

**Analysis of the Mental Health Bill,  
2014: Submission to the Health  
Committee of the Parliament of  
Uganda on February 8, 2018**



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**ANALYSIS OF THE MENTAL HEALTH BILL, 2014: SUBMISSION TO THE  
PARLIAMENT COMMITTEE ON HEALTH ON FEBRUARY 8, 2018**

**I. About the Organization**

The Initiative for Social and Economic Rights (ISER) is a Non- Governmental Organization (NGO) which was established to promote the effective understanding, monitoring, implementation, accountability and full realization of social and economic rights including the right to health especially for vulnerable groups including Persons with Disabilities (PWDs).

ISER is an ardent advocate for the adoption and use of a human rights based approach to healthcare service delivery and has actively engaged in advocacy for reform of the mental health laws in Uganda. It is against this background that ISER presents its proposals on the Mental Health Bill, 2014 (hereinafter referred to as the '*Bill*').

**II. Brief Overview**

The current legislation governing mental health in Uganda is the Mental Treatment Act, Cap 279 which was enacted in 1964. It has long been overtaken by key developments and interventions including, and most importantly, the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)<sup>1</sup> and its ratification by Uganda.<sup>2</sup>

From the use of derogatory terms such as 'idiots' and 'persons suffering from mental derangement' to subjecting PWDs to forced medical interventions without consent, and detention for indeterminable periods of time, the Mental Treatment Act violates the human rights of persons with psychosocial and intellectual disabilities to dignity, physical and mental integrity, independence, liberty, and freedom from cruel, inhuman and degrading treatment.

Although the PWDs Act, which was enacted by Parliament and assented by the President in 2006, is a much recent law, it makes provision for the protection of the human rights and freedoms of PWDs as a whole without specific reference to the uniqueness of psychosocial and intellectual disabilities. Also, the Act does not reflect the guarantees provided under the CRPD having been passed before the Convention entered into force.

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<sup>1</sup> The Convention on the Rights of Persons with Disabilities (CRPD) was adopted on 13<sup>th</sup> December 2006, opened for signature on 30<sup>th</sup> March 2007 and entered into force on 3<sup>rd</sup> May 2008  
[https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg\\_no=IV-15&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4&lang=en)

<sup>2</sup> Uganda signed the CRPD on March 30, 2007  
[https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg\\_no=IV-15&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4&lang=en)

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

The Bill is therefore a welcome and timely initiative which is instrumental to effect the much needed reform of mental health law in Uganda and it is critical it is in line with international human rights law and best practices.

**III. Policy and Legal Framework Guaranteeing Rights of Persons with Mental Disabilities**

The Constitution of the Republic of Uganda, 1995 emphasizes the inherent nature of human rights and fundamental freedoms thus they must be respected, upheld and promoted by all organs of Government and persons. With regard to mental health, specific focus is drawn to the rights to equality and non-discrimination, dignity, personal liberty, privacy, health, movement and freedoms from cruel, inhuman and degrading treatment.

The Health Sector Development Plan (HSDP) 2015/16 – 2019/20 emphasizes the importance of a human rights-based approach to health.<sup>3</sup> It states that the right of everyone to enjoy the highest attainable standard of physical and mental health is recognized in Uganda.<sup>4</sup>

The Second National Development Plan (NDP II) 2015/16 – 2019/20 is aligned with the 2030 Agenda for Sustainable Development.<sup>5</sup> Sustainable Development Goal 3 on Health calls upon the government to ensure healthy lives and promote well-being for all at all ages with a specific target on promotion of mental health and well-being.<sup>6</sup> This reiterated in the Common African Position of the African Union 2014 which highlights mental health a key priority area.<sup>7</sup>

One of the objectives of the Bill is to safeguard the human rights of persons with psychosocial disabilities thus the Bill “will be in line with International Human Rights Conventions and Standards.”<sup>8</sup> The International and Regional human rights framework has evolved over the years and offers comprehensive protection of the human rights and fundamental freedoms of persons with psychosocial and intellectual disabilities. Uganda has ratified several human rights instruments in this regard including the CRPD, UN Covenant on Economic, Social and Cultural Rights (CESCR), UN Convention on the Rights of the Child (CRC), UN Convention on Elimination of all forms of Discrimination Against Women (CEDAW), African Charter on

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<sup>3</sup> Ministry of Health, Health Sector Development Plan (HSDP) 2015/16 – 2019/20 at p.21.

