



Psychiatric hospitals in Uganda

A human rights investigation



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Foreword

I commend the hospitals in Uganda for granting access to Mental Health Uganda (MHU) and the Mental Disability Advocacy Center (MDAC) to conduct the first ever human rights monitoring mission in Ugandan psychiatric facilities. The findings of the monitoring are a vital source of information about the forms of torture and ill-treatment which take place and often go unnoticed. Abuse in psychiatric institutions is a global problem. Human rights monitoring is fundamental in preventing such forms of abuse, especially for people who are deprived of their liberty.

This report documents systemic human rights violations in our psychiatric hospitals. It is of deep concern that a system which is supposed to provide our brothers and sisters with mental health issues care actually violates their dignity. Importantly, this report shows that despite the good intentions of many, psychiatric hospitals are overcrowded, insanitary and lack in basic standards in a way which should shock us. The United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), which Uganda has ratified, clearly prohibits all forms of torture and ill-treatment including in health care settings in Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), and also in Article 25 (right to health). It is crystal clear that these standards also apply to psychiatric facilities.

The serious violations documented in this important report range from the unthinking practice of compulsion, as well as discriminatory detention based on the presence of a disability, and issues flowing from a poor quality of care. The practice of seclusion, for example, is particularly hard to read, and it is concerning that this is widely practiced at Butabika hospital. It is shocking indeed to read the accounts of people that have been placed in appalling seclusion rooms at the hospital, when they should be experiencing respect. As Ugandans, we cannot fold our arms and watch fellow Ugandans continue to be subjected to these human rights violations. We must challenge not only the symptoms of issue – including serious underfunding of psychiatric care – but also the causes, including the outdated institutional approach to the provision of psychiatry. This will never change, however, whilst lawlessness prevails. I was particularly concerned to hear that the majority of admissions to hospitals, resulting in compulsory confinement and forcible treatment, had no legal basis whatsoever. The disapplication of even the outdated 1964 Mental Treatment Act leaves people in a legal lacuna, and the government should now take action to pass new legislation.



People who use psychiatric services must now be consulted on the development and implementation of our national mental health system. Given the lack of human rights at present, reforms must explicitly implement international standards, and begin the move away from medical approach to disability. Instead, they should tackle the social barriers that restrict the lives of many.

Uganda adopted the Prevention and Prohibition of Torture Act in 2012. This important piece of legislation outlaws many of the practices which were found to be commonplace in psychiatric hospitals. Why should such forms of abuse be allowed to occur without attracting accountability?

I thank MDAC and MHU for producing this important human rights documentation. The relevant authorities of the Ugandan government are encouraged to use the evidence herein to take concrete steps to improve the situations of our fellow Ugandans who are placed in such institutions. Of course human and financial constraints represent a serious challenge, yet this must not be an excuse for failing to act. I call on the Ugandan government to begin the process of carefully examining the mental health budget along the lines recommended in this report. In addition, the government should ratify the Optional Protocol to the Convention against Torture, and prove to the world that there will be no hidden places where abuses can take place with impunity.

Mwesigwa Martin Babu
Member of the UN Committee
on the Rights of Persons with Disabilities
2012–2016



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“People with mental health issues were frequently locked in dark and cold seclusion rooms...”

Extract from monitoring findings

Executive summary

This report presents the findings from the first human rights monitoring of psychiatric facilities in Uganda. The monitoring sets out the forms and extent of torture, ill-treatment, and violence that take place in Ugandan psychiatric hospitals. It also explores the causes of these abuses, mindful of the economic and social realities of present-day Uganda. It is one of two reports by MDAC and MHU exploring abuses against people with mental health issues in the country.¹

Uganda is a developing country with limited resources. It has an underdeveloped and under-resourced mental health service governed by an outdated and unenforced law dating back to the colonial era. The law makes no reference to the human rights of people with mental health issues in psychiatric hospitals and offers no protection against ill-treatment or abuse.

The Ugandan government has signed up to a number of binding human rights commitments including the United Nations Convention of the Rights of People with Disabilities (UN CRPD) but such commitments have done nothing to promote, protect or fulfil the most fundamental rights of people in the Uganda's psychiatric facilities. Nevertheless, a new mental health bill is being considered, informed by very little evidence, as well as a mental health strategy. It was therefore an important time for Mental Health Uganda (MHU), a leading national organisation supporting people with mental health issues, to invite the Mental Disability Advocacy Center (MDAC) to jointly undertake human-rights focused monitoring of psychiatric hospitals (national, referral and private) in the country.

MDAC staff trained a number of staff from local human rights NGOs and users of mental health services on how to monitor mental health institutions prior to the monitoring visits, and then undertook two monitoring missions to nine psychiatric hospitals in October 2013 and again in April 2014.

One of the key findings is that people with mental health issues in hospitals were receiving treatment which, under international, regional and national law amount to torture, cruel, inhuman or degrading treatment or punishment, including violence and abuse. The degree, form and extent of abuse was found to differ from one hospital to next, but there were problems at all, clearly showing a system which violates the fundamental rights of people for whom it is supposed to care. Monitors found:

- People with mental health issues were frequently locked in dark and cold seclusion rooms, often naked, lying on the same floor where they were forced to urinate and without access to a toilet. Some people reported having missed or being denied food when secluded, a practice which must be banned. While two hospitals have stopped the use of seclusion, others continue with inconsistent, arbitrary and abusive practices. There were no procedures to regulate the practice and records were not kept.

- People with mental health issues were not free to leave hospital without the permission of staff, whether or not they were legally detained. No distinction was made between voluntary and compulsory admissions to hospitals, and many people were deprived of their liberty purely on the request of a family member. The majority were forcibly brought to psychiatric hospitals in shackles or ropes, and in very few cases was there any lawful authority for such practices.
- Compulsory and forced treatment was the norm, and the right to informed consent and refusal of treatment was completely denied. These practices are prohibited under international human rights law. People were administered medicines which have ceased being used in other parts of the world due to severe and often dangerous side-effects. National pharmaceutical management was found to be in crisis, with commonly used medicines being unavailable in many cases.
- The entire system was based on a highly pharmacological approach. Alternatives such as psychological or psycho-social interventions were virtually unknown and individualised care was completely absent.
- The conditions in many hospitals were appalling, including at Butabika hospital male and female acute wards, which were seriously overcrowded. In such settings there was an absence of anything resembling a therapeutic environment, and in many hospitals there was little action taken to prevent the spread of lice, mosquito-borne and other communicable diseases such as tuberculosis.



Photo: Butabika female acute ward April 2014. © MDAC.

¹ See also: MDAC and MHU, "They don't consider me as a person": Mental health and human rights in Ugandan communities (Budapest: 2014)..

- The physical health care needs of the majority of inpatients were neglected. One female patient told monitors that her arm was broken as a result of a fight on a female ward at Butabika but was never treated. There was no information available on deaths in psychiatric hospitals, and monitors were seriously concerned to hear that deaths were never independently investigated.
- Women with mental health issues were subjected to additional abuses. Women reported not being provided with sanitary pads and had to wear dirty underwear and were left without access to clean clothes or washing facilities. Cases were also reported of women's hair being shaved against their wishes to prevent the spread of lice and sometimes even pubic hair was shaved by male staff. This was reported at Butabika female admission ward.
- Food was not provided by the government in hospitals, except at Butabika. This was particularly concerning as many people with mental health issues had been abandoned by their communities and families and were left destitute. Monitors found that these people were frequently admitted to Butabika hospital.

Monitors also identified some of the causes for the ill-treatment and abuses that happened in hospitals. One of the key issues was that there were no alternatives to inpatient treatment in country. People were forced to leave their communities and receive treatment at inpatient units because no community-based services were available. Monitors were impressed by the unanimity with which health professionals, carers and people with mental health issues agreed about the need for development in this area. It should be noted that such a shift not only represents economic and development sense, but is required under international law.

The current Mental Treatment Act dates back in the 1930s with a few cosmetic changes made 50 years ago. The law makes no distinction between voluntary and compulsory admission and treatment. Where it does make requirements, such as in the area of recording and inspection, it has been systematically ignored by all staff. Monitors concluded that inpatient psychiatry was completely unregulated and operated outside the purview of the law, and that virtually all inpatients had therefore been arbitrarily deprived of their liberty.

The stigma of mental illness often went unchallenged in Uganda, making the recruitment of committed and educated staff particularly difficult. Monitors found that the majority of the day-to-day care of people detained was provided by family and friends in regional referral hospitals. Very few staff in hospitals were trained on how to conduct restraint, despite high levels of coercion being observed and reported.

Psychiatric facilities had no clearly defined complaints procedures and were not subject to independent monitoring or inspection, meaning that human rights violations took place behind closed doors. While the Ugandan Human Rights Commission has the remit to monitor such hospitals, they do not have the expertise to undertake thorough monitoring, and neither do civil society organisations.

One of the key conclusions of the report is that the provision of psychiatric treatment in the country must be subject to the rule of law. The lack of an operative legal framework places tens of thousands of Ugandans at risk of serious human rights violations without any way of accessing justice or achieving remedies for their situation. It is no longer acceptable that this important part of the Ugandan health system is left to its own devices.

The report makes a number of recommendations to strengthen respect and fulfilment of human rights. The recommendations focus on reducing coercion, violence and abuse in hospitals and tackling the causes. Recommendations also include training mental health practitioners in providing human rights-based care and support, and shifting away from the overwhelmingly institutional and pharmacological approach to mental health care, instead investing in the development of respectful, community-based alternatives.





Photo: Butabika hospital, April 2014. © MDAC.

“The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint constitute torture and ill-treatment.”

Juan E. Méndez
UN Special Rapporteur on Torture

1. Introduction, torture standards and hospitals visited

This report documents findings from the first ever human rights monitoring of psychiatric hospitals in Uganda and uncovers serious and systemic violations that require urgent action on the part of the Ugandan government. This report also complements the findings of our investigation into ill-treatment against people with mental health issues in the community.² The central purpose of both investigations are to examine the lives of Ugandans with mental health issues through the lens of human rights, and to contribute a strong evidence-base for real change. It is clear from the investigations that violence, ill-treatment, and even torture are widespread against people with mental health issues, and there is a need for fundamental reforms.

This report has three main chapters. The present chapter explains the need for human rights monitoring in psychiatric facilities, and provides information about Uganda, mental health and the provision of psychiatric care and treatment in the country. It then sets out fundamental human rights standards on the prohibition of torture and ill-treatment drawing on binding international, African and Ugandan law. Finally, the chapter lists the hospitals visited for the present investigation.

The second chapter examines the forms and prevalence of ill-treatment and abuse found during the process of the human rights monitoring. A thematic approach examines each issue in turn, including compulsion and coercion, deaths, detention based on the presence of a disability, health care and problems related to the standard and quality of care.

The third chapter of the report identifies some of the causes of the human rights violations uncovered, both at the micro and systemic levels. The chapter considers a number of factors including the lack of community-based mental health services, a breakdown in compliance with legal processes, insufficient staffing and training, and an absence of complaint procedures and independent monitoring inside institutions. Chapters two and three also provide conclusions that flow from international human rights standards, setting out a number of proposed recommendations.

1 (A). The need for human rights monitoring

The Mental Disability Advocacy Center (MDAC) is an international human rights organisation headquartered in Budapest, Hungary and London, UK. MDAC uses the law to secure justice, equality and inclusion for people with mental health issues and people with intellectual disabilities worldwide. Since 2002, MDAC has conducted extensive human rights monitoring, litigation and advocacy to challenge systemic human rights violations against people with mental disabilities³ in a number of countries.



Photo: A member of MDAC and MHU monitoring team obtaining information from patients on a female acute ward, April 2014. © MDAC.

² MDAC and MHU "They don't consider me as a person": Mental health and human rights in Ugandan communities, (Budapest: 2014).

³ In some places the term 'people with mental disabilities' is used. This term is used to refer to people with intellectual, developmental, cognitive, and/or psycho-social (mental health) disabilities. 'People with intellectual disabilities' generally have greater difficulty than most people with intellectual and adaptive functioning due to a long-term condition that is present at birth or before the age of eighteen. 'Developmental disability' includes intellectual disability, and also people identified as having developmental challenges including cerebral palsy, autism spectrum disorder, and fetal alcohol spectrum disorder. 'Cognitive disability' refers to difficulties with learning and processing information and can be associated with acquired brain injury, stroke, and dementias including Alzheimer's disease. 'People with psychosocial disabilities' are those who experience mental health issues, and/or who identify as mental health consumers, users of mental health services, survivors of psychiatry, or mad. These are not mutually exclusive groups. Many people with intellectual, developmental or cognitive disabilities also identify or are identified as having psychosocial disabilities.

Mental Health Uganda (MHU) is a national membership organisation, established in 1997, and represents people with mental health issues in Uganda. It has regional branches across the country and is one of the largest user-membership organisations of people with mental health issues on the African continent. In 2014 it had over 20,000 members nationwide.

In 2010, MHU and MDAC began looking at ways of addressing some of the systemic human rights violations that MHU had become aware of through engagement with their members. The two organisations decided to undertake a research and monitoring project to document abuses in a number of settings, including psychiatric facilities and in communities, and to provide an evidence base to inform future reforms.

The central aim of this report is to demonstrate to human rights donors and human rights organisations in Uganda that torture and ill-treatment happens in Uganda's psychiatric settings, and that people with mental health issues are worthy of their attention as much as anyone else. Torture and ill-treatment against people with mental health issues are often overlooked by Ugandan authorities and the public at large, a situation which also occurs in many other countries. A variety of factors contribute to the low priority given to these violations, including high levels of stigma associated with mental health issues.

One of the effects of this stigma is that even mainstream human rights organisations overlook violations against people with mental health issues in their anti-torture and human rights monitoring programmes in Uganda. While a number of human rights organisations have placed a specific focus on monitoring prisons, police cells and refugee detention centres, it is noteworthy that

psychiatric hospitals have failed to make the lists even though they are also places where people are deprived of their liberty.

It is hoped that this research will contribute to mainstreaming the human rights of people with mental health issues into broader torture-prevention work already taking place in Uganda, and will demonstrate the importance of ongoing and systematic monitoring. MDAC and MHU have identified a number of barriers to this mainstreaming which this report seeks to address:

- **A perception that psychiatric hospitals only provide care, treatment and therapy and do not violate human rights.** The present report clearly shows that human rights violations are systemic, rather than one-offs.
- **The public do not consider people with mental health issues as holders of human rights.** This fault-based judgment results in serious restrictions on the lives of many people with mental health issues and is the backdrop against which psychiatric provision in the country has, thus far, escaped detailed and independent scrutiny.
- **Civil society lacks the knowledge and skills on how to monitor psychiatric facilities.** This report outlines the methodology used to conduct monitoring and can be used as a springboard to develop future monitoring activities.
- **Mainstream human rights organisations lack the legal right to access psychiatric hospitals.** The findings of this report show the importance of providing independent access to these facilities, and reflect the obligation under international law on the Ugandan government to facilitate access as a crucial step in preventing torture and ill-treatment.

1 (B). Uganda country profile

Uganda is a land-locked country in East Africa and shares borders with Tanzania, Kenya, Sudan, Democratic Republic of Congo and Rwanda. The country gained independence from the United Kingdom in 1962. The Ugandan Constitution (1995) establishes the country as a republic with executive, legislative and judicial branches.⁴ The population is approximately 37.5 million people,⁵ and has a rapid annual growth rate of 3.4%.⁶ Uganda covers a total area of 241,000 km² (almost exactly the same land-mass as the UK). 88% of the population live in rural areas,⁷ and there are several ethnic and religious groups.⁸



Photo: Shutterstock

4 WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p. 12.

5 World Bank estimates of 2013. <http://www.worldbank.org/en/country/uganda>. (Last accessed 2 November 2014). The national statistics puts it at 35.4. See Ugandan Population Secretariat, Ministry of Finance, Planning and Economic Development.

6 Republic of Uganda, Population Secretariat, Ministry of Finance, Planning and Economic Development. See also WHO proMind report, Uganda, November 2011, p. 11.

7 Ministry of Health "Second National Health Policy", July 2010, p.2.

8 The largest ethnic group is Baganda (16.9%) followed by Banyakole (9.5%), Basoga (8.4%), Bakiga (6.9%), Iteso (6.4%), Langi (6.1%), Acholi (4.7%), Bagisu (4.6%), Lugbara (4.2%), Bunyoro (2.7%) and others (29.6%). The main religions are Roman Catholic (42%), Protestant (36%), Muslim (12%) and others (10%). Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html> (last accessed 24 September 2014).

Around two thirds of Ugandans live on less than two US dollars per day and the Human Development Index (which measures health, education and income) ranks Uganda at 161 out of 187 countries.⁹ More positively, Uganda has met the Millennium Development Goal of reducing the proportion of people whose income is less than one dollar a day by half.¹⁰ Life expectancy is 54 years for the general population (male 53, female 55), the infant mortality rate is 60.82 deaths/1,000 live births and the prevalence of HIV stands at 7.2%,¹¹ all representing serious development challenges in the country.

Instability in some neighbouring countries, along with internal conflicts among hostile groups, rebels, militia and armed gangs has resulted in the country hosting large numbers of refugees and internally displaced people.¹² These have impacted on the mental health situation in the country especially in regions that have been affected by civil strife.

1 (C). Mental health

World Health Organization (WHO) research on mental health in Uganda has found that no reliable data exists on the prevalence of mental ill-health, and few studies have been conducted.¹³ A 2004 study estimated the number of Ugandans with mental health problems at 35%.¹⁴ WHO identified a number of factors influencing mental health needs and services in the country, including the high prevalence of HIV/AIDS, significant groups of refugees and internally displaced persons, and the emigration of skilled medical workers, as well as poverty.¹⁵



Photo: Butabika female acute ward, April 2014. © MDAC.

Mental health services are one of twelve priorities to be addressed at all levels of health care provision under the Uganda Minimum Health Care Package, which was formulated as part of the 1999 National Health Policy. Increasing the provision of community mental health services and undertaking law reform are also identified as targets of Uganda's third Health Strategic Plan for the 2010-15 period.¹⁶ In 2001, user fees were abolished for all services provided under the minimum health care package in government health units.

There are two national referral hospitals in Uganda which provide tertiary mental health services to the population. Butabika hospital, based in the capital Kampala, has a bed capacity of 550, and there is also a 50-bedded mental health unit at Mulago national referral hospital.¹⁷ It is estimated that Butabika and Mulago hospitals admit up to 4,394 and 165 mental health inpatients respectively each year. These hospitals provide 6,146 and 364 inpatient consultations respectively per year, as well as 95,106 and 795 outpatients' consultations each per year.¹⁸

There are 13 regional referral hospitals with mental health units.¹⁹ The bed capacity of the mental health units of regional hospitals range from 16 to 40, and each attend to between 170 and 360 inpatients per year. In terms of outpatients, regional referral hospitals provide between 748 and 2,500 consultations per year and report an average inpatient length of stay of between two and three weeks.²⁰ The total number of mental health beds in the whole country is estimated at 937.²¹

9 Bertelsmann Stiftung's Transformation Index (BTI), Uganda Country Report, 2014.

10 Republic of Uganda, Ministry of Finance, Planning and Economic Development, "Millennium Development Goals Report for Uganda" September 2013, p.15.

11 See Central Intelligence Agency: <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html>, (last accessed 24 September 2014)

12 WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p.12.

13 Ibid, p.19.

14 Ibid.

15 Ibid, p.16 and 17.

16 Ibid p. 28.

17 Ibid, p. 21.

18 Ibid.

19 The regional hospitals are located in Arua, Fortportal, Gulu, Hoima, Jinja, Kabale, Lira, Mbale, Mbarara, Moroto, Mubende and Soroti.

20 WHO, proMind Profile on Mental Health in Development, Uganda, November 2011, p.19.

21 Ibid, 21.

In 1990, the Government of Uganda shifted responsibility for health care delivery from central government to districts as part of a health sector decentralisation reform process.²² Districts are autonomous and responsible for the health needs of their jurisdictions. The Ministry of Local Government oversees the operation of general hospitals through local district authorities.²³ Mental health services at district general hospitals and at health centres are practically absent and very little reliable data exists.²⁴

Uganda also has a private health care sector which includes private health clinics, traditional and complementary medicine practitioners and private not-for-profit agencies which offer a range of curative, palliative, rehabilitative and preventive services, both in specific facilities and in communities. The majority of private health care facilities and services are provided by faith-based organisations including the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Orthodox Medical Bureau and the Uganda Muslim Medical Bureau.²⁵ MDAC and MHU are aware of only one private not-for-profit agency (Kisiizi Mission Hospital) that provides both inpatient and outpatient mental health services.

