**Analysis of the Uganda Mental Treatment Act from a Human Rights and Public Health Perspective***

**1.0 Scope**

*Mental disorders affect one person in four in their lifetime, and can be found in 10 per cent of the adult population. It has been estimated that mental disorders and problems will increase by 50 per cent by the year 2020. Yet, according to the WHO: "All countries have to work with limited resources. Too often, prejudice and stigma hamper the development of mental health policies, and are reflected in poor services, low status for care providers and a lack of human rights for mentally ill people."[1] The presence of a comprehensive National Legislation on mental health is crucial in the observance of the rights of persons with mental disabilities. In fact the inadequate mental health legislation in countries around the world has been cited as the responsible for fuelling human rights abuses against people who need psychiatric care.*

*This essay examines the elements of international human rights law directly linked to persons with mental disabilities that are crucial in National mental health legislations. It critically considers the Uganda Mental Health Treatment Act as an example subjecting it to the test of human rights standards as spelled out in the United Nations Human Rights Instruments. The further examines the provisions of this Act from a public health perspective and concludes with recommendations on how the Act can be made better in light of human rights.*

## 1.1 Introduction

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[2] From this definition it is clear that mental health is an important aspect in defining the entire health of a person. Mental health refers to the balance between all aspects of life - social, physical, spiritual and emotional. It impacts on how we manage our surroundings and make choices in our lives - clearly it is an integral part of our overall health.[3] Mental Health is far more than the absence of mental illness and has to do with many aspects of ones life

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[1]NEWS.AMNESTY; Human rights imperative for mental health reforms; http://news.amnesty.org/index/ENGIOR400012005

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[3]http://www.nehb.ie/youthhealthne/mental%20health%20definition.htm



Electronic copy available at: http://ssrn.com/abstract=1006230

including: how the individual feels about him or her self; about others and how individuals are able to meet the demands of life.[4]

A mental disorder on the other hand means 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'. In this respect four categories of mental disorder are specified.[5] These include: Mental illness; Severe mental impairment[6]**;** Mental impairment[7]**;** and Psychopathic disorder[8]**;** It is notable that some forms of mental disorder fall outside the scope of these four categories; for example, a state of arrested or incomplete development of mind, which includes severe or significant impairment of intelligence and social functioning, but is *not* associated with abnormally aggressive or seriously irresponsible conduct.

The Uganda Mental Treatment Act[9] refers to persons of mental disabilities as persons of unsound mind.[10] Although some sections of this Act apply to people suffering from *mental disorder*, while others apply *only* to people suffering from one of the four specified categories of mental disorder, the Act does not differentiate between these persons and it treats them in exactly the same way.

### 1.2 Development of the Mental Health Care in Uganda

In Uganda, mental health services were started in 1916. Later, in1927 a Unit in Hoima prison was created to house persons with mental disabilities . This was followed by another unit in 1934 Unit at Mulago Hill.[11] In 1935, a Mental Treatment Ordinance -- to address legal aspects for management and protection of persons with mental illness and the community -- was adopted; the purpose of this law was to protect both the mental disabled persons and the community from the persons with mental disability.[12] Later in 1936 a Unit at Butabika with 1970 bed capacity was opened up; this was viewd as a fundamental achievement in mental health as it was the biggest center for the persons with mental disability in Uganda at the time. The Uganda Lunacy Act (Emergency admission of people of unsound mind to mental Hospital signed by gazetted chiefs, senior police, and senior civil servants) came into force in 1939, under this law

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[4] *ibid.*

[5] The Mental Health Act 1983 in England and Wales, part of the United Kingdom makes the definition of these categories. However this Act does not also define mental illness.

[6] A state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'

[7] Defined in the same way as severe mental impairment except that the phrase 'severe impairment' is replaced by 'significant impairment'

[8] 'a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) that results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'

[9] The Mental Treatment Act, Chapter 279, Laws of Uganda 2000.

[10] *Ibid,* section 1(f) defines persons with mental disabilities to mean an idiot or a person who is suffering from mental derangement.

[11] `The Uganda Draft Mental Health Policy (2000-2005), paragraph 1.2.

[12] *Ibid.*



Electronic copy available at: http://ssrn.com/abstract=1006230

once the gazetted chief, senior police officer or any civil servant signed one as having mental disabilities they would be considered so. There were further developments between 1954 and 1958 when mental health staff recruitment and training were intensified. This was followed by the opening of small mental health units in 8 districts with 3 bed capacity between 1962 and 1973, the purpose of which was to decentralize mental health services.[13]

In 1964 the Mental Treatment Act[14] came into force, this Act was passed to make provision for the care of persons of unsound mind and for the management of mental hospitals in Uganda. This Act has served as the National legislation on Mental Treatment up today.[15] Another development was realized in 1987 when a Mental Health Desk under the Ministry of Health Headquarters then in Entebbe was created.

