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MENTAL HEALTH AND ILLNESS IN UGANDA: THE GAPS AND SHORTFALLS OF THE STATE, LAW AND ITS PRACTICE

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MENTAL HEALTH AND ILLNESS IN UGANDA; THE GAPS AND SHORTFALLS OF THE STATE, LAW AND ITS PRACTICE.

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ABSTRACT

With mental health trending on social media and a growing cause for concern in the modern age, there is all the more need for the state and its laws to be able to reflect these changes and suitably protect the people's mental health. This article explores Uganda's mental health history as a backdrop to a discussion of various legal facets, particularly criminal law and torts, all in an effort to show the gaps and shortcomings affecting mental health and mental illness. It also presents an elaborate discussion on a spectrum of factors that affect mental health; and puts forward suggestions for reform in the mental health legislation and legal practice in Uganda for a better understanding and approach to mental health issues.

1.1 INTRODUCTION

> *If Hamlet from himself be ta'en away, And when he's not himself does wrong Laertes, Then Hamlet does it not, Hamlet denies it. Who does it, then? His madness. If't be so, Hamlet is of the faction that is wronged: His madness is poor Hamlet's enemy~* William Shakespeare, *The Tragedy of Hamlet*, Act V Scene 2

The history of psychiatry haunts our present. Our people remain chained and shackled in institutions and by ideas which colonisers brought to our continent and many other parts of the world. Indeed, we do remain 'objects of treatment and charity' and some of the worst human rights violations do occur in the very institutions that claim to provide mental health care services.[1]

In the seventeenth century, words like "madness"[2] used by William Shakespeare in his famous play, *Hamlet*, could pass as a reference to persons with mental health conditions. By the eighteenth century, these persons had almost no protection in law.[3] However, in the twenty-first century, significant strides in domestic and international law have been taken, such that terms like

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* Second year students of law at Makerere University. Gratitude to the Editorial Board for the guidance offered.

1 R. Alambuya, 'Human Rights Violations Experienced by People with Psychosocial Disabilities', Keynote address delivered at the Launch of the WHO Quality Rights Project and Tool Kit, New York, 28 June 2012

2 William Shakespeare, *The Tragedy of Hamlet*, Act V Scene 2

3 Kathleen Jones, Lunacy, Law and Conscience: The Social History of the Care of the Insane, 1744-1845 (2nd Edn Routledge 1998) 2.

"mad", "imbecile", "idiot" and "lunatic" would be considered derogatory[4] and an affront to the dignity of persons with mental illnesses and conditions.[5]

In *Purohit and Moore v The Gambia*[6], the African Commission on Human and People's Rights stated;

> *"Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities as the case may be, are entitled to without discrimination. It is therefore an inherent right which every human being is obliged to respect by all means possible and on the other hand it confers a duty on every human being to respect this right."*[7]

This growing recognition of mental illnesses and disorders has led them to now be legally characterized as disabilities. The regional and international systems have addressed this right through treaties, declarations and thematic resolutions.[8]

To this end, the 1995 Constitution of the Republic of Uganda, which has been praised for its bill of rights[9], recognizes people with disabilities and their human rights.[10] As such, mental health issues should be accorded the status granted to human rights as being 'universal, indivisible, interdependent, and

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4 Centre for Health, Human Rights and Development and Another v Attorney General, Constitutional Petition Number 64 of 2011.

5 Purohit and Moore v The Gambia, Communication Number 241/01.

6 Ibid.

7 Ibid, 57

8 Lance Gable and Lawrence O. Gostin, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (Vol. 63 Maryland Law Review, 2004) 23

9 Chapter Four of the 1995 Constitution of the Republic of Uganda. Professor Joe Oloka Onyango has stated that, "…the 1995 Constitution has been described as a human rights document in that it is suffused with human rights principles at every turn," 'Reviewing Chapter Four of the 1995 Constitution: Towards the Progressive Reform of Human Rights and Democratic Freedoms in Uganda' [2013] Study presented to the Human Rights Network—Uganda, 3.

10 Article 35 of the Constitution. This Article is also particular in extending the definition to include persons with mental health conditions by emphasizing that the State and society shall take appropriate measures to ensure that persons with disabilities realize their full *mental* and physical potential.

interrelated'.[11] People suffering from mental illness and those with mental health conditions should not face discrimination[12] and should have a right to, *inter alia*, liberty[13], privacy[14], fair hearing[15], freedom of expression[16] and education[17].

Despite the progress reported in as far as mental health issues are concerned, the law and the state have not done enough to protect people experiencing mental illness, and a number of gaps remain.[18]

The aim of this paper is not to solely discuss mental health vis-à-vis the law, but to show how the law, the state and its agencies have failed in their duty to protect and promote mental health, or how they have, in various ways, contributed to the problems facing the mental health sector. In order to do this, we point out a few loopholes in the law (particularly criminal law and the law of torts) that pertain to mental health. Another area of focus is the discussion on a few general aggravating factors contributing to the above stated issues.

1.2 WHAT IS MENTAL HEALTH?

Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[19] The breadth of this definition recognizes persons that are born with and have to live with mental illnesses and disorders.

Mental health is the foundation for the well-being and effective functioning of individuals.[20] It is more than the absence of a mental disorder; it is the ability

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11 Vienna Declaration and Programme of Action of 1993.
12 Article 21.
13 Article 23.
14 Article 27.
15 Article 28.
16 Article 29.
17 Article 30.
18 Steven Davey and Sarah Gordon, 'Definitions of social inclusion and social exclusion: the invisibility of mental illness and the social conditions of participation.' (2017) International Journal of Culture and Mental Health< http://dx.doi.org/10.1080/17542863.2017.1295091 > [accessed 27 June 2021]
19 Preamble to the Constitution of the World Health Organization.
20 <https://www.who.int/westernpacific/health-topics/mental-health> [accessed 10 June

to think, learn, and understand one's emotions and the reactions of others. Mental health is a state of balance, both with and within the environment. The World Health Organization also defines it as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[21]

1.2.1 Distinguishing mental health from mental illness

The focus on mental health in recent years has made reference to mental illness rarer.[22] However, there is a difference between the two. Mental health is the successful performance of mental function resulting in productive activities, fulfilling relationships, being able to adapt to change and cope with adversities.

