varying degrees of mental disorders and the spectra within each disorder. The Act also lacks provisions on judicial procedures and mechanisms to be referred to in the event that a dispute regarding involuntary admission arises.²²²

2.6.3 The PWD Act

The PWD Act recognises the right of persons with disabilities to enjoy the same rights as other members of the public in all health institutions including general medical care.²²³ Furthermore, the Act makes reference to the promotion of “special health services” required by persons with disabilities, including reproductive services, in line with the Convention. The

²¹⁸ Under the Ugandan Constitution, the right to health is not contained in Chapter IV “Bill of Rights” but in section XIV of the Preamble to the Constitution as an economic and social objective.

²¹⁹ Chapter 279 of the Laws of Uganda (n 113 above).

²²⁰ Sec 2(4) of MTA (n 113 above).

²²¹ See Preamble of MTA (n 113 above) which defines a person of unsound mind as an ‘idiot.’

²²² M Mulumba ‘An analysis of the Ugandan Mental Treatment Act from a Human Rights & Public Health Perspective.’ LLB thesis, Makerere University, (1997) 12.

²²³ Art 7(1) of the PWD Act (n 114 above).

absence of general health legislation, however, represents a challenge in the implementation of the right to health of persons with disabilities.

An area requiring careful consideration relates to free and informed consent to treatment, which should guide all medical intervention including vis-à-vis persons with disabilities. While it should be noted that this legal vacuum characterises the overall health system in the absence of a statute on the right to health outlining patients' rights, the right of persons with disabilities to receive medical care on the basis of their free and informed consent should be recognised in law on an equal basis with others.²²⁴

In the specific case of persons with mental and intellectual disabilities, the provisions of the MTA appear to be in direct conflict with the recognition under the PWD Act, of the need for persons with disabilities to enjoy the same rights as other members of the public in health, by virtue of legitimizing forced treatment.²²⁵

2.6.4 The Prisons Act

This Act aims at consolidating the law relating to prisons. It provides for the organization, powers and duties of prison officers, and for related matters.²²⁶ With regard to the right to health of prisoners, the Act provides for a medical officer to be stationed at every prison.²²⁷ Such officer is responsible for the health of every prisoner and should ensure that such prisoner is medically examined as prescribed by such officer.²²⁸

Section 39 mandates the medical officer to move a prisoner found to be of unsound mind by the magistrate from the prison to a mental hospital.²²⁹ Section 40 provides for the removal of prisoners that fall ill from prison to a hospital.²³⁰ Whilst in hospital, section 41 provides that the prisoner is to be manned by prisons personnel who should do all in their power to prevent the prisoners escape from the hospital.²³¹

The rights of prisoners with mental illness are recognised and guaranteed under international, regional and national human rights law. For prisoners with mental illness, the right to health entails an obligation on states to take concrete and targeted steps to ensure

²²⁴ See MOH Uganda's Health Sector Strategic Plan II & III (2010-2014).

²²⁵ Sec 13 of MTA (n 113 above).

²²⁶ See part 1 of the Act (n 115 above).

²²⁷ Sec 28 of Prisons Act (n 115 above).

²²⁸ As above.

²²⁹ Sec 39 of the Prisons Act (n 115 above).

²³⁰ Sec 40 of the Prisons Act (n 115 above).

²³¹ Sec 41 of the Prisons Act (n 115 above).

that they receive access to mental health services of the range provided to others within society not similarly placed without discrimination.

Chapter Three

3 Introduction

This chapter assesses the existence of policy and legislation on mental health in Uganda. Accordingly it ascertains whether such policy and legislation is in conformity with international human rights standards. The preceding is achieved firstly by giving an overview on the policy framework provided under the National Health Policy (NHP)²³² of Uganda. Particular emphasis is on the extent to which this policy provides for mental health services. Secondly the chapter briefly highlights the importance of legislation and policy. Thirdly, an outline of international and national standards on health policy is given. This outline forms the basis of ascertaining whether the NHP II complies with the standards earlier referred to. Fourthly, a discussion on Uganda's Draft Mental Health Policy (Draft Policy)²³³ and current National Health Policy follows. Fifthly, the chapter analyses the MTA and the Mental Treatment Amendment Bill (MTA Bill).²³⁴ Finally, the chapter concludes with a statement of the salient points.

3.1 Background

3.1.2 An overview of Uganda's health policy framework

The National Health Policy of Uganda (NHP)²³⁵ provides for mental health services to be part of the Ugandan Minimum Health Care Package (UNMHCP).²³⁶ In order to achieve this, the government of Uganda through the Ministry of Health (MOH)²³⁷ has established the Health Sector Strategic Plan (HSSP) in three phases.²³⁸ Under the health sector strategic plan I and II the government makes a commitment amongst other issues to provide mental health services in primary health care, repeal the MTA²³⁹, put in place a new law and formulate a policy on mental health.²⁴⁰ The HSSP III pays special attention to mental health and the control of substance abuse and the addition of the general objective of ensuring access to primary referral services for mental health, prevention and management of

²³² Ministry of Health Uganda, NHP II (July 2010).