The 2000-2004/ 5 Health Service Strategic Plan was launched with aims *inter alia* to provide minimum health care package for all (including persons with mental illnesses) and providing Mental Health Integration and Strengthening into general health. In 2003 African Development Bank Funded Re-development of Butabika Hospital with 450 bed capacity and 6 Regional units with 34 bed capacity.

The National Health Policy[16] has provisions on the legal aspects of health that have implications for the Mental Treatment Act.[17] The Policy provides that the policy objective is to review and develop the relevant legal instruments that govern and regulate health and health-related activities in the country, in order to ensure that principles and objectives of this policy are attained.[18] Thus the government is required to update, formulate and disseminate laws, regulations and enforcement mechanisms related Consumer protection, especially for the vulnerable groups including persons with disability; and stigmatization and denial due to ill health or incapacity *inter alia.*[19]

Today mental health is included as a component of the national minimum health care package.[20] It is now part of the health ministry budget. Mental health units are to be built at 6 of the 10 regional referral hospitals, and the capacity of the 900-bed national psychiatric hospital is to be reduced by half. Despite these developments however, the ratio of psychiatrists to the population is still very high being at 1:1,900,000.[21]

## 2.0 The Link Between Mental Health and Human Rights

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[13] *Ibid.*
[14] *Supra,* Note 8.
[15] It must be noted at this point that this Act has never been any amendment despite the numerous International Human Rights developments which have had implications on the various aspects pertaining to the treatment of persons with mental disabilities.
[16] The Uganda National Health Policy,.
[17] *Supra,* Note 8.
[18] *Supra* note 18, Paragraph 13.1.
[19] *ibid,* paragraph 13.2 (k and L).
[20] *ibid.*
[21] Irene Among; Working Together to Promote Community Mental Health: Daily Monitor 7th April 2006. at p. 20



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Just like other aspects of health, mental health and human rights are inseparable. Persons with mental illness are such a vulnerable group of persons that invoking human rights is one of the crucial ways of protecting them. Indeed as Oliver Lewis noted mainstreaming mental disability rights into our regular human rights agenda is a crucial step towards thinking seriously about protecting the rights of people with mental disability.[22] The following chapter discuses the mental health as an important aspect under the international Human Rights Law.

**2.1 Mental Health Rights under International Human Rights Law**

The modern era of human rights law commenced with the adoption of the Universal Declaration of Human Rights (UDHR) in 1948. In the next fifty years, governments have adopted a number of general and thematic human rights conventions. By ratifying these Conventions, governments have recognized international norms in new areas of justice and social policy once left to the complete discretion of domestic legislators as binding in their own legal systems. At present, there is no specialized international convention to addresses the particular concerns of individuals with disabilities or the subgroup of people with mental disabilities.[23] As this article will describe, however, existing human rights conventions that apply to all people, or to subgroups such as women and children, provide many important protections for people with mental disabilities.

While this article examines existing human rights protections, it is important to note that the landscape of international law may soon be changing for people with mental disabilities in the coming years. On December 19, 2001, the United Nations General Assembly made the momentous decision to begin work drafting a UN Disability Rights Convention. Resolution 56/ 168 created an Ad Hoc Committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities including those with mental disabilities."[24] As a result the United Nation Convention on the Rights of Persons with Disabilities was adopted on

International human rights law is built on the fundamental principle that all people should, be protected equally under the law. Article 1 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, provides that "all people are free and equal in rights and dignity"[25] this provision establishes the fact that people with mental disabilities are protected by human rights law by virtue of their basic humanity.

While the Universal Declaration of Human Rights establishes a fundamental set of human rights that applies to all nations, the UN drafted two international human rights conventions to promote the implementation and oversight of the rights it established. The two core UN human

[22] Oliver Lewis, Mental Disability Law in Central and Eastern Europe: Paper, Practice, Promise, 8 J. MENTAL HEALTH L. 293, 294 (2002), as quoted by Michael L. Perlin, International Human Rights Law and Comparative Mental Disability Law: The Universal Factors; Syracuse Journal of International Law and Commerce, Vol. 34, No. 2, 2007.

[23] Eric Rosenthal1 & Clarence J. Sundram (2003) ; International Human Rights and Mental Health Legislation; Mental Disability Rights International, Washington, DC; www.MDRI.org.

[24] Comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities, G.A. Res. 168, U.N. GAOR, 56th Sess., Agenda Item 119(b), U.N. Doc A/RES/56/168 (2001).

[25] G.A. Res. 217A (III), UN Doc.A/810 at 17 (1948).

rights conventions are the International Covenant on Civil and Political Rights (ICCPR)[26] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[27] Together with the Universal Declaration of Human Rights, they make up what is known as the "International Bill of Rights."[28]

In addition to the core UN conventions, regional human rights conventions and rights protection systems have been established in Africa,[29] Americas, and European human rights systems.

