MENTAL HEALTH LAW PROFILE

Mental health law reforms in Uganda: lessons learnt

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Ugandan mental health legislation, which dates from 1964, principally aims to remove persons with mental disorders from the community but also to protect their safety, by keeping them in confinement, although this has been without consideration for clinical care. In response to criticism from various stakeholders and advocates and the need to reflect modern clinical care, Uganda undertook to review and amend the mental health legislation, as part of the Mental Health and Poverty Project (MHaPP). We report on work in progress advancing new legislation.

The authors wish to acknowledge the MHaPP Research Programme Consortium. The Mental Health and Poverty Project (MHaPP) is a Research Programme Consortium (RPC) funded by the UK Department for International Development (DfID) (RPC HD6 2005–10) for the benefit of low- and middle-income countries. RPC members included Alan J. Flisher (Director) and Crick Lund (Coordinator) (University of Cape Town, Republic of South Africa); Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization); Arvin Bhana (Human Sciences Research Council, Republic of South Africa); Victor Doku (Kintampo Health Research Centre, Ghana); Andrew Green and Mayeh Omar (University of Leeds, UK); Fred Kigozi (Butabika Hospital, Uganda); Martin Knapp (University of London, UK); John Mayeya (Ministry of Health, Zambia); Eva N. Mulutsi (Department of Health, Republic of South Africa); Sheila Zaramba Ndyanabangi (Ministry of Health, Uganda); Angela Ofori-Atta (University of Ghana); Akwasi Osei (Ghana Health Service); and Inge Petersen (University of KwaZulu-Natal, Republic of South Africa).

Globally, about 25% of countries, with nearly 31% of the world's population, have no national mental health legislation, although some countries with a federal system of governance may have state mental health laws. Half of the countries which do have mental health legislation had their laws enacted before 1990, with some 15% having legislation that was enacted before 1960, well before the advent of modern treatments (World Health Organization, 2001).

In the Ugandan context, the overall objective of the mental health legislation of 1964 (the Mental Treatment Act) was to remove persons with mental disorders from the community but also to ensure their safety, by keeping them in confinement, although this was without consideration for clinical care. However, in response to criticism from various stakeholders and advocates and the need to reflect modern clinical care, Uganda undertook to review and amend its mental health legislation, as part of the Mental Health and Poverty Project (MHaPP) (Flisher *et al*, 2007), which included a review of the country's mental health system.

In this paper we briefly summarise aspects of the 1964 Mental Treatment Act and report on work in progress advancing the new legislation.

The old mental health law

The Mental Treatment Act came into force soon after independence in 1964, as a revised version of the colonial Mental Treatment Ordinance of 1935. It focuses largely on issues to do with the 'detention' of people with mental illness, thereby failing adequately to promote and protect their rights either within the healthcare context or in the community. The implicit perspective of the Act is that mental illness is a disgrace rather than a sickness. It does not provide for the rights of persons with mental illness in the community, and concentrates on those in mental hospitals. Many of the provisions of the Act are aimed at protecting the public from persons with mental illness (Mulumba, 2007). The law is basically concerned with treatment, as its title suggests, despite the fact that mental health services comprise more than just treatment. Furthermore, the law does not specify the principles for development and standards of services.

Need for a new law

Following the major health reforms in many other countries during the early 1990s, with the decentralisation of health services, with primary healthcare as the basis of health interventions and a national minimum healthcare package, the mental health programme in Uganda was mandated to integrate mental healthcare into healthcare services, at all levels, including the community level. At about the same time, mental health user support groups and associations became active and started advocating for human rights considerations in the law. Coincidently, as Uganda was reviewing its law, the World Health Organization (WHO) embarked on developing guidelines for mental health legislation. As Uganda was one of the countries which participated in this process, the MHaPP Uganda team was able to appreciate the gaps in the old law and the principles guiding development of the new law.