²³³ MOH draft policy (n 83 above).

²³⁴ MTA Bill (2010).

²³⁵ NHP II (n 232 above) 1.

²³⁶ See the NHP II (n 232 above) 16.

²³⁷ See MOH Resources: <http://www.library.health.go.ug> (accessed on 30 September 2011).

²³⁸ See MOH Health Sector Strategic Investment Plan (HSSIP) (2010/11 2014/15)1.

²³⁹ MTA (n 113 above).

²⁴⁰ MOH Health Sector Strategic Plan II, (HSSP II) (2000/1-2004/5).

substance use problems, psychosocial disorders and common neurological conditions like epilepsy is recognised.²⁴¹

The NHP II was preceded by the NHP I.²⁴² The development of the NHP II has been informed by the National Development Plan (NDP)²⁴³ the Ugandan Constitution²⁴⁴ and the new global dynamics.²⁴⁵

The major goal of the NHP II is to attain a good standard of health for all people of Uganda in order to promote healthy and productive lives.²⁴⁶ The implementation of the NHP II is guided by the values enunciated in the Ugandan Constitution²⁴⁷ and the Ugandan Patients Charter (Patients' Charter).²⁴⁸ The Patients' Charter defines the nature of patients' rights, responsibilities and the responsibilities of health workers.²⁴⁹

As a means of ensuring availability, accessibility, appropriateness and good quality of health services, the NHP II is bent on providing primary health care by decentralising the health system.²⁵⁰ In order to enhance sustainability, the NHP II shall explore alternative cost effective measures for health financing and services in particular for vulnerable groups.²⁵¹ In this regard, the NHP II will ensure that both public and private health sectors provide services included under the UNMHCP.²⁵²

3.2 International and national standards on the health policy implementation

3.2.1 The notion of 'progressive realisation' within the context of health policy implementation

The notion of progressive realisation previously in this chapter discussed entails an obligation on the part of states to take deliberate, concrete and targeted steps to realise the rights under the ICESCR. It is against such background that this section assesses how the UN Committee on ESCR under the auspices of General Comments 14 and 5, has utilised the notion of progressive realisation to set standards for policy implementation on the right to mental health under the ICESCR. These standards are by no means exhaustive. However, they are notably of vital importance with regards to the right to health.

²⁴¹ Health Sector Strategic Plan III (HSSP III).

²⁴² MOH National Health Policy I (NHP I) (1999 - 2009).

²⁴³ National Development Plan (NDP) (2010/11 - 2014/15).

²⁴⁴ Act 21 of 1995.

²⁴⁵ NHP II (n 232 above) 4.

²⁴⁶ NHP II (n 232 above) 11.

²⁴⁷ Act 21 of 1995.

²⁴⁸ Uganda Patients' Charter MOH Department of Quality Assurance (Patient's Charter) (October 2009).

²⁴⁹ As above.

²⁵⁰ NHP II (n 232 above) 13.

²⁵¹ NHP II (n 232 above) 13.

²⁵² NHP II (n 232 above) 13.

On the one hand, General Comment No 14 outlines the normative content of the right to health, and the obligations for states to progressively realise this right by ensuring that health services are available, accessible, and affordable and of appropriate good quality.²⁵³ Accordingly, the Committee on ESCR contends that states should adopt a national strategy to ensure the enjoyment of the right to health.²⁵⁴ Further that the strategy should be anchored on human rights principles.²⁵⁵ These principles should define the objectives of the strategy, the formulation of policies and corresponding right to health indicators and benchmarks.²⁵⁶ The national health strategy should also identify the resources available to attain defined objectives and the most cost-effective way of using those resources.²⁵⁷ The Committee on ESCR maintains that the norms of non-discrimination and people's participation must be an integral part of any policy, programme or strategy developed to discharge governmental obligations under article 12.²⁵⁸ It further affirms that effective provision of health services can only be assured if people's participation is secured by states.²⁵⁹ General Comment No 14 emphasises the need for national health strategy and plan of action to be based on accountability and transparency, noting that good governance is essential in the effective implementation of the right to health.²⁶⁰

On the other hand, under General Comment No 5, the Committee on ESCR reviews and emphasises some of the ways in which the issues concerning persons with disabilities arise in connection with the obligations under the ICESCR.²⁶¹ General Comment No 5 observes that the notion of progressive realization of the right to health for persons with disabilities entails a duty on the part of the state to take positive action in reducing structural disadvantages and give preferential treatment to such a vulnerable group.²⁶² Therefore states need to implement tailor suited programs to achieve the right to health for persons with disabilities.²⁶³ The Committee on ESCR maintains that such programs should be implemented in consultation with representatives at national level of persons with disabilities and should incorporate both the public and private sectors.²⁶⁴ Amidst resource constraints, the Committee on ESCR reiterates the need to double the protection of the rights of those

²⁵³ General Comment No. 14 (n 122 above).