In its efforts the United Nations has long recognized the need for increased international human rights, protections for people with mental and physical disabilities. In this regard, the UN appointed three Special Rapporteur on Human Rights and Disability who have found that people with mental disabilities experience some of the harshest conditions of living that exist in any society.[30]

The purpose of the Convention on the R ights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.[31] Under the Convention, Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[32]

The principles of the present Convention on Rights of Persons with Disabilities include:

i. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
ii. Non-discrimination;
iii. Full and effective participation and inclusion in society; Respect for difference and acceptance of disability as part of human diversity and humanity; Equality of opportunity;
iv. Accessibility; Equality between men and women; and

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[26] G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No.16) 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* 23 Mar. 1976.

[27] G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No.16) 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* 3 Jan. 1976.

[28] "The International Bill of Human Rights comprises the most authoritative and comprehensive prescription of human rights obligations that governments undertake in joining the U.N." David Weissbrodt, Joan Fitzpatrick, and Frank Newman, INTERNATIONAL HUMAN RIGHTS: LAW, POLICY, AND PROCESS 9 (3d edition, 2001). *See generally, The International Bill of Rights* (Louis Henkin, ed., 1981) (a collection of essays describing the history, interpretation, and application of the International Bill of Rights).

[29] African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *entered into force* 21 Oct. 1986. In addition to the general protections under the convention, the African Charter is the only one of the three regional conventions that explicitly creates special protections for people with disabilities. Article 18(4) of the African Charter states that "the disabled also have the right to special measures of protection in keeping with their physical and moral needs."

[30] *See* UN Economic and Social Council Resolution 2000/10, UN Doc. No. E/RES/2000/10, 27 July 2001. This report is available on the web at <http://www.un.org/esa/socdev/enable/dismsre1.htm>.

[31] Article 1 of the Convention

[32] *Ibid.*

v. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[33]

The principles of this Convention present vital human rights violations of which affect persons with mental disabilities in several ways.

The convention creates general obligations under which the state parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities including those with mental disabilities without discrimination of any kind on the basis of disability. Under this convention, state parties undertake to *inter alia* adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized under the Convention; take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities. As Professor Perlin has noted, the extent to which this obligation is honored will reveal much about the Convention's ultimate "real world" impact.[34] This convention is without question a relevant international human rights instrument in mental health disability issues, it creates obligations on state parties through which National Laws can be measured to conform to international human rights.

While international human rights law has grown tremendously over the last thirty years, the development of international law specifically to protect the rights of people with mental disabilities has been relatively limited. Human rights oversight bodies that monitor the mainstream conventions and establish reporting guidelines have dedicated little attention to the rights of people with mental disabilities.[35] The lack of language that pertains specifically to people with mental disabilities in the International Bill of Rights and other mainstream conventions has long hampered the application of these conventions to people with mental disabilities. As a practical matter governments that have ratified the International Bill of Rights, as well as activists and mental health professionals, simply do not know what the specific requirements of international conventions are as they apply to people with mental disabilities.

In recent years, there have been a number of non-binding UN General Assembly resolutions that can be used as a guide to the interpretation of binding convention-based rights. In 1991, the United Nations General Assembly adopted the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" (the MI Principles).[36] The MI Principles have a number of significant limitations – such as the lack of an explicit recognition of

[33] Article 3 of the Convention.
[34] Michael L. Perlin, Ibid, Note 21
[35] Despite the historical lack of attention to people with disabilities, a recent review by the UN High Commissioner on Human Rights finds that treaty-monitoring bodies are open to including people with disabilities and have established a few limited models of good practice. See The full report "Human Rights are for All: A Study on the Current Use and Future Potential of the United Nations Human Rights Instrument s in the Context of Disability" (Gerard Quinn & Theresia Degener eds., Office of the UN High Commissioner for Human Rights, February, Geneva 2002).
[36] G.A. Res. 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49 (1991).

the right to refuse treatment and a number of weak protections against involuntary treatment.[37] In addition, as Eric and Clarence note the MI Principles refer only to "patients" rather than people, which suggests that the rights of individuals with mental disabilities are a product of their medical status rather than their inherent value as human beings. As such, the MI Principles do not provide a model a model for the language of domestic legislation. They are, however, valuable in identifying core minimum standards prohibited by current international human rights law.[38] For instance the Inter – American Commission on Human rights cited these principles in the case of Victor Rosario Congo v. Ecuador[39] in which it stated that the principles were adopted by the United Nations General Assembly as a guide to interpretation in matters of protection of the human rights of persons with mental disabilities.

Having made a discussion of the international Human Rights instruments and how they provides for Mental health rights, the next part of this paper singles out the particular rights that need emphasis in any domestic legislation on mental health treatment.
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### 2.2 The major Rights of persons with mental disabilities; A Must Reflect in Domestic Legislation

Article 12 of the ICESCR establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The Constitution of the World Health Organization (WHO), adopted in 1946, first enunciated a right to health and mandated WHO to promote that right.[40] The Convention on the Rights of Persons with Disabilities adopted by the United Nation is a pertinent international instrument on the rights of persons with mental disabilities which crosscuts almost all the rights of persons with disabilities.