Uganda has a National Policy for Mental Health, Neurological and Substance Abuse Services, last revised in April 2010. It aims to improve access to primary care services supported by good-quality referral systems, as well as making psycho-social rehabilitation services available in communities.²⁶

The Mental Treatment Act 1964 is the current legislative framework and is seriously outdated. At the time of writing, a mental health bill was being reviewed by the Ministry of Justice and Constitutional Affairs before going to Parliament.²⁷ It was not possible for MDAC and MHU to obtain a copy of the bill. The drafting of the bill has occurred behind closed doors, rather than in a transparent way fully involving civil society.²⁸ It is surprising that the Department of Disability at the Ministry of Gender, Labour and Social Development which has the mandate on disability issues in the country has not been consulted during the process.²⁹

The Mental Treatment Act 1964 is a revised version of the colonial-era Mental Treatment Act of 1938. It regulated the detention of people with mental disorders and aspects of forced treatment. The focus of this outdated legislation is on restriction and the removal of rights, rather than protecting them.³⁰ It contains a number of highly offensive terms to refer to people with mental health issues, including “idiots”, “lunatics” and persons of “unsound mind”. The new bill has apparently taken more than a decade to draft, and delays have been attributed to questions over budgetary allocation. The bill is unlikely to be evidence-based as no research has been carried out.³¹ This makes the present report particularly timely and relevant.

Uganda’s fluctuating health budget accounted for 7.2% of the national budget in 2013/2014, significantly less than the 15% target set by the Abuja Declaration³² which Uganda has committed itself to reach.³³ It is estimated that 2% of the annual health budget is spent on mental health services, but the exact amount is impossible to ascertain as there are no official figures.³⁴ Mental health issues are not covered by the existing social insurance scheme and it is not clear whether they will be covered by the proposed National Health Insurance Scheme.³⁵ It is estimated that 2.3% of Ugandans are impoverished by medical bills.³⁶

22 Uganda is divided into 112 districts which are further divided into county, sub-county, parish and village levels. Health facilities at the district level are graded according to the various administrative zones they serve and are linked to local councils. General hospitals are at district level and under local council authority, covering populations of 500,000 and above. Below general hospitals are health centres and village health teams covering smaller sub-populations. See WHO, proMind Profile on Mental Health in Development, Uganda, November 2011, p. 23.

23 WHO, proMind Profile on Mental Health in Development, Uganda, November 2011, p. 23.

24 Ibid, p 19.

25 Ibid, p. 43.

26 The Mental Health Policy also seeks to increase mental health services through decentralisation, collaboration and partnership with all relevant mental health stakeholders including users and their families. See WHO proMind research, p.28.

27 MDAC/MHU interview with Dr David Basangwa, Director of Butabika Hospital, 3 April 2014, Kampala, Uganda.

28 MDAC/MHU discussion with staff at vulnerable unit of Uganda Human Rights Commissions on 22 August 2014. United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), Article 4(3) states that “in the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations”.

29 MDAC/MHU interview with Beatrice Nabalime Kaggya, Commissioner on Disability and Elderly, 22 August 2014, Kampala, Uganda.

30 For one analysis see, Joshua Ssebunnya et al, “Mental health law reforms in Uganda: lessons learnt” International Psychiatry, volume 11 number 2, (May 2014): p.39.

31 Ibid, p. 40.

32 WHO, the Abuja Declaration: Ten Years On. Available at <http://www.ppdafrika.org/docs/policy/abuja-e.pdf> (last accessed 24 September 2014).

33 New Vision, Uganda’s Leading Daily, “Health budget increased, but...” published 19 June 2013, available at Uganda Daily News Vision: <http://www.newvision.co.ug/news/644115-health-budget-increased-but.html>, (last accessed 12 February 2014).

34 WHO, proMind “Profile on Mental Health in Development”, Uganda, November 2011, p.31.

35 Ibid.

36 Ibid.

Hospitals are financed from the governmental health budget and augmented by other donors.³⁷ The Third Health Sector Strategic Plan allows local councils to receive grants directly from the Ministry of Finance to fund district health care services (that is health care service delivery at local council level V, which is then allocated to lower levels).³⁸ Both Butabika and Mulago hospitals in Kampala and the regional hospitals have self-accounting status which allows them to receive money

directly from the Ministry of Finance, Planning and Economic Development.³⁹ However, regional referral hospitals are still managed by the Ministry of Health.⁴⁰ The Ministry of Health provides leadership and coordination in the sector, and is therefore responsible for the entire health system through bringing together stakeholders at the central, district and community levels.⁴¹

1(D). Prohibition of torture: International, regional and national legal framework

Uganda has signed and ratified several United Nations and African Union human rights treaties. Many of these protect the rights of people who have been deprived of their liberty. The absolute prohibition on torture and ill-treatment is regarded as a fundamental principle of international law.

1(D)(i). United Nations standards

Uganda ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in September 2008. The government should have sent a report on the steps it has taken to implement the Convention to the relevant UN committee in September 2010, but it has yet to do so.⁴² By ratifying the CRPD, the Government has voluntarily committed to ensuring that all Ugandan laws, policies and practices comply with rights set out in the CRPD. A number are particularly relevant to the present study, including Article 14 which requires that no person should be subjected to arbitrary detention or deprivation of their liberty, and further outlines that the presence of a disability cannot in itself constitute an appropriate justification for detention.⁴³

The CRPD also prohibits torture, cruel, inhuman and degrading treatment or punishment, requiring the Ugandan government to take effective legislative, administrative, judicial and other measures to prevent people with disabilities from being subjected to such practices.⁴⁴ This also places an obligation on the government to take action to tackle other forms of ill-treatment against people with disabilities, wherever they take place. In addition, the CRPD requires action to be taken in cases where people with disabilities experience exploitation, violence or abuse – including prosecuting perpetrators where necessary.⁴⁵ Recognising that abuse and ill-treatment against people with disabilities occurs as a result of stigma and discrimination, the CRPD establishes a duty on governments to combat stereotypes, prejudices and harmful practices,⁴⁶ including those practices which violate their physical and mental integrity.⁴⁷



Photo: Shutterstock

37 The Health budget covers the expenses of the Ministry of Health, national hospitals, regional referral hospitals, primary health care, NGO health units, Uganda Aids Commission and the Health Service Commission. The budget allocation is guided by the Budget Framework Paper (BFP) which takes into account the Health Sector Strategic Plan, the National Health Policy (NHP) and priorities set by the National Health Assembly and the Joint Review Mission. See WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p. 30.

38 The district local government under the Ministry of Local Government has the mandate to plan, budget and implement health policies while the district health teams coordinate resource mobilization and monitoring overall district performance. So Hospitals below regional referral hospitals are run under the directives of the Ministry of Local Government manage by the Hospital Management Committee. See WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p. 23.

39 WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p. 31.

40 Ibid, p. 23.

41 Ibid. Ministry of Health functions include strategic planning, setting standards and quality assurance, advising ministries, departments and agencies on health-related matters, capacity development and technical support supervision, policy analysis etc.

42 UN CRPD Article 35.

43 UN CRPD Article 14 (1) (a) and (b)

44 UN CRPD, Article 15 (1) and (2).

45 UN CRPD Article 16

46 Ibid, Article 8 (1) (b).

47 Ibid, Article 17.

The UN Convention against Torture (CAT) establishes an absolute prohibition on torture and other forms of cruel, inhuman or degrading treatment or punishment, and was ratified by Uganda in 1986. The Convention defines torture as:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent of or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to any lawful sanction.⁴⁸ [Emphasis added]

Under the Convention, governments have an obligation to train government personnel on the prohibition against torture, including medical professionals and others involved in the treatment of detainees.⁴⁹ Similarly, the International Covenant on Civil and Political Rights (ICCPR),⁵⁰ and UN Convention on the Rights of the Child (CRC),⁵¹ guarantee the humane treatment of people and their right to freedom from torture and other cruel, inhuman or degrading treatment or punishment.

1(D)(ii). African standards

As a Member State of the African Union, Uganda has ratified a number of regional treaties which also contain binding human rights obligations. By doing so, the government of Uganda is under an international legal obligation to ensure that all Ugandan laws, policies and practices comply with the provisions in the texts.

The African Charter on Human and Peoples' Rights prohibits all forms of degradation, including torture, cruel, inhuman, or degrading punishment and treatment.⁵² It provides for the right to enjoy the highest attainable state of physical and mental health,⁵³ and contains provisions specifically for older people and persons with disabilities.⁵⁴ It also sets out that people have the right to live in a satisfactory environment favourable to their development.⁵⁵

The African Charter further provides standards regulating the treatment of people who are deprived of their liberty,⁵⁶ and obliges states to extend special protection against ill-treatment to women and children through a Protocol on the Rights of Women,⁵⁷ and through the African Charter on the Rights and Welfare of the Child.⁵⁸

The Robben Island Guidelines⁵⁹ come from a resolution of the African Commission to develop guidelines and measures for the prohibition of torture and other forms of ill-treatment, specifically relevant to the African continent. The Guidelines call on governments to establish independent national institutions to visit all places of detention in order to prevent ill-treatment,⁶⁰ guided by United Nations principles on the functioning of national human rights bodies.⁶¹

The African Commission on Human and Peoples' Rights is the body established to assess whether the African Charter has been violated. In some cases it has ruled that "cruel, inhuman, or degrading punishment or treatment is to be interpreted to provide the widest possible protection against abuses, whether physical or mental", and that personal suffering and indignity violate the right to human dignity which is an inherent basic right of all persons, regardless of their mental capabilities or disabilities.⁶²



Photo: Shutterstock

48 Convention against Torture, Article 1.

49 Convention against Torture, Article 10.

50 International Covenant on Civil and Political Rights, Article 7 and 9-11. Ratified by Uganda in 1995.

51 UN Convention on the Right of the Child, Articles 20 and 37. Ratified by Uganda in 1990.

52 African Charter on Human and Peoples' Rights, Article 5.

53 Ibid, Article 16(1).

54 Ibid, Article 18(4).

55 Ibid, Article 24.

56 African Charter on Human and Peoples' Rights, Article 6 and Article 7.

57 Protocol to the African Charter on Human and Peoples' Rights on the Right of Women, Article 4(1).

58 African Charter on the Rights and Welfare of the Child, Article 16.

59 Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment.

60 Ibid. at para 41.

61 UN Paris Principles Relating to the Status and Functioning of National Institutions for the Protection and Promotion of Human Rights, UN A/Res/48/48, 20 Dec. 1993.

62 African Commission on Human and Peoples' Rights, *Purohit and Moore v. The Gambia*. Communication No. 241/2001, May 2003.

1(D)(iii). National standards

The Ugandan Constitution (1995) has several relevant provisions. It requires that persons deprived of their liberty must only be kept in a place authorised by law for that purpose.⁶³ Specifically, a person thought to be of “unsound mind” or addicted to drugs or alcohol can be deprived of their liberty for the purpose of care and treatment and for the purpose of protecting the community.⁶⁴ It should be noted that these provisions are beneath those required by international law as they directly discriminate against people on the basis of the presence of a disability.

Other legislation establishes that a judge can indefinitely postpone criminal proceedings and order the indefinite detention of a defendant regarded as a “criminal lunatic” in a mental hospital or other place of detention.⁶⁵ A person found not guilty of a crime by reason of insanity is labelled a “criminal lunatic” and can be indefinitely detained under Ugandan law. In these cases, it is a government minister – not a judge – who decides on the person’s eventual freedom.⁶⁶ These provisions clearly conflict with the prohibition on arbitrary detention under international law,⁶⁷ and are discriminatory against people with mental health issues.

Despite these problems, the Constitution also contains some valuable protections. It prohibits all forms of torture or cruel, inhuman or degrading treatment or punishment.⁶⁸ Article 1 of the Constitution sets out national objectives and principles to guide state policy, including that “the State and Society shall recognise the rights of persons with disabilities to respect and human dignity” (Objective XVI). The Constitution goes on to place an obligation on state institutions to take appropriate measures to ensure that all persons with disabilities can realise their full mental and physical potential,⁶⁹ and extends additional protections against abuse for children and “vulnerable people” (undefined).⁷⁰ The right to equality and freedom from discrimination is also guaranteed, including prohibiting prejudice and discrimination based on disability (which includes mental disability).⁷¹ Finally, the Constitution guarantees equal protection of the law for all persons and in all spheres of political, economic, social and cultural life.⁷²

The Persons with Disability Act 2006 mandates all organs, agencies of government and people (undefined) to respect, uphold and promote the fundamental rights and freedoms for all persons with disabilities as enshrined in the Constitution.⁷³ The Act prohibits any person or institution from subjecting a person with disability to torture, cruel, inhuman, or degrading treatment, violence or abuse, as well as prohibiting exploitation and discrimination.⁷⁴

In 2012, Uganda adopted the Prevention and Prohibition of Torture Act. This piece of legislation defines torture as:

*Any act or omission, by which severe pain or suffering whether physical or mental, is intentionally inflicted on a person by or at the instigation of or with the consent or acquiescence of any person whether a public official or other person acting in an official or private capacity for such purposes as [...] (c) intimidating or coercing the person or any other person to do, or refrain from doing, any act.*⁷⁵

Under this legislation, an act of torture is aggravated when the victim is a person with a disability.⁷⁶ A schedule to the Act outlines a non-exhaustive list of acts which may constitute torture including those which are physical, mental or psychological, or pharmacological.⁷⁷ It sets out some gruesome examples of torture which could be prosecuted, including systematic beating, head banging, punching, kicking, striking with truncheons, rifle butts, and jumping on the stomach; food deprivation or forcible feeding with spoiled food, animal or human excreta; electric shocks; being tied or forced to assume a fixed and stressful body position; and harmful exposure to elements such as sunlight and extreme cold.

In respect of acts which constitute mental torture, the Act includes holding a person incommunicado in a secret place of detention; confining a victim to a solitary cell or in a cell put up in a public place; and inflicting shame such as stripping a victim naked, parading them in a public place, shaving their head, or putting a mark on their body against their will.

63 Constitution of Uganda 1995, Article 23 (2).

64 Constitution of Uganda 1995, Article 23 (1)(f).

65 Trial on Indictment Act (CAP 23), section 45 (3).

66 Trial on Indictment Act (CAP 23), section 48(2). See similar provisions in the Magistrate Court Act (Cap 16), section 113-117.

67 Universal Declaration of Human Rights, Article 9; International Covenant on Civil and Political Rights, Article 9.

68 Constitution of Uganda 1995, Article 24.

69 Constitution of Uganda 1995, Article 35.

70 Ibid, Article 17 (c).

71 Ibid, Article 21 (2).

72 Ibid, Article 21 (1).

73 Persons with Disability Act, section 32.

74 Ibid, section 42.

75 Prohibition and Prevention of Torture Act, 2012, section 2.

76 Ibid, section 5 (c).

77 Ibid, second Schedule.



Photo: Monitoring training participants pilot visit to Butabika, September 2013. © MDAC.

Pharmacological torture is listed as including the administration of drugs to induce a confession or reduce mental competence and other forms of deliberate and aggravated cruel, inhuman or degrading pharmacological treatment or punishment.⁷⁸

The Prevention and Prohibition of Torture Act considers severe pain and suffering to include prolonged harm caused by or resulting from the intentional infliction or threatened infliction of physical pain or suffering, and the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality of a victim.⁷⁹ The Act does not define what amounts to “cruel, inhuman, or degrading treatment” but mandates the courts or any other body to be guided by its definition of torture and the circumstance of each case.⁸⁰

The legislation is robust and actually exceeds the minimum standards required by international law in some respects. Uganda must take action to enforce and implement the provisions within the framework of psychiatric treatment too. Improvement and progress in mental health care services in Uganda must be based on respect for human rights standards.

1 (E). Hospitals visited

MDAC and MHU conducted two monitoring missions to a total of nine psychiatric hospitals in Uganda. These hospitals included the two national referral institutions (Butabika and Mulago: both in the capital Kampala), the regional referral hospitals at Kabale and Mbarara in the western region, Arua and Gulu in the northern region, and Soroti and Mbale in the eastern region. Monitors also visited the Kisiizi Mission Hospital, which is the only non-government facility providing inpatient and outpatient mental health services in the country. The missions took place in September/October 2013 and again in April 2014. All visits were announced and monitors gained entry to each facility based on a memorandum of understanding which MHU had previously established with each of the hospitals. MDAC and MHU commend the staff in hospitals for their openness and willingness to talk to monitors about the challenges of their work, and for sharing their opinions on the things that need to be changed.

In September 2013, MDAC and MHU trained 12 participants from mainstream human rights organisations and people with mental health issues on monitoring human rights in psychiatric hospitals.



Photo: Different wards at Butabika hospital, April 2014. © MDAC.



Photo: MDAC and MHU monitoring training, September 2013. © MDAC.

During the first mission monitors went to all wards at Butabika hospital. The second monitoring visit to Butabika focused only on the male and female acute wards because these were identified to be the most problematic. The findings outlined in this report relating to Butabika, therefore, primarily flow from these two wards.

The monitoring team consisted of MDAC’s project manager for Africa and a consultant with expertise of monitoring psychiatric hospitals in the UK, and two people from MHU (the Executive Director and the former Chair of the board, who is also an expert by experience). In addition, two additional participants from the training took part in some monitoring visits. Monitors spoke to patients and their carers, health professionals and administrative staff, reviewed medical records and observed the hospitals’ environments to assess how human rights were being respected, protected and fulfilled. Monitors discussed the initial findings of the first round of monitoring with staff at each facility during the April 2014 visit, during which they sought clarifications and evaluated any changes made since the first visits. The methodology is set out more fully in the **Appendix**.

78 Ibid, Second Schedule.

79 Ibid, section 2(2)(a) and (b).

80 Ibid, section 7.



Map of hospitals visited in September/October 2013 and April 2014.

- Butabika National Referral Hospital – Kampala
- Mulago National Referral Hospital – Kampala
- Kabale Regional Referral Hospital – Kabale
- Mbarara Regional Referral Hospital – Mbarara
- Arua Regional Referral Hospital – Arua
- Gulu Regional Referral Hospital – Gulu
- Soroti Regional Referral Hospital – Soroti
- Mbale Regional Referral Hospital – Mbale
- Kisiizi Mission Hospital – Rukungiri District

Table 1. Mental health facilities visited

	National Referral				Regional Referral Hospitals						Private Hospital		
Name	Butabika Hospital		Mulago Hospital		Kabale Hospital	Mbarara Hospital	Arua Hospital	Gulu Hospital	Soroti Hospital	Mbale Regional	Kisiizi Mission Hospital		
Location	Central region		Central region		Western region	Western region	Northern region	Northern regions	Eastern region	Eastern region	Western region		
Number of beds	total	550 ⁸¹	M ⁸²	25	32	36	40 bed capacity	40 bed capacity ⁸³	40/50 bed capacity ⁸⁴	40 bed capacity	40 bed capacity ⁸⁵	25 ⁸⁶	
	M/A ⁸⁸	70/80 ⁸⁸	F	25									
	F/A ⁸⁹	70	C	15									
Total number of beds according to WHO, 2011 Report	550		50		26	20	40	30	35	22	N/A		
Number of patients on day of visits	total	690	M	5	20	24 ⁹⁰	10 and has never gone beyond 20	19	20	3(two female & a male)	15 males 16 female	23	25 ⁹¹
	M/A	130/150 ⁹²	F	10									
	F/A	130 ⁹³	C	3									
Average length of stay	2 to 3 weeks		12 days		3 weeks	10 days	2 weeks	2 weeks	2-3 weeks	2-3 weeks	2-3 weeks		
Longest stay in hospital	Above 5 years		1 month		1 month	3 weeks	3 Months	3 months	2 months	2 months	8 months ⁹⁴		

81 Number of beds throughout the whole hospital.

82 Nurses referred to ward capacity when responding to number of beds. Monitors did not see 25 beds in either the male (M) or female (F) wards and saw 9 beds on the children's (C) ward during the second visit.

83 Monitors saw 12 beds in first male dormitory, 5 beds in the second male dormitory and 12 beds in the male dormitory.

84 Monitors saw 14 and 13 beds in the male and female wards respectively, and there were 5 beds in the children's ward.

85 Monitors saw 10 beds on the male ward and almost the same number in the female ward.

86 This is one dormitory for males and females, including carers.

87 Male acute ward.

88 On the first visit the nurse told monitors there were 70 beds, and during the second visit monitors were told there were 80 beds.