The term 'mental illness' collectively refers to all diagnosable mental disorders — characterized by alterations in thinking, mood, or behaviours associated with distress or impaired functioning.[23] There are many different mental disorders, with different presentations, but they are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others.[24] Mental disorders include: depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders including autism.

2021]

21 World Health Organization, Mental health: strengthening our response (2014) https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response [Accessed 12 June 2021]

22 Rebecca Lawrence, 'Mental illness is a reality—so why does 'mental health' get all the attention?' [2021] The Guardian, https://www.theguardian.com/commentisfree/2021/jul/14/mental-illness-sidelined-mental-health-treatment [accessed 10 June 2021]

23 'Mental health' (*Wikipedia*) <https://en.wikipedia.org/wiki/Mental_health#Distinguishing_mental_health_from_mental_illness> accessed 10 June 2021

24 WHO report (2019). Mental disorders. World Health Organization (WHO), Geneva, Switzerland <https://www.who.int/news-room/fact-sheets/detail/mental-disorders> [accessed 11 June 2021]

The Mental Health Act[25] is silent on the definition of mental health. However, it defines mental illness as a diagnosis of a mental health condition in terms of accepted diagnostic criteria made by a mental health practitioner or medical practitioner authorized to make such diagnosis and includes depression, bi-polar, anxiety disorders, schizophrenia and addictive behaviour due to alcohol/substance abuse as some of the examples of mental illness.[26] The Act also defines a person with a mental illness as 'a person who is proven, at a particular time, by a mental health practitioner to have mental illness, at that particular time, and includes a patient'.[27]

Similarly, in a country that has been marred by military conflict throughout much of its post-independence history, many refugees and survivors from war-torn areas suffer from post-traumatic stress disorder (PTSD) and depression, among other mental illnesses and conditions.[28] In Uganda, depression, anxiety disorders, and elevated stress levels are the most common mental disorders, sometimes leading to suicide attempts.[29] Uganda is ranked among the top six countries in Africa with high rates of depressive disorders.[30]

Mental health as an important public health and development issue in Uganda has been recognised to be not only a clinical problem but also a serious public health problem in the country, resulting in the inclusion of mental health as one of the components of the National Minimum Health Care Package.[31]

1.3 HISTORY OF MENTAL HEALTH LAW IN UGANDA

25 Mental Health Act, Cap 249 of the Laws of Uganda.
26 Ibid Section 2.
27 Ibid.
28 Liz Ford, 'Civil War Pushes Stress Levels To Record High In Uganda' (2008) <https://www.google.com/amp/s/amp.theguardian.com/katine/2008/jun/05/development.uganda> [accessed 27 June 2021]
29 Farzaei, M. H., Bahramsoltani, *et al*, A Systematic Review of Plant-Derived Natural Compounds for Anxiety Disorders (2016) Current Topics in Medicinal Chemistry, 16(999)
30 Miller, A. P., Kintu. M., and Kiene, S. M, Challenges in measuring depression among Ugandan fisherfolk: a psychometric assessment of the Luganda version of the Centre for Epidemiologic Studies Depression Scale (CES-D) (2020) BMC Psychiatry, 20(45) <https://doi.org/10.1186/s12888-020-2463-2> [accessed 12 June 2021]
31 Cluster 4 of the Ministry of Health National Health Policy.

Mental health care became nationally recognized in 1916, on the basis of the mental health laws that existed in England.[32] The first unit to offer mental health services was established in the infamous Hoima Prison.[33] The sole purpose of the facility was to house those condemned by society as mentally unfit.[34]

With the success that had been achieved at this Unit, another was built at Mulago Hill in 1934.[35] In 1940, all the patients who were at Hoima prison were transferred to Mulago.[36] The continued success of these centres contributed greatly to the first piece of legislation in Uganda that regulated mental illnesses, the Mental Treatment Ordinance, in 1935.[37] It is noteworthy that the popular missionary hospitals that were established did not have mental health units, a trend which has persisted until today.[38]

In 1955, a mental health unit at Butabika with bed capacity of nineteen thousand seventy was opened. This was viewed as a fundamental achievement in mental health as it was the biggest centre for the persons with mental disability in Uganda at the time.[39] Currently, Butabika National Referral Mental Hospital is Uganda's second largest hospital and can house 700 to 800 people at a time, although its bed capacity is 550.[40]

After 1936, there were a number of other developments. Between 1954 and 1958, training and recruitment of mental health staff increased, and small

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32 Frances Renee Gellert, 'Medical Illness, Socially Acceptable Treatment and Barriers to Health' (Independent Study Project (ISP) Collection, 2017) 9.

33 Ibid.

34 Chrispus Nyombi and Moses Wasswa Mulimira, Mental Health Laws in Uganda: A Critical Review (Part I) (2011) <https://ssrn.com/abstract=1967749> [accessed 27 June 2021]

35 Ibid.

36 Norman D. Nsereko, The Evolution of Mental Health Understanding and Practice in Uganda (Vol. 19 International Journal of Emergency Mental Health and Human Resilience, 2017) 1.

37 Ibid.

38 The Uganda National Health Research Symposium Report, Achieving Universal Coverage for Quality Mental Health Care in Uganda (2019) 6.

39 Ibid.

40 Daily Monitor, 'Inside Butabika: The Fear of Mental Treatment' (2015) <https://www.monitor.co.ug/uganda/magazines/healthy-living/inside-butabika-the-fear-of-mental-treatment-1619294?view=htmlamp> [accessed 19 June 2021]

mental health units in 8 districts with 3 bed capacity between 1962 and 1973 were opened to decentralize mental health services.[41] Additionally, people with mental health problems would be locked up in hospitals such as Soroti Hospital, which doubled as prisons.[42] The people often blamed (and many still do) mental illness on witchcraft or some other supernatural causes.[43]

In 1999, Mental Health Uganda was founded. Mainly donor-funded, it came to operate across 18 districts, setting up drug banks to ensure the consistency of medication supply and organising group saving schemes. It also had provision for start-up loans so members might have an opportunity to generate income and contribute to their families' well-being. Other organisations included the Uganda Schizophrenia Fellowship, with active user bases in Masaka and Jinja, and Basic Needs Uganda.[44]

The organisation which pioneered service user involvement, however, was *Heartsounds*. Founded in 2008 in collaboration with mental health service users and psychiatrists in the Butabika-East London Link, *Heartsounds* defined itself as being the first to truly tap what it referred to as the under-utilised resource of people with lived experience of mental illness.

