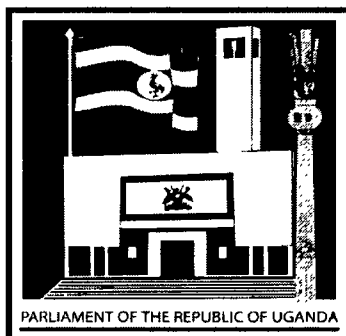




REPUBLIC OF UGANDA

REPORT OF THE SECTORAL COMMITTEE ON HEALTH ON THE MENTAL HEALTH BILL, 2014

MAY, 2018

OFFICE OF THE CLERK TO PARLIAMENT

PARLIAMENT BUILDING

KAMPALA-UGANDA

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1.0 INTRODUCTION

Rt. Hon. Speaker and Hon. Members,

The *Mental Health Bill, 2014* was read for the first time on 15th August 2015. However, the 9th Parliament was unable to consider the bill and thus it was saved. Consequently, on 21st July, 2016, the 10th Parliament reinstated the bill, and the Committee on Health, in accordance with rule 185(c), commenced with the consideration and scrutiny.

2.0 BACKGROUND TO THE BILL

The current law, 'the Mental Treatment Act, 1964', is outdated and does not take into account;

- a) The discovery of medicines and other treatment interventions that have revolutionalized the care of persons with mental illnesses
- b) The human rights and medical treatment standards of persons suffering with mental illness.

The overall objective of the Mental Treatment Act, 1964, was to remove persons with mental illnesses from society and keep them in confinement without serious consideration for clinical care, medical treatment standards and human rights of persons suffering with mental illness.

Consequently, the enactment of *the Mental Health Bill, 2014* is intended to;

- Ensure that persons with mental illness are enabled to seek treatment voluntarily and to ensure their safety and protection of their rights.
- Ensure safety of the people who come into contact with persons with mental illness and also establish the Mental Health Advisory Board.
- Operationalize the National Health Policy which identifies mental health services as an essential aspect of health care. The policy advocates for mental health services at all levels to be integrated into general health care

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and prescribes for the update and enforcement of appropriate laws to promote mental health.

2.1 OBJECT OF THE BILL

The bill seeks;

- a) To provide for care and treatment for persons with mental illnesses at primary health centers
- b) To Provide for the admission in, for treatment and for discharge from, health units and mental health units, of persons with mental illness
- c) To ensure that persons with mental illness are enabled to seek treatment voluntarily
- d) To ensure the safety and protection of their rights and safety of the people who come into contact with them, and;
- e) To establish the Mental Health Advisory Board

Furthermore, the Bill is intended to operationalize the National Health Policy which identifies mental health services as an essential aspect of health care. The policy advocates for mental health services at all levels to be integrated into general health care and prescribes for the update and enforcement of appropriate laws to promote mental health,"

The purpose of the proposed Mental Health Bill is to bring the care and management of the people with mental health challenges in line with the principles of the National Health Policy. The proposed Bill takes into account the currently available evidence-based approaches of managing mental Health challenges. The Bill seeks to safeguard the human rights of those who are affected and will be in line with the International Human Rights Conventions and Standards.

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3.0 METHODOLOGY

a) During the consideration and scrutiny of *'the Mental Health Bill, 2014'*, the Committee met and received memoranda from the following;

- 1) The Ministry of Health (MOH)
- 2) Butabika Hospital
- 3) The Ministry of Gender, Labour and Social Development
- 4) Butabika Recovery College
- 5) Mental Health Uganda
- 6) Mental Disability Association (MDAC)
- 7) Uganda AIDS Commission
- 8) The African Center for Child Mental Health
- 9) Initiative for Social and Economic Rights (ISER)
- 10) The National Council of Traditional Healers and Herbalists Associations (NACOTHA)
- 11) Mr. Kabale Benon Kitafuna
- 12) Dr. Stella Nyanzi
- 13) Heart Sounds Uganda
- 14) Uganda Prisons Service
- 15) School of Public Health (Collage of Health Sciences)

b) In addition to the above, the Committee also undertook a Study visit to Nairobi, Kenya, from 25th to 31st March, 2018, to bench mark on the best practices in Mental Health service delivery

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In the course of scrutiny of the bill, the Committee noted that there were strong views in support of the Bill as well as some areas that require harmonization. These include;

a) Mental illness

There is no agreed upon definition of the term 'mental illness. Some authors refer to the term 'mental illness as "*a variety of disorders causing severe disturbances in thinking, feeling and relating to others. Persons suffering from mental illness have a substantially diminished capacity for coping-up with the ordinary demands of life*".