<sup>4</sup> Ibid.

<sup>5</sup> The Republic of Uganda, The Second National Development Plan (NDP II) 2015/16 – 2019/20, paras. 322-323 at pp. 89-90.

<sup>6</sup> SDG 3.4 accessed at <https://sustainabledevelopment.un.org/post2015/transformingourworld>

<sup>7</sup> HSDP at p.21.

<sup>8</sup> Memorandum, Long Title and Clause 3 (d) of the Bill.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

Human and Peoples Rights (ACHPR), and the African Charter on the Rights and Welfare of the Child (ACRWC).

The Committee on the Rights of Persons with Disabilities and Committee on Economic, Social and Cultural Rights are tasked with monitoring States' implementation of the CRPD and CESCR respectively. In executing this mandate, the Committees have adopted General Comments to comprehensively interpret specific provisions of the Conventions. These include CESCR General Comment No. 5 on Persons with Disabilities, CESCR General Comment No. 14 on the right to the highest attainable standard of health, CESCR General Comment No. 20 on Non-discrimination in economic, social and cultural rights, the CRPD General Comment No. 1 on Equal recognition before the law, CRPD General Comment No. 2 on Accessibility, and CRPD General Comment No. 3 on Women and Girls with Disabilities.

The CRPD is of particular note. Legislation passed pertaining to persons with mental disabilities must be in line with Articles 5 (Equality and Non-discrimination); 12 (Equal Recognition before the law); 13 (Access to Justice); 14 (Liberty and Security of Persons); 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment); 16 (Freedom from exploitation, violence and abuse); 17 (Protecting the Integrity of the Person); and 25 (Health) of the CRPD.

This legislative and policy framework outlined above is the basis and lens through which ISER analyses the Mental Health Bill herein below.

#### **IV. Analysis of the Bill**

##### **A. Overarching Issues**

###### **1. Medical necessity versus Human Rights**

It is evident throughout the Bill that there is a conflict between the medical and human rights approaches to persons with psychosocial disabilities. Whereas Part III specifically guarantees the protection of human rights of patients, the Bill continues to reinforce the medical necessity approach with regard to treatment and admission of patients. The rights and freedoms of persons with psychosocial disabilities are given with one hand and taken with another for instance the right to equality before the law, right to exercise one's legal affairs, freedom from cruel, inhuman and degrading treatment, the right to dignity, the right to give free and informed consent to medical interventions, the right to privacy from among others.

A patent illustration of this clash is reflected in Clause 42 of the Bill. Sub Clause (1) states that a mental health practitioner has a duty to inform the patient of his or her rights prior to administering treatment. However, Sub Clause (2) is to the effect that a psychiatrist has the

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

powers to order that the rights of a voluntary patient are restricted or denied if it is in the interest of the patient to do so.

It is important to keep in mind that the 1995 Constitution of Uganda envisaged scenarios where human rights of an individual may be restricted in public interest under Article 43. There are strict guidelines for limitation of the enjoyment of human rights which must not exceed what is “acceptable and demonstrably justifiable in a free and democratic society.” Also crucial to note is the fact that some particular human rights and fundamental freedoms are non-derogable including freedom from cruel, inhuman and degrading treatment.

Therefore, there is no legal justification for the blanket authorization of psychiatrists to restrict or deny the human rights of patients under their care without consideration of the law on limiting the enjoyment of human rights. In addition, protection from liability for acts and omissions done in good faith offered to medical practitioners under Clause 71 will be ineffectual if there is evidence that the said act or omission was a violation of human rights and fundamental freedoms of the patients outside the prescribed parameters for restriction of their enjoyment.

**2. Acts that Constitute Torture, Cruel, Inhuman and Degrading Treatment of PWDs are permitted in the Bill.**

The Bill carries the spirit of the outdated Mental Treatment Act insofar as it provides for forms of treatment which amount to cruel, inhuman and degrading treatment. These include electroconvulsive therapy (Clause 11), seclusion (Clause 12 & 13), mechanical bodily restraint and bodily restraint (Clause 14).<sup>9</sup> The justification for these practices in the Bill is incapacity of the patients to give consent, protection, safety and wellbeing of the patient, for medical treatment and to prevent the patient from destroying property.