In as far as legislation went, The Mental Treatment Act came into force in 1964 as a revised version of the colonial Mental Treatment Ordinance.[45] However, this Act was heavily criticized and before being repealed, was described as outdated and offensive.[46] Thus, in 2018, the Mental Health Act was passed and effectively became the national legislation on Mental Health in Uganda.

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41 Supra Note 37.

42 Richard M. Kavuma, 'Changing Perceptions of Mental Health In Uganda' (2010) <https://www.google.com/amp/s/amp.theguardian.com/katine/2010/may/19/mental-health-uganda [accessed 15 June 2021]

43 Ibid.

44 The organization remains a leader in advocacy training and income generation projects across the country.

45 Joshua Ssebunnya, Sheila Ndyanabangi and Fred Kigozi, 'Mental health law reforms in Uganda: lessons learnt' (Vol. 11 International Psychiatry, 2014) 39.

46 Fred Kigozi *et al*, 'An Overview of Uganda's Mental Health Care System: Results from an Assessment Using the World Health Organization's Assessment Instrument for Mental Health Systems' (WHO-AIMS) (International Journal of Mental Health Systems, 2010) 2.

2.0 MENTAL HEALTH AND CRIMINAL LAW IN UGANDA

Mens rea[47] is an essential element in establishing criminal liability in Uganda. Discussed below are a few aspects which we believe the law needs to take into account or revise, because they actively affect the state of mental health and subsequent formation of necessary *mens rea* by defendants accused of particular crimes. We seek to show that some of the tests applied are rather rigid and application of the law may not always be as clear-cut as is implied by these tests.

2.1 Insanity as a defence

The defence of insanity is provided for under section 11 of the Penal Code Act.[48] The provision states;

> *"A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is through any disease affecting his mind incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission; but a person may be criminally responsible for an act or omission, although his mind is affected by disease, if such disease does not in fact produce upon his mind one or other of the effects above-mentioned in reference to that act or omission."*

2.1.1 M'Naghten rules

These were established in the case of *R v M'Naghten.*[49] The facts are that in January 1843, at the parish of Saint Martin, Middlesex, Daniel M'Naghten took a pistol and shot Edward Drummond, who he believed to be the British Prime Minister Robert Pell, wounding him fatally. Drummond died five days later and M'Naghten was charged with his murder. He pleaded not guilty by reason of insanity and was so found.

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47 *Mens Rea* has been defined as *"The state of mind that the prosecution, to secure a conviction, must prove that a defendant had when committing a crime, criminal intent or recklessness."* Black's Law Dictionary (8th edn, 2004) 3124.

48 Cap 120 of the Laws of Uganda

49 (1843) 8 E.R. 718; (1843) 10 Cl. & F. 200

The rules from this case form the definition of legal insanity. They provide that a defendant wishing to rely on the defence of insanity must show that:

- They laboured under a defect of reason
- Caused by a disease of the mind; so that either
- He did not know the nature and quality of his acts, or that he did not know what he was doing was wrong.

However, this set of rules ignores the complications with mental health/disorders. As already elaborated above, there is a wide variety of disorders in existence, each affecting different individuals differently causing different behavioural patterns. The same is true even where two individuals are suffering the same condition.

Stephen J Morse highlights one of the cautions that the Diagnostic and Statistical Manual of Mental Disorders (DSM) raises; "There is enormous heterogeneity within each disorder category. That is, people who technically meet the criteria for the diagnosis may have quite different presentations."[50]

The general defence is thus too narrow in its test for insanity and too broad in terms of its concept of disease. The result of this is that many defendants whom most people would regard as insane cannot use the defence, while some whom most would regard as sane are forced to use it if they wanted to avoid liability for an offence.[51]

In the same vein, lack of control is not well understood conceptually or scientifically in any of the relevant disciplines such as philosophy, psychology, and psychiatry, and we lack operationalized tests to accurately identify this type of lack of capacity.[52] The American Bar Association and the American

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50 Stephen J. Morse, Mental Disorder and Criminal Law, (2013) 101 J. Crim. L. & Criminology 885, 889 < https://scholarlycommons.law.northwestern.edu/jclc/vol101/iss3/6 > [accessed 14 June 2021]

51 Norrie A, *Insanity and Diminished Responsibility, Crime, Reason and History: A Critical Introduction to Criminal Law* (3rd edn Cambridge University Press 2014) 237-273 <https://doi.org/10.1017/CBO9781139031851.017 > [accessed 30 June 2021]

52 Stephen J. Morse, *Uncontrollable Urges and Irrational People*, 88 VA. L. REV.

Psychiatric Association also urged the rejection of control tests for legal insanity on these grounds.[53]

Further, the test is narrow as it ignores the existence of mental disorders or conditions suffered by individuals where they are aware that the law forbids those actions but they do them anyway, owing to some delusions or other compulsions. A good example is schizophrenia, a mental disorder characterized by continuous or relapsing episodes of psychosis. Here, clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time.[54]

2.2 A defendant's background and social factors as a contributor to mental capacity to commit a crime or mens rea

Criminal law addresses problems genuinely related to competence and responsibility, including consciousness, the formation of mental states such as intention, knowledge and comprehension, the capacity for rationality, and compulsion, but it never addresses the presence or absence of free will, the alleged ability to act uncaused by anything other than one's own self.[55] Defendant X would only be excused from liability if he is suffering a mental disorder affecting his rational capacity. Morse states that there is confusion that behaviour is excused if it is caused.[56] However, causation *per se* is not a legal or moral mitigating or excusing condition.[57] Shouldn't it be?

1025,1060–62 (2002)

53 American Bar Association, Criminal Justice Standards Committee, ABA Criminal Justice Mental Health Standards § 7-6.1 cmt. (1984); Am. Psychiatric Ass'n, American Psychiatric Association Statement on the Insanity Defense, reprinted in 140 American Journal of Psychiatry 681 (1983).