This right to the highest attainable standard of mental health entails a right on the part of people with mental disabilities to services that are (a) available (b) accessible (c) acceptable and of (d) appropriate and good quality. To be appropriately available, services must be provided in "sufficient quantity" by "trained medical and professional personnel." The requirement that services be "acceptable" means that they must be provided in a manner that is culturally appropriate and respectful of medical ethics. For services to be of appropriate quality, they must also be culturally acceptable, medically appropriate, and provided in a safe and clean environment.

#### 2.2.1 The Right to informed consent

MI Principle 11 establishes that "no treatment shall be given to a patient without his or her informed consent...." Implicit in the formulation of Principle 11 is the concept of a right to refuse treatment since a person may choose to withhold consent. This is provision is vital in

[37] Eric Rosenthal and Clarence Sundram, *Recognizing Existing Rights and Crafting New Ones: Tools for Drafting International Human Rights Instruments*, in INTERNATIONAL HUMAN RIGHTS OF PEOPLE WITH INTELLECTUAL DISABILITIES (reviewing a number of the critiques of the MI Principles)

[38] Eric Rosenthal & Leonard S. Rubenstein, *International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness* 16 INT'L J. L. & PSYCHIATRY 257 (1993) (describing the use of the MI Principles as a guide to the interpretation of related provisions of human rights conventions).

[39] Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R., OEA/Ser.L/V/II.95 Doc.7 rev. at 475, (1998).

[40] General Comment No. 14 (2000)(E/C.12/2000/4) on the right to the highest attainable standard of health (art. 12 of the International Covenant on Economic, Social and Cultural Rights), adopted by the Committee on Economic, Social and Cultural Rights at its twenty-second session in April/May 2000.

instances where the persons with mental disabilities are subjected to treatment even without their consent of consent of any of their legal representative. This provision attempts to provide persons with mental disabilities with a right to opt whether to go for a particular treatment or not as it is in the case of physical health.

### 2.2.2 Rights to Dignity

The mandate that health services should be provided in such a way as to protect the "rights and dignity" of individuals with disabilities places a broad range of rights within institutions within the ambit of the right to health. The right to dignity is protected under the International Covenant on Civil and Political Rights (ICCPR) as well reflecting the central importance of the concept of human dignity as a cornerstone from which all other rights proceed. As Article I of the Universal Declaration of Human Rights proclaims, "All human beings are born free and equal in dignity and rights." Under Article I of the UN Convention on the Rights of Persons with Disabilities, it is provided inter alia that the purpose of the Convention is to promote respect for the inherent dignity of persons with disability, (which includes persons with mental disabilities). Thus persons with mental illnesses have a right to be treated with dignity and this should be provided for under the domestic legislation.

### 2.2.3 Non-Discrimination

A fundamental human rights obligation that is relevant for all areas of mental health legislation is the protection against discrimination. This right is recognized both in the UN Charter (articles 55-56) and the Universal Declaration of Human Rights, which protects "everyone," Non-Discrimination is further emphasized under the ICESCR and the ICCPR under article 26.[41] The concept of non-discrimination is closely linked with the concept of equality stated in Article 1 of the Universal Declaration of Human Rights: equal in dignity and rights." The protection against discrimination is, first and foremost, a promise that people with disabilities will enjoy the same legal rights as all other individuals. Article 5 of the UN Convention on the Rights of Persons with Disabilities makes provision for equality and non-discrimination, under this article States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.[42] Under the Ugandan Constitution, this right is provided for in Article 21 generally and specifically Article 21(2) which talks about persons with disabilities.

### 2.2.4 Affirmative Action and Reasonable Accommodation

Both the ICCPR and the ICESCR have been interpreted to require more than equality under the law; they require special efforts to ensure that individuals with mental disabilities can enjoy the benefits of equal protections. Therefore both the ICCPR and the ICESCR have been interpreted to require "affirmative action." The Economic and Social Committee has gone even further than the Human Rights Committee by including in its definition of discrimination under the ICESCR the "denial of *reasonable accommodation* based on disability which has the effect of nullifying or impairing the recognition, enjoyment or exercise of economic, social or cultural rights."[43] Under Articles 6 and 7 the UN Convention on the Rights of Persons with Disabilities, provisions for

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[41] It provides that *"All persons are equal before the law and are entitled without any discrimination to equal protection from the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex...or other status".*

[42] Section 5 (1).