89 Female acute ward.

90 This data reflects what nurses told monitors for the first visit and the second visit. The data is not separated by gender since staff were only able to provide the overall totals. In March 2014 there were 69 inpatients (35 females and 34 males) and 632 outpatients. Monitors saw six beds in total in the first male dormitory with no mattresses, and six beds in the second male dormitory, totaling 12 beds.

91 Monitors were told that the hospital started the week with 40 in patients.

92 On the first visit there were 130 patients and on the second visit there were 150.

93 A nurse told monitors that the ward started the week with 180 patients.

94 The patient stayed from July 2013 to March 2014 because no one knew where they were from and the hospital had to ask for people to come forward on radio in Kabale.

1(E)(i). Butabika hospital

Butabika hospital was established in 1955 and is the country's only national referral mental health institution, which means it is the only specialist psychiatric hospital. Its website states that it provides "specialist inpatient and outpatient care and management for all patients with mental and psycho-social problems on a referral basis",⁹⁵ but also provides primary care consultations. It receives over 4,000 first admission inpatients and 2,000 readmissions each year.⁹⁶ Butabika hospital houses all the forensic beds in Uganda, an alcohol and drug rehabilitation centre, a children's ward,⁹⁷ along with several other wards and an outpatients department. Butabika and Mulago hospital are teaching and research hospitals.

The mission statement of Butabika hospital is "to offer super specialized and general mental health services; conduct mental health training, mental health related research and to provide support to mental health care services in the country for economic development." Its vision statement is "a population in a state of complete mental, physical, and social wellbeing which is a prerequisite for development and poverty alleviation and a community in a state of complete mental, physical and social well-being as a prerequisite for development and poverty eradication."⁹⁸

The hospital director reported an annual budget of six billion Ugandan shillings (approximately 1.9 million EUR). He stated that the hospital spends approximately 6.5 EUR per inpatient per day.⁹⁹ Two and a half billion shillings are spent on wages (approximately 790,000 EUR), with recurring costs including medication, logistics and food totalling two billion shillings (628,000 EUR), with approximately one and a half billion shillings (approximately 480,000 EUR) spent on 'capacity development' (described as the use of vehicles). The director did not provide any documentary evidence of these sums to monitors. The budget for Butabika is the only identified mental health budget in the country. No mental health units in regional referral hospitals receive ring-fenced budgets and hospital administrators at regional referral hospitals were unable to say how much was spent on mental health in their units.



Photo: Entrance of Butabika hospital, April 2014. © MDAC.

Butabika staff told monitors about a community mental health department which previously ran a satellite programme with ten outreach clinics, but provided no evidence that the service was still operating.

1(E)(ii). Other hospitals

Mulago national referral general hospital was founded in 1913 and expanded through additional construction in 1962.¹⁰⁰ The mental health (psychiatric) department is one of the speciality units under its medical services department. In a year, the inpatient mental health unit admits about 165 patients and provides consultations to approximately 364 people.¹⁰¹ The entire hospital has a bed capacity of 1,790 with a 40 to 50 bed-capacity mental health unit. It is a teaching and research hospital associated with Makerere College of Health Sciences. Its mandate is to "provide super-specialised health care, training and conduct research in line with the requirement of Ministry of Health."¹⁰²

The mental health units of regional referral hospitals are similar in terms of structure. A few years ago, the Ugandan government made remarkable progress and replaced small and prison-like mental health units at Mbale, Kabale, Mbarara and Soroti with newer and more dignified structures. However, some staff who spoke to monitors thought it would have been better to have invested in community mental health services.

95 Butabika hospital website, <http://www.butabikahospital.com/> (last accessed 5 December 2014).

96 WHO reported that in the 2009/2010 financial year, Butabika provided 4,394 first time inpatient care and 1,752 re-admissions. See WHO, proMind "Profile on Mental Health in Development", Uganda, November 2011, p. 41.

97 Additional children's beds can be found at Mulago psychiatric unit and have also been recently established at Gulu Hospital.

98 Butabika Hospital website, <http://www.butabikahospital.com/> (last accessed 5 December 2014).

99 If you take the number of patients on the days when monitors visited and divide the whole 6 billion by 690 (number of patients) and by 365 (number of days), you get 23,823 shillings or 6.5 Euros per day.

100 Mulago hospital website, <http://mulago.or.ug> (last accessed 15 September 2014).

101 WHO proMind, "Profile on Mental Health in Development", Uganda, November 2011, p. 21.

102 Mulago hospital website, <http://mulago.or.ug> (last accessed 5 December 2014).



Photo: Structure of old mental health units in regional hospitals, unit in Kabale hospital, October 2013. © MDAC.

Monitors collected the following contextual information about the regional facilities. Arua hospital was established in 1938 and the mental health unit was established in 2005. In 2013 its records showed 720 inpatients. Mbale hospital was constructed in 1920 and the mental health unit was constructed in 2009. The total number of inpatients in 2013 was 712, while the hospital also provided services to 7,241 people on an outpatient basis. Gulu hospital was constructed in 1934 as a British military hospital. It later became a regional referral hospital and the mental health unit was constructed in 2004. Soroti hospital was constructed in 1943 and the mental health unit is as old as the hospital but was upgraded 5 years ago. Kabale hospital was constructed in 1941 and Mbarara hospital was established in 1940. They all showed similar trends in terms of the estimated yearly inpatients and the number of consultations provided to outpatients. None of the hospitals were able to provide monitors with statistics on the number of people who were deemed not to have mental health issues following a consultation.

The only non-government hospital, the Church of Uganda Kisiizi mission hospital, is a 260-bedded private not-for-profit rural health care provider. It was founded in 1958 and established a mental health unit in 1997, housed in a building that was constructed in 1960. It has plans to construct a new mental health unit and monitors saw the land that had been allocated for this along with the architectural plan. The hospital provides both inpatient and outpatient medical services, including mental health care. From February 2013 to 2014, it had 490 inpatients of whom 337 were new cases, and also provided outpatient services to over 4,100 people through its community outreach mental health clinics. It also has a school of nursing and is notable for its community health insurance scheme for over 35,000 members, including people with mental health issues.



Photo: Kisiizi mental health unit, April 2014. © MDAC.



Photo: New mental health unit Mbarara hospital, April 2014. © MDAC.

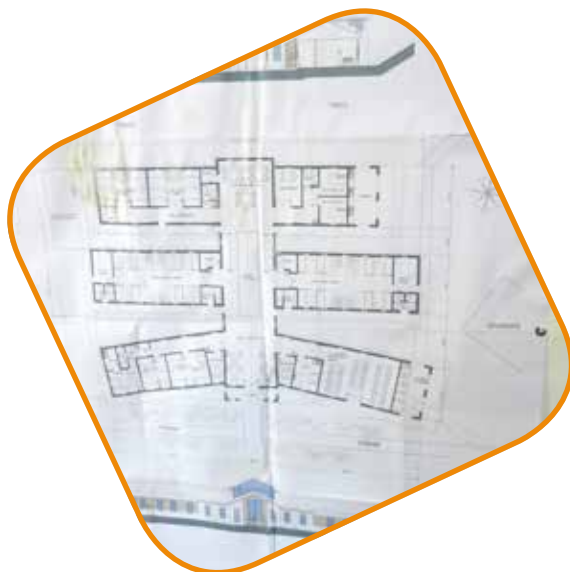
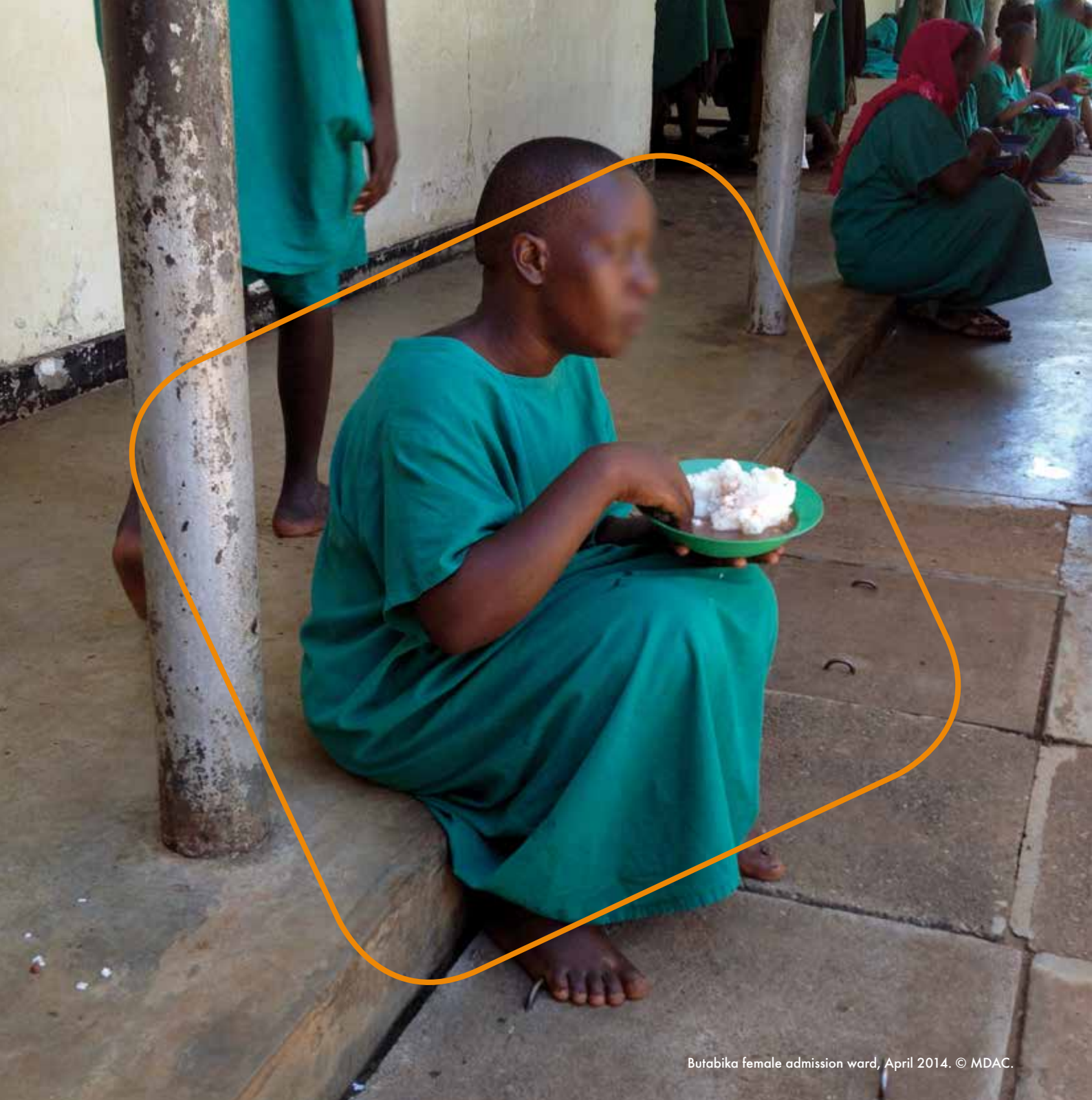


Photo: Architectural plan for the envisaged new mental health unit at Kisiizi hospital, September 2013. © MDAC.



Butabika female admission ward, April 2014. © MDAC.

“Almost all seclusion takes place naked. While long periods can be spent in the seclusion room, when the room is being cleaned, the patient will be asked to go out into the courtyard, still naked.”

Young male patient at Butabika hospital

2.

Monitoring findings: Ill-treatment and abuse in psychiatric hospitals

This part of the report sets out the core findings from the monitoring missions conducted to the psychiatric facilities in the country, focusing on forms and prevalence of torture, ill-treatment and abuse. Butabika is distinctly different to the other mental health facilities in the country, being a specialist tertiary care hospital which does not allow carers to stay with inpatients.

The other regional hospitals all allowed or required carers to provide care to patients. As a result, Butabika is much more closed and has a qualitatively different regime. In this chapter of the report, therefore, the findings from Butabika are presented separately from the other hospitals under each subsection.

2(A). Coercion and compulsion

This section presents on the prevalence of coercion and compulsion that can amount to torture, ill-treatment and, in some cases, deaths. The section considers a number of specific practices including the use of seclusion, physical restraints and forced treatment without consent.

2(A)(i). Seclusion

“They put us in the cold room naked.”

Female patient, Butabika hospital female acute ward

Monitoring showed that seclusion was common in most psychiatric hospitals in the country. Monitors found the practice to be totally unregulated and placing people with mental health issues at a high level of risk. This severe form of restriction of liberty, often placing people in locked cell-type rooms and in appalling conditions, was found to take place without any assessment, documentation or regulation, and was arbitrarily applied.

Ugandan law requires hospitals to register the number of patients restrained or placed in a seclusion room, recording when it happened, the period of time for which the measure was applied and the reasons for the application of such measures.¹⁰³ None of the hospitals visited complied with any of these basic provisions.

The failure to abide by even basic provisions is a matter of serious concern from a human rights perspective. It should be noted that the Prevention and Prohibition of Torture Act 2012 identifies the solitary confinement of a person in a cell as an act which may constitute torture.¹⁰⁴ International law also sets out an absolute prohibition on torture and other forms of ill-treatment.¹⁰⁵ The UN Special Rapporteur on Torture has also pointed out that solitary confinement and prolonged restraint of people with mental disabilities in all settings are prohibited.¹⁰⁶



Photos: Seclusion rooms of Butabika acute admission wards, October 2014. © MDAC.

¹⁰³ Mental Treatment Act 1964, section 16.

¹⁰⁴ Ibid.

¹⁰⁵ UN Convention against Torture, Articles 1 and 16; CRPD, Article 15.

¹⁰⁶ Juan Mendez, UN Special Rapporteur on Torture and Other cruel, Inhuman and Degrading Treatment or Punishment “Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development”, 22 Session of Human Rights Council. A/HRC/22/53, 1 February 2013.

Butabika hospital

The director of Butabika hospital informed monitors that seclusion was used when a patient was perceived to be “violent and aggressive.” He stated that staff would then administer a sedative against the person’s will and wait for the medication to take effect. On one of the wards visited, a patient was documented as having “stripping herself naked and restless”. For this she was placed in seclusion. The director also reported that seclusion was commonly used for patients who attempted to escape, and as a deterrence to other patients from attempting to escape, indicating that the practice was used as a form of punishment. This is completely prohibited under international law.¹⁰⁷

Monitors noted that there was inadequate management and oversight of this potentially fatal practice. The director of Butabika claimed that staff used a “standard operating procedure” on seclusion and assured monitors that there would be a copy of this on the wards as he was unable to locate it in his office. Staff on both the female and male acute admissions wards reported that they had never heard of such a procedure, and nor were they aware of any guidelines, policy or other written documentation on seclusion. A nurse with around twenty years’ experience told monitors: “We learn the rules in school”.

Seclusion was used arbitrarily, even at the whim of untrained nurses, and was not always properly recorded. Monitors found that, where minimal recording had occurred, this usually took the form of a note in the day book on the ward stating that a particular patient had been put in seclusion with a brief reason such as “because of aggression”. There was no record of how patients placed in seclusion were monitored on an ongoing basis, and on one occasion monitors were assured that a patient had left seclusion when they actually found her still locked in a room, without the knowledge of the nurse in charge of the ward.

On the first visit of monitors to the female admission ward in October 2013, one of the six seclusion rooms was occupied, and in April 2014 two were occupied. Seclusion rooms had no observation holes on the doors, so there was no way to see inside. Monitors heard a woman asking: “Please open for me”. This person had missed lunch, and it was not clear to anyone when she would be released.

None of the seclusion rooms had toilets or buckets, forcing people placed into them to defecate and urinate on the floors. Each seclusion room had an elevated concrete bench so that the patient could lie down. Monitors noted that urine from the seclusion rooms flowed into the corridors under the doors of occupied cells. Each cell had a small window which was above eye level, thus occupants could not see anyone else, and could only just see a small sliver of sky.

Nurses at Butabika stripped patients naked before placing them into seclusion, allegedly to prevent them from hanging themselves. As monitors passed by one of the rooms, the woman inside banged on the door: she could obviously hear people in the corridor. A nurse told monitors that if she continued banging it would mean that the medication was not working, and so they would go in and give her another injection.

Staff reported that the time that patients were placed in seclusion rooms varied from a few hours to two days. Some patients told monitors that they had been secluded for longer than two days. On the acute male ward, patients were keen to describe their frightening experiences of seclusion and the appalling environment inside cells. “We are beaten in the rooms and our clothes are removed,” one patient told monitors, although it was impossible to corroborate such claims. A young male patient told monitors that he had spent around seven hours in seclusion (he was not sure of the exact amount of time) because he had tried to escape from the hospital. Commenting on his case, a nurse told monitors that seclusion was justified “as he was quite bewildered and might get lost, [and] if he got into the community he might be vulnerable to the locals, and if someone got hurt there could be legal action against the hospital.”

A young man who had been detained at Butabika also told monitors that, “almost all seclusion takes place naked. While long periods can be spent in the seclusion room, when the room is being cleaned, the patient will be asked to go out into the courtyard, still naked.”

Other hospitals

Monitors found that seclusion also took place in the majority of psychiatric hospitals in the country, with a couple of exceptions. At Kabale hospital, seclusion had reportedly not been used for two years, as staff said that they preferred to sedate patients. At Mbarara hospital, staff informed monitors that they rarely secluded people, but said that family members or carers of patients would put their relatives into seclusion rooms. This was also reported by staff at other hospitals visited by monitors. Staff at Mbarara told monitors that “the family members do everything: they admit, they feed, they bathe, they restrain, they comfort, apparently they even put people in seclusion when the staff are not around.” Although staff frowned on relatives using seclusion, it was apparent to monitors that such practices take place with the collusion of staff who leave empty seclusion rooms open and unlocked and with doors that could easily be bolted from the outside. “How else can they [carers] go into town to buy food?” asked one psychiatric clinical officer.



Photos: Seclusion room at Mbale hospital on the left and Mbarara hospital on the right, April 2014. © MDAC.

107 Ibid.

Monitors were told that carers secluded their relatives to ensure that the patient could not run away or get out of the sight of their relative, to enable carers to take a shower, cook, go out to buy food or medicine, or as a means to give the relatives respite from the burden of care.

In some hospitals, monitors noted that patients in seclusion were given a mattress to sleep on if assessed as safe (that they would not destroy the mattress), while many patients across the country were required to sleep on concrete floors amongst their own faeces and urine. Monitors were told about one 37-year-old man who was admitted to Mbarara, sedated and placed in a seclusion room overnight because there was only one female nurse on duty. A psychiatric clinical officer (PCO) told monitors his opinion about seclusion:

“At times we misjudge, we think we are helping them but we are distressing them. We don’t have [a] good number of staff who will be talking to patients. For a patient who is violent, the seclusion is used not because it is good but because it is convenient [...] Staff have not worked out a maximum time limit for seclusion [...], how can so few staff cope with so many patients?”

Staff at Kisiizi hospital told monitors that patients were secluded mostly at night when there was just one nurse with no student nurses, which clearly cannot be regarded as an acceptable justification for such a serious restriction of liberty. During the day, “students are supposed to talk to patients”, staff told monitors. Staff managed distress displayed by patients either by sedating them or secluding them. Patients’ views were not sought. There was no evidence in any of the hospitals that reassurance or de-escalation techniques were used.

Staff at Mulago and Arua hospitals reported that their hospitals had no seclusion rooms and they had found no need for them. Instead, there, patients were heavily sedated. The head of Arua hospital said, “we have tried seclusion but it is more destructive, and if it is there it becomes a means of treatment which is not good.”

2(A)(ii). Restraint

“We watched through the external window as three nurses held him, grabbed his arm, put a pill in his mouth which he was forced to leave open while it dissolved and while being given an IV injection simultaneously.”

MDAC and MHU monitors observation
at Butabika male acute ward

Physical restraint by relatives and community members was reportedly common prior to hospital admission. Monitors were told that this was because the majority of patients were taken to hospitals during crises and families knew little or nothing about alternatives.¹⁰⁸ In hospitals, physical restraint was reported to



Photo: Manacles collected by Kisiizi mental health unit, used in restraining patients by family carers to take them to the hospital, April 2014. © MDAC.

take place when a patient was taken to seclusion rooms or when being physically restrained and to allow for injections to be administered. The purpose of injections according to staff, was to chemically restrain the person concerned. Both were used in situations where patients reportedly refused treatment. Staff in few hospitals had received any training on how to conduct physical restraint in a safe manner.