²⁵⁴ General Comment No. 14 (n 122 above) 53.

²⁵⁵ As above. See also World Health Organisation (WHO) 'Mental Health Care Law: Ten Basic Principles' WHO Doc No. WHO/MNH/MND/96.9: <http://www.who.org> (accessed on 15 October 2011).

²⁵⁶ As above.

²⁵⁷ General Comment No. 14 (n 122 above) 54.

²⁵⁸ As above.

²⁵⁹ As above.

²⁶⁰ General Comment No. 14 (n 122 above) 55.

²⁶¹ General Comment No. 5 (n 163 above) 2.

²⁶² As above.

²⁶³ The Committee on ESCR General Comment No 3: the Nature of States' Parties Obligations (Art 2(1) of the ICESCR) UN Doc E/1991/23.

²⁶⁴ UN Standard Rules (n109 above) 14(2).

most vulnerable by the adoption of relatively low cost targeted programs.²⁶⁵ States should additionally endeavour to harness resources from the international community through international cooperation and assistance in order to progressively realise the rights under the ICESCR.²⁶⁶ General Comment No 5 further recognises the importance of the Standard Rules in providing guidelines for implementation of the rights of persons with disabilities.²⁶⁷

3.2.2 Domestic standards on the implementation of health policy under the Ugandan Patient's Charter

In a bid to progressively realise the right to health, the MOH has developed a legal and regulatory framework under the Patient's Charter, in order to ensure the access of all people to high quality health services as guaranteed under economic and social objective 20 of the Constitution.²⁶⁸

The objectives of the Patient's Charter include empowering health consumers to demand high quality health care, promoting the health of patients and outlining the responsibilities of health workers.²⁶⁹ The Patient's Charter guarantees the right of everyone to receive medical care without discrimination.²⁷⁰ In this light, it recognises the right of everyone to participate in or be represented in the development of health policies, in order to ensure that respective health needs of patients are appropriately catered for.²⁷¹ The Patient's Charter recognises that a safe environment where the underlying determinants of the right to health are provided is integral to ensuring full enjoyment of this right.²⁷² It guarantees the patients' rights to safety and security, informed consent, continuity of care, confidentiality, access to information and judicial safeguards.²⁷³ Key aspects of this Charter are its provisions on review which aim to ensure that policy and legislation is relevant to the health needs of patients at all times.²⁷⁴

²⁶⁵ General Comment No 3 (n 263 above) 12.

²⁶⁶ General Comment No 5 (n 163 above) 13.

²⁶⁷ General Comment No 5 (n 163 above) 7 See also Rule 14 of the Standard Rules (n 109 above).

²⁶⁸ Patients' Charter (n 248 above) & Act 21 of 1995.

²⁶⁹ Patients' Charter (n 248 above) sec 2&3.

²⁷⁰ Patients' Charter (n 248 above) art 1 & 2.

²⁷¹ Patients' Charter (n 248 above) art 5.

²⁷² Patients' Charter (n 248 above) art 4.

²⁷³ Sec 8, 10, 14, 15, 16 & 19. Patients' Charter (n 248 above).

²⁷⁴ As above.

3.3 NHPII objectives on mental health services and their extent of compliance with international standards

The NHP II has further developed several policy objectives through which it aims to achieve its goals. Regarding mental health, a key objective involves the strengthening, organisation and management of national health systems in Uganda in order to build capacity for the efficient delivery of the UNMHCP. Mental health services are to be provided as part of UNMHCP. This package comprises the following.²⁷⁵

- health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response;
- maternal and child health;
- prevention management and control of communicable diseases,
- prevention management and control of non-communicable diseases.

Whilst the NHPII recognises the need to prevent control and manage mental health as above stated, it also outlines the content of the nature of service to be provided under the UNMHCP.²⁷⁶

Accordingly, the NHPII mandates government to ensure access to cost effective and affordable mental health services.²⁷⁷ The NHPII further emphasises on the adoption of comprehensive advocacy tools that will sensitise both the users and providers of these services on various health related matters.²⁷⁸ Further in order to ensure the provision and delivery of sustainable mental health services, the NHPII provides for effective monitoring and evaluation processes to be carried out in partnership with all relevant stake holders from various sectors in the country.²⁷⁹ In order to beef up monitoring and evaluation strategies, the NHP II provides for periodic health research to be conducted so as to determine the appropriate way to manage and control non-communicable and communicable diseases.²⁸⁰ However, the NHPII is yet to develop a framework for monitoring and evaluation.²⁸¹ The policy has a legal and regulatory framework premised on reviewing relevant laws in Uganda to ensure their enforcement.²⁸² These mechanisms can help clients seeking redress for poor service provision.²⁸³ In order to ensure efficient delivery of the UNMHCP government is

²⁷⁵ NHPII (n 232 above) 1.

²⁷⁶ NHPII (n 232 above) 16.

²⁷⁷ NHPII (n 232 above) 17.