54 World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders Clinical Descriptions and Diagnostic Guidelines,* <https://www.who.int/classifications/icd/en/bluebook.pdf > [accessed 30 June, 2021]

55 Stephen J. Morse, 'Mental Disorder and Criminal Law', (2013) 101 J. Crim. L. & Criminology 885, 897 < https://scholarlycommons.law.northwestern.edu/jclc/vol101/iss3/6 > [accessed 14 June 2021]

56 Ibid, 898

57 Ibid.

There is relatively strong evidence that physical and emotional child abuse is associated with later forms of antisocial behaviours in children, adolescents, and young adults.[58] A life history, childhood or background marred with physical abuse, absence of parental figures or sexual trauma can play a causal role in a defendant's behaviour.

Take for instance the case of *Liundi v R.*[59] The appellant had an insecure, unhappy childhood and as such had an almost pathological dependence on her husband, whom she saw as her parents and siblings. After two years of a happy marriage, her husband chased her from their marital home, the result of which she made a poisonous concoction which she gave to her 4 children and herself.

She wrote two letters admitting guilt, and requesting that the husband be left out of prosecution. At the trial, a well experienced and qualified psychiatrist testified at trial that while she knew what she was doing in writing the letters, she did not know it was wrong because she believed that in chasing her away, her husband had ordered her to kill herself and their children. The court held that in asking the husband not to be involved in prosecution for the murders, the appellant fully appreciated that what she was doing was wrong and invited punishment, so therefore, she was guilty.

This case shows that social factors and background do indeed, in some cases (not all), substantially play a causal role in criminal behaviour and ultimately formation of necessary *mens rea*, and the control test under the McNaughten's Rules ignores this. It also neglects the reality that there are mental disorders/disabilities that affect individuals in more complex ways than the clear-cut 'knowledge that what one is doing is wrong'.

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58 Herrenkohl, RC.; Herrenkohl, EC.; Egolf, BP.; Wu, P. The developmental consequences of child abuse: The Lehigh Longitudinal Study. In: Starr, RHJ.; Wolfe, DA., editors. The effects of child abuse and neglect: Issues and research, (Guilford Press, 1991) 57-81

59 [1976–1985] EA 251

In addition, several studies[60] have shown that physical abuse at an early age influences subsequent adolescent and adult behaviour negatively. One study found adolescents who had been physically abused in the first 5 years of life were more likely to have been arrested as a juvenile for violent and nonviolent offenses.[61] These findings extend the literature on delinquency and aggression by showing that physical abuse predicts subsequent violent delinquency, at least according to arrest data. These effects persisted during a 17-year period and extended through late adolescence.

The above discussed factors show that these external factors that are often ignored during deliberations in court play a big role in influencing mental health of defendants, and ultimately their *mens rea*. While these factors do not mean that the defendants are not blameworthy or should not be held responsible for their criminal actions, a broader discussion or examination of causative factors would give a better understanding of the defendant's case, as well as guide courts and the state on long term solutions to curb crime at its root.

2.3 Provocation as a defence and the 'suddenness' requirement

Provocation will apply only to a charge of murder, and if successfully pleaded the conviction will be for manslaughter. The classic definition of provocation was given by Devlin J in Duffy (1949)[62]:

> *"Provocation is some act, or series of acts, done (or words spoken) which would cause in any reasonable person, and actually causes in the accused, a sudden and temporary loss of self-control, rendering the*

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60 Smith C, Thornberry TP. 'The relationship between child maltreatment and adolescent involvement in delinquency Criminology' (1995);33: 451–481. *See also* Stouthamer-Loeber M, Loeber R, Homish DL, Wei E Dev Psychopathol. Maltreatment of boys and the development of disruptive and delinquent behavior (2001) Fall; 13(4):941-55

61 Lansford, J. E., Miller-Johnson, S., Berlin, L. J., Dodge, K. A., Bates, J. E., & Pettit, G. S, Early physical abuse and later violent delinquency: a prospective longitudinal study, Child maltreatment, (2007) 12(3), 233–245. <https://doi.org/10.1177/1077559507301841> [accessed 1 July, 2021]

62 R v Duffy [1949] 1 ALL ER 932

> *accused so subject to passion as to make him or her for the moment not the master of his mind."*

However, section 192 of the Penal Code Act[63] requires that the unlawful act be done in the heat of passion due to *sudden* provocation.[64] It is also generally agreed upon that previous knowledge of facts doesn't amount to provocation, that is, one who assaults another based on knowledge of facts that he found out about many weeks later will not give backing to a plea of provocation.

In the case of *Okwang William v Uganda*,[65] the appellant was convicted of murder and sentenced to death. He stabbed the deceased in the abdomen with a knife and claimed to have been provoked by having found the man who had earlier spoilt his wife and made her pregnant. The court explained that:

> *"Knowledge of previous adultery would ordinarily disentitle a husband from pleading provocation without any other intervening insult or unlawful act. The plea of provocation would therefore, not be available to an accused who assaults a paramour of his wife many weeks after hearing that he had committed adultery with his wife. However, knowledge by a husband that his wife and her paramour had committed adultery makes the plea of provocation available to the husband if he finds his wife and her paramour in the act of adultery."*

The court therefore found that he had ample time for his passion to cool down from the time he knew of the pregnancy to when he assaulted the deceased and the defence of provocation was therefore not available to the appellant.

However, there are cases where years of abuse are endured and eventually culminate into murder. The application of the objective test for provocation presupposes that everyone must react in the same particular way, yet these

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63 Cap 120 of the Laws of Uganda

64 The same was maintained in the case of Nyaga vs Republic [1965] EA 496. It was held that for the defence of provocation to succeed the assault must be done in heat of passion before the accused has had time to cool down and the provocation must be sudden.

65 [2007] UGCA 59

women suffering from what is commonly known as 'battered women's syndrome' would present different reactions. The majority of women who successfully use this defence of provocation do so in response to killing a violent partner.