The UN Human Rights Council has classified involuntary treatment and other psychiatric interventions in health-care facilities as forms of torture and ill-treatment.<sup>10</sup> Legitimizing such practices in national laws under the context of being in the best interest of the person or the public or due to incapacity violates the CRPD because “as long as they inflict severe pain and suffering, they violate the right to dignity and the absolute prohibition of torture and cruel, inhuman and degrading treatment.”<sup>11</sup> The UN Special Rapporteur on Torture and other Cruel,

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<sup>9</sup> Clauses 11, 12, 13 and 14 of the Mental Health Bill, 2014.

<sup>10</sup> United Nations Human Rights Council (2013) “*Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*” adopted by the UN General Assembly on February 1, 2013 at the 22<sup>nd</sup> Session A/HRC/22/53 at para 64.

<sup>11</sup> Ibid.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

Inhuman or Degrading Treatment or Punishment, Juan E. Méndez has also emphasised that contravention of the CRPD through coercion and forced interventions cannot be legitimate or justified under the medical necessity doctrine.<sup>12</sup> The freedom from cruel, inhuman and degrading treatment is non derogable under Article 44 of the 1995 Constitution of Uganda thus it must be expressly guaranteed in Part III of the Bill which is not the current position.

The lack of protection for freedom from cruel, inhuman and degrading treatment under the Bill, in addition to violating patient's rights, will only serve to deter patients from voluntarily seeking mental health services.

**3. Continued Institutionalization of persons with mental illness**

Clause 9 of the Bill provides for involuntary examination, admission and treatment at a mental health unit. It can be initiated by a relative of a person with mental illness, a concerned person<sup>13</sup> and a health unit which determines that the patient should be transferred to a mental health unit as an involuntary patient or the treatment is changed from voluntary to involuntary.<sup>14</sup> The time frame for involuntary admission under the Bill is six months but it can be extended for a further period of one year which equates to one and half years of institutionalization even in instances where a patient sought mental health services voluntarily.

While the Bill has a caveat in Clause 9 (8) that states “a person shall only be admitted as an involuntary patient where involuntary admission is the only means by which that person may be provided with care, treatment and rehabilitation that will benefit him or her,” involuntary commitment should only be reserved for the most severe cases where the person is in immediate danger of harming him/herself or others. The Bill already has provisions for this which it terms ‘emergency admission and treatment.’ In Clause 2, the Bill defines emergency treatment as treatment necessary to save the life of that person or “prevent the person from behaving in a way that is likely to result into serious physical harm to that person or any other person.” It is not clear why involuntary commitment is necessary.

Even worse, although Clause 18 (1) of the Bill recognizes that there are instances where a patient voluntarily seeks mental health services at a health facility, Sub Clause (4) states that a voluntary patient may be treated like an involuntary patient to deny him or her discharge from the facility. This will only serve as a hindrance to access to mental health services by Ugandans for fear of involuntary admission.

This also contravenes Uganda's human rights obligations under the CRPD. Article 19 of the

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<sup>12</sup> United Nations Human Rights Council (2013) “*Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*” supra at para 64.

<sup>13</sup> Clause 9(a) of the Bill.

<sup>14</sup> Clause 9(b) of the Bill.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

CRPD guarantees the right of PWDs to live independently in the community, have control over their everyday lives, choose where and with whom to live, and make choices on an equal basis with others. Detention of persons with psychosocial disabilities in institutions without their consent is an infringement of their right to live independently guaranteed under the CRPD.<sup>15</sup> The Committee on the Rights of Persons with Disabilities recognizes that community support which includes friends and families of persons with psychosocial disabilities are important to realize their full inclusion and participation in the community. The Government of Uganda therefore has a duty under Article 4 of the CRPD to enact legislation which promotes full inclusion and participation of PWDs in the community.<sup>16</sup>

Given that the process of involuntary admission denies persons with psycho social disabilities of the autonomy to make decisions and to live independently, it is essential that it is only done in the most severe of cases as outlined above and in the instances where it is done, procedural safeguards should be put in place and the system should be as formal and transparent as possible to safeguard the rights of persons with psycho social disabilities. Procedural safeguards that should be put in place include options to challenge this admission before the board and before courts of law.