The fifth and most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association) defines a mental disorder as: *"a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning"*. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. Expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society"

The 10th and most current edition of the International Classification of Mental Disorders (ICD-10, WHO) avoids the complexities of the terms disease or illness and rather uses mental disorder, defined as: *'the existence of a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone without personal dysfunction should not be included in mental disorder as defined here'*.

b) Mental Disability

The Committee noted that;

Most definitions of disability recognize that there must be impairment and functional limitation. The Collins English Dictionary defines disability as *a general or specific intellectual handicap, resulting directly or indirectly from injury to the brain or from abnormal neurological development*

In Uganda, disability is broadly defined as *"a substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participation"*. (Persons with Disability act 2006)

(c) Psychiatric Disability

The term psychiatric disability is used when mental illness significantly interferes with the performance of major life activities, such as learning, working, and communicating, among others.

To qualify for disability as mental disorder it must: interfere in one's ability to work in order to provide for themselves financially; significantly reduce one's capacity to complete tasks of daily living (shopping, self-care, food preparation, etc.); prevent one from caring for him-, or herself and/or others.

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Recommendation

The Committee therefore recommends the use of, Mental Illness as it is the one in use by the known international classification guidelines.

4.2 MENTAL HEALTH ILLNESS BURDEN

The Committee was informed that;

Mental Illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate with others and functionality. Different people have different experiences, including people with the same diagnosis (National Alliance on Mental Illness, 2018).

Mental disorders account for 13% of the global burden of disease. Uganda has been ranked among top six countries in Africa with the highest cases of mental disorder- according to World Health Organization (WHO). The Uganda National Health Survey (2005/2006) estimated that 7% of all households in Uganda have a disability, and of these, 58% had at least one family member with mental illness.

There are common mental disorders (eg depression, anxiety, and alcohol use disorders among others) and severe mental illnesses (eg bipolar disorders, psychosis and epilepsy). The latest WHO report (2006) indicates that at least 7.4% Ugandans suffer from common mental illnesses, particularly depression, anxiety and alcohol use disorders. At the health facility level WHO estimates that at least 33% attend for a mood disorder such as depression. The number could be higher because many victims stay in the villages without care. It is estimated that the treatment gap for mental disorders (defined as the proportion of those that get treatment to the total that need it) Uganda is 85% meaning that only 15% of those with mental ill health that need care, do get it.

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For instance, previous studies in Uganda have put the prevalence of Bipolar disorder at 3% of the total Ugandan population while epilepsy has been estimated at 3% in the community and 17% in health facility attendances (*WHO-AIMS Report on Mental Health System in Uganda, WHO and Ministry of Health, Kampala, Uganda, 2006*)

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There were 1.4 community based inpatient beds per 100,000 persons, by 2005. These are beds in the regional referral mental health units. These beds are now much fewer (0.9 beds/100000 population) since the beds have not increased but the population has grown to nearly 40 million.

The mental Hospital also houses 116 forensic beds but there are hardly mentally ill offenders admitted there. This is because it is not secure enough for such patients. As a result these patients continue to be kept in prisons around the country. There are no forensic beds elsewhere in the country.

There are 13 Regional Referral Mental health Units and one National mental Hospital with 550 beds. However, the bed occupancy is 150% indicating a 50% rate of extra cases. The National mental hospital has a few specialized units.

There are 30 beds in the children and adolescent health unit, dedicated to the children and adolescents with mental illness in the country since there are no specific services dedicated to the children with mental illness in other regions in the country.

Thirty of the beds at the mental hospital are dedicated to alcohol and drugs rehabilitation services. There no other beds in the country dedicated for this purpose. A few beds are available in the private hospitals but the number has not been established. Much of the country has no access to specialized mental health services such as child and adolescent and alcohol and drug rehabilitation services. Of necessity, some specialized care may need to be residential, whether public or private.

Observation

The Committee observed that

The 30 beds available for these specialized services (children and adolescents) at the national referral hospital are not adequate to serve the entire country.

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The procedure for admitting and discharging persons with mental disorders is not feasible in the present context where the numbers are quite big.