In contrast, almost exclusively, successful pleas of provocation in response to a relationship breakdown and/or infidelity are raised by men (although of course this does not mean that these are the only cases in which men are successful in pleading provocation).[66] In Uganda, among ever-married women who had experienced physical violence, the most common perpetrator was the current husband/partner (56%), followed by a former husband/partner (29%).[67]

Similarly, among ever-married men who had experienced physical violence, the most common perpetrator of the violence was the current wife/partner (33%).[68] These statistics go to show how common it is for the continued assault inflicted onto them by their partners to culminate overtime into one final act that results into murder of the perpetrators, even when it happens after an incident that may make the final act seem disproportionate. As a result, the requirement of the provocative act needing to be sudden or immediate ignores this aspect.

It is unconscionable that such victims are not able to seek protection under the law, yet those that act in a sudden rage are. Carline notes that "acting due to a fear of serious violence defence is not about a loss of self-control but based upon a recognition that some domestic violence victims live in desperate situations in which extreme fatal action may seem to be the only means by which to survive."[69]

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66 Thomas Crofts and Arlie Loughnan, Provocation: the Good, the Bad and the Ugly [37(1) Criminal Law Journal, 2011] 23

67 Uganda Bureau of Statistics, Uganda Demographic and Health Survey (2016) Kampala, Uganda, the DHS Program ICF Rockville, Maryland, USA January 2018. 316

68 Ibid

69 Anna Carline, 'Reforming Provocation: Perspectives from the Law Commission and the Government' (2009) Web Journal of Current Legal Issues, Volume 2, Issue 2 Web JCLI, <http://webjcli.ncl.ac.uk/2009/issue2/carline2.html > [accessed 4 July 2021]

3.0 MENTAL HEALTH AND THE LAW OF TORTS

A tort is generally a civil wrong. Just like the prior section, this one highlights and discusses those aspects of the law of tort with disputed consequences on mental health/illness.

3.1 Period of limitations

Section 3 of the Limitation Act[70] dictates that no action founded on tort shall be brought after the expiration of six years from the date on which the cause of action arose.

In *Stubbings v Webb & Anor*[71], the respondent issued a writ on 18 August 1987, when she was over 30 years old, claiming damages against the appellants, her stepfather and stepbrother, for mental illness and psychological disturbance allegedly caused by the former's sexual and physical abuse of her as a child between the ages of 2 and 14 and rape by the latter when she was aged 12.

The respondent's case was that although she knew that she had been raped and persistently sexually abused by the appellants she did not realise she had suffered sufficiently serious injury to justify starting proceedings for damages until September 1984, when she realised that there might be a causal link between her psychiatric problems in adult life and her sexual abuse as a child. However, the respondent's action was time-barred and as such, it failed.

This case goes to show how the statutory period of limitation restricts dispensation of justice, especially and particularly when it comes to mental afflictions that present themselves at later stages of adult life. A good example is *Post Traumatic Stress Disorder*.

This arises as a delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost

70 Cap 80 of the Laws of Uganda
71 [1993] 1 All ER 322

anyone.[72] So, individual A, on whom violence is actuated at the ages of 5 through 12 that suffers post-traumatic stress disorder with violent tendencies, would not be able to seek justice against his attackers, presenting a reprehensible result of the law's application.

4.0 AGGRAVATING FACTORS

Under this section, the paper will examine factors that exacerbate the issues with mental health. We will look at the causes of these factors, all in effort to show how the state/government, the law and its implementation have contributed to, worsened, failed or fallen short in terms of mental health/mental health disorders.

4.1 The legal considerations

The 1995 Constitution of the Republic of Uganda is the supreme law in the country and any other law which is contrary to it is null and void to the extent of its inconsistency.[73] The Constitution provides for the deprivation of liberty of persons with 'unsound mind' or those addicted to drugs and alcohol.[74] This provision creates a few issues with regards to people with mental illnesses and disorders.

Firstly, it is discriminatory, a violation ironically outlawed by the same Constitution.[75] It could make it very difficult for those persons with mental disabilities who have learned to cope in their society from enjoying their basic right of liberty like every other citizen and would be a failure on the part of the State, which has a duty to ensure that these people realise their full mental and physical potential.[76]

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72 World Health Organization, The ICD-10 Classification of Mental and Behavioural Disorders Clinical Descriptions and Diagnostic Guidelines, <https://www.who.int/classifications/icd/en/bluebook.pdf > [accessed 15 July 2021]

73 Article 2(1) and 2(2) of the 1995 Constitution of the Republic of Uganda.

74 Article 23(1)(f)

75 Article 21

76 Article 35

Secondly, while the mischief that the provision tries to remedy is security of the person and the community, the catch-all term "persons of unsound mind" is vague[77], and ignores the complexities and severity of particular mental illnesses and disorders over others. Depression, for example, which is a mental disorder that could just about affect anybody, could be reasonable grounds to deprive one of their liberty.

While every human right[78] has to meet the tri-partite limitation test[79], of being legal, necessary and proportionate[80], where would the law stand in grey areas like postpartum depression which affects many mothers today? Could someone deprive a mother of her liberty because her depression could potentially be a danger to her new-born child?[81]

The Mental Health Act, similarly, has provisions that raise a few concerns. To start with, the mental health tribunals that the Act provides for to investigate, arbitrate or advise on complaints concerning decisions made in relation to patients[82] are established when necessary by the Board[83]. Concerns about the administration of justice are raised since the Act seems to overlook delayed justice[84], particularly when you consider the fact that the Board is mandated to meet at least once every three months.[85]

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77 Additionally, the term is also derogatory.

78 Except those listed in Article 44 of Constitution.

79 Charles Onyango Obbo and Andrew Mwenda v Attorney General, [2004] UGSC 81

80 Ibid. Mulenga JSC quoted the case of *Mark Gova and Another v Minister of Home Affairs and Another [SC. 36/2000: Civil Application No. 156/99]* where the criteria laid out was that the legislative objective which the limitation is designed to promote must be sufficiently important to warrant overriding a fundamental right, the measures designed to meet the objective must be rationally connected to it and not arbitrary, unfair or based on irrational considerations, the means used to impair the right or freedom must be no more than necessary to accomplish the objective.

81 The argument would become even more lopsided in favour of the deprivation of liberty of such a mother when you consider the Constitution's anti-abortion stance that shows just how much the law in Uganda values the lives of children. *See* Article 22(2) of the 1995 Constitution of the Republic of Uganda.