The Kenyan Mental Health Bill, 2014 provides for alternatives to institutionalization. It states that in mental health service delivery, priority should be given to community health care and primary health care as opposed to institutionalization.<sup>17</sup> It also requires the State to make efforts towards re-integration of persons with mental illness into the community and provision of aftercare services to enable them to live a decent and dignified life outside the health facility.<sup>18</sup>

#### **4. Access to Community Based Mental Health Services and Adequate Human Resources**

While the Bill discusses the provision of mental health services in health centres, it does not adequately address the need for accessible and affordable mental health services, provided on an equitable basis. Although mental health services should be integrated at all levels of the health system, they have been predominantly concentrated in urban areas and at national and regional hospitals, remaining out of reach for those who need them most. The availability of functional facilities within the community with access to medication, diagnostic and therapeutic equipment and the necessary and sufficient staffing including but not limited to psychiatrists, psychologists, psychiatric nurses, counselors, psychotherapists; would obviate the need for users to travel long distances seeking health services. Moreover, when people

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<sup>15</sup> CRPD General Comment No. 1 on Equal Recognition before the law at para 44.

<sup>16</sup> Ibid at para 46.

<sup>17</sup> Clause 6 (2) of the Mental Health Bill, 2014 of Kenya.

<sup>18</sup> Clause 6 (3) of the Mental Health Bill, 2014 of Kenya.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

with mental illness are discharged from a facility, they require reintegration into the community and specialized after care services, these could be provided if there are functional community based mental health services. Kenya is proposing similar provisions in its mental health bill. The State is further tasked to promote community mental health care by “providing appropriate resources, facilities, services, personnel and programmes to allow the persons with mental illness to be attended to at a community level” and ensuring that there is a supportive environment which facilitates access to care, treatment and after care services.<sup>19</sup> Community mental health services include the provision of outpatient services to persons with mental illness in health centres and general hospitals, rehabilitation and aftercare services following discharge from a facility, supervised home care and support and services for promotion of mental health.<sup>20</sup>

It is imperative the Bill underscores that community based mental health services should be provided in an affordable, accessible and equitable manner to all. It should set out resources a facility should have to meet the mental health needs of its patients.

**5. Insufficient Protections Accorded to Vulnerable Groups Including Women, Children and Older persons**

Women and girls with disabilities are exposed to multiple and intersecting forms of disability and are susceptible to violence in mental health institutions including forced sterilization.<sup>21</sup> The Committee on the Rights of Persons with Disabilities in General Comment No. 3 explains the various forms of violence to include “involuntary undressing by male staff against the will of the woman concerned, forced psychiatric medication, and overmedication which can reduce the ability to describe and/or remember sexual violence.”<sup>22</sup>

The Committee also drew a link between age and impairment and found that for older persons with disabilities, these two grounds of discrimination, separately or jointly, can increase their risk of institutionalization<sup>23</sup> which infringes their fundamental human rights.

Children as a vulnerable group are deserving of special protection. The bill is silent on children, except to the extent that it mentions children in prison. Yet the Special Rapporteur on torture, cruel, inhuman and degrading treatment or punishment found children in institutions at greater risk of mental health trauma, violence and abuse including sexual abuse

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<sup>19</sup> Kenya Mental Health Bill (2014) at clauses 6, 8.

<sup>20</sup> Kenya Mental Health Bill (2014) at clause 8(2).

<sup>21</sup> CRPD General Comment No. 3 (2016) on Women and Girls with disabilities at para 55.

<sup>22</sup> Ibid at para. 53.

<sup>23</sup> See the report of the United Nations High Commissioner for Human Rights on the human rights situation of older persons (E/2012/51) submitted to the Economic and Social Council.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

and found the severe emotional pain they face from seclusion can amount to inhuman treatment.

The Bill should have a Clause that reiterates that vulnerable groups, particularly women, children and older persons should be afforded special protection due to their heightened vulnerability to multiple forms of discrimination. The Bill should also call for the end of institutionalization and seclusion of vulnerable groups like children including preventing their future admission into institutions.

**6. Full Participation of Persons with Psychosocial Disabilities**

Aside from including a person with a psychosocial disability on the proposed Uganda Mental Health and Advisory Board following nomination by mental health service user organizations,<sup>24</sup> the Bill is silent on the need for full participation of persons with psychosocial disabilities.