The Bill should provide for sensitizing the public about the causes of mental illness the methods of prevention of mental illness.

The idea of treating people at the primary health care level is very progressive.

There is need to address child psychiatry which is a growing discipline.

Recommendation

The Committee recommends that Government should;

- a) Establish a framework for extending Mental Health care services to regional and Primary Health Centres.***
- b) Encourage the Private sector to participate in mental health care services.***

4.4 ALTERNATIVE TREATMENTS

The Committee noted that;

Alternative healers provide an alternative system of care for the mentally ill. They are a culturally accepted resource in communities. Mental illnesses are a common reason to visit traditional healers and religious leaders as an alternative.

Abbo and others in their study (2009) found that majority (65.1%) of people that visited traditional healers had psychological distress. Of these ill health, nearly 30% had severe mental illness (bipolar disorder or schizophrenia), 14.6% had the more common mental disorders (depression and anxiety) while 3.9% had suicidality.

Observation

The Committee observed that;

While these traditional healers and religious leaders are accepted and widely used by communities, there is no legal framework to regulate their activities and at times they may cause harm and delay in seeking effective evidence based treatments in health facilities even for patients with severe mental disorders and suicide.

Recommendation

This matter will be conclusively dealt with in the Indigenous and Complimentary Medicine Bill, 2015, which is before Parliament.

4. 5 STIGMA AND MENTAL ILLNESS

The Committee noted that;

The stigma surrounding mental health and its treatment is one of the greatest barriers to mental healthcare. It causes discrimination, deprivation and exclusion of individuals and reduces access to care by individuals who need it the most. Despite the high prevalence of mental illness in Uganda, previous studies in Uganda have consistently demonstrated that stigmatizing of the mentally ill is still highly prevalent and not only by the general population but also by health providers.

According to Dr. Mutamba of Butabika Hospital in 2005 indicated that the hospital had 34.6% of patients in the out patients department and 42.5 % of those in the in patients felt stigmatized, indicating that local beliefs were the major cause of mental illness. One such belief is that mental illness is contagion us.

Observation

The Committee observed that;

Stigma makes communities to be discriminative and exclude people with mental illness from community activities including work and development activities which they would otherwise engage in, perpetuating poverty of families and communities. The vicious cycle of poverty and mental illness has been well elaborated in low income countries such as Uganda.

Due to stigma, people that need care do not seek medical help because of poor health seeking behavior, non-identification or inadequate accessibility to services.

Recommendation

The Committee recommends that Government should;

- a) Allocate resources for mobilization and sensitization of the communities on the mental health care services.***
- b) Work towards eliminating discrimination, deprivation and exclusion of individual's access to mental health facilities and services.***

4.6 HUMAN RESOURCE

The Committee was informed that;

According to *WHO-AIMS Report on Mental Health System in Uganda, WHO and Ministry of Health, Kampala, Uganda, 2006*, the total number of human resources working in mental health facilities is 1.13 per 100,000 persons as at 2005. The breakdown according to profession is as follows: 0.08 psychiatrists; 0.04 other medical doctors; 0.78 nurses; 0.01 psychologists; 0.01 social workers; 0.01 occupational therapists; and 0.2 psychiatric clinical officers; Only 1% of the medical doctors and 4% of the nurses were specialized in psychiatry.

Currently, the country has at least 30 registered psychiatrists, 225 psychiatric clinical officers and 2117 psychiatric nurses. Of the Psychiatrists, 80% are based in Kampala. Of the Psychiatric clinical officers about 50% are based in the central region, 20% in western Uganda and 15% each in northern and Eastern regions of Uganda. Of the psychiatric nurses, 40% are registered nurses while the remaining 60% are certificate nurses.

Also many nurses are deployed at service points where they are not able and at times not allowed to offer Mental Health services but instead work as general nurses.

In the hospitals, there are 0.04 psychiatrists per bed in community based psychiatric inpatient units. As for nurses, there are 0.16 nurses per bed in community based psychiatric inpatient units.

Observation

The Committee expressed concern over the low staffing levels of mental health workers required in so as to serve the country more equitably and efficiently that cannot cop-up with the growing burden of mental health challenges in the country.

Recommendations

The Committee recommends that Government should make deliberate efforts to train and recruit mental health service providers.