The prevention and management of violence and aggression is a difficult and sensitive task. An emphasis on whole systems thinking, good communication, long-term care planning and verbal de-escalation are required to successfully reduce the risk violent behaviour. Physical restraint should never be undertaken by those who are untrained.

Butabika

Monitors witnessed physical restraint at Butabika when patients were being brought into the hospital and while treatment was administered by force. Monitors saw a male teacher being brought by police and accompanied by the headmaster of the school. His hands were tied in front with ropes and the headmaster reported that the teacher had been violent at school. The teacher was physically restrained while nurses administered an injection.

Nurses informed monitors that patients were brought to hospital when they were experiencing a crisis and were usually admitted under physical restraint. Patients told monitors that they were frequently restrained in order to be placed into a seclusion room. Staff reported that training on restraint had been held at Butabika given by experts from the East London Mental Health Trust.

¹⁰⁸ To know more about people with mental health issues being restrained outside hospitals, see MDAC and MHU, “They don’t consider me as a person”: Mental health and human rights in Ugandan communities, (Budapest: 2014).

Other hospitals

A male patient at Arua hospital explained to monitors how he was brought to the hospital:

“About 8 or 9 people escorted me to the hospital. If I remember well, my hands were tied at the back and [my] feet were also tied, [and] they used a taxi.”

It appeared to monitors that this was common practice as they witnessed people being brought to hospital with hands and feet tied at both Mbarara and Gulu hospitals. At Kisiizi, staff showed monitors manacles and ropes used to restrain patients and transport them to the hospital.

The only occasion where monitors saw a patient handcuffed to his bed was at Mbale male psychiatric unit. This was a forensic patient who was being watched by a prison officer. The officer informed monitors that the reason he was handcuffed was to prevent him from escaping and not because he was violent.

Monitors were told that Sheffield Health and Social Care Trust, from the UK, had partnered with Gulu hospital to train staff on how to conduct restraint in a safe manner. Staff at Kisiizi also mentioned that they had benefited from a one-off training on restraint offered by Butabika hospital.

The current Mental Treatment Act requires hospitals to record “the full name of every patient who is or has been under bodily restraint or in solitary seclusion in a separate room since the last entry, and when and for what period and reasons.”¹⁰⁹ Monitors found no evidence that such recording or monitoring took place. There were no practice guidelines on how physical restraint should be managed, recorded, or reviewed.

2(A)(iii). Forced treatment and lack of consent

“But I must treat him because he is sick.”

Psychiatric Clinical Officer at Gulu

The current Mental Treatment Act makes no reference to consent to treatment. It assumes that compulsory admission, by definition, permits compulsory treatment. This is despite the fact that most involuntary admissions have no legal basis (see Chapter 3). As a consequence, even if one were to accept the connection between compulsory admission and compulsory treatment, it would be clear that almost all compulsory treatment must be regarded as without any legal basis. Staff told monitors that it was virtually inconceivable that patients could make a rational decision to refuse anti-psychotic medication.

Monitors found that patients were not provided with sufficient information to give informed consent to treatment. It was reported in hospitals that when patients or relatives asked that information would be provided, but most patients were not aware that they could ask for this. It was only with Electro Convulsive Therapy (ECT) that patients’ consent was consistently sought, however it was also reported that when the person was considered ‘incapable’ of providing consent then this could be obtained from relatives.

Consent?

The standard admission form in hospitals had a section on consent on page two. It had three separate sections:

- “I give consent for medical treatment.”
- “I give consent for to be sterilized.”
- “I give consent for to be amputated.”

Scrutiny of consent forms across the country showed that they were almost never completed. In one hospital monitors asked why the section for medical treatment was not completed when discussing psychotropic medication. Staff responded that it was because psychotropic medication “is not medical treatment”.

Butabika

The principle of informed consent to treatment does not exist at Butabika hospital. Patients are forced to take medication, particularly if they want to be discharged. A number of patients told monitors that the way they dealt with the problem of being overmedicated was to palm their medication and not take what they were prescribed. There was no record in any of the notes scrutinised that this was a concern to staff. In particular, staff explained to monitors that large numbers of patients impeded any chance of close observation for non-compliance with medication.

However, when patients refused medication upon admission or to the knowledge of the nurses, they could be physically restrained and have medication forced down their throat or administered as an injection.



Photo: Shutterstock

109 Mental Treatment Act 1964, section 16.

2(A)(iv). Deaths

“...there will be no contact with the coroner. No inquest.”
Psychiatric Clinical Officer, Gulu

No research has been carried out on the number of deaths in mental health units or the causes of these. In practice, when a person dies in a mental health unit there is no investigation to find out the cause. Section 17 of the Mental Treatment Act requires the medical superintendent to inform a coroner of the death of any patient in a mental health hospital, and requires a coroner to hold an inquest. Monitors found that this does not happen, despite the crucial need to undertake such investigations to avoid further deaths. Suicides in mental health units were reported to be rare but no statistics were available on this. Many deaths were reported to result from pre-existing conditions such as AIDS.

Butabika

Staff explained, somewhat simplistically, that mental health issues per se do not kill and that if a patient died in a mental health unit it must have been as a result of physical illness. Staff did not provide monitors with any statistics on the number of the patients who had died at Butabika. During MDAC and MHU training in March 2014, a participant from Heart Sounds Uganda (a mental health service user organisation that provides peer support to patients in Butabika) raised concerns about the number of deaths at the hospital which had not been investigated.

As at other hospitals, staff reported that when a patient died, the family was informed (for those who had a valid contact address) and the body was taken away for burial. This fails to comply with current legal requirements to inform a coroner with a view to an inquest taking place.

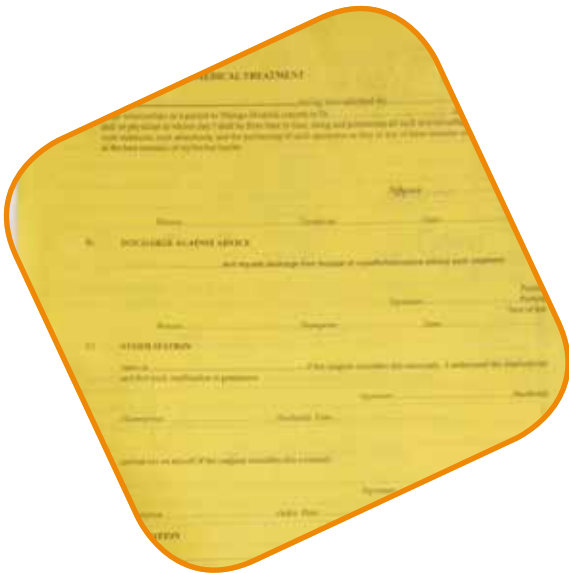


Photo: Admission form authorising discharge based on medical advice which monitors learned was not applicable for people with mental health issues, April 2014. © MDAC.

Other hospitals

A nurse at Kabale hospital honestly told monitors:

“In a psychiatric ward there is nothing like consent. We get consent from the attendants [carers]. He [a male patient] has no insight, he is a psychiatric patient.”

Monitors asked patients at a hospital why they sometimes refused medication, and they reported a variety of reasons such as because it made them put on weight, caused impotence, or restlessness. Despite these reasons, staff at Gulu hospital staff told monitors that “there is no way a relative will bring a patient here (hospital) and refuse treatment.”

At Mulago, staff reported:

“Patients need to be provided with information regarding why they are sick, [the] importance of drug compliance, [and] side effects because if staff do not tell patients they will think they have a new sickness and will go to the traditional healers for treatment for it.”

A carer of a male patient at Arua told monitors: “These people (nurses) just come and give the medicine and they don’t tell us what it is for, but when I ask they will tell. What I know is that they are giving medicine for the sickness which I explained to them.” The patient commented “I know the colours of medications but not the names, I have not been informed of the medication.”

Monitors found that patients were not informed of what treatment staff considered to be appropriate to their needs. Their views were not considered and there was no distinction between voluntary and compulsory treatment. No alternatives to medication were offered to patients.



Sign post at Soroti hospital; monitors learned that mental health units at regional referral hospitals used to be constructed next to the mortuary, April 2014. © MDAC.

Other hospitals

It is inevitable that in a country with such a low life expectancy (52.65 years for men and 55.35 years for women),¹¹⁰ and with a high prevalence of HIV/AIDS,¹¹¹ mental health patients will be in need of physical medical treatments when in psychiatric hospitals. However monitors were informed that it was not common for mental health patients to die whilst admitted on mental health units because they would be transferred to general hospital wards if their physical health condition seriously deteriorated.

It appeared in many hospitals that the following practice, reported by a staff member at Mulago hospital, would take place:

“We satisfy ourselves that they are dead and the doctor clarifies the cause of death on the death certificate. We contact the caretaker [caregiver] and arrange for the body to be moved to the mortuary with a view to the family taking it home for burial. There will be no contact with the coroner. No inquest.”

At Arua, staff told monitors that when a patient died on the ward no post mortem was done “because the hospital does not use the Mental Health Act.” Staff said that if patients died then the reason was because they had been admitted with a serious life-threatening physical ailment, such as HIV. One opinion expressed to monitors was that whatever the legislation said, a post-mortem would be unnecessarily invasive and distressing for families.

At Gulu, staff reported the case of a young boy who sometime in 2012 had committed suicide by hanging himself in a seclusion room. No investigation took place, it was alleged, because his own father had placed him in seclusion.

2(A)(v). Conclusions and Recommendations

Monitoring findings show that deaths in hospitals are not investigated and no official statistics exist. As such, monitors were unable to ascertain the extent of deaths in Ugandan psychiatric hospitals. The high levels of coercion uncovered, including the practices of seclusion and restraint, clearly have the potential to be life-threatening either in themselves, due to the effect of these measures on the physical integrity of patients, as well as through aggravating their mental state. This unacceptable situation clearly poses significant threats to the right to life of people with mental health issues detained in hospitals, a right which is and guaranteed under international and national human rights law.¹¹² The Ugandan state has totally failed to discharge its minimum obligation to protect the lives and physical integrity of those placed in psychiatric hospitals across the country.

The suicide of one young boy which was reported at Gulu, and the alleged failure to conduct an investigation, was of particular concern to monitors. The government of Uganda has an absolute obligation to prevent, identify and address situations where people with disabilities are at risk of death or serious ill-treatment, including in respect of children who are detained.¹¹³

From a legal perspective, the high levels of coercion and ill-treatment observed by monitors raises serious human rights concerns. The United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee) has expressed concern about coercion and involuntary practices (including the use of seclusion) in mental health settings and has called on states to abolish non-consensual practices such as force treatment and restraint.¹¹⁴

The following are recommendations which should prompt urgent action by the Ugandan government.

Seclusion

- i) Urgently reduce coercive practices in psychiatric facilities, including the use of seclusion, by developing a national action plan to abolish their use within the shortest timeframe possible.
- ii) Train mental health hospital staff on de-escalation techniques.
- iii) Immediately develop rules and protocols requiring the recording and monitoring of any use of seclusion prior to abolition.
- iv) Patients should never be placed in unhygienic conditions, or deprived of light and warmth, and their clothes should not be removed.
- v) Ensure that relatives or other persons are never able to place a patient into seclusion.
- vi) Efforts must be made to discuss with patients what techniques should be used when they experience periods of crisis, rather than relying on default options of seclusion and physical or chemical restraint.
- vii) Share the experiences from some hospitals where seclusion has been abolished.

Restraint

- i) Enforce the obligation that every individual use of physical or chemical restraints must be recorded, and subjected to independent monitoring.
- ii) Reducing the use of all forms of restraint should be made a priority as part of an overall national strategy to reduce coercion in psychiatric hospitals.
- iii) Require that patients are informed of a right to complain and have every incident of restraint independently investigated, including the possibility of obtaining redress for violations.

110 CIA World Factbook, “Uganda”, available online at: <https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html> (last accessed 6 December 2014).

111 6.7 percent of adults aged between 15 and 49 are HIV-positive, while at least 500,000 people have been infected with the virus in the past five years. World Health Organization, “Uganda: The Humanitarian Situation”, available online at www.afro.who.int/en/downloads/doc_download/2972-uganda.htm (last accessed: 6 December 2014).

112 UDHR, Article 3; ICCPR, Article 6(1); CRPD, Article 10; ACHPR, Article 4; and Constitution of Uganda Article 22.

113 CRPD Committee, Committee’s Concluding Observation: 12 May 2014, Sweden, CRPD/C/SWE/CO/1.

114 Ibid.

- iv) Require all psychiatric staff to undergo compulsory and regular training on preventing the escalation of violence and aggression and in the use of alternative methods.

Forced treatment and lack of consent

- i) Require and enforce the principle that all treatment provided to people with mental health issues must be based on their free and informed consent, including in respect of mental health interventions.
- ii) Set up an immediate independent committee, with people with mental health issues themselves, to advise on the development of more dignified mental health treatment in psychiatric facilities.
- iii) Develop a national policy to implement the use of advance directives to ensure that the will and preferences of people with mental health issues are respected in relation to the care they receive at times of crisis.
- iv) All inpatients and their carers should be given detailed explanations of the nature, purpose and possible side effects of proposed medication or treatments, and of any alternatives. This should be provided in accessible formats.
- v) A presumption must be established, in the law, that all persons with disabilities, including people with mental

health issues, have the capacity to make informed decisions about their treatment. Restriction of this right to decide should only ever be exceptional.

Deaths

- i) Take urgent action to identify all deaths that have occurred in Ugandan psychiatric institutions in recent years, and undertake investigations to determine the causes of death and inform relatives where required. Where this has not happened, such cases must be referred to coroners.
- ii) Any future deaths should be immediately reported to an independent authority, specifically to the coroner. Bodies should never be disposed of before such a report has been made and directions have been given.
- iii) Immediately collect and publish statistics on death rates and reasons for deaths in all Ugandan psychiatric institutions, and outline key reforms necessary to mitigate the factors which contribute to them.
- iv) Independent investigations into all deaths in institutions should take place regardless of the request of a family member or relative.

2(B). Detention on the basis of a disability

Monitors found that admissions of patients to psychiatric hospitals frequently occurred without any legal authority. Detention was often justified on the basis of the presence of a disability (mental health issues) which falls foul of the prohibition on disability-based discrimination in international law.

Urgency orders last for ten days and no appeal mechanism exists. In practice, patients are not released on the expiry of any such order. Hospital staff were unable to tell monitors which patients were on urgency orders and which were not. While some patients were (probably) admitted on the basis of an urgency order, no data was available on the numbers of admissions.

2(B)(i). Admission

“Some people on urgency orders come with papers and some without.”

Psychiatric Clinical Officer, Kabale hospital

Most admissions to psychiatric hospitals across Uganda are initiated by patients’ relatives and sometimes by neighbours or community members. The 1964 Mental Treatment Act allows for compulsory detention and treatment for people on an “Urgency Order”. This allows an assistant police inspector or higher rank, any doctor or any chief to forcibly take a “person alleged to be of unsound mind” to any facility if they are “satisfied that it is necessary for the public safety, or for the welfare of that person”.¹¹⁵ The definition of a “person of unsound mind” includes an “idiot” or a person who is “suffering from mental derangement”.



Photo: Butabika acute female ward, September 2010. © MDAC.

115 Mental Treatment Act 1964, section 7.

Alternatively, patients could be brought to a psychiatric hospital on the basis of a "Reception Order". The majority of the Mental Treatment Act is devoted to arrangements and processes for the use of such orders, although monitors did not meet a single person who was detained on a reception order and very few staff had heard of them.

Butabika

Staff from regional psychiatric hospitals frequently explained that they used urgency orders to transfer patients to Butabika hospital. In Butabika, many clinical staff were unable to explain what urgency orders were. One ward manager – the person responsible for the welfare of up to 150 people – did not appear to know of the existence of the Mental Treatment Act, let alone its provisions. Her understanding of an urgency order was that, "when people are disturbed we need to medicate them as a matter of urgency." The hospital held no data on how many patients were on urgency orders. Even though police frequently brought patients to the hospital, this reportedly often happened without any orders having been made. The significance of this is not simply that the paperwork was not in place, but rather that many patients were denied their liberty without any lawful basis.

Monitors asked how decisions to admit someone to the hospital were made. The director of Butabika said that to admit a patient, he/she "has to be sick". In addition, the "mental symptoms should be severe enough for the patient to be admitted," a decision made by a doctor, the director explained. Monitors visited the wards and found that, just as in other hospitals visited, it was actually nurses, not doctors, who made the majority of admission and treatment decisions. However, the word 'doctor' was used commonly to refer to anyone who could administer treatment: that is psychiatrists and psychiatric clinical officers (nurses with additional training). Patients often referred to nurses, medical students and attendants when in uniform as "doctors".

Butabika is meant to provide specialised care but few patients there were referred from district hospitals. Relatives, carers, community members and police all reportedly took people to Butabika when they showed any symptoms of mental health issues, and this usually occurred without any referral from a lower hospital. It was also reported that Butabika was the only place where 'vagrants' could be dealt with.

Staff at the hospital reported that the majority of patients admitted to the hospital were brought when they were in a period of crisis. Monitors observed two people being admitted to the male acute ward. The director of Butabika said "we do not use the Mental Treatment Act any more" confirming that compliance with the law on the statute books had been abandoned several years ago. "Ninety percent" of the patients in the hospital, he estimated, did not want to be there, showing that the majority of them had been deprived of their liberty on an involuntary basis. There was no legal or operational requirement on staff to distinguish between those patients who were admitted voluntarily and those who were admitted involuntarily.

The director explained that a patient was discharged, "when the symptoms have gone down, the patient has developed insight, and agrees to comply with their medication at home." So in order to leave the hospital, the patient must admit they had a mental illness and agree to comply with medication. If these criteria were not met, the patient would continue to be treated indefinitely.

In law, patients or relatives can ask for the patient to be discharged against medical advice. All staff interpreted this to mean that *only* relatives could ask for a patient's discharge. This was theoretically possible, but a nurse with 18 years' experience in the hospital said that she had never known this to happen. Even if in theory it was possible for a relative to discharge someone, international legal standards require that detained persons have direct access to a judge to test whether their deprivation of liberty can be justified. Uganda has a systemic problem in this regard, as there are no admission criteria currently in operation: psychiatric admission is essentially a lawless domain where decisions about liberty and bodily integrity are all taken arbitrarily. Hence, each person in Butabika who wants to leave but is denied is unlawfully detained, contrary to international human rights law. It can be considered that the occasional person who arrives with papers on an urgency order are legally detained for the first 10 days, although even this is questionable from a human rights perspective.

Other hospitals

With only one exception, staff at all hospitals told monitors that they considered forced admission to be "voluntary", as the family was "volunteering" their relative into the care of the hospital. There was considerable confusion among all staff about urgency orders and reception orders, and monitors were convinced that the law currently on the statute books was not applied.



Photo: Staff at Kisiizi displaying the manacles used on patients to take them to the hospital, April 2014. © MDAC

Monitors witnessed four police officers bringing a middle-age woman to Mbale hospital. They had no paperwork. Monitors asked the senior police officer why the woman had been brought to the hospital. He responded that, “she was violent last night and has beaten someone. The person came and complained so we have to bring the lady to the hospital.” The police officer considered her a “public nuisance” who could get hurt, and hurt other people, even though he accepted that she had lived in the same place for three years and had not harmed anyone. Staff took the woman to have a shower and gave her medication which caused her to sleep. Monitors saw no overt signs of behavioural disturbance and asked the staff member in charge of the ward why the woman had been admitted when she looked well and responded to all questions coherently. The staff replied that her lack of insight (meaning her inability to recognise she allegedly had a mental illness) could be assessed “from the way she looked and because she lived alone in an isolated area for all these years.” This is a clear example of the need for independent scrutiny of admission assessments.

At Mulago hospital, urgency orders were used to provide a legal justification for the forcible transfer of patients to Butabika. In Kisiizi Mission hospital the manager of the mental health unit told monitors that since 2007, when she had started working there, only one patient had been admitted on an urgency order. At Arua, staff said they did not use the law as they thought it applied only to Butabika hospital. In Gulu, monitors observed the arrival of a young man whose family had tied him by his hands and feet and brought him to the hospital in the boot of their car.

If a person wanted to have someone manacled and transferred to Kisiizi hospital, it was reported that the local blacksmith would provide manacles for 15,000 shillings (approximately 4 EUR).