The Bill does not expressly protect the right of persons with mental disabilities to participate in the formulation of their treatment plans. Their will and preferences, as far as practically possible, should be the primary consideration in decisions concerning their care, treatment and admission. This is the position in the Kenya Mental Health Bill, 2014.<sup>25</sup>

Yet their meaningful participation is a right under our Constitution and international human rights law and it should be reiterated in the Bill. Article 4(3) of the CRPD requires States to actively consult with and involve persons with disabilities. Meaningful participation is an integral feature of the right to health. In Uganda, persons with psychosocial disabilities have often been deprived of this right because of stigma and beliefs about their presumed incompetency and it is imperative the bill underscores their right to participation.

**7. Minimum Living Conditions at Facilities Should be as Close to Possible to a Normal Life**

The Bill does not provide for the minimum living conditions which should exist at a mental health facility to ensure that it is as close as possible to a normal life of persons their age. Under the Kenya Mental Health Bill, 2014, some of these include facilities for recreation and leisure activities, facilities for education and religious practice, facilities for communication, vocational rehabilitation measures to promote reintegration of the person in the community including counselling and facilities necessary to ensure the privacy and dignity of the patients.

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<sup>24</sup> Clause 57 of the Kenya Mental Health Bill, 2014.

<sup>25</sup> Clauses 26 (1) and 28 (1) of the Kenya Mental Health Bill, 2014.

## **8. Independent Monitoring Mechanisms for Services and Facilities Serving People with Mental Disabilities**

Article 16 (3) of the CRPD calls on States to ensure services and facilities serving people with disabilities are independently monitored to prevent abuse. We commend the broad composition of the Mental Health Advisory Board that, among other things, monitors health units and ensures they meet the standards.<sup>26</sup> Beyond the Mental Health Advisory Board in clause 60 of the Bill, independent monitoring mechanisms should have access to these institutions and include representatives of various stakeholders including Ministry of Health, Ministry of Gender, Labour and Social Development, Equal Opportunities Commission, Uganda Human Rights Commission, the Health, Gender and Human Rights Committees of Parliament, Persons with Disabilities, and Civil Society.

## **9. Informed Consent and the Withdrawal of Consent**

Guaranteeing informed consent is integral to individual autonomy and dignity. The Bill has a number of strong provisions reiterating the need to obtain the patient's consent (Clause 31) and requires the patient to receive sufficient explanation with sufficient information including warning of the risks associated with treatment. The explanation should be communicated in a language and form the patient understands. The consent should be documented in the patient's records.<sup>27</sup> This is in line with best practices on consent.

However, Clause 31(5) should require the provider seeking consent to discuss alternatives with the patient. While the Bill allows consent to be withdrawn, it requires written withdrawal of consent (Clause 32) which can be problematic for those who are illiterate.

## **10. Right to Legal capacity and Equality before the Law is Insufficiently Protected**

Legal capacity is the ability to hold rights and duties (legal standing) and the power to act on them or exercise them (legal agency).<sup>28</sup> PWDs have been denied their right to legal capacity through substitute decision-making regimes such as guardianship and mental health laws that permit forced treatment.<sup>29</sup>

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<sup>26</sup> Clauses, 57 and 60 of the Mental Health Bill (2014).

<sup>27</sup> See for example Clause 30(e) of Kenya Mental Health Bill (2014).

<sup>28</sup> This differs from mental capacity which refers to the decision making skills of a person which naturally differ from one person to another and may be different for a given person depending on many factors, including environmental and social factors. See CRPD General Comment No. 1 (2014) on Article 12 of the CRPD: Equal Recognition before the law, by the Committee on the Rights of Persons with Disabilities adopted by the Committee on Rights of Persons with Disabilities at its eleventh session March 31 – April 11, 2014, at para 13.

<sup>29</sup> Ibid.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

Article 12 of the CRPD requires State parties to ensure that “appropriate and effective safeguards” are put in place to ensure that personal representatives simply support and do not inhibit decision making of PWDs. They therefore must respect the rights, will and preferences of the person, be free of conflict of interest and undue influence, be proportional and tailored to the person’s circumstances, act for the shortest time possible and be subject to regular review by a competent, independent and impartial authority or judicial body.<sup>30</sup> Those safeguards “shall be proportional to the degree to which such measures affect the person’s rights and interests.”<sup>31</sup>

In addition, persons with mental illness should be given the opportunity to plan in advance, as a form of support, and state what their wishes and preferences which should be followed at a time when they are not in position to communicate to others.<sup>32</sup> It is against this standard that we assess the provisions pertaining to legal capacity.