4.7 HEALTH PROMOTION AND DISEASE PREVENTION

The Committee observed that;

- Sensitization on Mental Health issues and disease prevention interventions are very critical requiring the sector to refocus its plans/budgets on

preventive interventions especially community mobilization and empowerment.

Recommendation

The Committee recommends that;

- a) Government should adopt a multi-sectoral approach to enhance collaboration with development partners to undertake Mental Health promotion and disease prevention interventions.***
- b) Messages for behavior change must be redesigned to communicate in a manner that gives adequate information to the population on health promotion.***

4.8 COMMUNITY MENTAL HEALTH SERVICE DELIVERY (CMHSD)

The Committee was informed that to avert the negative situation;

The Ministry of Health intends to establish, a Community Mental Health Service Delivery Strategy (CMHSDS) that involves integrating the evidence-base within existing clinical models. This is commonly used for integration of mental health treatment and care into the community to reduce dependency on primary health centers.

The essential components of a comprehensive, integrated model of CMHSs include: acute and emergency response, community continuing care services, assertive rehabilitation teams, partnerships with general practitioners and other human services agencies.

Recommendation

The Committee recommends that Government should work out a plan on the implementation of the Community Mental Health Service (CMHSDS).

4.9 MENTAL HEALTH AMONG THE CHILDREN AND ADOLESCENTS

The Committee was informed that;

In Uganda the burden of MNS disorders in children and adolescents has been increased because of the effects of war, exposure to violence including defilement, poverty, physical, emotional and sexual abuse, commercial sex and sex for survival, addiction to substances such as alcohol and cannabis, infection or being affected by HIV and AIDS and other diseases like malaria resulting in psychological and/or intellectual handicap, bereavement and separation.

Others causes include, Epilepsy which is common and it is often complicated by stigma, and delayed access to treatment. Without treatment it may cause brain damage and additional accidental injuries.

The Committee further learnt that according to the Child and Adolescent Mental Health Policy Guidelines, 2017;

- a) Children and adolescents are vulnerable to certain specific Mental, Neurological and substance use disorders due to their incomplete physical, mental and social growth and development
- b) In Uganda, demographic data showed that children under 15 years of age are a significant proportion of Uganda's population, 16,898,000 (49.7%); and of these 337960, (2%) children are living with some form of disability (UBOS, 2014, UNICEF, 2014).
- c) The Health Management Information Systems (HMIS) indicate low identification and attendance for treatment of such diseases and epilepsy compared with the prevalence estimated at 1-2% (MoH Reports 2012).

Observation

The Committee observed that;

Child and adolescent Mental Health is a key public health concern underpinning the wellbeing of the child population, the development to healthy adults and the prevention of mental illnesses

The consequences of MNS disorders include; reduced ability to participate in education, relationships and work, both in childhood as well as later in adult life

Recommendations

The Committee recommends that;