Process of revising the law

It should be noted that the WHO recommends reviewing mental health laws every 5–10 years (World Health Organization, 2003) and that, before embarking on drafting legislation, a number of preliminary steps should be undertaken:

- Identify the country's principal mental health needs and problems, as well as existing and likely barriers to the implementation of new mental health policies, plans and programmes.
- Examine existing mental health law and identify general laws that address mental health issues, looking at specific aspects that are lacking or in need of reform, and examining barriers with respect to their implementation.
- Study those international human rights conventions and standards that include provisions related to mental health, and identify governments' obligations for fulfilling the requirements of those instruments.
- Study components of mental health legislation in other countries, especially those with similar

https://doi.org/10.1192/S1749367600004367 Published online by Cambridge University Press

socioeconomic and political structures and backgrounds.

- Build a consensus and negotiate for change.
- Educate the public on issues of mental health and human rights.

The process of revising the Ugandan law began with the development of a memo on principles, gaps to be addressed and justification for the review. This was followed by evaluation of the existing law using a WHO checklist.

The exercise revealed the strengths and weaknesses of the existing legislation, and helped in the identification of provisions for inclusion in the new law. A drafting committee was then constituted for the task. Mental health laws from other countries such as Kenya and South Africa were reviewed, in addition to information on mental health in the country to guide the drafting exercise. Furthermore, wide stakeholder consultation was undertaken before the final draft was submitted for restructuring by the Ministry of Justice into legal language.

The new legislation

The revised mental health bill provides for a number of changes in the administrative pattern of mental health services in the country, in conformity with the UN Convention on the Rights of Persons with Disability (CRPD), to which Uganda is a signatory. It makes mental health services part of all health facilities. Outdated terms, such as 'lunatic', 'idiot' and 'person of unsound mind', which have long carried derogatory connotations, were substituted with new terms such as 'person with mental illness' or 'patient', and 'detention' was replaced by 'admission'. Furthermore, the bill provides definitions of important terms such as 'mental disorder'. This is expected to significantly reduce stigma and discrimination.

In the new bill, the criteria for voluntary and involuntary admissions and treatment are explicitly spelt out. Decisions for examination, admission and treatment are to be undertaken at a mental health unit and performed by a psychiatrist or senior psychiatric clinical officer (a clinical officer with 2 years of specialised training in psychiatry).

The new bill has a specific focus on the rights of persons with mental illness. For example, one of the clauses states: 'In upholding the rights and performing the duties under this part, regard shall be given to the best interests of the patient'. The new bill is silent on protecting the public from persons with mental illness.

Challenges and enabling factors

The process involved a number of challenges. First, it was quite bureaucratic and slow; it took close to 10 years to reach the stage of drafting the bill. Because mental health has been a low priority, some stakeholders never responded when called upon. Convincing the Ministry of Finance that the mental health bill was worth the extra cost it would impose on the Ministry of Health's budget was also a struggle. Resource constraints meant that assessment of the existing mental health law was not to be informed by formal research. Furthermore, there were frequent changes of ministers of health, which took the process back many steps each time. Also, the Ministry of Health lacked an in-house legal officer, hence the drafting committee had to depend on volunteers and the first parliamentary counsel from the Ministry of Justice, who was not up to date with the current approaches in mental healthcare.

In contrast, the enabling factors included:

- persistence by mental health specialists in advocacy for the law
- the growth of the mental health user movement and non-governmental organisations (NGOs) operating in the field of mental health
- the existence of a legislation task force in the Ministry of Health, where mental health was represented
- the strong commitment to the drafting of the bill by the Junior Minister of Health in Charge of General Duties
- advocacy and lobbying of the political leadership at the Ministry of Health, by the parliamentary Committee for Disability
- the inclusion of the review of the bill in the Ministry of Health's strategic plan
- increasing demand for the law to cover mental health services that had been successfully integrated into primary healthcare
- the earlier findings of the situation analysis of the mental health system and the policy briefs to the Ministry of Health by the Mental Health and Poverty Project.

Conclusion

The proposed mental health bill is much needed and timely, as the 1964 Mental Treatment Act is outdated in terms of language and concepts, and is not in line with either contemporary mental healthcare or current practice in the Ugandan health system. The new act should reflect the major changes in treatment, philosophy and practice.

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https://doi.org/10.1192/S1749367600004367 Published online by Cambridge University Press