Although Clause 44 (1) of the Bill states that persons with mental illness have the right to manage their own affairs, Sub-Clause (2) does not give them the right to appoint a personal representative of their choice. However, this Clause, by depriving them of appointing a guardian or manager to manage their financial affairs is depriving them of their legal agency, a central component of legal capacity. In addition, factors which will be relied on to determine incapability of a patient to manage their affairs are not disclosed yet given the weight of such decisions, the process should be clear and transparent. It is especially important for PWDs when they have to make fundamental decisions regarding their health and finances. While there are instances where determining the will of a person is difficult, the use of instruments like advance directives and powers of attorney can be encouraged to ensure there is no arbitrariness in determining the will of the person. Moreover, PWDs should be able to have the right to modify their will and service providers should continue to seek informed consent.

Section 46 (2) of the Bill provides that the personal representative appointed by court shall act as a manager of the estate and guardian of the person with mental illness. However, it does not lay down the guidelines which personal representatives must follow to ensure that they do not abuse the powers given to them to the detriment of the person with mental illness.

The Bill also does not provide a defined time period in which personal representatives can act on behalf of the patients nor how they can be removed which leaves the patients prone to

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<sup>30</sup> Article 12 (4) of the CRPD.

<sup>31</sup> Ibid. Article 12 (4) of the CRPD.

<sup>32</sup> CRPD General Comment No. 1 on Equal Recognition before the law, supra at para 18.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

abuse of the wide discretion. Yet measures that curtail legal capacity should be finite and subject to periodic review.

Provision for safeguards to protect legal capacity must be incorporated in the Bill and be watertight to ensure that the right of PWDs to exercise their rights and control their affairs is respected and upheld.

**11. Confidentiality of Information Should Be Protected**

The privacy of personal, health and rehabilitation information of persons with disabilities should be protected.<sup>33</sup> The Bill is silent on this except for clause 41 and it should contain strong provisions on the confidentiality of information and clearly enumerate conditions where disclosure is permissible that is when required by law or court order, to prevent serious harm to the person with mental illness and others.

**12. Reiterate Importance of Prevention**

The Bill is silent on prevention. Although it discusses treatment, it does not discuss the need for mental health interventions to be comprehensive and include prevention especially targeted at those most vulnerable including refugees, older persons, children, women and those affected by catastrophic emergencies. Nor does it mention the need for awareness raising and training on mental health interventions.

**13. Include Clauses on the Need to Invest Resources**

While the Bill as a whole has a number of progressive provisions that will advance the rights of persons with mental disabilities and ensure their access to treatment within the community including in primary health centres, it is silent on resources. Yet it is necessary for the State to invest in resources, both human and financial resources. The CRPD and CESCO task state parties to “take measures within the maximum of its available resources” to progressively realize the rights discussed in this Act.<sup>34</sup>

The Bill should include a clause defining the obligation of the State and reiterating that the State should be required to ensure that there is funding for mental health services and meet requirements for staffing, facilities, medication, equipment and other interventions to ensure the highest attainable quality of available, accessible and affordable mental health services. Otherwise the obligations set out in the Bill regarding access to health services will remain aspirations on paper.

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<sup>33</sup> Art. 22(2) of the CRPD.

<sup>34</sup> Art. 4(2) of the CRPD.

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

**Commentary on Specific Provisions**

Clause	Contents of the Clause	Comment	Proposal
<p>Clause 9 (1) (a) and Clause 18 (4)</p>	<p>Clause 9 (1) states that a person qualifies for involuntary examination where –</p> <p>(a) a request is made a relative or a concerned person where –</p> <p>(i) the person to be admitted does not qualify to be admitted using the criteria for emergency admission or voluntary admission; and</p> <p>(ii) it is not possible to get an examination from a senior mental health practitioner before admission.</p> <p>Clause 18 (4) states that “a voluntary patient who meets the criteria of involuntary treatment and admission may be denied discharge.”</p>	<p>There are no clear circumstances which would lead to involuntary admission.</p> <p>It is not clear if it simply means that anyone who refuses treatment on request of a relative or concerned person shall be subjected to involuntary treatment without examination by a mental health practitioner.</p> <p>This provision leaves the patients at the mercy of third parties such as the relatives and concerned persons which power may be abused to the detriment of the patient.</p> <p>In addition, the denial of voluntary patients discharge yet they sought health services by their own has the potential to deter other patients from seeking health services voluntarily, a barrier to access to mental health services.</p>	<p>It should be clearly stated when a patient in these circumstances will be subjected to involuntary admission especially if a request is being made.</p> <p>To have a defined criteria for a patient to meet to be classified as an involuntary patient, consider adding. The following conditions in the Bill;</p> <ul style="list-style-type: none"> <li>• There must be evidence of a mental illness of a specified severity;</li> <li>• If there is a serious likelihood of immediate or imminent harm to that person or to other persons and there will likely be deterioration of the person’s condition if admission or treatment do not occur;</li> <li>• Two accredited health practitioners have to determine that</li> </ul>