82 Section 14(3) of the Mental Health Act

83 Section 14(1) of the Mental Health Act

84 Contrary to the popular adage that 'Justice delayed is justice denied.'

85 Section 11(1) of the Mental Health Act

The Act also provides for emergency admission and treatment, including in cases where the person has behaviour which may lead to serious financial loss to him or herself.[86] Specifically, the Act provides for cases where a relative, concerned person or the Police can initiate emergency admission to a health unit or a mental health unit.[87] This provision raises great concerns with regard to the right to liberty and non-discrimination of persons with mental illnesses and disorders.

Would persons with addictions qualify to have their liberty stripped away through emergency admission, simply because their behaviour may lead to financial loss to themselves or to others? The provision also seemingly overlooks the freedom that such persons are entitled to in as regards their finances.

Concern has also been raised with regard to the derogatory language used to refer to persons with mental disabilities in various statutes that are still operating in the country. This debate found its way to the Constitutional Court, in the case of *CEHURD and Another v Attorney General.*[88] The petition challenged the laws, practice and usage towards persons with mental disabilities as far as criminal justice was concerned, in provisions in the Trial on Indictments Act[89] and the Penal Code Act.[90]

The petitioners averred that the terms "idiots" and "imbeciles" used in these laws were discriminatory and amounted to inhumane and degrading treatment, in addition to being contrary to the international instruments that Uganda had ratified.[91]

The Constitutional Court found that these provisions were indeed derogatory. Despite the aforementioned judgment in the CEHURD case, there are laws and

86 Section 22(1)(b) of the Mental Health Act
87 Section 22(3) of the Mental Health Act
88 Constitutional Petition Number 64 of 2011.
89 Section 45(5) of the Trial on Indictments Act, Cap 30 of the Laws of Uganda.
90 Section 130 of the Penal Code Act, Cap 120 of the Laws of Uganda.
91 The United Nations Convention on the Rights of Persons with Disabilities and the African Charter on Human and People's Rights.

statutes that have similar language but are still in use today, providing a continuing violation to the dignity of persons with mental disabilities. These include the Constitution[92], Evidence Act[93] and the Contracts Act[94], to mention but a few.

4.2 The economic considerations

Outpatient care is growing but can be expensive. A WHO survey found that approximately 37% of the daily minimum wage was needed to pay for one day's worth of antipsychotic medication while approximately 7% of the daily wage was needed to pay for one dose of antidepressants.[95] With these exorbitant prices, many choose not to seek medical assistance, while the few that do seek it, fail to afford it. As a result, the statistics of unresolved, untreated cases continues to grow or stay stagnant.

4.3 Neglect of psychiatry and mental health

Every year, the Parliament sits and a budget for that financial year is read, dictating how much revenue or money is apportioned to various sectors of government and the state. Change has been slow, with psychiatry and mental health remaining one of the most neglected areas of medicine.

As of October 2017, there were 33 registered psychiatrists to serve a population of approximately 38 million, over half of whom were based in or on the outskirts of Kampala.[96] Approximately 1% of the government's national health care expenditure is directed towards mental health, and this seems unlikely to change in the near future. Of this, just over half is directed towards Butabika.[97]

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92 Article 23(1)(f)
93 Section 117
94 Sections 11 and 12
95 World Health Organization, WHO proMIND: Profiles on Mental Health in Development: Uganda (Geneva, 2012) 40
96 Uganda Medical and Dental Practitioners Council, Specialist Register. <www.umdpc.com/registers/Specialist%20Register.xls > [accessed 10 June, 2021]
97 Kigozi et al., An Overview of Uganda's Mental Health Care System, 3

With such few resources it is undoubtedly hard for these institutions to ably handle treatment of so many mental health patients, let alone implement outreach and sensitization programs to those in need of assistance.

4.4 Ignorance

In a study of severe mental illness in two districts in Eastern Uganda, Catherine Abbo reported that just as communities drew on multiple explanatory models for psychosis, they also sought multiple solutions. "Traditional healing and biomedical services", she noted, "were used concurrently by over 80% of the subjects".[98]

While there are only 32 western-trained, psychiatrists in the country, there is a ratio of one witch doctor for every 290 Ugandans.[99] This coupled with the expenses associated with professional mental health services leaves no wonder as to which alternatives patients opt for.

There is a lot of unfamiliarity regarding the many facets of mental health and disorders. There are, in existence a number of metal disorders, the complexities of which are not known or understood by everybody. This can be attributed to limited circulation of information regarding these conditions. However, it can also be accredited to the small number of facilities dealing with mental health related issues.

Further, there is a lot of stigma surrounding Butabika hospital[100] and mental health as a whole based on the misguided belief among some communities that all mental illness results from witchcraft. This drives people to resort to either traditional healers or not to seek medical guidance whatsoever to avoid being ostracized by their societies. The state has therefore not done enough

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98 C. Abbo, Profiles and Outcome of Traditional Healing Practices of Severe Mental Illnesses in Two Districts of Eastern Uganda (Global Health Action 2011) 11.

99 Ibid.

100 Farida Bagalaaliwo, 'Inside Butabika: The fear of mental treatment' (Daily Monitor, 2015) <https://www.monitor.co.ug/uganda/magazines/healthy-living/inside-butabika-the-fear-of-mental-treatment-1619294> [accessed 19 June 2021]

sensitization and education of the general population in regards to mental health, a constantly growing concern.

4.5 Challenges faced by psychiatrists and psychiatric institutions

Most general health workers are ill- and equipped, with very few having had some training in mental health care. With the limited knowledge on mental health, many general health workers admitted knowing mental illness only by the severe forms – characterised by psychotic features. They thus fail to identify and attend to those whose mental health problems do not present with obvious psychiatric symptoms, resulting in fewer cases being reported. This has implications regarding resource allocation, to the disadvantage of mental health.[101]

The numbers of psychiatric nurses is still dismal. According to David Kyaligonza, assistant commissioner nursing services at Butabika hospital, the ideal mental hospital setting would have a ratio of one nurse to six patients but at Butabika, this number is one nurse for every 55 to 60 patients.[102]

According to a study conducted by the World Health Organization, only 57 percent of clinics had at least one psychotropic medication in each class, meaning the medication someone needs is highly unlikely to be available in Uganda.[103] In other cases, the drugs are too expensive and are thus scarce, yet the same drugs are sometimes to be taken by patients even for life. For example, Samuel Malinga, the clinical officer in charge of Tiriri health centre said a month's supply of carbamazepine for Ewunyu (a patient) would cost about UShs 12,000 (around $5.40) which he could not afford.[104] As a result few patients get the requisite treatment.