[43] General Comment 5.

women and children with disabilities are made respectively. Article 6(1) of the Convention recognizes that women and girls with disabilities are subject to multiple discrimination, under Article 6(2) it creates obligations on States Parties to take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the Convention. Article 7 on the other hand provides that States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children[44]and that in all actions concerning children with disabilities the best interest of the child shall be a primary consideration. From these provisions, women and children with mental disabilities are protected and recognized as the most affected members of society when faced with disabilities In the case of Uganda this right is provided for under Article 32[45] of the constitution, this provision states that the State has to take affirmative action in favour of groups marginalized for the purpose of redressing imbalances which exist against them, in this case persons with mental disabilities are a group with a disability hence need affirmative action.

### 2.3.4 Inhuman & Degrading Treatment

Under Article 7[46] protection in the ICCPR against "inhuman and degrading treatment" is one of the most important protections under international human rights law for people with mental disabilities. It is such an important part of the ICCPR to mental health rights, it is designated as one of the provisions that is "non-derogable" It is notable that the first sentence of Article 7 is a verbatim repetition of Article 5 of the UDHR, which is widely considered to be binding, customary international law. Thus, the protection against torture or inhuman and degrading treatment is applicable even to countries that have not ratified the ICCPR. This article requires governments to establish protections that would prevent unnecessary physical or mental suffering.[47] While Article 7 as a whole is non-derogable, there is an important distinction between "torture" and "inhuman and degrading treatment" under this provision of the ICCPR.[48] Under article 15 of the UN Convention on the Rights of Persons with Disabilities, persons with disabilities should not be subjected to

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[44] Article 7(1).

[45] Article 32(2) there under provides that parliament shall make relevant laws including the establishment of am equal opportunities Commission to ensure the full purpose of this right.

[46] Article 7 reads in full: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

[47]General Comment 20(44) states that "Article 7 relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim."

[48] For an action to constitute torture, pain and suffering must be inflicted upon a person by a government authority (or some person acting under government authority) for some unlawful purpose. While "intent" plays some role in determining whether a practice constitutes inhuman and degrading treatment, this is not required to demonstrate a violation of Article 7. This distinction is extremely important when looking at the application of Article 7 requirements to the treatment of people in psychiatric hospitals or social institutions. 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. The linkage between the protection of individuals in medical research and the protections against torture and inhuman treatment in the language of the ICCPR is an indication that this protection was not intended to be limited to politically- motivated actions by government authorities but is also applicable to medical or scientific practices. Also see Eric Rosenthal, *The International Covenant on Civil and Political Rights and the Rights of Research Subjects, in* ETHICS IN NEUROBIOLOGICAL RESEARCH WITH HUMAN SUBJECTS 265, 266 (Adil E. Shamoo, ed., 1997).

torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation and States Parties are obliged to take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities on an equal basis with others from being subjected to torture or cruel, inhuman or degrading treatment or punishment.[49] This right is similarly guaranteed under Article 24 of the Ugandan Constitution.[50]

### 2.3.5 Right to privacy

One of the most pervasive violations of human rights in psychiatric facilities is the violation of the right to privacy. People may be forced to live for years in dormitory- like wards where they are never able to have a moment of solitude. They may have no secure place in which to place their personal possessions or their clothing. They may have no privacy when bathing or toileting. Institutions may resort to convenient but degrading practices like "gang showers" in which groups of patients are stripped naked and hosed down. Even when they have a single or double room, staff or other patients may be able to violate their personal space. Intimate meetings with friends, family, or even a spouse may be restricted. Communication with family or friends is often monitored, and letters are opened. MI Principle 13(1) protects the right to privacy, freedom of communication, and private visits. The right to privacy is also protected as a right in and of itself under Article 12 of the UDHR and Article 17 of the ICCPR, which states that "[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence..." Article 17 specifies that "[e]veryone has the right to the protection of the law against such interference...." this right therefore accrues to those that have mental disabilities. Under article 22 of the UN Convention on the Rights of Persons with Disabilities, No person with disabilities, regardless of place of residence or living arrangements, should be subjected to arbitrary or unlawful interference with his or her privacy *inter alia.* Provision recognizes that Persons with disabilities have the right to the protection of the law against such interference or attacks and State parties.

### 2.3.6 Liberty & Security of the Person

Article 9 of the ICCPR establishes that "[e]veryone has the right to liberty and security of the person. No one shall be subjected to arbitrary detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." UDHR Articles 3 and 9 provide similar protections. Article 9 requires governments to adopt legislation to protect against arbitrary detention in psychiatric facilities. The MI Principles contain detailed guidelines that are helpful in interpreting the protections against improper detention in a psychiatric facility.[51] The same is provided for under Article 14 of the UN

[49] Article 15(2), Convention on the Rights of Persons with Disabilities.

[50] It provides that "No person shall be subjected to any form of torture, cruel, inhuman or degrading treatment or punishment."