²⁷⁸ As above.

²⁷⁹ NHPII (n 232 above) 18.

²⁸⁰ NHPII (n 232 above) 19.

²⁸¹ NHPII (n 232 above) 30.

²⁸² NHPII (n 232 above) 20.

²⁸³ NHPII (n 232 above) 21.

obligated to harness resources from private-public partnerships and the international community.²⁸⁴ Resource mobilisation must be achieved in line with principles of equity, transparency and accountability.²⁸⁵ By this token, the NHPII obligates government to train human resource on mental health issues, promote community participation and management of mental health issues; ensure the availability and access to efficacious, safe, good quality and affordable medicines, provide and maintain health infrastructure in an adequate and sustainable manner.²⁸⁶

The NHP II is seemingly compliant with the international human rights standards set out above. It is driven by the norms of non-discrimination, equality, equity and public participation, as enunciated under General Comment No 14, the Ugandan Constitution and the Patients' Charter. All are cardinal to the effective realisation of the right to mental health as outlined under the ICESCR. Furthermore, as a means of ensuring progressively realisation of the right to mental health, the NHPII establishes the UNMHCP through which mental services are to be provided. Government is further mandated to ensure efficient delivery of this package through low cost targeted programs by amongst other matters, providing access to essential medicines, training of human resources, revamping health infrastructure. In all these endeavours, government is further mandated to assess performance through monitoring and evaluating the policy.

Although the integration of mental health services into primary health care is laudable, it carries the risk of rationing the contents of the UNMCHP.²⁸⁷ Consequently, the mental health needs may not be met in a wholesome manner. This is evidenced through the non-recognition of prisoners under the NHPII as a vulnerable group. The NHPII recognises only women and children as vulnerable persons. Therefore, although the NHPII prioritises equality and non-discrimination, the absence of a specific provision protecting persons with mental disabilities and prisoners renders it solely inadequate to cater to their respective health needs.

²⁸⁴ NHPII (n 232 above) 24 & 25.

²⁸⁵ As above.

²⁸⁶ NHPII (n 232 above) 21-24.

²⁸⁷ MOH Resources 'Uganda's Minimum Health Care Package: Rationing with the Minimum?' <http://www.health.library.go.ug> (accessed on 20 October 2011).

3.4 Uganda's draft mental health policy and prisoners' right to mental health

The government of Uganda has had a draft mental health policy for the past 9 years.²⁸⁸The current draft policy has been developed in response to the inadequacies and challenges of the current system in meeting the mental health service needs of the Ugandan population.²⁸⁹Anchored on the principles of non-discrimination, equity, community participation and public-private partnership, this policy guides the development of programs and plans in areas considered to be priority to improve the mental well being of Ugandans.²⁹⁰ One of such areas is prisons.²⁹¹

To this end, the policy mandates government to ensure that all prisoners and people under the criminal justice system have access to quality mental, neurological and substance abuse services in accordance with the existing laws and human rights obligations.²⁹²The policy also recognises the importance of including anti-poverty measures in new policies by ensuring equitable allocation of funds for mental health, as a priority health area within the overall health budget.²⁹³The policy obligates government to ensure a multi-disciplinary approach to mental health care by engaging among other stake-holders, psychiatrists, clinical and counselling psychologists and psychiatric social workers.²⁹⁴ The policy advocates for increased public and private partnerships and public participation as a means to reduce on inadequacies in mental health care provision.²⁹⁵The policy mandates the government to ensure a sustained supply and equitable distribution of essential psychotropic medications, and protection of budgets for these medications in order to avoid frequent stock-outs.²⁹⁶It reiterates the need to have effective monitoring and evaluation mechanisms so as to adequately assess the disease burden and needs of mentally ill persons.²⁹⁷

²⁸⁸ Mulumba (n 222 above) 12.

²⁸⁹ MOH draft policy (n 84 above) 11.

²⁹⁰ MOH draft policy (n 84 above) 10.

²⁹¹ MOH draft policy (n 84 above) 6-11.

²⁹² MOH draft policy (n 84 above) 12.

²⁹³ MOH draft policy (n 84 above) 13.

²⁹⁴ MOH draft policy (n 84 above) 14.

²⁹⁵ MOH draft policy (n 84 above) 15.

²⁹⁶ MOH draft policy (n 84 above) 14 &15.

²⁹⁷ MOH draft policy (n 84 above) 17.

3.5 Mental health legislation

3.5.1 Critical assessment of the MTA

The MTA is an outdated colonial replica of English Law which was last revised in 1964.²⁹⁸ The MTA was enacted to make way for custodial care of persons with mental disorders as implicit in the name. In this sense its primary concern is the treatment of mentally ill persons within psychiatric institutions. Furthermore, the MTA provides for the care of persons of unsound mind and for the management of hospitals in Uganda.²⁹⁹ It is strictly limited to the magisterial process of conducting an inquiry into the state of mind of a person believed to be of unsound mind; detention, care and treatment, discharge and release of such person.³⁰⁰ In its present state, the MTA is neither exhaustive with regards other concerns of persons with unsound mind, nor is it in tune with the prevailing needs of persons with mental illness in Uganda. Such criticism is justified for six main reasons.