Photo: Monitors reviewing records at Mbarara hospital mental health unit. © MDAC.

There appeared to be no distinction between voluntary and compulsory admission and treatment in any of the hospitals monitored. The law allows for a patient to be discharged when hospital staff agree that he/she is ready to be discharged.¹¹⁶ A member of staff at Arua hospital argued that, “if you have not improved, we will keep you here. It would be clinically irresponsible not to.”

2(B)(ii). Record-keeping

“At times you have to deal with so many patients and you can forget or there is no time to record everything.”

Staff member at Butabika Hospital

Record-keeping at all hospitals was noted by monitors to be completely insufficient. There was no consistent recording of the legal status of patients. Minimal records only referred to the ongoing treatment patients as evaluated by nurses for handover purposes in respect of shifts. Even though all patients had their personal files, the documentation in these files and handover books were observed to be thin and inconsistent. Information was recorded in a selective manner. When information was recorded, it was often limited to simple descriptions of symptom management. This inadequate recording reflected a limited understanding of both the nature and significance of compulsory detention and treatment in all mental health hospitals.

Butabika

Despite asking the director and several ward staff, monitors saw no evidence that Butabika hospital had any written guidelines about admission procedures, or any procedures related to patient care, and completely inadequate record-keeping. Monitors looked at the day book during the second monitoring visit and it had a few lines about two new admissions, a couple of lines about patients who had been placed in seclusion, and sparse notes on those who had received rapid tranquillisation. On the top page it was written that two patients were secluded on the day of the visit but monitors could only see notes about one of these cases. Staff admitted that they failed to record things when they forget. For example, it was noted that seclusion start times were recorded, but not end times, and the same was evident in relation to admissions and discharges.

Other hospitals

Record-keeping at other hospitals was also noted to be completely inadequate. However, the level of patients’ details differed from one hospital to the next. Monitors found the most detailed recording at Kisiizi Mission Hospital. There was nothing individual or personal about the records of most patients in the majority of hospitals, with only key symptoms and interventions being recorded at most.

116 Mental Treatment Act, section 18.



Photo: Peter C Alderman Foundation at Soroti mental health unit, April 2014. © MDAC.

One patient's description was simply "restless and talkative" and another note said "patient calm- 20 mg diazepam start". There should be a specific and uniform standard or guide for all hospitals to record information. Monitors saw a database of all admissions, discharges and outpatients contacts only at the mental health unit in Arua. The system being used there had been donated by the Peter C Alderman foundation.¹¹⁷

2(B)(iii). Conclusions and recommendations

International law has sent mixed messages as to whether it is lawful to detain someone for reasons related to their mental health. In 2006, the UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted. Article 14 of the CRPD states that disability status cannot be a valid criterion in detention decisions, and this is the subject of intense international debate.¹¹⁸

The Committee on the Rights of Persons with Disabilities has called on States to repeal laws and prohibit the detention of children and adults with disabilities with reference to their disability status (including perceived mental health issues). This includes ending involuntary hospitalisation and forced institutionalisation.¹¹⁹ The Committee recommended to Tunisia that, until it puts in place new legislation, all cases of persons with disabilities who are deprived of their liberty in hospitals and specialised institutions should be reviewed with a possibility of appeal.¹²⁰ The Committee requested States to allocate more financial resources to persons with mental health issues who require a high level of support, and to ensure that there are sufficient community-based outpatient services to support them.¹²¹ It also expressed concerns on urgent detention measures with ex facto safeguards,¹²² and has called on States to establish a mechanism to monitor the situation of people with disabilities in detention centres and to take steps to protect their dignity.¹²³ The Committee has also called on States to adopt a broad strategy to counter forced institutionalisation, including providing support in decision making to persons with disabilities, and for addressing the needs of homeless people with mental health issues.¹²⁴

The Robben Island Guidelines were developed in 2002 and although they do not expressly mention mental health or disability, the scope of their protection is any place where a person is deprived of liberty. It sets out that States should ensure that anyone deprived of their liberty "can challenge the lawfulness of their detention."¹²⁵

With regard to records, unless things are written down it is difficult to improve quality and challenge decisions. This is particularly important in places where people are deprived of their liberty. At the African regional level, the Robben Island Guidelines place an obligation on governments to "ensure that comprehensive written records of those deprived of their liberty are kept at each place of detention, detailing, inter alia, the date, time, place and reason for the detention".¹²⁶

117 For further information, see <http://www.petercaldermanfoundation.org/> (last accessed: 5 December 2014).

118 See for example, the written comments of the government of Germany and Denmark to the draft general comment on Article 12 of the CRPD by the UN Committee on the Rights of Persons with Disabilities, available online at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (last accessed: 6 December 2014).

119 UN Committee on the Rights of Persons with Disabilities, General Comment No. 1, 11 April 2014, CRPD/C/GC/1; UN Committee on the Rights of Persons with Disabilities, Concluding Observations of the Committee: Azerbaijan, 12 May 2014, CRPD/C/AZE/CO/1.

120 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: Tunisia, 13 May 2011, CRPD/C/TUN/CO/1.

121 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: Sweden, 12 May 2014, CRPD/C/SWE/CO/1.

122 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: Spain, 19 October 2011, CRPD/C/ESP/CO/1.

123 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: El Salvador, 8 October 2013, CRPD/C/SLV/CO/1.

124 Committee on the Rights of Persons with Disabilities "Committee's Concluding Observations: Paraguay, 15 May 2013, CRPD/C/PRY/CO/1.

125 Robben Island Guidelines, Article 32.

126 Robben Island Guidelines, Article 30. In addition, Article 31 of the CRPD: "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies [...]."

Admissions

- i) All people with mental health issues detained against their will must only be detained in line with a law that does not discriminate on the basis of the presence of an actual or perceived disability.
- ii) The bias towards inpatient psychiatric treatment should be ended, through shifting national priorities to the roll out of community based mental health care, and a gradual reduction in the numbers of psychiatric hospital beds.
- iii) In the meantime, each person deprived of their liberty must have a meaningful right to appeal admission decisions and their ongoing detention. They must be informed in a language and manner that they can understand how to use the appeal system, and they must be provided with free and quality legal advice and representation so that their rights are protected.
- iv) Butabika hospital should stop admitting patients for a wide variety of reasons, and instead encourage community-based treatment of people with mental health issues. It should refer patients back to the community, and expand its community-based services.
- v) All patients should have a plan focused on their discharge which is independent of the wishes or desires of family members or caregivers. Family members or other caregivers should not have the power to make decisions about the ongoing detention or discharge of a relative.
- vi) Take measurable steps to trace patients' lost families and educate and support them to assist their relatives to live in the community.
- vii) All patients currently held without lawful authority should immediately be allowed to leave psychiatric hospitals. New legislation is required to make a clear distinction between voluntary and involuntary admission and detention, along with reviews of the legal status of all patients.
- viii) Upon admission, all patients should be provided with information about their rights and how to complain about decisions taken in respect of their admission, detention, treatment, etc.
- ix) Decisions about admission and treatment must be distinguished and there should be a presumption against compulsion.

Record-keeping

- i) Each hospital should be required to keep records of all detention, admissions and discharges, as well as proper, standardised medical and nursing notes.
- ii) The Ministry of Health should provide all hospitals a standard and structured format for recording patient information.
- iii) The data should be collected in a consistent format and should be forwarded to the Ministry of Health on a monthly basis for regular analysis. Data should be accessible in a way which protects the privacy of patients, and in order to improve services provided.

2(C). Access to physical healthcare

"There are lots of mosquitos here especially at night but there are no nets."

A patient, Arua hospital

Monitors noted that the poor conditions in many institutions visited meant that patients were at high risk of infection from communicable diseases or of suffering physical injuries when locked up in overcrowded facilities. It was noted that, in the majority of cases, patients' physical and general health were completely neglected. General hospitals had protocols for mental health patients to be transferred to general wings when they developed physical ailments, however the efficacy of such procedures was open to question.

Malaria is endemic in Uganda and is the leading cause of illness in the country, especially among young children. The Ministry of Health estimates that in a given year, at least 13 million cases of malaria are reported across the country.

The 2011 World Health Statistics show that Uganda's malaria mortality rate was 103 per 100,000, more than seven times that of neighbouring Kenya (12 per 100,000), 18 percent higher than in Tanzania and 9 percent higher than the average in Sub Saharan Africa.¹²⁷

Butabika

Staff informed monitors that there was an infirmary at Butabika where patients who developed physical illnesses were taken. Nevertheless, on the male ward, monitors witnessed a man who appeared to have multiple fractures to his arms. He was bandaged and plastered from his shoulders to his fingers on both arms. The bandages were dirty and flies had settled on them. Monitors were told that the injuries were caused in a failed escape attempt, but they also heard from other patients that the injuries were caused by police brutality before he was brought to the hospital.

¹²⁷ World Health Organization, World Health Statistics 2011 (Geneva: WHO, 2011).



Photo: Male ward at Gulu hospital mental health unit, April 2014. © MDAC.

Overcrowding at Butabika raises clear public health concerns. Monitors saw no evidence of mosquito nets or other preventive measures against mosquito-borne infections. In addition, a patient on the female acute ward informed monitors that she was HIV positive but had been given only mental health drugs since admission.

Health care at Bukatbika

Monitors met a 32-year-old woman at Kisiizi hospital who said she was HIV positive. She and her carer said that in February 2013 her left arm was broken from a fight while she was in Butabika's female acute ward. It was never treated.

"Everything in Butabika was not good", she said. She had been at Kisiizi for six weeks and staff told monitors that hospital surgeons would have to re-break the arm and set it properly, and then she would go through physiotherapy, before being discharged. Before being admitted to Butabika she lived in her aunt's house but the housekeeper starved her and tied her to the bed with a rope so tight that she suffered permanent nerve damage in her arm. Her right arm pulled up to her shoulder and her fingers twitched.

Other hospitals

At Kisiizi hospital, staff told monitors about a patient who had a history of mania but had only been treated on this occasion for malaria on a general ward. She was ready for discharge but was instead transferred to the mental health ward. She had exhibited no symptoms of mental illness but as she was known to the service she had to be assessed by them before discharge. In effect she had to prove herself sane as part of her recovery from malaria.

The lack of mosquito nets in hospitals was an issue to some patients. A 25 year old male patient in Arua who was happy with most things in the hospital said the lack of mosquito nets was his major concern. He told monitors that he could not complain to the staff because nobody in the ward had a mosquito net and even if he did complain nothing would happen. Monitors saw one of the few patients with a mosquito net in a female ward and when asked how they got the net, the husband said "it is our personal net, we had to buy it because there are lots of mosquitoes in the ward".



Photo: Soroti hospital female ward, October 2013. © MDAC.

Some staff at the hospitals argued that mosquito nets posed a ligature risk and that alternatives such as sprays would be appropriate to mental health wards. Whatever the solution, wards must be in a position to protect patients from contracting malaria during their inpatient treatment.

The severe overcrowding and shared living spaces in a number of hospitals visited by monitors also clearly presented a risk of communicable diseases spreading like wildfire. In one hospital, patients were required to share beds. One patient told monitors:

"So, we sleep 2 to a bed, head to head. It is not good if he snores, but TB is more worrying. There is lots of TB here. I don't know how much because they don't test for it."



2(D). Conditions and patient safety

“The nurses are hospitable but the fellow sick people are wild. I felt insecure here without a caretaker.”

Female patient at Mbale hospital

The conditions of the hospitals differed. Butabika was overcrowded meaning that some patients had to sleep on mattresses on the floor and sometimes two to the same bed. In the other hospitals carers slept on floor mats or mattresses, a practice that was common not only on the mental health wards. Carers supported staff with nursing care and their presence contributed to the prevention of fights or violence among patients or with other carers. All hospitals were minimally staffed and patients reported to monitors that they felt safer in hospitals where they could stay with their carers.



Photo: Young lady at mental health unit of Kisiizi hospital who said her arm was broken from a fight at Butabika female admission ward and was never treated, April 2014. © MDAC.

Butabika

During the monitoring visit in April 2014, the hospital's capacity was 550. At the previous visit the director had reported that the hospital had 690 patients, and that this figure sometimes went up to 750 people. The hospital was seriously overcrowded, with this being given as a reason by the director for not allowing patients' carers onto the wards. "If I already have 750 patients", he said, "one carer per patient will make it 1,500 people in the hospital".

Monitors spent most of their time on the male and female acute wards. The male ward was built for 80 beds but had 96 beds when visited. The night prior to the monitoring visit in April 2014, there were reportedly 150 patients. The female ward was also seriously crowded, and had 130 patients on a 70-bedded ward. Monitors were told that the number had reached 180 patients on that ward in the previous week according to the nurse in charge.

The wards were overcrowded because Butabika detains anyone brought to its gates: little discretion was used by staff to turn people away or to tell them they might be better off in their community. Another factor was reported to be the fact that Butabika was the only hospital in Uganda to provide food to its patients.

The wards were chaotic and understaffed. Both male and female wards ran with one trained nurse and two auxiliary, untrained personnel on duty. Some patients didn't have specific beds assigned to them meaning some people were required to share beds and mattresses with whomever they wanted. A male patient said that some patients urinated on the beds and floor and described the ward as filthy and uncomfortable.

Numerous patients explained to monitors that fights were common. A number of patients showed wounds on their hands and chests to the monitoring team. Staff levels were so low that the wards were clearly dangerous places for patients and staff alike. On the female admissions ward, monitors witnessed a fight breaking out: one patient slapped another hard on the face. In an instant, several women got involved, shouting and hitting each other. No staff member intervened. Eventually the patients resolved the matter themselves. A staff member who had worked at Butabika for over 10 years described the situation as "a boxing ring at night".

Other hospitals

The other hospitals visited had less severe overcrowding, and in some cases were operating below their official capacities.

Mulago hospital in Kampala was positively spacious compared with Butabika. The men's ward contained 17 beds but only five were occupied by patients at the time of the visit in April 2014. In this hospital and others, patients had up to three carers: in some cases the patient's spouse would come, in other cases a parent. Some patients had children with them too. Hospitals relied on the support which carers provided to patients and overlooked the numbers of carers present in the hospital, as was also observed to be the case on general wards.

Monitors were told that relatives made patients feel more secure and protected from other patients who might distress them. One female patient at Mbale told monitors:

“The nurses are hospitable but the fellow sick people are wild. I felt insecure here without a caretaker. I used to scream out or run away. When I came back to my senses the nurses began to talk to me. They decide for me. I did not like it here. The ward is very noisy, this one is screaming, that one is screaming.”

However, safety was a real concern for many patients. Except for Mbale and the recently constructed Mbarara unit, most mental health units in the hospitals had broken glass in the windows. Although some windows were made of polycarbonate, most used ordinary glass and the jagged glass shards were left unrepaired. At Mulago, when monitors inquired about broken glass, staff said they had put in a request to the maintenance department six months previously.

2(E). Pharmacology and boredom

“There is no radio or television, no access to information. I feel like a prisoner just sitting at one place.”

A male patient at Arua hospital

Most hospitals visited by monitors had no occupational therapy or any activities to occupy patients on the ward. Patients reported pervasive boredom in all institutions, which led them to feel unproductive and clearly had an impact on their rehabilitation. The majority of hospitals were tantamount to warehouses and were based on high levels of pharmacological treatment and lacked any therapeutic aspect.

Butabika

Monitors saw an occupational therapy department at Butabika hospital meant for patients who had been considered to have improved, to help them learn, practice or revive their skills. The director told monitors that other forms of treatment beside medication included psychotherapy, occupational therapy, and occasional family and group therapy. While some of these activities may have been going on, monitors found no evidence of anything other than medication being offered to the approximately 300 patients on the male and female acute admission wards. Monitors left with the clear impression that other forms of treatment or therapy, if provided at all, were minimal, because all of the patients with whom monitors spoke mentioned only medication. Monitors were told that the hospital employed three occupational therapists and two clinical psychologists to provide interventions other than medication, but no results of their work were available.

The children’s ward at Butabika had toys and an open space where children could play. Its staff saw their role as interacting with and supporting the children, an approach made possible by a higher staff-patient ratio. Monitors saw student nurses and staff playing football with children in the yard in front of the children’s ward. Monitors also observed a psycho-education class taking place on the substance abuse ward.



Photo: MDAC and MHU monitors speak to a person at Butabika occupational therapy department, April 2014. © MDAC.

The Occupational Therapy department had a large banner with the slogan “skills training is an essential occupational therapy tool in patients’ recovery and full integration into the community”. The activities described on the banner included gardening skills, cultivation, weeding, harvesting, preparing, sharing and partying. None of these activities, however, took place at Butabika. The director explained that, although most patients would need to be rehabilitated into the world of agriculture, he was concerned that the press would accuse him of using his patients as slave labour if patients were to engage in agricultural activities. Monitors saw patients just sitting around in the courtyards on the locked wards doing nothing and were happy to have strangers visiting to whom they could talk.



Photo: Table tennis at Gulu mental health unit, April 2014. © MDAC.

Other hospitals

There was a limited understanding of the value of occupation and engagement in other hospitals visited by monitors. Gulu was the only hospital where monitors saw games such as table tennis, board games and darts. However medical students were playing table tennis with each other but not with patients during monitors’ visit. When this was brought to the attention of the staff, the head of the unit responded: “I don’t see why they shouldn’t have some fun.” One of the four volunteers at the occupational therapy department informed monitors that at times he taught some of the patients how to play the games.

The only occupational facilities were noted by monitors at Kisiizi and Gulu hospitals. In Gulu four service users were reported to volunteer at the occupational therapy section providing guidance to patients on how to do craft work with paper. In these two hospitals service users had been hired as staff members and monitors were told that they would spend much of their time with current patients. During the visit to Gulu, a volunteer told monitors of one patient:

“The staff are frightened of him. They lock themselves in the office and he gets angry because he wants to tell them his troubles. On one occasion he got to the television and smashed it up. So now the patients don’t have a TV. Most PCO’s do not know how to handle the patients.”

It is important to note that this was an exception to the general boredom and pharmacological practices observed by monitors.

A male patient at Arua expressed his dissatisfaction with boredom on the ward after acknowledging that he could walk freely within the hospital grounds:

“There is nothing you can do here. When I get up I just brush my teeth and wait for tea. When you feel like practicing running, since I like to run, they might think that the problem or the sickness has started again. I feel like a prisoner just sitting at one place.”

However, the male patient thought the hospital was good because he met different friends and was able to learn from some of the people there. “Here in the hospital you can meet people with the same issue who can give you more advice.” Some of the things he did not like about the hospital included that there was no radio or television, and no access to information. “You see, I am a Chelsea fan but did not watch the match yesterday.”



Photo: John Bosco, one of the volunteers at Gulu occupational therapy department, April 2014. © MDAC.

Only at Mulago did monitors see a designated children’s playground for the children’s ward.

In Gulu, the children’s ward had been recently opened two months prior to monitors’ second visit.¹²⁸ The children’s ward had toys and books for children to play with. The manager of the children’s ward showed monitors an empty room next to the building which they planned to transform into a children’s playground.



Photos: Children’s ward playground Mulago hospital on the left, and the newly established children’s ward at Gulu mental health hospital, April 2014. © MDAC.



¹²⁸ Prior to setting up this ward, children were admitted with adults. The manager decided to establish the ward after he visited Sheffield hospital in the UK. The ward admits only children below 12 years. All the 5 beds had mosquito nets, and children admitted to that point were reported to be those with seizure disorders who were kept on the ward for observation. The ward reportedly did not admit children with autism but tried to support relatives and carers in caring for their children. There were no children on the ward on the day of the visit by monitors.

2(F). Hygiene

“The toilets have been blocked for some days and there is no money to repair them.”

Staff at Kabale hospital

The majority of patients with whom monitors spoke were not content with poor hygiene conditions in most psychiatric facilities, despite patients and staff saying that cleaners had been employed to keep the wards clean. Monitors were struck at the stench on many of the wards visited.

Butabika

Butabika has both ceramic toilets with water and pit latrines outside in the yard. The floors of the ceramic toilets were frequently wet and some of the sinks were destroyed awaiting repair. Toilets were filthy and emitted a strong stench of urine and faeces. On the female acute ward monitors saw five toilets for 150 patients. Many patients came from rural areas where they commonly used pit latrines, and many of these patients reported that they preferred them as they found them easier to use. Not only were they unfamiliar with the ceramic toilets but toilet paper was not regularly available. Monitors saw patients washing outdoors directly from taps located in the yard.