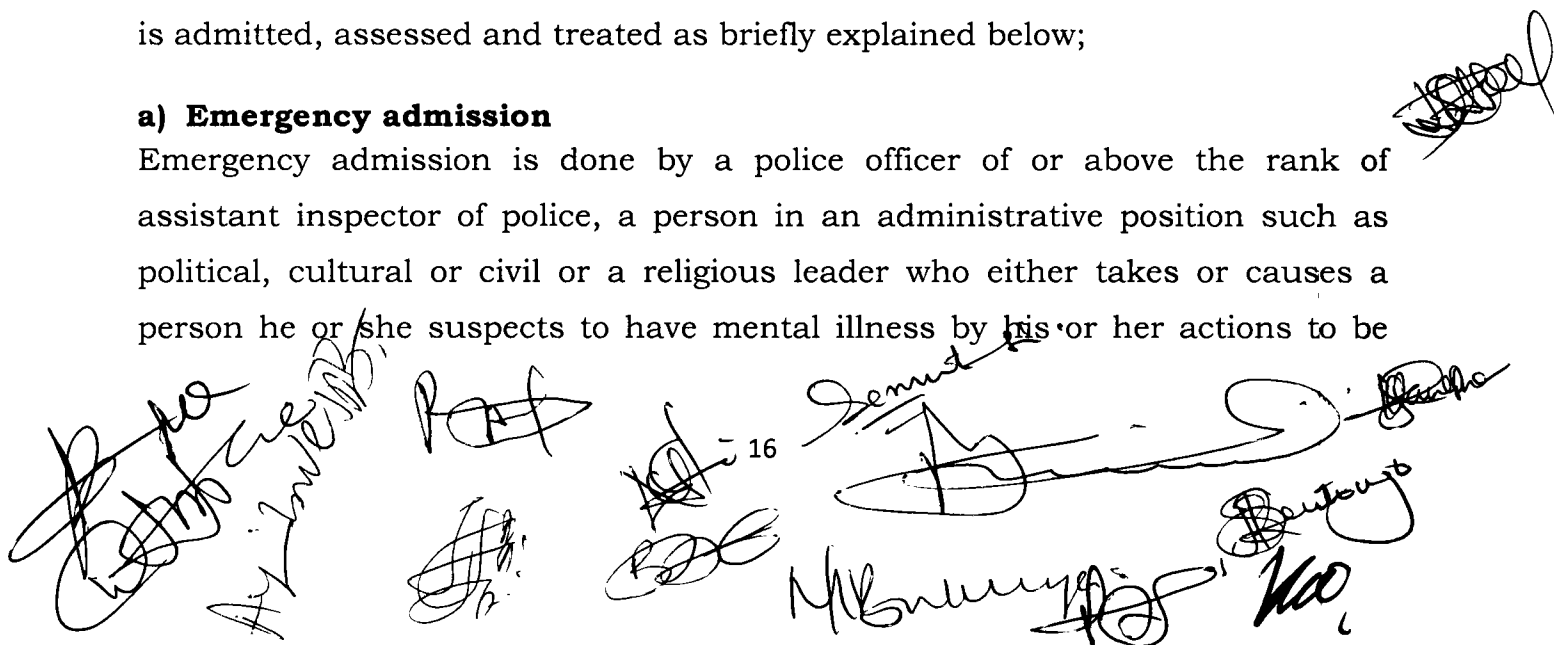
- a) Government should put in place a progressive legal, policy and regulatory framework to address accessibility and affordability by the children and adolescents to alcohol and drug rehabilitation services.***

4.10WAYS OF ADMISSION AND TREATMENT FOR PERSONS WITH MENTAL HEALTH

The Committee learnt that there are four ways by which a person with mental illness is taken to a health unit or mental health unit for assessment, admission and treatment. The four ways are; emergency, voluntarily, involuntarily or assisted care. Each type has peculiar circumstances under which a person with mental illness or one who has such signs and symptoms is admitted, assessed and treated as briefly explained below;

a) Emergency admission

Emergency admission is done by a police officer of or above the rank of assistant inspector of police, a person in an administrative position such as political, cultural or civil or a religious leader who either takes or causes a person he or she suspects to have mental illness by his or her actions to be



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b) Assisted admission and treatment

c) Voluntary admission

d) Involuntary Admissions

Observation

- Since mental illness affects a person's ability to understand, most of the admissions at health units or mental health units are by emergency or involuntary admission which often times requires the involvement of the Police.

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health unit to enter any premises, without a warrant to apprehend the person for purposes of taking him or her for medical attention.

- The bill further empowers the police to refer a person arrested for a criminal act who is suspected to have mental illness to take the person to a health unit for assessment.
- However, the Bill does not provide for funding of the above activities as well as the mechanism of training police officers or establishing a unit to specifically handle persons with mental illness so that the officers are equipped with the skills and facilities of affecting the apprehension of such persons without abusing their human rights.

Recommendation

The Committee recommends that;

- a) Government should fund the Police adequately in order to empower it effect the apprehension of persons with mental illness in a humanly manner and consequently take them to health units for assessment and treatment.***
- b) There is need for a deliberate effort by Government to establish specialized unit and accordingly, train and skill police officers and other persons who are empowered by the bill in the administration and apprehension of persons with mental illness for purposes of taking them for assessment and treatment so that it is done in accordance to human rights standards.***

4.11 STUDY VISIT TO NAIROBI- KENYA

During the consideration of the Mental Health Bill 2014, a delegation from the Committee under-took a study visit to Nairobi- Kenya from 25th to 31st March, 2018, to bench mark on the best practices in *Mental Health* service delivery. The delegation had informative interactions with several stakeholders including the academia on issues of Mental Health Policy and Mental Health treatment.

The information received greatly guided the Committee during processing of the Bill.