The first unsettling aspect of the MTA the absence of a definition of mental illness and the use of disturbing terms in reference to the treatment of persons of unsound mind.³⁰¹ For example, the MTA interprets the word unsound mind as an 'idiot' or person suffering from 'derangement' without further defining these terms.³⁰² Of equal importance is the use of the terms detention as opposed to admission and release as opposed to discharge.³⁰³ These terms imply that a person has been imprisoned and not admitted to a health facility.

Secondly, the MTA does not provide for access to legal safeguards for mentally ill persons through for example access to tribunals and advocates.³⁰⁴ Tribunals could be better placed in handling issues concerning such persons as opposed to magistrates; whose primary concern is the interpretation of the law. Advocates could be instrumental in informing mentally ill persons of their rights which for the most part they are unaware about.

Thirdly, the nature of detention envisaged under the MTA has the effect of depriving mentally ill persons of their liberty.³⁰⁵ Furthermore, in the absence of guidelines for the detaining officer to adhere to prior to and during such detention under the Act, the detention could very well be arbitrary and not in conformity with standards required under the ICCPR,

²⁹⁸ Mulumba (n 222 above).

²⁹⁹ MTA (n 113 above).

³⁰⁰ MTA (n 113 above).

³⁰¹ MTA (n 113 above) 1(f).

³⁰² As above.

³⁰³ MTA (n 113 above) 20.

³⁰⁴ MTA (n 113 above).

³⁰⁵ MTA (n 113 above).

the Body of Principles and the MI Principles respectively. Such detention may also interfere with a persons' right to be treated in a non-discriminatory manner.

Fourthly, the MTA does not guarantee the right to privacy of mentally ill persons. Suffice to observe that such person's privacy may be interfered with especially once under involuntary incarceration, where they could be stripped naked and restricted from communicating with family members.

Fifthly, the MTA is insensitive to the rights of mentally ill persons to refuse or accept treatment.³⁰⁶ Informed consent to treatment is important with regards to the protection of the inherent dignity of mentally ill persons. They should not be given treatment at will even where they do not consent to receive such treatment.

The MTA does not recognise the need for providing community based care and treatment as an alternative to institutionalised care.³⁰⁷ Further not only does the MTA not recognise community based care but it requires the family to mentally ill person to bear the cost of admission to the institution.³⁰⁸ Community based care is essential in providing rehabilitation and reintegration for the mentally ill persons. Further, the state should ideally bear the cost of treatment for mentally ill persons. Such persons are under the custody of the state and deserve to the greatest extent possible, to be fully looked after by the state on account of their vulnerability.

It is safe to contend therefore that the provisions of the MTA are seemingly premised on welfare first and the rights of mentally ill persons come second. Whilst the MTA is concerned with protecting the community from mentally ill persons, it is disregarding the fact that mentally ill persons also have rights which need to be safeguarded whether under institutionalisation or in the community.

3.5.2 The Mental Treatment Amendment Bill 2010 (MTA Bill) and the protection accorded to prisoners

The analysis under this section focuses on part five of the MTA Bill, which outlines the nature of mental health treatment for prisoners and offenders.³⁰⁹ There are six positive aspects that the MTA Bill highlights with regards access to mental health services for prisoners. The first is an assessment of the mental health status of prisoners and children.³¹⁰

³⁰⁶ MTA (n 113 above).

³⁰⁷ MTA (n 113 above).

³⁰⁸ MTA (n 113 above).

³⁰⁹ MTA Bill (n 234 above) secs 50-56.

³¹⁰ MTA Bill (n 234 above) sec 50(1).

Accordingly, the head of prisons is obliged to inquire into the mental status of any prisoner who may exhibit signs of mental illness.³¹¹ This inquiry is to be conducted by a psychiatrist, medical practitioner or mental health practitioner.³¹² Once any of these persons has examined the prisoner in question then a report is made with regards to the appropriate form of care, treatment or rehabilitation for the prisoner.³¹³ Early identification of mental illness is necessary for the proper assessment and treatment of the mental health needs of the prisoner concerned.

Secondly, the legislation prefers treatment first to incarceration by allowing a mentally ill offender to be treated under a mental health facility prior to prosecuting such an offender. This is done with regards to the gravity and nature of the offence, the psychiatric history of the offender, mental health state at the time the offence was committed, the likely detrimental effect that prosecution may have on the mental health of the offender and the community's interest in prosecution.³¹⁴

Thirdly, the legislation adequately provides for those unfit to stand trial to undergo an assessment. Further that any charges are levelled against them, be dropped whilst they undergo treatment.³¹⁵

Fourthly, the legislation provides that persons found not guilty by virtue of their mental disability should be treated under a mental facility and be discharged once their mental disorder sufficiently improves.³¹⁶ The emphasis under the preceding two sections is focused on treatment and rehabilitation, which are indispensable for the full recovery and reintegration into society of prisoners with mental illness.