Lice were prevalent on many wards. To prevent the spread of lice, staff would shave patients' hair. In some cases monitors were told that this takes place against their will and goes as far as forcibly shaving patients' public hair. This raised gender concerns, particularly because male staff members would shave the hair of women.

The reason provided by staff to monitors for shaving was to limit the spread of lice, along with other actions such as a fumigation team that would visit every two weeks. The fumigation appeared to be ineffective as monitors could see that the lice problem was widespread. One of the reasons was that mattresses were simply uncovered foam slabs, and monitors noted that they were infested. Another cause was a general lack of supply of general hygiene products such as soap, shampoo, lotion or other toiletries.



Photo: Foam mattresses at Butabika hospital. © MDAC.

Shaving at Butabika

Monitors: What about pubic hair?

Staff: Yes, that is also shaved,

Monitors: Who shaves the pubic hair?

Staff: Many times the women do it themselves.

Monitors: Many times?

It became evident that nurses also shave some of the women.

Monitors: A female or male nurse?

The nurses looked at each other.

Staff: Ideally a female nurse. There are times when no female nurse is available.

Staff on Butabika female acute admission ward

Patients wore uniforms, many of which were dirty. Staff said that female patients had a free supply of sanitary towels but because the hospital did not provide underwear and had no laundry facilities, women had to wear the same dirty underwear for many days, even when they were menstruating. Patients complained to monitors very vocally that they found this practice disgusting and degrading. A female patient who otherwise worked as a cleaner gave her professional opinion: “This place is so dirty! They don't know how to clean it!”



Photos: Toilets in Arua mental health unit on left and at Soroti on the right, April 2014. © MDAC.

Other hospitals

In all hospitals patients were expected to buy and use toilet paper. Monitors noted that some patients were without as they could not afford it. Monitors learned from staff that the Department of Health wanted hospitals to use more sanitary flush toilets and that local councils had prohibited the construction of pit toilets.

In the hospitals visited by monitors it was clear that most people preferred to use pit latrines. At Kabale, similarly to other hospitals, monitors noted that the water input into the toilets were broken, causing the flush toilets to fail and the toilets to block. The rest of the ward had a pervasive smell of urine, and

the floor was wet. Staff informed monitors that the toilets had been blocked for some days prior to the monitoring visit, and the hospital had no money to repair them. Patients had to walk a couple of hundred meters up a hill to the pit latrine. The few patients who did not express revulsion at the state of the toilets on the ward said they could be improved.

In the majority of mental health units hygiene conditions were no different from that of general hospital wards. Broadly speaking, monitors observed that patients' conditions in regional hospitals were better than at Butabika, with carers present to assist in providing showers and wash clothes.

2(G). Gender-based discrimination

"No washing your knickers. Why? Bloody, dirty knickers!"

Patient, female acute ward at Butabika

Butabika

Women's hair was shaved without their consent at Butabika. Some women come in with long hair, which staff said would get tangled because there was no oil or combs available in the hospital. Monitors spoke to a female and male nurse and asked them about the procedure. They were not very forthcoming, but monitors were left with the impression that they sometimes shaved women's heads by force.

Issues around menstruation and cleanliness were observed to be a low priority in the overwhelming chaos that was found on the female admissions ward at Butabika. On the female acute ward, a woman who was admitted when menstruating and had stayed in the hospital for two weeks told monitors she had been wearing the same underwear ever since admission.

Monitors spoke with another woman who was the mother of five children. She told monitors that she wanted to go home, and that her oldest child was 12 and her youngest just 6 months. "I'm still breastfeeding", she told monitors. A participant at a joint MDAC/MHU advocacy training session also gave testimony of absconding from the same ward after she had given birth and was prevented from going home. She, too, had wanted to breast feed her baby.

Staff considered gender-appropriate care, at best, to be a luxury as opposed to a right: "It's like there are male gynaecologists: we are clinicians."

Other hospitals

Gender insensitivity was not as visible in the other hospitals visited by monitors. This may be because patients were with their carers who provided a variety of necessary supports. Hospitals generally had separate wings for male and female patients. In Kisiizi, men and women were placed in the same dormitory, with male and female areas demarcated by a hanging sheet. In all hospitals the patients' carers stayed on the same wards as the patient regardless of whether the carer was male or female.

2(H). Food

"This patient is on the ward. Has no attendants. Has no feeds. But is on treatment: chlorpromazine 200 mg and diazepam 20 mg."

Record on a patient's file at Kabale hospital

A lack of food was a major concern at most hospitals as patients and carers were generally expected to provide their own food in regional hospitals. Butabika was the only hospital that provided food to patients even though patients complained

about the fixed diet, the quality and nutritional content. Regional hospitals faced challenges in providing food to destitute patients and regional hospitals transferred destitute patients to Butabika for treatment solely because they would be fed there.

Butabika

Monitors arrived on the female acute ward as lunch was being served. This consisted of a plateful of porcho (maize flour cooked with water to a dough-like consistency) and boiled

beans. Some patients seemed pleased that at least they had a guaranteed meal, regardless of quality. One female patient, however, described the meal as "disgusting". Many others concurred, explaining that they never received vegetables or meat. Patients said that porridge was served for breakfast without enough sugar and matooke (plantain) and beans for lunch with the beans sometimes being undercooked.

A 45-year-old female patient who was not eating during lunch told monitors: "I only drink tea and a nurse usually helps me to boil water and sometimes buy me bread. I dislike porcho and beans every day."

Another lady in her late 30s told monitors: "I suffer from ulcers and have not eaten since yesterday because I dislike porcho and beans." Monitors asked if she had informed the nurses and her response was "there is nothing they can do". She ended the conversation with monitors with these words: "I do not want more questions because I am hungry."

Nevertheless, monitors witnessed patients complaining to staff that they were hungry. Nurses only expressed limited sympathy saying: "They [patients] would say that, especially when there are visitors. The government is providing food. Other hospitals don't provide any food."



Photos: Porcho and beans served for lunch at female admission ward at Butabika hospital, April 2014. © MDAC.

This demonstrates a dilemma for Butabika. As the only hospital in a position to feed patients, it was pleased to be able to offer something. Nevertheless, with the tiny budget available it was clearly unable to provide healthy food and patients would clamour for what was available, whilst also complaining about its quality.

Other hospitals

Food was not provided in any of the regional hospitals, although this was not specific to mental health units alone. Staff confirmed that psychiatric patients needed to eat well especially when on medication. This view was shared by both patients and carers. A husband who was caring for his wife on the female ward at Arua told monitors: "Food here is your own problem and when she takes medicines she wants to keep eating." A female patient at Mbale whose relative abandoned her prior to her admission and had no carer at the time of the visit told monitors: "I did not eat for a week. Then the nurses noticed and got provisions."

At Kisiizi hospital, a carer informed monitors how she had left school for the six months she had been with her brother at the hospital. In order to pay for his food, the family had to sell some of their land. She told monitors that she would go outside the hospital fence to buy food from a local market. As this was the only way to feed her brother, she said that the family was eager for him to be discharged as soon as possible.

Carers provided food for patients either by buying cooked food or preparing food at the hospitals. Each hospital had an allocated area that served as a kitchen for carers who supported one another. Lack of food in the hospital was seen as a major reason for carers and patients to request discharge.

Patients and carers told monitors that hospitals should provide proper kitchen space and some food provisions as some patients would stay the whole day without food. In Gulu, monitors spoke to a female patient who was breast-feeding her child and by 1 pm she had not eaten anything since morning, but was planning to buy food at lunch when food had been prepared. Her mother wondered what they would do when their money ran out.

In contrast, Mbale hospital seemed to have slightly more leeway than other units in helping destitute patients. Where a patient had no relatives, the social worker could ask the hospital to provide one meal a day. Some staff suggested to monitors that "giving people medicine without food can be ill-treatment or torture."



Photo: Family carers preparing food at Soroti mental health unit, September 2013. © MDAC.

2(I). Access to medicine

"It is common for drugs to be out of stock."

Staff at Soroti hospital

First generation anti-psychotic medication such as largactyl (also known as chlorpromazine or CPZ) was used at all hospitals and this medication was provided without cost to inpatients. Newer atypical anti-psychotic drugs are not available as they were considered too expensive to be provided by hospitals, although they could be prescribed for patients who could afford to pay for them. Drugs were centrally procured and were frequently out of stock.

The Uganda national essential medicines list requires drugs such as haloperidol and fluphenazine to be available at national referral hospitals and regional referral hospitals only.¹²⁹ The other drugs on the list that were required to be available at Health Centre IV and hospitals above include amitriptyline, diazepam, and carbamazepine. From Health Centre II and above, chlorpromazine was on the list. At hospitals, fluoxetine, sodium valproate, lithium carbonate and nicotine replacement are supposed to be made available.¹³⁰ Drugs not listed on the national essential medicine lists but that are part of the World Health Organization essential psychotherapeutic medicines list (2009) are methadone and clomipramine. Despite these lists, the majority of drugs were found to be in short supply.

The national drugs list excludes newer medications. The key reason old medications are still used was because of their cost. Even if hospitals could afford the newer treatments, this would create a problem for inpatients who would then have to pay for such drugs as outpatients. Families struggle to buy first generation drugs so the chances of them buying risperidone or olanzapine were not high. Hospitals generally lacked the facilities to conduct blood tests, despite lithium being available.

Hospital staff told monitors that cessation of medication was a major cause of relapse and yet the national pharmacy which determines what drugs will be available and distributes them frequently fails to keep hospitals adequately stocked. Many patients complained about the side-effects of the older treatments, but neither they nor the hospitals could afford the newer medications.

Butabika

Medication was the central tool of treatment at Butabika as at other hospitals. Talking therapies, social, environmental, and occupational treatments were rare.



Photo: Shutterstock

On arrival most patients were given a standard cocktail of rapid tranquilisation, whether they were violent or not. This standard rapid tranquillisation package comprised of a 200mg chlorpromazine intra muscular (IM) injection and a 20mg intravenous (IV) injection of diazepam. This was given at the discretion of nurses, without the prescription of a doctor. Monitors reviewed the day book and it stated that the package was given "due to refusal of medication".

One of the consequences of the reliance on first generation anti-psychotic medication was the increased frequency and severity of side effects, as reported by patients. On Butabika male acute ward monitors witnessed a man with his eyes rolled up and his neck tipped backwards slightly in the recognisable sign of oculogyric crisis, a dangerous side effect of antipsychotic medication. He stopped monitors at the gate and told monitors that he was feeling bad because of the medication and its side effects. Some time later monitors noticed that staff had done nothing to respond to this dangerous problem.

Other hospitals

Across the country, monitors found that failures in drug supply impeded the ability of services to provide pharmaceutical interventions. At Gulu hospital, monitors learned that during their second second visit, the hospital had had no artane (anti-parkinsonian medication) or haloperidol in stock for the previous two weeks, no promethazine had been available for one month and there was no fluoxetine. Where psychotropic medication is given under compulsion, hospitals must be able to deal with the well-understood side effects. At Mulago, the pharmacy informed monitors that they were out of lithium, procyclidine, clonazepam and risperidone and were proud to say that fluoxetine had been in stock for five consecutive months. They further told monitors that risperidone was available once but had not reappeared on the stock lists. At Mbale, staff reported that the hospital was out of haldol and sodium valproate during the monitoring visit.

129 WHO proMind, "Profile on Mental Health in Development", Uganda, November 2011, p. 41.

130 Ibid.

Monitors learned that when drugs are not available from the hospital pharmacy, relatives were encouraged to buy them on the open market or from other patients. This places an additional burden on inpatients and their families. The medication available at street markets was also said not to be reliable. Monitors learned that caregivers were encouraged to bring their purchases back to ward staff for checking. There had reportedly also been cases where traders were out of anti-psychotics and instead sold anti-histamines.

Electro-convulsive therapy (ECT) was conducted at some of the hospitals visited. In all cases it was conducted in a modified form under anaesthetic and with the use of muscle relaxants. At a number of hospitals monitors were told that the ECT machine had broken down and they were not able to mend it. In some,

staff reported that the machine was not used as there was no access to adequate medical support.

At Mulago, however, ECT was used occasionally in its fully modified form along with muscle relaxants and a general anaesthetic. Monitors saw the ECT machine stored in a bay not far from other patients on the women's ward and close to the children's ward, which is probably where it was used.

At Soroti, staff said that if a patient was to have ECT, which was relatively rare, the hospital paid for the general anaesthetic but the patient or family members had to pay for the muscle relaxant.



2(J). Conclusions and Recommendations

In the case of *Purohit and Moore v. The Gambia*,¹³¹ the African Commission on Human and Peoples' Rights castigated that country's outdated mental health system, which has striking similarities to mental health provision at Uganda's Butabika hospital. The Commission criticised the lack of "therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities... which falls short of satisfying the requirements laid down in Articles 16 and 18(4) of the African Charter."¹³²

The Commission set out that it was "aware that millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment" of the right to health. It also set out an obligation on governments "to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind."¹³³

The CRPD also sets out the right "to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".¹³⁴ Key provisions are that any medical treatments should be offered "on the basis of free and informed consent".¹³⁵ The right to health is also an entitlement for people who want to access and use mental health services. State Parties, including Uganda, are required to take measures that ensure all mental health services (including medication) are fully accessible to persons with disabilities at all levels,¹³⁶ apply budgetary resources and create skills among health personnel to effectively comply with the right to health care (such as malaria prevention).¹³⁷ State Parties are also urged to adopt measures to eliminate barriers to access basic services including sanitation,¹³⁸ and to raise awareness of the rights of women and girls with disabilities among managers of services.¹³⁹

Healthcare

- i) Adequate funds must be available to hospitals to ensure that patients are protected against malaria.
- ii) Steps should be taken to prevent against the spread of communicable diseases in psychiatric hospitals, including through reducing overcrowding, regular preventive and curative treatment for disease, and ending practices such as requiring patients to share beds.

131 Communication No. 241/2001 (2003) AHR/LR 96.

132 African Commission on Human and Peoples' Rights, *Purohit and Moore v. The Gambia*, Application No.241/2001, Judgment 15-29 May 2003, para. 83. Articles 16 and 18(4) set out the rights to enjoy the highest attainable state of physical and mental health and the right of the elderly and persons with disabilities to special measures of protection in keeping with their physical or moral needs.

133 *Ibid.*, para. 84

134 CRPD, Article 25.

135 CRPD, Article 25(d).

136 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observation: Paraguay, 15 May 2013, CRPD/C/PRY/CO/1.

137 Committee on the Rights of Persons with Disabilities, Concluding Observations of the Committee: Peru, 16 May 2012, CRPD/C/PER/CO/1.

138 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: El Salvador, 8 October 2013, CRPD/C/SLV/CO/1.

139 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observations: Costa Rica, 12 May 2014, CRPD/C/CRI/CO/1.

Food and conditions

- i) Ensure that adequate food and nutrition is made available to all patients at regional referral hospitals, ensuring that budgets are allocated to this.

Therapeutic environment

- i) Ward programmes must be developed to provide constructive activities to patients and support them to develop the skills necessary to live independently outside hospitals.

Hygiene

- i) Urgent action should be taken to improve hygiene standards at all facilities.
- ii) The conditions should be regularly recorded and inspected by public health inspectors.

Gender

- i) A policy should be developed to ensure gender-sensitivity in the provision of mental health care by the Ministry of Health in collaboration with other relevant ministries and specialised civil society organisations, including women with mental health issues themselves.

Access to healthcare

- i) All healthcare must be provided on the basis of the free and informed consent of all people with mental health issues in psychiatric hospitals.
- ii) Alternatives to pharmacology should be developed as a priority, including the use of talking and other therapies.
- iii) The performance of the National Drug Store should be reviewed to ensure that it can provide medicines required.
- iv) In order to improve the safe use of psychotropic medication, newer atypical anti-psychotic medication should be made available at a price which the people of Uganda can afford.



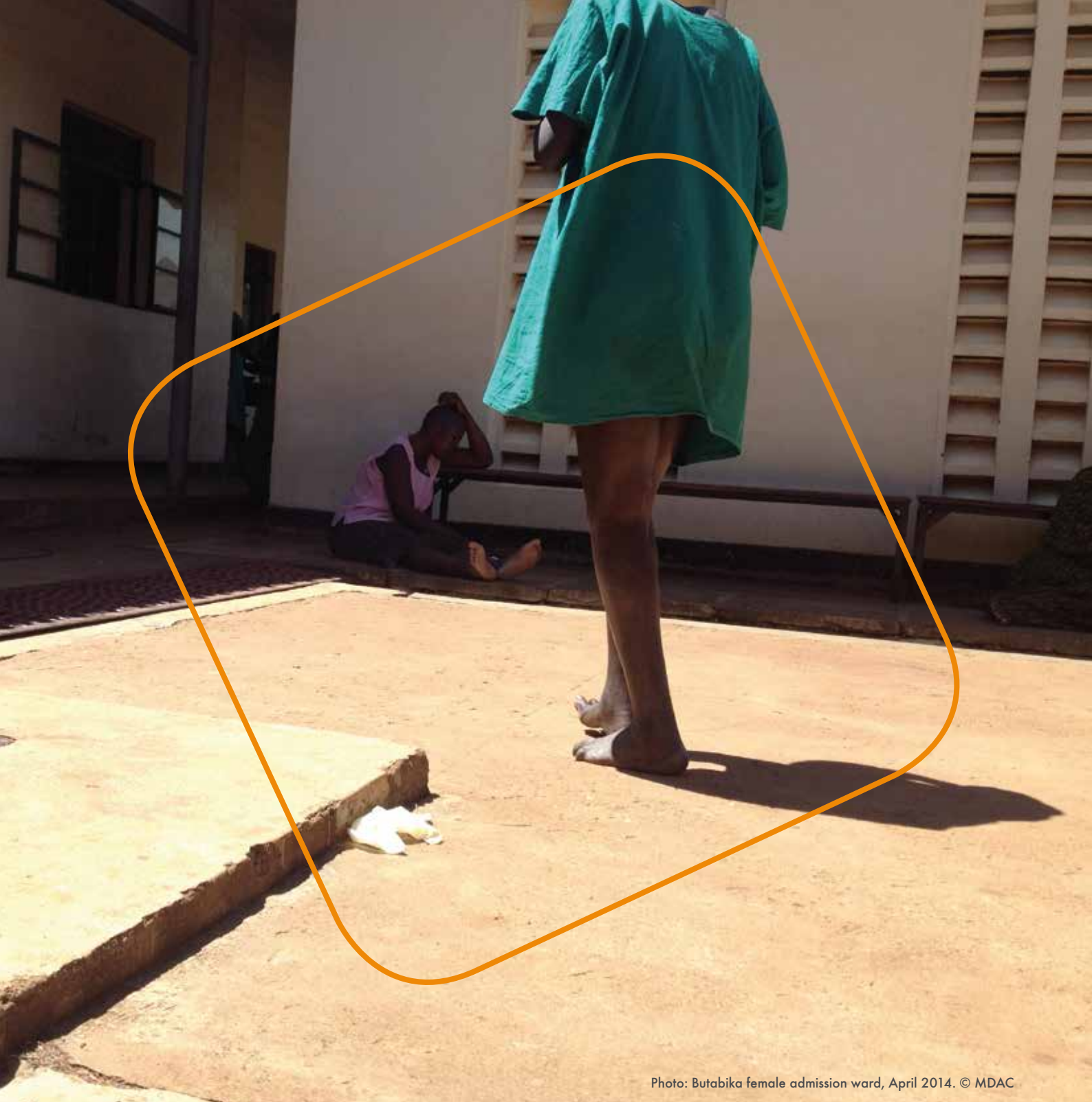


Photo: Butabika female admission ward, April 2014. © MDAC

***“It is necessary for us to trickle down into the community,
[where] we can break the circle.”***

Psychiatric Clinical Officer, Kabale

3. Causes of ill-treatment and abuse

This section of the report assesses the causes and reasons for the forms of ill-treatment and abuse against people with mental health issues that monitors found through monitoring in Ugandan psychiatric hospitals. It starts by considering the lack of community-based mental health and other services,

then moves on to consider the lack of compliance with the law, as well other drivers including low staffing levels in hospitals, the lack of regular and holistic training for mental health care practitioners, and the absence of effective complaints and independent monitoring mechanisms.

3(A). Community-based services

“When you see people in the outreaches they stay in touch with their communities. From here they go home afterwards. The problem is in the community and if we admit them nothing has changed at home. It is lost time. There is no better hospital than the home. There is no better support than the family. You sedate people because they want to run home. If they were at home you would not need to sedate them like that. If occasionally people did need to be admitted, then they could go to the district health centres which are much closer to the families. By having an integrated physical and mental health care service you would promote a holistic approach.”