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

			<p>the patient has a mental illness;</p> <ul style="list-style-type: none"> <li>• Treatment can only be given by way of admission into the facility;</li> <li>• Any restrictions must be based on the person's needs, be genuinely justified and be the result of rights-based procedures and combined with effective safeguards;</li> <li>• A maximum time of involuntary admission must be given.</li> </ul> <p>(see clause 31 of Kenyal Mental Health Act (2014))</p> <p>There should also be facilities designated by law to conduct involuntary admissions.</p> <p>The person involuntary admitted or family or representatives should have right to appeal involuntary admission to the Board.</p>
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**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

<p>Clause 9 (9)</p>	<p>The time period for involuntary admission is not more than six months.</p> <p>However, this can be extended to a further period of one year, coming to a total of one year and six months as a possible time frame.</p>	<p>This period is too long moreover under unclear circumstances to hold an involuntary patient.</p> <p>In addition, subjecting patients for such a long period of time where they may be exposed to involuntary treatment including electroconvulsive therapy, seclusion, and mechanical bodily restraint and bodily restraint amounts to cruel and inhuman treatment.</p>	<p>This time period should be reduced to a maximum of six months to ensure that the right of the patients to liberty and freedom of movement is not infringed.</p> <p>Clause 31 (2) of the Kenya Mental Health Bill, 2014 provides that a mental health facility should only receive an involuntarily admitted patient for the duration necessary to stabilize the patient.</p>
<p>Clauses 11, 12 and 14</p>	<p>These provisions respectively provides for electroconvulsive therapy, seclusion, and mechanical bodily restraint and bodily restraint for patients on involuntary and emergency treatment without consent.</p> <p>The justification for these practices is that they are necessary for the protection, safety and wellbeing of the patient or other person they may come in contact with.</p>	<p>The justification of ‘protection, safety and wellbeing of the patient and other persons’ is too wide to warrant the use of these practices which have been condemned worldwide for inflicting pain on persons with mental illness.</p> <p>The Bill does not provide any restraints with regard to how long a patient can be subjected to such treatment which leaves patients exposed to severe pain and suffering. It is left entirely to the</p>	<p>The Bill should adopt the stand taken by other African countries e.g Kenya on electroconvulsive therapy for involuntary and emergency admission where consent of the patient has not been obtained. It is expressly prohibited under Clause 34 (2) of the Kenya Mental Health Bill, 2014.</p> <p>There should be clear and defined instances in the Bill when a patient will be subjected to seclusion and restraint.</p>

		<p>discretion of the psychiatrist.</p>	<p>For instance the Mental Health Bill of Kenya Clause 36 provides for instances when restraint and seclusion can only be used. These include:</p> <ul style="list-style-type: none"> <li>• Where it is the only means available to prevent immediate or imminent harm to the patient.</li> <li>• It must also not be prolonged beyond a period which is strictly necessary to administer treatment to the patient in order to allow him or her to cohabit peacefully with patients at the facility, their family or community members, whatever the case may be.</li> </ul> <p>All instances of restraint and seclusion must be recorded in the patient’s medical records.</p> <p>The Kenyan Bill also expressly provides that patients who are restrained and secluded to be kept in safe and humane conditions under the constant care and supervision of a</p>
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**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