[51] The MI Principles establish both substantive standards and procedural protections necessary to protect against arbitrary detention in a psychiatric facility. An extensive body of case law from the European system of human rights interpreting the protection against arbitrary detention under the European Convention establishes a number of additional rights that may be greater than those established under the MI Principles. While this body of case law is binding only in countries that have ratified the European Convention, it may provide useful guidance in understanding the requirements of the ICCPR. Unlike the Article 7 protection against inhuman and degrading treatment that is nonderogable, protections established under Article 9 are subject to limitation under very specific circumstances. The "Siracusa Principles" set forth internationally accepted standards for the derogation of certain

Convention on the Rights of Persons with Disabilities, this provision states that States Parties shall ensure that persons with disabilities, on an equal basis with others are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and in no case shall the existence of a disability justify a deprivation of liberty.[52] This provision is generally provided for under Article 23[53] however it is taken away under provision (f) of the same Article.[54]

### 2.3.7 Psychiatric commitment - procedural protections

The MI Principles permit detention for a "short period" which must be specified by domestic law "for observation and preliminary treatment pending review" by an independent body. Any involuntary commitment after this time can only be ordered by "a judicial or other independent and impartial body established by domestic law in accordance with procedures laid down by domestic law." The review body determines whether the individual subject to detention meets the substantive criteria discussed above.[55] The Principles actually provide for the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patients health needs and the need to protect the physical safety of other.[56]

It is now important to examine the mental health Legislation of Uganda and make an assessment of its compatibility with this provision of the MI principles and other human rights safeguards for persons with mental illnesses.

## 3.0 The Uganda Mental Treatment Act From a Human Rights Perspective

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rights. The MI Principles protections against improper civil commitment to a psychiatric facility mirror many of the Siracusa Principles. Consistent with the MI Principles, the Siracusa Principles emphasize key policy goals that should be incorporated into mental health legislation. Any limitation of a person's right to be free from detention must be "strictly necessary" to achieve a legitimate public objective – such as public safety. In addition, there must be "no less intrusive or restrictive means available" to meet the same objective. Thus, the Siracusa Principles underscore the fact that any involuntary psychiatric commitment should be a last resort, used only after all the options for appropriate community treatment and support have been explored.

[52] Article 14(1) b.

[53] The Constitution of the Republic of Uganda.

[54] This provides that if a person is suspected to be of unsound mind their liberty can be take away. This provision is unfair to persons with mental illnesses as it tends to protect the public more.

[55] The determination as to whether the person should be committed, while initially a medical or psychiatric determination is ultimately subject to judicial review to ensure that the determination is consistent with legal standards. The review body shall have at its disposal one or more qualified mental health practitioners, but they must also be independent of the institution seeking to commit the individual (Principle 17(1)). A person subject to involuntary commitment "shall have the right to appeal to a higher court…." (Principle 17(7)). Individuals subject to involuntary commitment have a right "to choose and appoint counsel to represent the patient as such, including representation in any complaint procedure or appeal." (Principle 18(1)). This counsel shall be provided without payment if the individual lacks resources to pay. Where necessary, the government should also provide the assistance of an interpreter. (Principle 18(2)). A person subject to commitment proceedings and his or her personal representative or counsels have the right to "attend, participate and be heard personally in any hearing." (Principle 18(5)). The individual or counsel can request an independent mental health report and may present "oral, written or other evidence…." (Principle 18(3)). The MI Principles also set forth procedures for making a patient's records available to the patient or counsel (Principle 18(4)). While the person subject to commitment has a general right of access to his or her records, this right may be limited where "disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others." As domestic law shall permit, records should be made available to counsel.

[56] MI Principle 9(1).

Domestic legislation, specifically the Uganda Mental Treatment Act,[57] should not provide fewer protections than are recognized in the MI Principles and other UN Human Rights Instruments since these human rights instruments have provisions creating obligations on state countries to protect the rights of persons with mental disabilities as has been discussed above. In 1993, for instance the World Conference on Human Rights meeting in Vienna reemphasized the fact that people with mental and physical disabilities are protected by international human rights law and that governments must establish domestic legislation to realize these rights. In what has come to be known as the "Vienna Declaration," the World Conference declared that "all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities."[58]

Despite the existence of these protective provisions in the instruments, most countries do not have comprehensive national legislation on mental health. In reflecting on some of the countries, Michael L Perlin made interesting findings. He wrote that on a site visit to Nicaragua he and a colleague were shown the Nicaraguan mental health law which in its entirety was two brief paragraphs.[59] The conclusion that one can draw from such a law is that it can not in any way provide for protective measures for rights of persons with mental disabilities. This actually shows how some states are yet to comply with the obligation under the United Nation Convention on the rights of persons with disabilities of adopting all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the conventions.[60]

**Human Rights Gaps in the Uganda Mental Health Treatment Act**

This Act has no clear definition of what constitutes mental illness. The term unsound mind is used in the Act to refer to mental illness but the application is left to clinical judgment. Although it should be based on 'objective medical expertise' and be of a 'kind or degree warranting compulsory confinement', the validity of continued confinement depends upon the persistence of the disorder. In this regard therefore, declining to define what is meant by 'unsound mind', the European Court of Human Rights observed, in *Winterwerp v. The Netherlands*[61], that 'it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitudes to mental illness change... so that a greater understanding of the problems of mental patients is becoming more widespread'. Therefore the continued failure of the Act to define what constitutes mental illness leads to the infringement of people's rights since they are left at the mercy of psychiatric developments.