4.6 Failures of government institutions

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101 Kigozi, supra

102 Bagalaaliwo, supra

103 Byrne Maura, '5 ways Uganda is improving mental health care' (The Borgen Project, 21 July 2019) <borgenproject.org/5-ways-uganda-is-improving-mental-healthcare > [accessed 19 June 2021]

104 Daily Monitor article that report questioning handling patients in Butabika

Butabika National Referral Mental Hospital was established in 1955 and provides general and specialized mental health treatment for mental health patients. It is currently the only National Referral Mental Health Institution in the Country.[105]A lot of criticisms over the years have been made regarding the treatment of patients admitted in the hospital. In 2016, for example, with support from CEHURD, a patient, Benon successfully lodged a civil complaint against the Attorney General for mistreatment at Butabika Hospital during two periods of admission, in 2005 and in 2010.

While at Butabika, Benon was undressed and locked in seclusion—a small cold dark room measuring about two square metres, and that supposedly helps 'cool' the patient when they are agitated. The room had no windows or source of light, bedding, toilet or urinal. He was forced to urinate and defecate on the floor, sleep on a concrete platform and received no medical attention during this time. The case highlighted how seclusion practices violated the human rights of patients at Butabika Hospital, and were in contravention both of Uganda's Constitution and numerous international conventions on disability rights.[106]

The Mental Disability Advocacy Centre(MDAC) published a report titled: "Breaking point," that also detailed other criticisms of the Hospital. The hospital wards were found to be dirty, overcrowded and lacked basic protections of human dignity such as privacy and personal beddings. There was evidence of malnutrition in many wards and many residents had skin conditions, cuts and poor general hygiene.

The report also found that mentally-ill patients are overdosed with drugs even when they are not violent and asked police to open investigations into the allegations of torture and ill-treatment at the facility.[107] These and many others

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105 < https://www.butabikahospital.go.ug/about-us > [accessed 19 June 2021]

106 Pringle Y. (2019) Conclusion. In: Psychiatry and Decolonisation in Uganda. Mental Health in Historical Perspective. Palgrave Macmillan, London <https://doi.org/10.1057/978-1-137-60095-0_8 209-219> [accessed 15 June 2021]

107 Daily Monitor, Report Questions Handling of Patients in Butabika (Butabika National

not only worsen the conditions of the in-patients, but also discourage intending patients from seeking help they need from what should be the best facility in the country.

There is also the challenge posed by the unaffordable services provided, even at government health institutions. In *Center for Health, Human Rights & Development & 2 Ors v The Executive Director, Mulago Referral Hospital & Anor*,[108] the 2nd and 3rd Plaintiffs were a lay Ugandan couple, the 3rd Plaintiff a Non-Governmental Organization working on health and other human rights awareness and enforcement.

The action was brought against the 2nd Defendant in representative capacity for the actions or inactions of staff of Mulago National Referral hospital (a government hospital) in the unlawful disappearance of one of the babies delivered. Here, the judge discussed the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health. He noted that the case pointed to a bigger problem in the country:

> *"PW1 explained that for the 9 months of her pregnancy, she only went for antenatal care once in the early stages and for the rest of the pregnancy she was in the village taking local herbs. PW1 did not even know that she was carrying two babies in the pregnancy. In the circumstances of this case, it is easy to infer that the reason PW1 had only one antenatal visit and did not know she had twins was because she could not afford the costs of accessing health care services. This points to a violation of the obligations of Uganda enumerated above…In particular it points to a violation of the obligation to fulfil the right to health…It also reflects a violation of Article 2(a), (b) of the Protocol to the African Charter on Human and Peoples Rights on the Rights of*

Referral Mental Hospital, 1 July 2017) <https://www.butabikahospital.go.ug/news/14-report-questions-handling-of-patients-in-butabika > [accessed 19 June 2021]

108 [2017] UGSC 10

> *women in Africa which requires state parties to take appropriate measures to provide adequate, affordable and accessible health services…"*

This is just one case out of the many others existent in Uganda. Time after time, those in need of these services are failed by government health institutions, even when the state is obligated to provide these services, more so at affordable rates.

4.7 Reliance on international funding

Uganda is one of the 3rd world countries that is heavily dependent on foreign aid. For instance, in 2019 Uganda received over 2 billion USD in net official development assistance and official aid received.[109] This foreign aid almost always comes with strings attached, with requirements for Uganda to prioritise other sectors over health care, and in particular mental health care. This leaves many gaping holes in the system, affecting implementation of related and relevant policies, establishing outreach programs and many other things that ideally would push the drive towards better mental health facilities and mental health in general.

4.8 Largely centralized approach to mental health care

Worldwide, a number of reforms have been undertaken with the intention of improving access to mental health services. Notable among these is the integration of mental health services into primary health care (PHC), which has been one of the most fundamental healthcare reform recommendations globally.[110]

Primary health care is an overall approach which encompasses the three aspects of: multisectoral policy and action to address the broader determinants

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109 Net Official Development Assistance And Official Aid Received (current US$) – Uganda, World Bank <data.worldbank.org > [accessed 15 July, 2021]

110 Fred N Kigozi, Joshua Ssebunnya, 'Integration of mental health into primary health care in Uganda: opportunities and challenges' Mental Health in Family Medicine (Radcliffe Publishing, 2009)

of health; empowering individuals, families and communities; and meeting people's essential health needs throughout their lives. "Primary care" is a subset of PHC and refers to essential, first-contact care provided in a community setting.[111]

Providing mental health services in PHC involves diagnosing and treating people with common mental disorders within the general framework of available health services, putting in place strategies to prevent mental disorders, ensuring that primary healthcare workers are able to apply key psychosocial and behavioural science skills, as well as ensuring an efficient referral system for those who require more specialised care.[112]

The efforts towards decentralization can be seen in section 20(1), Mental Treatment Act 2018, and despite the dominance of decentralised approaches and the policy of mental health in primary care within international mental health, psychiatric services remained highly centralised with Butabika Hospital as the focal point of psychiatric provision and expertise.[113] As a result, interested and affected people from far districts for whom accessibility is difficult lose out on these services. It also contributes a great deal.