Psychiatric Clinical Officer at Kabale

The transition from institutional to community-based services for people with disabilities requires both a shift of priorities and budgets. This transition is not only desirable to ensure that people with mental health issues can remain members of their communities, but is also now a requirement on governments flowing from international law.

Despite these requirements, Uganda has no formal or fully established community mental health services, rehabilitation programmes, day care centres or community-based crisis programmes.¹⁴⁰ Mental health care services within primary health care are almost non-existent. WHO research shows that approximately 70% of the 188 Health Centre VI (each covers 100,000 population) in the country has one psychiatric nurse providing basic mental health services limited to the provision of drugs and not including diagnosis.¹⁴¹ The research shows that the 1,182 Health Centre III (each covers 20,000 population) provides emergency treatment and referrals through general clinical officers and registered nurses. The 3,517 Health Centre II (each covering 5,000 population) are to provide services such as follow-up of patients diagnosed at higher hospitals and sedation of violent patients who are then referred to higher hospitals. The majority of Health Centre at this level have one enrolled nurse along with a nursing assistant or aid.¹⁴²

Minimal informal community services are provided by civil society organisations such as Basic Needs Uganda, Mental Health Uganda, Heart Sounds Uganda and the Transcultural Psycho-social Organisation. Some of these provide psycho-social support, peer support, and livelihood programmes to people with mental health issues. Monitors also met staff from the Peter C Alderman Foundation which supports civil war victims in Gulu, Arua and Soroti through the provision of post-trauma psycho-social support. The African Centre for Torture and Rehabilitation of Torture Victims also provides similar services in Gulu and Kampala. The lack of availability of such services, however, to the majority of Ugandan society means that people with mental health crises are significantly more likely to be admitted to psychiatric hospitals.

Hospital staff told monitors that they wanted to work with communities in villages to help them understand how to support with people with mental health issues. They said that the treatment of destitute patients would be improved through the provision of more community-based services, and would be identified at an earlier stage.

Community outreach provides a more humane, cost-effective, efficient and less stigmatising approach to providing mental health care, and this position was supported by a number of staff to whom monitors spoke. The unanimity of experienced mental health staff in support of community mental health services was so striking to monitors that it is worth setting out.

140 WHO proMind, “Profile on Mental Health in Development”, Uganda, November 2011, p. 41.

141 Ibid., p. 43.

142 Ibid.

“Every year, I am sitting here and seeing the same patients coming and going, but I don’t intervene to break social problems that are causing the relapses. What is the way forward? It is necessary for us to trickle down into the community, [where] we can break the circle when a relative brings someone for you to give chemicals but you don’t know whether the cause of relapse really needs medicines... We really want community mental health and not psychiatric mental health.”

Psychiatric Clinical Officer, Kabale

“The argument is that community outreach is not necessary since there is an institution, but if they bring services closest to the people it will be much cheaper, considering the time patients spend here [in hospital], the transport to come here and how much money patients spend when in hospital.

If I was in charge, or if you would have asked me, I would have closed down this place. There is no better ward than home, no better care than relatives care. Here we spend more on medicine, have to sedate patients to sleep because you don’t want patients to walk about or escape, and patients will escape because they are not comfortable here.

...When they come to the hospital it is a different environment and they have to abide by the rules here, but when we PCO go their communities we have to abide by their rules, and as a group in the community they can support each other. Patients who need to be managed by hospitals can be taken to district hospitals, so they should create small rooms in district hospitals for such people.”

Psychiatric Clinical Officer, Mbarara

“Community mental health work is beneficial because more than 100 patients can be seen every month with minimal cost from the hospital. We visit two health centres in a month and wish we can increase the number. We saw 66 and 95 patients during such outreaches. The costs involve a driver, fuel and staff time. Districts are not doing much when it comes to community mental health, not just the Rukungiri districts but all. When I go out there, what takes much of my time is talking to patients, I get tired and lack words by the time I am done. When I go to community outreach, I see patients running to the vehicle and I ask myself what if I never came? You see, if these 90 and 100 patients I see in the community will come to here [hospital], where will I put them? The work will never stop!”

Psychiatric Clinical Officer, Kisiizi Mission Hospital

At Soroti, staff informed monitors that there was a community mental health clinic currently being run as a pilot project in the sub-counties of Katini and Asuret. It was run by Dr Monroe (from Butabika) in conjunction with Makerere University. They had held training for health workers from Health Centres III and II. They also trained village health teams to provide counselling and to identify those who had suffered trauma. A mobile mental health team and a village health team identified and mobilised the communities themselves, without the requirement of the hospital to do this. The project was inaugurated in October 2013 and implementation started in January 2014. The mobile clinics had begun work the week before monitors’ second visit.

In Asuret sub-county, monitors found that workers were gathering data from households, the general public and school children on their knowledge and attitudes relating to mental health and the symptoms of mental illness. Monitors were told that this was a beneficial approach because mental health staff were going down to the grassroots. According to people working on this project the main problem was the sustainability of the project, which was only funded for a two-year period by the Canadian government.

Monitors were told that costs of providing community outreach programmes were lower than the costs associated with providing inpatient treatment, however a detailed cost analysis for inpatient care had never been done. One senior psychiatric clinical officer at Mbarara hospital calculated that outreach services are relatively inexpensive and estimated the following costs for a one-day community outreach clinic:

- Three staff salaries: 40,000 shillings each (13 EUR).
- Fuel: 50,000 shillings (16 EUR).
- Driver: 6,000 shillings (1.90 EUR).
- Total: 96,000 shillings (30 EUR).

Up to 100 people per day could be treated at such a clinic, according to the psychiatric clinical officer, meaning that the entire service would cost just 0.30 EUR per patient, although this meant that patients had to pay for their medication. The PCO, however, did strike a note of caution as this kind of one-day outreach would mean that there would only be five minutes to spend with each patient, which was insufficient from his perspective.

Monitors also heard from people with mental health issues, patients and their carers about the need to strengthen community-based services. A patient on the male ward at Arua hospital told monitors that he and his carer had had to travel for three hours by car to get to the hospital. They had been at the hospital for two weeks and he had not been able to work on his farm. When monitors asked where he would like to receive treatment, he said:

“It is better being medicated at home because transport is very expensive, and hiring a car to and from the hospital is about 100,000 shillings [28 EUR]. Food is a problem because going back home to get food is not possible, charcoal to cook food from hospital is expensive, and also accommodation, we sleep on the floor and even mosquitos at night is a problem.”

The carer of a woman at Arua also told monitors that they lived 20 kilometers from the hospital and that they had been at the hospital for a week. He thought that his wife's condition was improving and appreciated the way in which staff related to her. When asked if he thought treatment at hospital or in the community was better, he asked:

"Can we get free treatment at home? It is better because when we are at home there is enough food and relatives will be visiting. Few relatives have visited us in the hospital; just the wife's father and cousin have visited."

They buy food and the mother-in-law cooked at the hospital. Their children (3 years and 5 months old) were at home with his brother and he had gone home a few times to visit the children but thought it was better for his wife to stay in hospital. He told monitors that he was a farmer who grew beans, sweet and Irish potatoes, but was lucky that he had a brother to help with his farm while he was in the hospital.



3(B). Barriers to providing community-based mental health services

People with mental health issues, patients, carers and staff in psychiatric hospitals described a number of barriers to providing greater levels of community-based services. The barriers identified were attitudinal, socio-economic and financial. They are set out here, and recommendations are set out later in this chapter.

Staff training is limited to the provision of care in institutions

Staff were quick to tell monitors that their training did not fully equip them to be able to provide services to people in the community. One member of staff at Mbarara hospital told monitors that "some health workers find it difficult to work in the communities because their training is focused on institutionalised care." A number of staff members in psychiatric hospitals explained that this form of training meant that many saw their professional obligations in a very limited way, often not going beyond handing out drugs to patients.

Abandonment

Staff and patients reported that some relatives and carers saw Butabika as a place for relatives who wanted to abandon their family members. Butabika staff informed monitors that some people took their relatives to the hospital and intentionally provided incorrect contact details to avoid future contact.

Staff at Mbarara corroborated this problem, but added that it reflected the fact that families were often overwhelmed with the burden of supporting a family member with mental health issues, and that many had no other options.

'Super-specialised services' at Butabika, and an institution of last resort

As the only tertiary mental health facility in the country, it was perceived that Butabika was able to provide mental health services that were unavailable elsewhere. The observations of monitors and information provided by staff suggested the this reputation may be some way from the reality'. Staff at other hospitals also questioned the specialised nature of services purportedly available at the hospital. One staff member at another hospital expressed scepticism about Butabika:

"Go to Butabika and come back and tell me how many patients should be there? We do not refer to Butabika, not because we don't want, but what services will be provided there that we don't provide here? What specialised treatment is Butabika giving? Is it the name which is important or is the services which is important? Butabika should be providing highly specialised services."

At Soroti, staff cited a number of reasons for referring patients to Butabika, including for the provision of specialist treatments, to deal with patients deemed at risk of escape, treatment of drug-resistant illnesses, when a patient was a member of staff at their own hospital, or for dealing with destitute patients. This is similar to what monitors were told at Kabale, where staff explained that they would refer patients to Butabika where they were unable to provide their own food, and those with suicidal tendencies who could not be managed in open wards, or where a diagnosis was uncertain. Forensic patients would also be sent to Butabika.

Butabika clearly has a complex role within Ugandan psychiatry, often meaning that it bears the brunt of failures to provide services at a much more local level. However, monitors were also told that Butabika's special status meant it received the most investment, and that this in itself hindered the development of community mental health services. It is time to fundamentally review the position of Butabika.

Limited or no budget to explore alternative models of care or outreach

Hospitals and mental health units lacked a budget to offer alternative forms of care. No hospital has conducted an inpatient cost analysis to understand how much was spent on inpatient psychiatric services. Regional referral hospitals have an aggregate budget but the budgets fail to break down the cost per unit in general hospitals, a situation which was reported to monitors by administrators at Kabale hospital. Monitors also found that there was no funding to cover basic essentials in order that outreach services could take place, such as fuel or staff allowances.

Among other government hospitals visited by monitors, only Mbale mental health unit reported that the administration had allocated a small budget for community outreach. In Kisiizi, the director reported that both inpatient mental health and community outreach services were budgeted, particularly from the insurance scheme that the hospital runs.

Over reliance on aid agencies to run community outreach programmes

Staff reported that most community outreach programmes were funded by aid agencies and some programmes were offered by NGOs. Effective community mental health outreach programmes are not possible without specific budgetary allocations. Where outreach services were provided, this was usually funded by external aid agencies for time-limited periods. In Mbarara, monitors were informed that the four outreach visits per month had been reduced to two because of financial constraints. These services were funded by Oxfam and THET (an international aid agency.) Neither the hospital nor central government provided any financial assistance for the scheme.

In Gulu, the World Health Organization provided the mental health unit with a car which they had wanted to use for outreach, resettlement and occasional transfers to Butabika. Staff reported to monitors, however, that the hospital administration had insisted that the car be used by the whole hospital and the needs of the mental health unit had been deprioritised. WHO reportedly provided the car to Gulu hospital because it was a war-ravaged area. Another car was given to the hospital for malaria prevention activities but was reportedly misused, with WHO subsequently removing it.

In Arua, the Uganda Society for Disabled Children provided assistance to the mental health unit to provide monthly community outreach services in health centres in Kobogo and Rinokam

Unaffordable and inaccessible medication in communities

Medication was provided without cost to inpatients, which was not the case for outpatients. It is obvious that people with mental health issues, their relatives and carers found this an important reason for admitting people to hospital. In addition to this, key medications were not available at district levels, meaning that some patients ended up being transferred to Butabika. In Arua, staff told monitors that hospital drugs were not taken for outreach services because accountability was a problem.

Forensic patients and foreign nationals

Hospitals had few social workers who were sometimes shared with the physical health wards. In Arua a social worker told monitors that before a forensic patient was discharged, a social worker needed to prepare the community to accept them: "if not the community will kill him/her."

The large number of refugees from Rwanda in Uganda presented a significant challenge in terms of locating the family, persuading them to agree to the patient's return and then arranging for them to be transported to the border.

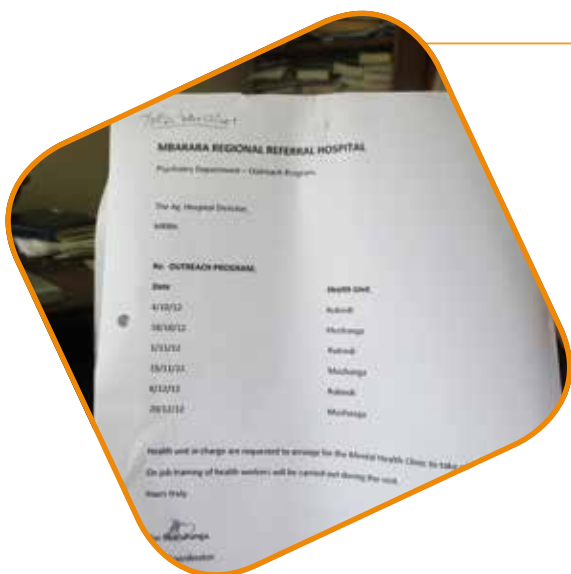


Photo: Paper showing the community outreach programme at Mbarara hospital, April 2014. © MDAC.

3(C). Lack of legal compliance

“Uganda has a general problem of forgetting laws on the shelves.”

Medical Director at Kisiizi

Monitors found that officials, experts by experience, staff, and representatives of civil society organisations all agreed that the current Mental Treatment Act is no longer fit for purpose. There are high expectations in respect of the new Mental Health Bill in representing a step towards a more humane and legally compliant inpatient mental health treatment.

Any new legislation will only make a difference if it is actually implemented and enforced in practice. Monitors found little evidence of respect for the current legislation. Staff openly said that the law had no business interfering in the relationship between mental health staff and the patients they were caring for. Monitoring in psychiatric facilities showed that even the minimal requirements of the present law are either forgotten or consciously disobeyed.

According to the head of Arua mental health unit, the 1964 Mental Treatment Act “is completely ignored”. This was because, he said, that psychiatric staff in regional hospitals had the (erroneous) belief that it only applied to Butabika hospital. The lack of legal compliance and regulation represents a serious gap in the rule of law itself.

Even at Butabika, the director of the hospital stated categorically that implementation of the 1964 Act has been abandoned, despite the fact that the legislation had not been repealed. It was not clear whether the current legislation was officially abandoned, or when, and so it is impossible to ascertain the number of years that Ugandans with mental health issues had been subjected to unlawful procedures, torture and ill-treatment.

3(D). Lack of information and awareness about rights

“The problem with patients’ rights is that rights cause more trouble than being good to them. If you [referring to patients] know your rights, go where you can have your rights. You will either take your drugs or you do not want our help.”

Staff at Gulu hospital

In October 2009 the Ministry of Health published a national Patients’ Charter for all patients which promised to “bring about the awareness of patients rights and responsibilities that has been lacking among the population of Uganda”.¹⁴³ The charter promised to “motivate the community to participate in the management of their health by promoting disease prevention, timely referral of patients to health facilities for immediate attention of their health problems and concerns”.

Monitors found that most staff in mental health units had never heard of the charter, and those that had heard of its existence hadn’t read the full version. Some staff told monitors that they had seen posters with the headline obligations. Most did not see it as their role to share information about these rights with the patients they treated.

Patients’ rights

- Staff: Yes there is a patients’ charter.
Monitors: Can I see a copy?
Staff: Sorry we seem to have run out.
Monitors: Perhaps one of the patients could give me one then?
Staff: We did not have enough for the patients so we only gave them to the staff.

Conversation with a Senior Officer at Kabale Hospital

143 Ugandan Ministry of Health Department of Quality Assurance, Patients’ Charter, 2009.

The lack of impact of the Charter wasn't just on mental health wards. Mulago hospital conducted a survey of their patients, including on the mental health unit. They found that 82% patients and 69% of health workers had never heard of the patients' charter, and that 56% of patients said that they did not know their rights as patients, despite 72% having a secondary education.¹⁴⁴

Soroti was the only hospital where the Charter was displayed and observed by monitors during the first monitoring visit to the hospital. It was both in English and Ateso, the local language, however it was placed in the office so most patients would not have been able to see it. Staff accepted the need to do more to ensure that patients knew of it, but said that this should depend on the mental state of the patients as it could take some time to explain. In Kisiizi, the staff reported that patients were not told of their rights and the director of the hospital proposed that videos on rights could be made, translated into local languages and played on TV in consultation areas to educate patients who were waiting to be reviewed.

'It does not apply here'

One Psychiatric Clinical Officer at Soroti said: "I would strike out the section on participation and having the right to refuse treatment. It does not apply here."

At this hospital monitors were invited to a meeting with staff which took place in a room with a poster about the Patients' Charter on the wall. During the meeting, at the next desk, the Psychiatric Clinical Officer continued to see outpatients and sign their attendance records. He continued to have these conversations throughout the meeting under the poster guaranteeing "the right to privacy".

At Mbarara, staff informed monitors that the hospital administration had placed an emphasis on providing information about the charter. Staff told monitors, however, that the challenge for them was ensuring that the rights were actually observed practice. One staff member told monitors that there should be an annual evaluation of mental health services at least once in a year, so that patients could tell them what needed improvement.

At Butabika, monitors asked the nurses how the patients are informed about their rights.

Staff: It's the job of the doctor or nurse to explain the rights.

Monitors: So does this happen in practice?

Staff: No. The doctor doesn't explain rights, so therefore nor do the nurses.

Monitors: What rights do the patients have?

Staff: The patient has the right to know their illness. They have the right to take medication, and the right to refuse. If they refuse the oral medication, then the medication is given by injection.

At Arua, a senior staff member explained that they had developed a draft copy of the charter and would share this with monitors if he could find a copy. He said:

"Rights are not put in terms of rights, no health worker walks up to patients to tell them about their rights, not many health workers are educated about rights even."

At Mulago hospital a senior staff member said that he had never heard of the charter but took a note about it and promised to investigate. He expressed gratitude to monitors for informing him of its existence.

Discussion with a male patient at Arua

Monitors: Do you know of your rights in the hospital?

Patient: Rights to get medication, to ask doctors some questions and medical care.

Monitors: How do you know about these rights?

Patient: No one told me, for me I know that I should have some rights. Doctors [referring to PCOs and nurses] tell us only about cleanliness and not rights.

144 Kagoya H.R, et al., "Awareness of, responsiveness to and practice of patients' rights at Uganda's national referral hospital", African Journal of Primary Health Care and Family Medicine 2013;5(1), at 491, available online at: <http://www.phcfm.org/index.php/phcfm/article/view/491/659> (last accessed: 6 December 2014).

3(E). Staffing levels

Low staffing levels are an obvious reason for the widespread ill-treatment that many people with mental health issues experienced in psychiatric facilities visited. On the whole, staff were tired, overstretched and clearly at risk of burnout within the context of overcrowding in a number of hospitals.

The following table shows the staffing levels at each of the hospitals visited, as reported by staff and observed by monitors.



Table 2: Staffing at mental health hospitals.

	Psychiatrists	Psychiatric clinical officers ¹⁴⁵	Clinical psychologists	Psychiatric social workers	Psychiatric nurses ¹⁴⁶	Occupational therapists	Mental health attendants ¹⁴⁷
Butabika hospital ¹⁴⁸	8	5	2	None	134	3	No information available
Mulago hospital	2 ¹⁴⁹	5	1	None	4	None	5
Kabale regional hospital	1 available by phone	6	None	None	3	None	2
Mbarara regional hospital	1 ¹⁵⁰	3	None	None ¹⁵¹	7	None. ¹⁵²	None
Arua regional hospital	1	9	None	None ¹⁵³	8 ¹⁵⁴	None	None
Gulu regional hospital	1	6	None	None ¹⁵⁵	3	1 ¹⁵⁶	6
Soroti regional hospital	None ¹⁵⁷	5	None	None ¹⁵⁸	1 ¹⁵⁹	None	None
Mbale regional hospital	None	6	None ¹⁶⁰	1	6	None ¹⁶¹	None
Kisiizi Mission Hospital	1 who visits annually	1	None	None	3	None ¹⁶²	2

145 No distinction has been made between senior and junior psychiatric officers. The difference relates to the number of years spent in practice. PCOs spend three years in undergraduate studies and undertake an additional two year full-time residential diploma in mental health.