The Act has no provisions, to include safeguards for "compliant incapacitated" people such as access to tribunals and advocates. Establishment of the tribunal to specifically handle matters of persons with mental disabilities would mean that the persons in such a tribunal would be better acquitted with the rights of the mental disabled persons other than leaving such sensitive issues

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[57] *Ibid,* note 8.
[58] Vienna Declaration and Program of Action, World Conference on Human Rights, Vienna, 14-25 June 1993, U.N. Doc A/CONF.157/24, para. 63.
[59] Michael L. Perlin, Ibid Note 21.
[60] Article 4.1(a).
[61] (1979)

to be handled by magistrates who most likely do not appreciate the issues of persons with mental disabilities. On the other hand advocates would defend the rights of persons with mental disabilities who may not even be aware of their rights. Indeed it has been concluded that without the availability of such counsel it is virtually impossible to imagine the existence of the bodies of involuntary civil commitment law, right to treatment law right to refuse treatment law, or any other aspect of forensic mental disability law that are now taken for granted.[62] Absence of these portrays the Act as incompatible with the Human Rights.

Detention is a matter of the 'degree or intensity' of deprivation of liberty rather than its 'nature or substance'. Therefore conditional discharge under section 20 of the Act has always been used to deprive liberty of the patients released on trial. For instance the chief medical officer subjects such a patient to conditions for their residence, occupation and also order surveillance on them as he deems fit. This provision amounts not only to a certain degree of detention but also deprives the victims of their liberty which right is given under the UN Human Rights Instruments discussed above and Article 23 of the Ugandan Constitution.

The Act makes no acknowledgement of fairness or equality under the law for those with mental illness. Those suffering from mental disorder are to be detained. There is no mention of treatability, the need for the patient to benefit or even for the intervention to be in the patient's best interest. This in a way infringes the patient's right to be treated fairly and equally under the law and at the same time fails to recognize their right of affirmative action under Article 32 of the Constitution of Uganda since they a marginalized group with disability.

The Act lacks any provision, which guarantees the privacy of the mental disabled persons. In many hospitals especially where they are detained involuntarily mental disability persons are kept in conditions which violate their privacy for instance they have no privacy when bathing or in toilet, they are striped naked and "gang showered". Even when they have a single or double room, staff or other patients may be able to violate their personal space. Intimate meetings with friends, family, or even a spouse are restricted. Communication with family or friends is often monitored, and letters are opened this violates MI Principle 13(1) which protects the right to privacy, freedom of communication, and private visits.

Under the Act there is nothing like the Right to informed consent yet MI Principle 11 provides that "no treatment shall be given to a patient without his or her informed consent...." Implicit in the formulation of Principle 11 is the concept of a right to refuse treatment since a person may choose to withhold consent. The act there fore in not human rights sensitive when it fails to provide for this right.

The Act does not make integrated community programs as an alternative to institutional care which in one way or another affects rights of persons with mental disabilities. It is provided under Principle 3 of the MI Principles that every person with mental illness has the right to live and work as far as possible in the community. On the other hand Principle 7 provides that every patient has the right to be treated and cared for as far as possible in the community in which he or she lives and this can only be limited where a person meets formal standards for civil commitment as provided under principles 15-17. Under general comment 5 of the United Nations Committee on Economic, Social and Cultural Rights it is recommended that

[62] Michael L. Perlin(1999), Mental Disability Law: Civil and Criminal, Chapter 3, 2nd ed

governments should adopt legislation and policies that enable persons with disabilities to live an integrated self-determined and independent life. The importance of such a provision in the National Legislation is that it does away with the likely hood of discriminating against persons with disabilities by giving them different treatment from that of the general public. In fact as Eric and Arlene have concluded, "governments that provide service to people with disabilities exclusively in institutions without providing meaningful alternatives in the community, may be found to violate international human rights law by providing services in a discriminatory manner"[63]

From the above discussion one can ably argue that the Uganda Mental Health Treatment Act is an Act insensitive to the tests of human rights, archache and not fit in today's era of human rights. However it can also be argued that many of the provisions of this Act are aimed at protecting the public Health as the following paragraphs discuss.

### 3.1 The Uganda Mental Health Act from a Public Health perspective

The mental Health Treatment Act makes provisions which though seem to conflict Human Rights, they seek to protect the Public Health. For instance it makes provision for voluntary admitions under section 5 for private paying patients which may be through applications by relative, friend or person alleged to be of unsound mind. Under section 6 it is expressly provided that for public safety a person suspected to be of unsound mind can be moved to suitable hospital or other place of detention. Under section 13 of the Act, every such patient is subject to the directions and control of the chief medical officer and any officer attached to the mental hospital, this provision is meant to protect the public form such persons with mental disabilities. Under section 20 if a patient is realized on trial, they are kept on observance and surveillance which is all meant to protect the public from persons with mental illnesses. The act also provides for protection of the public in case of any escape of patient under section 21. Section 37 protects the public from patients who are strangers.