Fifthly, the legislation prefers probation orders rather than imprisonment for persons with mental disorders at sentencing stage.³¹⁷ Additionally, if a convicted prisoner becomes mentally ill whilst serving sentence, the MTA Bill allows for the transfer of the prisoner to a mental health facility.³¹⁸

Notwithstanding the preceding positive aspects of the MTA Bill, some of its provisions are not sensitive to the mental health needs of prisoners with mental illness. For example, the MTA Bill does not equally regard the rights of mentally ill prisoners as those not

³¹¹MTA Bill (n 234 above) 50(1) a & b.

³¹²MTA Bill (n 234 above) 50(2).

³¹³MTA Bill (n 234above) 50(2).

³¹⁴MTA Bill (n 234 above).

³¹⁵MTA Bill (n 234 above).

³¹⁶MTA Bill (n 234 above).

³¹⁷MTA Bill (n 234 above).

³¹⁸MTA Bill (n 234 above).

mentally ill. This is exhibited by the absence of a provision providing for the right to judicial review by an independent body.³¹⁹ Secondly, the legislation does not provide for secure facilities for mentally ill offenders. The absence of an independent tribunal to address complaints of mentally ill persons is a denial of their rights to access justice and equality guaranteed under the Constitution of Uganda and the international human rights instruments previously in this paper cited. The lack of provision of secure facilities for mentally ill persons is tantamount to denying them the right to liberty and security of the person as guaranteed under the international and national instruments cited in the preceding chapter. In essence where prisoners with mental illness are unable to access justice from an independent tribunal, the state is failing in providing reasonable accommodation for such persons to fully realise a full and healthy life.

3.6 Research findings

3.6.1 The position in Uganda's Prisons

An onsite visit to Luzira Upper, Murchinson Bay and Luzira Womens' Prisons, provided practical insights on the prevailing living conditions and mental health care services for prisoners with mental illness.³²⁰

Luzira Upper had an initial capacity of 600 prisoners.³²¹ However its prison population stood at an estimated 2772, out of which there were only 50 known cases of mentally ill prisoners.³²² The majority of these were on remand.³²³ Of the 50, 21 had been admitted to an improvised ward designated for mentally ill prisoners.³²⁴ The ward was already filled to its capacity.³²⁵ Three quarters of those admitted into the ward were under prolonged detention pending ministers' orders for release. There were no laid down procedures to determine the onset of mental illness within the prison apart from the elementary judgment carried out by the officer in charge and nursing assistant. Most cases were identified through odd behavior exhibited by the prisoners.³²⁶ For example, violent outbursts, withdrawal symptoms, being idle for long periods, tear off clothing and feeding on live rats in preference to the prescribed meals.³²⁷ When such behavior is exhibited, prisoners who become suicidal are compelled to take medicines to calm them down and placed in seclusion. Other forms of deterrence

³¹⁹ See section 58 of the MTA Bill (n 234 above).

³²⁰ Visited by the author on October 18 20 & 27 2011 respectively of the three, Murchinson Bay Hospital Prison is the national prisons' referral hospital and first point of referral for all sick inmates from all prisons in Uganda.

³²¹ Informal discussion with Wilson Magomu Officer in Charge of Luzira Upper Prison on 18 October 2011.

³²² As above.

³²³ Magomu(321 above).

³²⁴ As above.

³²⁵ As above.

³²⁶ As above.

³²⁷ As above.

include ropes which are used to restrict prisoners from causing any further havoc. Depending on the severity of a prisoners' condition whilst in seclusion, the visiting psychiatrist is alerted. The services of the psychiatrist are not availed to the prisoners as often as required. The norm is for a psychiatrist from Butabika, the National Mental Health Referral Hospital to visit the prison once monthly. However, in most cases routine assessments and follow-up are rarely conducted. The officer in charge admitted that the officers at the prison are not trained to look after mentally ill inmates but only those who are not mentally ill. Therefore, it is probable that the care being provided in prisons is insufficient. In the same vein one mentally ill prisoner remarked:

I do not like the way I am handled at times...they are very rough with me especially when bathing me...I am handled with the barbaric standards of the Touaregs of West Africa...I do not like what the medicines does to me after I take them... they make me stick out my tongue and when that happens my fellow prisoners think I am an animal and keep away from me.

Impliedly, the prisoner was communicating his displeasure with the manner in which he is at times treated by the prison officers and his fellow inmates. In this regard, the officer in charge of the prison admitted that at times prisons officers and other inmates not similarly placed have worries of their own and therefore cannot cope with the stress that comes with looking after mentally ill prisoners.