4.9 COVID-19

With the emergence of the COVID-19 pandemic, the government of Uganda instituted and enforced a lockdown effective 18th March 2020 that saw closure of schools, halting of all nonessential services and businesses and so on in an effort to control the spread of the disease.

However, owing to a number of factors, the frustration that came with this has been seen to have staggering negative effects on mental health especially the urban and periurban dwellers who mostly "live from one pay check to another"

111 What is PHC? World Health Organization <https://www.who.int/activities/what-is-PHC> [accessed 10 June 2021]

112 Kigozi and Ssebunya, supra

113 Pringle Y. Psychiatry and Decolonisation in Uganda. Mental Health in Historical Perspective. (Palgrave Macmillan, 2019) <https://doi.org/10.1057/978-1-137-60095-0_8>209-219 [Accessed 15 June 2021]

with barely any savings made.[114] Sustained stress exposure causes people to turn to damaging behaviour like crime, reckless sexual acts, violence, domestic abuse, and substance abuse.[115]

Given the social-economic impact of the corona virus, the mental health of all individuals, families, and society has been affected.[116] This has increased anxiety of contracting the disease among vulnerable populations like the ill-equipped frontline health workers, elderly persons, people with underlying chronic illnesses (HIV, tuberculosis).[117] Persons believed to have been exposed to COVID-19 were being hunted down and shamed by the communities in which they live, and even those that have recovered still face stigmatization.[118] Law officers like the police and military reportedly used violent means to enforce lockdown measures.[119]

5.1 SUGGESTIONS FOR REFORM

There should be quicker and more deliberate measures for integration of mental health care into PHC. The advantages of integrating mental health services into PHC include, among others: reduced stigma for people with mental disorders and their families, improved access to care, human rights

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114 Index Mundi, Uganda population below poverty line—Economy (2017) <https://www.indexmundi.com/uganda/population_below_poverty_line.html> [accessed 15 June 2021]

115 Kagaari James PhD, 'Mental health in Uganda' (Global Insights Newsletter, February 18, 2021) <https://www.apa.org/international/global-insights/uganda-mental-health#> [accessed 12 June 2021]

116 Ainamani, H. E., Gumisiriza, N., and Rukundo, G. Z, 'Mental Health Problems Related to COVID-19: A Call for Psychosocial Interventions in Uganda. Psychological Trauma: Theory, Research, Practice, and Policy.' Advance online publication, (2020) 12(7) <http://dx.doi.org/10.1037/tra0000670> [accessed 24 June 2021]

117 Ainamani supra

118 The Independent Uganda, COVID-19 recovered patient decries hostility, stigma (2020) <https://www.independent.co.ug/covid-19-recovered-patient-decries-hostility-stigma/> [accessed 24 June 2021]

119 Esagala, A., Mabala, R., Lubowa, A., & Buule, G, Canes, Tears in Kampala over Coronavirus, Daily Monitor (2020) <https://www.monitor.co.ug/News/National/Photos-that-willcompel-you-cancel-your-journey-Kampala/688334-5505362-g3u0ib/index.html> [accessed 15 June 2021]

protection, reduced chronicity and improved social integration, as well as improvement in the human resource capacity for mental health.[120]

The integration has been noted to improve access, availability and affordability of services, thereby producing better outcomes.[121] While the government has undertaken inclusion of mental health as one of the components of the National Mental Health Care Package[122], training and recruitment of mental health professionals, in-service training of general health workers in mental health, and making psychotropic medicines readily available, the integration is still lacking.

Amendment of statutes to reflect respect for dignity of the persons suffering from mental illnesses should be undertaken. The potential of persons living with disability cannot be realized if their dignity is not ensured. Therefore, the language used in all statutes must respect the dignity of such persons, and indeed of all individuals. It must also uphold their equality with is other persons.

The provisions of the Constitution and Mental Health Act should also recognise the liberty of persons with mental illnesses and the fact that they should not be deprived of their liberty arbitrarily. This right should be approached cautiously and limited in a manner that is legal, proportional and necessary. Similarly, the Mental Health Act should be amended to provide a stricter punishment for the torture of mentally ill persons[123] in order to match the aggravated status that these persons are accorded in other statutes like the Penal Code Act. This could reduce their stigmatization and mistreatment in both their communities and in the mental health units.

There should be the adoption of a broader spectrum for establishing liability for crimes or torts. Looking into defendant's upbringing will allow the state to

120 Kigozi, supra
121 ibid.
122 Cluster 4 of the Ministry of Health National Health Policy
123 Section 11(a) and (b) of the Mental Health Act prescribe a fine or a term of eighteen months' imprisonment.

appreciate these factors and deal with the causes of criminal behaviour from the root, rather than punishing criminals after the milk is already spilled.

More flexible methods of reform for convicted criminals that include therapy or counselling even with incarceration to address early trauma, abuse and other factors that contribute to later aggressive or violent behaviour that led to these crimes. The state needs also to look at the adjustment of the defence of provocation to include even culminate factors/effects and not just the constraint of sudden and temporary loss of control.

5.2 CONCLUSION

There are a lot of loopholes, inconsistencies and oversights in as regards to how mental health and mental illnesses are handled by the law and by the practice of the State. This article set out to uncover some of these murky areas in order to expose instances and situations in which people with mental disabilities face/may face grave injustices. Fortunately, the 2018 Mental Health Act shows that the State is recognizing the need to provide reform for protection of these persons.

However, with the laws and practices that have been pointed out in this article still in place today, and with no framework in place for reform, what we consider enough *just* may not be. We risk committing injustices against a group that deserves our utmost attention—and, just like the high depression rate during the COVID-19 lockdown has shown, a group that could include anyone of us.

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