### 4.0 Recommendations

All patients who lack decision-making capacity, with regard to medical care, both mental and physical, should be treated in line with the Lord Chancellor's proposals *Making Decisions*.[64] It is proposed here that psychiatrists should no longer be responsible for recommending detention of patients. The Government should draw up a list of 'Grounds for Notification'. This could mirror the arrangements for persons with mental disabilities or for when patients present a risk to the public by continuing to drive when they suffer from medical conditions that preclude driving.[65] The doctor has a duty to notify the relevant authority not to take legal action to restrict the patient.[66] The grounds would need to be clear and specific. It is quite proper in a democracy, for parliament (rather than psychiatrists) to determine the grounds including whether or not 'risk to self' is a matter for detention.

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[63] Eric Rosenthal & Arlene S. Kanter, The Right to Community Integration: Protections under United States and International Law, in DISABILITY RIGHTS: INTERNATIONAL AND NATIONAL PERSPECTIVES 1(M. Breslin, S. Yee A. Meyerson, eds. 2002) as quoted by Michael L. Perlin, ibid, note 21.

[64] LORD HIGH CHANCELLOR (1999) *Making Decisions on Behalf of Mentally Incapacitated Adults*. London: The Stationery Office: http://pb.rcpsych.org/cgi/content/full/25/4/126#REF

[65] A. S. Zigmond: (2001) Psychiatric Bulletin; Reform of the Mental Health Act 1983; the Green Paper; The Royal College of Psychiatrists.

[66] Ibid.

When a psychiatrist sees a patient whose condition includes those factors identified by the Government, then the law would require the doctor to notify whatever body, perhaps a tribunal or the magistrate's court, the Government sees fit to organize for this purpose. [67]The notification might include a statement on whether or not the notifying psychiatrist believes a hospital is the proper place for detention; if it is determined that detention is appropriate. This would presumably depend on whether or not the person consented to medical intervention and would benefit from it. The Government may set out clear steps to be taken in response to such notification, including, perhaps, an approved social worker having to present the case to the tribunal (or court) for a decision to be made as to whether or not the patient should be incarcerated away from the rest of society.[68]

Although psychiatrists would have a duty under law to notify the appropriate body, they would not be involved with recommending detention of such patients. Treatment would, of course, only be with the patients' consent (they retain capacity). If the patient appealed to a higher court it would be for the tribunal to justify its decision. However it should be noted that this recommendation is yet to be practical in developing countries like Uganda, this is so because today, the right to counsel of persons with mental illnesses is unheard of yet these are instrumental in the entire process of admitting and treating persons with mental illnesses

"The principles governing mental health care should be the same as those which govern physical health.[69] The vast majority of the people receiving treatment in a mental hospital or psychiatric unit are *informal* patients, which means they are in hospital on a *voluntary* basis and have exactly the same rights as a person being treated for a physical illness.[70] For instance People with physical illness who lack capacity can be treated without their consent only if it is either an emergency, and the treatment cannot wait until they are capable, or the treatment is in the patient's best interest (the operation or other treatment will be in the best interest of the patient if, but only if, it is carried out in order to save his or her life or ensure improvement or prevent deterioration in physical or mental health).[71]

"Mental health services must take into account that patients have rights too - it is essential that people with mental illness have a right to inform and participate in all decision-making and policy formulation that affect them,"[72]

**5.0 Conclusion**

Mental health can be approached and defined in many ways. The most essential in grasping the concept 'Mental Health' is that it should be seen as a broad issue, not only as something relating to mental disorders or being the matter of psychiatrists and psychologists only. There is no health without mental health. Thus, mental health: is everybody's business; an issue of everyday life originating in families, schools, workplaces, leisure time activities; an indivisible part of general health; an important resource for both society and individual and is much more than

[67] ibid.
[68] *ibid.*
[69] A. S. Zigmond: (2001) Psychiatric Bulletin; Reform of the Mental Health Act 1983; the Green Paper; The Royal College of Psychiatrists.
[70] The Mental Health Act 1983 an outline guide.
[71] F. v. West Berkshire Health Authority and another, 1989.
[72] Recommendations which Amnesty International has addressed to a number of European states.

mental disorder. The essay above has tried to entrench the concept of human rights in this important aspect of person's health and critically examining the Uganda Mental Health Treatment Act from the human Rights and Public Health Perspective. It can easily be summarized from the discussion that the link between mental Health and Human Rights is enormous and hence worth recognition in the national policy and legislation more specifically the Mental Treatment Act which should be balanced with the Public Health concept.

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