Murchinson Bay Prison had an estimated total of 1434 inmates, a figure three times its holding capacity.³²⁸ Of these, 29 were mentally ill and admitted in a ward designed for such prisoners.³²⁹ Of the 29, 17 were on remand, six convicts and nine remands pending ministerial orders.³³⁰ The ages of prisoners ranged from late twenties to early forties. Most of the cases were brought into prison as drug addicts and relapse due to non access to drugs.³³¹ However, it is probable that some of the illnesses develop whilst in prison as a result of the stressful prison ambience.³³² It was observed that the frequency of treatment provided to mentally ill prisoners depends on the seriousness of the illness.³³³ Once it is perceived by the prison officers and the nursing assistant that a prisoner may require psychiatric services, the psychiatrist is informed. The most common manifestations of mental illnesses are stress, epileptic seizures, schizophrenia, manic and psychotic disorders. Treatment provided comprised counseling and medicines.³³⁴ Admittedly, counseling services

³²⁸ Informal discussion with Selestine Twesigye Officer in Charge at Murchinson Bay on 20 October 2011.

³²⁹ As above.

³³⁰ As above.

³³¹ As above.

³³² As above.

³³³ As above.

³³⁴ As above.

require a trained counselor to be on call in order to constantly supervise and monitor the treatment of mentally ill prisoners. Further, whilst the prison staff acknowledged the importance of such services, language was cited as a barrier to their effective provision. The prison admitted to having a sufficient supply of drugs but very few trained medical staff to cater to respective needs of the prisoners.³³⁵

The situation at Luziras' Womens Prison is relatively different. The facility seems to contain its capacity of 347 inmates.³³⁶ Further, sanitation and living conditions appear fairly decent in view of the prison population.³³⁷ However, the exact number of mentally ill inmates was not provided although the Deputy Officer in Charge intimated that there were several cases of mentally ill prisoners.³³⁸

3.6.2 Challenges in prison management

The visits revealed similarities in relation to challenges encountered in the general management of prisons and prisoners with mental illness. The primary challenge is cited as inadequate finances. Consequently, prisons do not have trained medical staff and prison staff, separate facilities to keep mentally ill prisoners, constant supply of appropriate mental health medicines to meet the mental health demands of prisoners.

Secondly the prison population imposes a huge demand in the manner in which the various needs of mentally ill prisoners are addressed.³³⁹ It is the prison population which determines the levels of sanitation, amounts of balanced meals and access to mental health services.³⁴⁰ Scarcity of resources gives rise to conflict. More so for mentally ill prisoners who require taking strong medication which requires a healthy diet provided at regularly intervals.³⁴¹ Resultantly, the combination of a poor diet and strong medication weakens the mentally ill persons as their conditions deteriorate.³⁴² Currently, prisoners are entitled to a single portion of maize meal and beans once daily, which is barely sufficient.³⁴³ A general complaint amongst prisoners was that the meals are not fresh and are inadequate, drinking water is not boiled hence subjecting them to several water-borne diseases, sanitation is poor

³³⁵ As above.

³³⁶ Informal discussion with Everlyn Lanyero Deputy Officer in Charge Luzira Womens' Prison on 27 October 2011.

³³⁷ As above.

³³⁸ Twesigye (328 above).

³³⁹ Magomu (321 above).

³⁴⁰ As above.

³⁴¹ Informal discussion with a member of the Prisons Health Team of Uganda Doctor Alex Kakoraki on 25 October 2011.

³⁴² As above.

³⁴³ Informal discussion with three mentally ill prisoners X, Y & Z on 22 October 2011.

and the use of the 'bucket system' as a means of bowel relief is health hazardous and unhygienic.³⁴⁴

Thirdly, the absence of trained personnel medical and otherwise to treat and manage mentally ill prisoners, to run routine assessments for mental illness and to conduct screening for mental illness upon entry into prison is a huge challenge.³⁴⁵ The screening of mentally ill persons is performed by general observation of either the Officer in Charge or a nursing assistant.³⁴⁶ Once mental illness is suspected, the prisoner is then referred to the visiting psychiatrist who attends to prisoners once monthly.³⁴⁷ Nursing assistants are untrained but out of practice have acquired little knowledge in dispensing drugs. Although, the prison can refer an inmate for treatment to Butabika, the prisons officers noted that hospitals do not appreciate prisoners in the manner that they do. Further that at times where a prisoner is violent, the hospital staff may not treat such prisoner. Consequently the prisoner is stigmatised. Further that once sent for further treatment at Butabika, prisoners have been known to escape due to lack of security. Consequently, the prisons officer expressed a general reluctance in referring prisoners to hospitals.

Whilst it was a generally considered view that prisons are not well suited to cater to the needs of mentally ill prisoners, the reality of mentally ill prisoners within prisons, requires more efforts through a multi-disciplinary approach to train people in a culturally understandable way to manage mental illness.³⁴⁸ It is curable provided the appropriate intervention is made at the appropriate time.³⁴⁹

In conclusion, the thematic focus under the international standards discussed in this chapter is premised on ensuring that persons with disabilities receive the same level of medical care within the system as other members of society. To this end, the CESCRC maintains that states should implement low cost effective targeted mental health programs. Whilst Uganda has made strides in effecting such measures through policy, the reality on the ground proves otherwise. This state of affairs presupposes two things. Either these measures are not adequately tailored to meet the unique mental health needs of prisoners with mental illness or they lack proper implementation. The problem is further compounded by the presence of a mental health law which does not protect or promote the rights of persons with mental health problems; the delay in repealing this law and enacting a new one

³⁴⁴ As above.