			<p>qualified mental health practitioner.</p> <p>In addition, representatives of the patient must be given prompt notice of the seclusion or restraint of the patient. Restraint and seclusion must also be a last resort and should not be used as a punishment to the patient for the convenience of the staff of the facility.</p>
<p>Clauses 40 (2) and 41 (1) on the right to information and disclosure of information</p>	<p>A relative or a concerned person shall also be provided with information about the admission and treatment of the patient.</p>	<p>Sharing medical information with any relative or concerned person without consent of the patient is a violation of their right to privacy and confidentiality of health information.</p> <p>This provision cuts across all patients including voluntary patients who should be in position to decide if they want the information shared and with who.</p>	<p>Information should not be shared with anyone without consent of the patient. Where consent cannot be obtained, disclosure should be made to a personal representative appointed by the patient.</p> <p>It should be in circumstances where it is extremely necessary to share the information for the best interests of the patient and in the absence of a personal representative that such health information should be disclosed to any other person.</p>

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

			<p>The Bill should also guarantee protection of confidential health information of patients which is disclosed to any third party on their behalf, including a personal representative by criminalizing further disclosure to other persons. This is extremely important because of the stigma associated to mental illness and to preserve the dignity and integrity of the patient.</p>
<p>-Clause 41 (2) on denial of access to information</p>	<p>A mental health practitioner may deny a patient access to their health information where disclosure may seriously prejudice the patient or cause him or her to conduct themselves in a manner which will prejudice the health of another person.</p>	<p>Access to information is a constitutionally guaranteed right which has been reiterated in the PWDs Act, Patient Charter and several human rights instruments ratified by Uganda. This provision is problematic insofar as it gives the medical practitioners wide discretion to deny a patient access to their health information.</p>	<p>In such instances, the medical practitioner should also be able to also use his or her discretion to determine a time when the patient can receive their information at a later stage because a blanket denial amounts to a violation of the patient's right to access their health information.</p>
<p>Clause 46 (1) Appointment of a personal representative by court</p>	<p>The provision states that 'where an order is made that a person is not capable of managing his or her affairs or a person with mental illness does not</p>	<p>This provision, though it is in good faith, has the potential of sidelining the wishes and preferences of the patient.</p>	<p>The Court should only come to the conclusion that a person is unable to manage their affairs if it is in possession of a</p>

**INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS**

	<p>appoint a personal representative, court will appoint a suitable relative to be his or her personal representative.’</p>	<p>Instead of substituting the decision maker and excluding the person with a mental disability, there should be supported decision making for the person with mental disability in line with article 12 of the UNCRPD.</p> <p>It also does not provide for service of the application made to the patient before a manager is appointed.</p>	<p>certified true copy of the admission and treatment particulars of the person with mental illness. A similar position is reflected in Clause 42 (3) of the Kenya Mental Health Bill.</p> <p>In addition, the Court appointed personal representative should hold such position for a defined period of time until the patient is able to appoint one of his or her choice or approve the appointee of the court.</p> <p>The wishes and preferences of the patient should take precedence at all times. Therefore, if the patient had previously intimated whom they would like to act as their personal representative, this choice should take precedence to a court appointed one. To determine the will of a person with a mental disability, instruments like</p>
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			power of attorney can be developed.
Clause 55 on the duties of the local authorities	<p>The local council executive has a duty to monitor persons with psychosocial disabilities in their area who are released from prison to ensure that they do not present a risk to the residents of the area.</p> <p>Where the local council executive establishes that the person is a risk to the residents of the area, the executive shall cause the person to be admitted in a mental health unit as an involuntary patient.</p>	<p>The statement “where the local council executive establishes that the person is a risk to the residents of the area” is too vague to warrant automatic admission of a person to a mental health institution moreover as an involuntary patient.</p> <p>This provision gives the executive wide powers yet they do not have the expertise to examine and determine whether the person will be a harm to him/herself or others.</p>	The local council executive’s powers should be reduced to simply advising the person to seek mental health services or taking the person to the nearest health unit for examination.

**V. Conclusion**

People with psychosocial social disabilities and users of mental health services face multiple forms of discrimination and face a confluence of vulnerabilities including stigma, discrimination, and poverty. It is important that legislation protecting their rights, in addition to providing for access to treatment, safeguards the rights to autonomy, agency, dignity and human rights guaranteed under the Constitution of Uganda and International and Regional human rights instruments. The Mental Health Bill, if revised to incorporate the suggestions above, has the potential to do so.



### **About the Initiative for Social and Economic Rights**

ISER is a registered Non-Governmental Organization (NGO) in Uganda founded in February 2012 to ensure full recognition, accountability and realization of social and economic rights primarily in Uganda but also within the East African Region.

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