146 This does not distinguish between enrolled psychiatric nurses and registered psychiatric nurse. The difference is that enrolled nurses have undergone two years of undergraduate training while registered nurses have completed three years of undergraduate training.

147 They are employed by hospitals to provide general non-clinical support.

148 These statistics draw on WHO statistics.

149 One of these is purely focused on administration and teaching.

150 Three more psychiatrists are restricted to teaching.

151 There is one social worker for the whole hospital.

152 There are three occupational therapists which cover the whole hospital, including the mental health unit.

153 The hospital also benefits from one social worker funded by the Peter C Alderman Foundation, along with one nurse and once PCO.

154 It also has two general nurses who work on shift but are not psychiatric nurses.

155 The hospital also receives support from nursing staff provided by the Peter C Alderman Foundation.

156 This is the head of the unit, and he has four volunteers who are patients.

157 Staff reported during the first monitoring that a psychiatrist from Butabika visits the unit every three months. On the second monitoring visit, staff reported that the psychiatrist visits once a month.

158 Two social workers were said to cover the entire hospital.

159 During the first monitoring visit staff reported having 3 nurses.

160 One volunteer psychologist was at the hospital during the first visit to the hospital.

161 There was reportedly one occupational therapist at Mbale in 2012, however monitors were informed that he was unable to undertake any activities due to a lack of facilities.

162 There is one occupational therapist for the whole hospital, who visits the mental health unit twice per week.

Staffing levels were poor at all mental health facilities. In Soroti, the Psychiatric Clinical Officer told monitors that a lack of nurses was the biggest problem as they had just one nurse. Staff informed monitors that about three weeks prior to the second monitoring visit to the hospital, consultants from the Ministry of Health had visited the unit for a survey. This was part of implementing the Ministry of Health five-year plan regarding staffing in mental health units at regional referral hospitals. According to this plan, each regional hospital should have a resident psychiatrist, a medical officer with a specialisation in psychiatry, a principal clinical psychiatric officer – all of which were lacking on the unit – along with two senior clinical psychiatric officers, four clinical psychiatric officers (the unit had only three), and two medical social workers who visited the mental health unit once in a while. The hospital also had a psychologist, occupational therapist and a psychiatrist who visited once a month. In the same hospital monitors learned that it was entirely unstaffed at night except for a single security guard and this seemed to be a general problem for the whole hospital.

Butabika has a staff to patient ratio of between 1:50-70. While Butabika may wish to provide “specialist inpatient and outpatient care”, monitors saw little evidence of anything beyond crowd control, and it would be difficult to imagine much more being possible when there were only three staff for up to 150 patients on a ward. Staff could not even remember patients’ names and during the visit referred to patients as “this one” and “that one”.¹⁶³ The hospital was struggling under the weight of the number of patients, and the director estimated that it was under-staffed by two-thirds. The low level of staffing clearly created an unstable and dangerous environment for many.

The responsibility for human resources in health management falls under the Human Resource Development Division and the Human Resource Management Division at the Ugandan Ministry of Health. The Health Service Commission is an autonomous institution that is charged with recruitment and deployment of human resources. The recruitment of health workers for national and regional hospitals fall under its jurisdiction.¹⁶⁴

3(F). Staff training

Monitors found a lack of sufficient or regular training for health professionals, particularly in areas including human rights, patients’ rights, and de-escalation. There were no training manuals available for staff beyond clinical manuals. Monitors found that only a small number of staff had received training relating to restraint.

Few staff had any knowledge about the 1964 Mental Treatment Act. One staff member told monitors:

“Training on the Mental Treatment Act for professionals stops in schools. I would like to see refresher courses since after school many people forget.”

Senior Psychiatric Clinical Officer at Mulago

Training for health professionals is the responsibility of the Ministry of Health and the Ministry of Education and Sports. The Ministry of Education and Sport is responsible for pre-service training for health workers while the Ministry of Health is responsible for in-service education and training for health professionals.¹⁶⁵ Doctors are required to renew their professional registration each year, and nurses are required to do so every three years, including in the mental health field. To do so, they are required to attend a minimum amount of continuing professional training sessions each year.

Butabika hospital provides training to students in mental health care. Health care professionals with authority to prescribe drugs are also required to receive orientation training in mental health and in the areas of mental health recognition and referral.¹⁶⁶ Every mental health worker must spend time on a rotational basis at Butabika or on the mental health units at regional referral hospitals.

163 MDAC and MHU are mindful that within the wider context of Uganda people often refer to people as “this one” or “that one” not necessarily because they do not know the person’s name.

164 WHO proMind, “Profile on Mental Health in Development”, Uganda, November 2011, p. 34.

165 Ibid., p. 38.

166 Ibid., p. 39.

3(G). Complaints procedures

An effective complaints system is an important protective mechanism for people who are deprived of their liberty. The Ugandan Human Rights Commission has the constitutional mandate to “investigate, at its own initiative or on a complaint made by any person or group of persons against the violation of any human right”.¹⁶⁷

The Commission received only two complaints against hospitals and health centres in 2012.¹⁶⁸ The Commission’s 2014 annual report states that deprivation of personal liberty/detention was the most commonly registered human rights violation in 2013, followed by violations of the right of freedom from torture and cruel, inhuman and degrading treatment or punishment.¹⁶⁹ The highest number of complaints were lodged against police officers and individuals.

The Patients’ Charter sets out the obligation on each hospital to designate a person or committee “to receive, investigate, and process patient’s complaints”, setting out that any complaints about “the quality of medical care shall be referred to the attention of the facility in-charge”.¹⁷⁰ The currently-applicable but unenforced law from 1964 does not set out any rights for people to complain.

Monitors asked both staff and patients about the existence of complaints procedures in all hospitals visited but found little or no evidence such procedures existed anywhere. Service users and carers were largely unaware that they had a right to complain, let alone about how to make a complaint. Monitors observed a passive acceptance by patients of the power of staff to make whatever decision they wished without any right of challenge. Staff seemed bewildered at the thought that service users or their carers might wish or need to make a complaint against them. A staff member at Mbarara said:

“No, patients do not know their rights. Even the staff do not know their rights. There are no leaflets. It is the hospital’s job to produce the leaflets and they do not. We have not had the opportunity to educate the patients about their rights. [...] If patients knew their rights they might pursue the government. They want to keep us in this position. People have no experience of complaining. Mostly they [patients/carers] praise us. We must put all this in perspective. If we were to observe their rights it would cause confusion. Even the Constitution has not been translated into all local languages.”

A staff member at Kabale also told monitors their view of complaints from patients against nurses.

“Generally our people (patients) are not assertive, and at times they fear to complain. We really need to sensitise patients about their rights and work on the fears. At times they think complaining is not right and that when they complain the staff will not treat them nicely or refuse to give them medication.”

A psychiatrist at Mbarara explained the need for such systems to be put in place:

“There is no clear complaint mechanism or procedure to handle complaints. This needs to be worked on as relatives can give up and lose trust in the system if their complaints are not addressed or they don’t receive any feedback.”

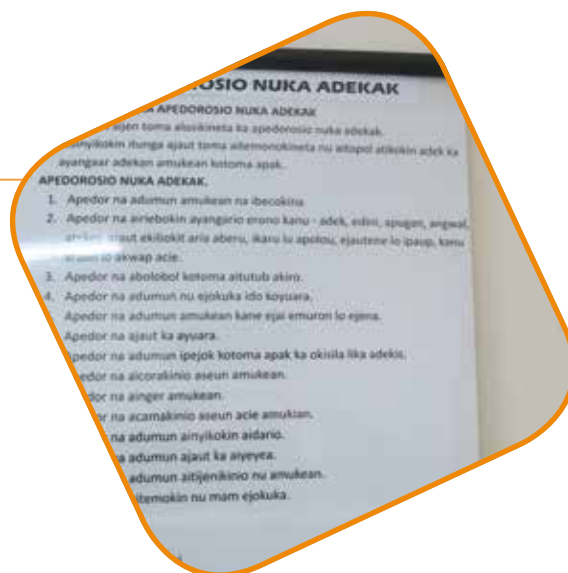


Photo: Soroti patients rights charter translated into Ateeso local language, October 2013. © MDAC.

167 Uganda Constitution, Article 52(1).

168 Uganda Human Rights Commission, 15th Annual Report of the Uganda Human Rights Commission to the Parliament of the Republic of Uganda, (Kampala: UHRC, 2012). Complaints were against hospitals in Masaka and Soroti. The type of complaints made were not specified.

169 Uganda Human Rights Commission, 16th Annual Report of the Uganda Human Rights Commission to the Parliament of the Republic of Uganda, (Kampala: UHRC, 2014), p. 4.

170 Patients’ Charter, section 19.

3(H). Independent monitoring and inspection

Uganda has ratified the UN Convention on the Rights of Persons with Disabilities (CRPD). Article 16(3) sets out that “in order to prevent the occurrence of all forms of exploitation, violence and abuse, state parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities”. Article 33(2) further requires Uganda to have one or more independent mechanisms to monitor implementation of the CRPD while Article 33(3) requires that civil society, in particular people with disabilities and their representative organisations, should be involved and participate fully in the monitoring process.

Uganda is yet to ratify the Optional Protocol to the UN Convention against Torture (OPCAT) which allows a UN committee to inspect any place where a person can be deprived of liberty.¹⁷¹ It obliges those governments to establish an independent inspectorate to regularly visit all places of detention to prevent all forms of torture and ill-treatment. In 2012, the Ugandan Human Rights Commission recommended that the government of Uganda ratify OPCAT,¹⁷² to show its commitment to ending abuses in all places where people are deprived of their liberty.

Uganda has signed up to the Robben Island Guidelines,¹⁷³ which requires states to establish, support and strengthen independent national institutions such as human rights commissions, ombudspersons and committees of parliamentarians with a mandate to conduct visits to all places of detention. The purpose of such monitoring should be the prevention of torture, cruel, inhuman and degrading treatment or punishment.

Presently, no national or regional human rights bodies exist with the remit of monitoring the human rights of users in mental health services in Uganda. Neither Butabika hospital nor inpatient psychiatric units at regional hospitals have ever undergone any form of independent monitoring prior to this investigation.¹⁷⁴

The 1964 Mental Treatment Act states that the government must appoint a minimum of two people “in respect of each mental health hospital”,¹⁷⁵ who should inspect “every part of the mental health hospital” at least every three months, and during these visits they must meet each patient, assess documentation, enter remarks in a “visitors book”,¹⁷⁶ and write reports.¹⁷⁷ Visitors have access to the institution at any time, for as long as they please, and may have access to all patients.¹⁷⁸ None of the hospitals monitors visited had such visitors. The system had reportedly fizzled out several decades ago.

The National Council for Disability has a mandate to monitor and evaluate the implementation of the CRPD and disability policies in Uganda,¹⁷⁹ however no independent monitoring had taken place in psychiatric facilities as required under Article 16(3).

The Constitution mandates the Human Rights Commission to “visit jails, prisons, and places of detention or related facilities with a view of assessing and inspecting conditions of the inmates and make recommendations.”¹⁸⁰ The annual report of the Human Rights Commission published in 2014 looked at conditions in places of detention and the human rights of detainees and staff working in police cells, prisons, remand homes and military detention facilities, but not psychiatric facilities.¹⁸¹ The Commission also inspected 374 health care facilities to assess access to essential health goods and services during 2013. The Commission informed MDAC and MHU that they visited Butabika hospital in 2013 and the future annual report will include their observations.¹⁸² The Commission’s staff also emphasised that they will need training on how to monitor psychiatric hospitals.

The lack of focus on what happens inside Uganda’s psychiatric institutions, and the abuses highlighted in this report, result in a system where human rights abuses can occur with impunity. Psychiatric institutions must be included among the places warranting regular inspection by the Human Rights Commission.

171 Defined as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.” Article 4(2), OPCAT.

172 Uganda Human Rights Commission, 15th Annual Report of the Uganda Human Rights Commission to the Parliament of the Republic of Uganda, (Kampala: UHRC, 2012), p. xxxv.

173 Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa, 2nd edition, part 2, para. 41.

174 WHO proMind, “Profile on Mental Health in Development”, Uganda, November 2011, p. 28.

175 Mental Treatment Act 1964, section 24.

176 Ibid., section 25.

177 Ibid., section 26.

178 Ibid., section 27.

179 “Uganda draft Initial Status Report on CRPD Implementation”, 2010, p. 56. (Not yet submitted.)

180 Ugandan Constitution, Article 52(1)

181 The Commission inspected 1,060 places of detention including 6 remand homes, 20 military detention facilities, 142 prisons, 225 police stations and 667 police posts. Uganda Human Rights Commission, 16th Annual Report of the Uganda Human Rights Commission to the Parliament of the Republic of Uganda, (Kampala: UHRC, 2014), p. 25.

182 MDAC and MHU meeting at the Ugandan Human Rights Commission, Office of the Human Rights Commission, in Kampala, 4 April 2014.

The 2011 draft Mental Health Bill (the most recent copy which monitors could access) proposes a Mental Health Advisory Board which among other tasks will carry out an inspection function.¹⁸³ The bill does not specify who should carry out the inspections, what powers they would have, to whom they would report and does not clearly require a level of independence.

Butabika, the hospital in which we documented the most human rights violations, is twinned with the Institute of Psychiatry in London and is visited by colleagues from the UK. However, a supportive role is fundamentally different from an inspectorial one. There is no evidence that this arrangement has brought about any independent external scrutiny of what goes on inside the wards.



3(I). Conclusions and Recommendations

The lack of mental health services in the community represents a failure by the Ugandan government to implement the right to independent living in the community for all persons with disabilities, including people with mental health issues. As has been described above, psychiatric institutions based on a strongly pharmacological approach are the predominant services provided to people with mental health issues. From the perspective of international human rights law, the Ugandan government must take real action in this area, particularly given the evidence presented herein of widespread human rights violations in psychiatric institutions. The UN Committee on the Rights of Persons with Disabilities has repeatedly urged governments to take concrete, measurable steps and set clear time frames, benchmarks and steps to establish community-based services, including rights-based mental health services, as an alternative to institutions.¹⁸⁴

The absence or lack of enforceable legislation is of serious concern, meaning that mental health care and abusive practices can take place without any regulation whatsoever. Uganda must now stop stalling on the passage of new, robust legislation based on and extending human rights protection to those people who use psychiatric services in the country. It should do this through the passage of legislation as soon as possible,¹⁸⁵ and must ensure that people with mental health issues and their representative organisations are involved in the process.¹⁸⁶

It is also clear that a rights-based culture in mental health care is unlikely to take place unless there is a major drive to inform practitioners and people with mental health issues about their rights. The CRPD also places an obligation on the Ugandan government to promote training of professionals and staff working with people with mental health issues on human rights standards and obligations.¹⁸⁷ Given the serious and widespread abuses uncovered in this report, this should be given high priority. The following steps are also recommended.

Community-based services

- i) The development of community-based services for people with mental health issues should become a national priority, rather than the continued funding of institutional psychiatry.
- ii) Regional referral hospitals should be allocated a ring-fenced budget to carry out community outreach programmes.
- iii) Pilot programmes should be sponsored by the central government and independently monitored. Where there is support from international donors, the sustainability of projects must be carefully planned.
- iv) Ensure that adequate mental health care services are available at all levels of the health care system, including at the primary healthcare level, and are based on human rights standards.
- v) Undertake research and draw on academic and professional expertise to develop alternative models of psychiatric care beyond the current pharmacological approach, and which are based on the principle of informed consent.

Legal regulation and compliance

- i) New legislation to regulate the provision of mental health care must urgently be enacted. The legislation must be based on core human rights standards.
- ii) Hospitals should be required to inform all users of their services about their human rights and the national Patients' Charter. The use of a variety of formats and languages in providing this information is encouraged.
- iii) People with mental health issues, their representative bodies and wider civil society should be invited to be closely involved in these reforms.

183 Draft Mental Health Bill (September 2011).

184 Committee on the Rights of Persons with Disabilities, Committee's Concluding Observation: Paraguay, 15 May 2013, CRPD/C/PRY/CO/1.

185 CRPD, Articles 4(1)(a) and (b).

186 Ibid., Article 4(3).

187 Ibid., Article 4(1)(i).

Complaints and independent monitoring

- i) Each health care facility must establish an effective and independent complaints mechanism for all users of their services. Information about complaints procedures must be provided to all users, including the right to appeal to an independent body.
- ii) Ratify the Optional Protocol to Convention against Torture (OPCAT) and implement the Robben Island Guidelines, and establish regular, independent monitoring of all psychiatric facilities in the country.
- iii) Immediately establish an independent monitoring body with the mandate to examine implementation of the UN Convention on the Rights of Persons with Disabilities under Article 33(2), and with a mandate to enter, inspect and prevent incidences of torture and ill-treatment under Article 16(3).
- iv) All complaints, monitoring and inspection reports should be published on a regular basis. The findings of these should be monitored by central government with a view to addressing systemic human rights violations.



Photo: Logo of the Ugandan Human Rights Commission.



Appendices

Methodology

The present study represents the first ever human rights monitoring of psychiatric hospitals in Uganda. In preparation for the monitoring of psychiatric facilities, MDAC and MHU first conducted a four-day monitoring training course for 16 participants from a range of backgrounds in October 2013 in Kampala, Uganda. The aim was to prepare them for undertaking the monitoring that led to the production of this report. A number of the participants had experience of Ugandan mental health services. These 'experts by experience' were major participants in the process. Some had taken on staff roles in hospitals as peer support workers. They were accompanied by lawyers, mental health clinicians and members of human rights NGOs on the course. The course also involved a one-day pilot monitoring visit to Butabika hospital for participants to gain practical monitoring experience as a team. MDAC and MHU then worked with participants to contextualise and adapt monitoring guides and checklists based on a toolkit for monitoring human rights in mental health and social care institutions.¹⁸⁸

After the training, the monitoring team comprised two representatives from MDAC, the Africa Project Manager and an external consultant with a background in human rights monitoring, and two representatives of Mental Health Uganda. The team visited at least two psychiatric units from each administrative region (Northern, Western, Eastern and Central Province) on a preliminary basis.

All visits were announced and based on prior agreement received from requests submitted by MDAC and MHU. Each hospital was visited twice, the first time in October 2013 and then again during the team's return trip in April 2014. The second mission included two new monitors, and was designed to confirm or contradict findings from the first mission, and to monitor any changes that had taken place. Each member of the team took their own notes or wrote their own journals. The findings of this report are based on a qualitative thematic analysis of the information collected, including direct quotations where appropriate.

Each monitoring visit lasted from 9am to 4pm and commenced with formal introductions to senior hospital staff, commonly with a director, a hospital administrator and a chief nurse. The team discussed the purpose of the visit with them, and gathered information about the key challenges they identified in their hospitals. Monitors when moved to the ward(s) to be visited. On each occasion, a preliminary conversation with the ward manager or the 'in-charge' of the ward took place, before the team went on to the residential areas to observe the physical environment and talk with those patients who were willing.

Apart from Butabika hospital, the majority of patients with whom monitors spoke were accompanied by family members or carers, who were an important source of information. At some hospitals patients or carers were sitting in groups, and were most comfortable with the support of others. Some conversations were held as group meetings, while other people chose to disclose sensitive matters to monitors in private. Some patients and carers spoke English, and some only spoke their local language. MHU monitors and other patients frequently offered help to overcome language barriers. Wherever possible, female wards were visited by female monitors and in particular the Chair of the Board of MHU proved invaluable in this regard. On each visit monitors examined individual files and the 'handover book' in which notes were left by staff from one shift for those coming after them.

The monitoring team experienced openness and hospitality in every hospital visited. The team acknowledged that, unlike a mandatory inspection by a statutory body, the hospitals were under no obligation to host such visits. This openness is to be commended.

In April 2014, monitors also met representatives of the Ugandan Human Rights Commission to discuss the work of the Commission and how the human rights of people with mental health problems could best be protected in the future.

¹⁸⁸ The Institutional Treatment, Human Rights and Care Assessment (ITHACA Project Group), ITHACA Toolkit for Monitoring Human Rights and General Healthcare in Mental Health and Social Care Institutions, (Health Service and Population Research Department, Institute for Psychiatry, King's College London, London: 2010), available online at www.mdac.org.

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It is the hope of MDAC and MHU that this report helps in improving the humane delivery of mental health services in Uganda based on human rights standards, and contributes to the total elimination of all forms of torture, ill-treatment, violence and abuse against people with mental health issues in psychiatric hospitals in the country.