³⁴⁵ Informal discussion with Professor Segane Musisi, Professor of Psychiatry and Head of Department of Psychiatry at Mulago General Hospital on 27 October 2011.

³⁴⁶ As above.

³⁴⁷ Informal discussion with Assistant Commissioner of Prisons David Asiimwe Ahimbisibwe on 26 October 2011.

³⁴⁸ Musisi (345 above).

³⁴⁹ As above.

and the absence of a functioning mental health policy specifically catering for prisoners' mental health. The fore-going factors render the access of mental health services for prisoners with mental illness impracticable.

Chapter Four

4 Conclusion

Prisoners with mental illness live under very stressful and intolerable conditions in Uganda's Prisons. The prisons are overcrowded, the diet is inadequate, insufficient and unbalanced and the general sanitation is poor. Secondly, there are very few trained personnel in psychiatry to treat prisoners with mental illness. Currently the prisoners are treated by a visiting psychiatrist once monthly, in whose absence an untrained nursing assistant assumes responsibility. Additionally, prisons suffer from frequent stock-outs in medicines. Thirdly, although Uganda has in place a national health policy, the policy neither recognises prisoners as vulnerable groups nor their need to access mental health services. Uganda is yet to enact a mental health policy to specifically cater to the needs of mentally ill prisoners. The current mental health legislation is outdated and irrelevant to the needs of mentally ill prisoners. Although there is a new law in the offing, the process of enacting the mental health bill into law has been very slow.

In this regard, subjecting prisoners to inhuman living conditions, not providing access to the highest attainable standard of mental health services, the absence of a specific mental health policy to cater for mental health needs of prisoners and the presence of a mental health legislation which does not promote the rights of mentally ill persons, is a violation by Uganda of their right to health and of its national and international human rights obligations previously outlined.

5 Recommendations

The missing link in the mental health provision matrix is hugely a question of resources and commitment. Respect for human rights coupled with financial prudence and empathy present a formidable approach to the effective treatment of prisoners with mental illness. The recommendations that follow are premised on this assertion and outline the steps that the Government of Uganda must take in the same regard.

5.1 Mental health legislation

Government must speedup the process of enacting Uganda's Mental Treatment Amendment Bill into law. Consequently, this law should safeguard the right of prisoners with mental illness to access mental health services. It must ensure that this new law protects and promotes the rights of persons with mental health problems, primarily by promoting human rights, community care and equal opportunities. Key emphasis should be on using a multi-disciplinary approach to care as opposed to a medical approach alone.

5.2 Mental health policy and services

Government must hasten the process of implementing the Draft National Policy on Mental Health, Neurological and Substance Abuse Services. It must dedicate more budgetary resources in mental health policy and planning processes. Further it should refrain from relying solely on donor funds which are for the most part unsustainable. Government must institute measures to encourage and finance research on the mental health disease burden amongst the prison population. In so doing, the evaluation and development of mental health programs and services is positively impacted. Government must build capacity by training human resources in psychiatry in order to ensure that the most senior medical personal responsible over mentally ill prisoners is adequately and sufficiently qualified.

5.3 Legislative procedures relating to the arrest, detention and trial of mentally ill offenders

Government must release persons with psychosocial disabilities under prolonged detention to uphold their rights guaranteed not only by international and local human rights laws, but also the Ugandan Constitution. It must work with the prisons commission, the Law Society of Uganda and the mental health service providers to promptly identify such prisoners in order to issue orders for release and prescribe the proper mental health services to be given.

Government must also set a time frame for trial on committal as a measure to reduce high incarceration rates and subsequent congestion in prisons. Furthermore, it must promote alternative dispute resolution in criminal matters to reduce custodial sentences and congestion in prisons. Non-custodial sentences are not utilised as often as they should. Measures such as community service, parole, fines, police bonds, bail must be utilised in matters involving minor offences as a measure to decongest prisons.

5.4 Prison conditions

Government must increase funding for mental health treatment in prisons. It must allocate sufficient resources to the Ugandan Prison Service in order to ensure effective implementation of the Ugandan Prisons Act. Firstly, the allocation of funds directed towards the management of prisons should be decentralised. Decentralisation of finances would equip respective prisons channel the funds towards programs catering to the specific mental health and other needs of prisoners, in a more sustainable way. Government must also facilitate and ensure professional development of prison staff in the areas of human rights and mental health and improve living conditions for staff and prisoners. Consequently, prison

staff will be empowered to adequately address the various mental health needs of mentally ill prisoners.

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