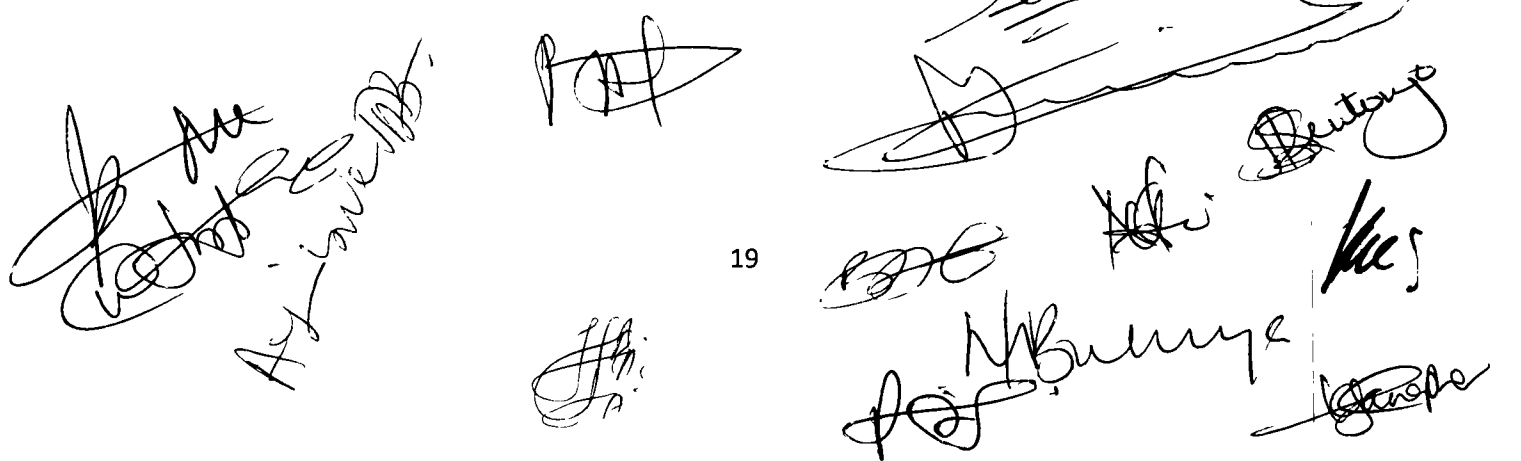
The delegation was informed that the Kenya Mental Health Policy 2015-2030 is a commitment to pursuing policy measures and strategies for achieving optimal health status and capacity of each individual. The goal of this policy is to attain the highest standard of mental health. This policy recognizes that it is the responsibility of every person in the public and private sector to ensure the goal is attained.

The Mental health policy interventions are broad and cut across other sectors, and consequently, this calls for a multi-disciplinary and inter-sectoral approach in the implementation of the policy.

Lessons learnt

The delegation noted that,

- The policy was developed through a consultative process involving the public, private and non-state actors under the stewardship of the Ministry of Health.
- Best practices in the Management and governance of *Mental Health* service delivery can be achieved through the promotion of global **governance which** refers to the implementation of policies and **practices** that promotes equitable health systems as defined by the World Health Organization (WHO).
- The concept of governance in mental health includes standards of quality and attention centered on the patient, and incorporates the consumers of mental healthcare in the decision-making process.



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Recommendation

The Committee recommends that;

- ***Government should adopt World Health Organization (WHO) best practices in the Management and governance of Mental Health service delivery by ensuring global practices that promote equitable health governance systems through policies and as defined by WHO.***
- ***Government should improve the quality of service and ensure respect of human rights in mental health units and social care facilities as are provided in the WHO Quality Rights tool kit and Checklist for Evaluating a Mental Health Plan.***

4.12 TREATMENT OPTIONS

Many of the stake holders that appeared before the Committee expressed reservations on clauses 11 and 12 of the Bill. The clauses provide for the treatment options for persons with mental illness.

a) Clause 11 provides for **Electroconvulsive therapy**. Electroconvulsive therapy (ECT) is defined as a procedure, done under general anesthesia, in which small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. It is also defined as referred to as shock treatment, for psychiatric illness in which seizures are electrically induced in patients to provide relief from mental disorders.

ECT often works when other treatments are unsuccessful and when the full course of treatment is completed. The committee was informed that ECT is an ancient treatment option which ought not to be included in the bill

because it is given without anesthesia hence leading to memory loss, fractured bones and other serious side effects.

Committee observation

The Committee observed that much of the stigma attached to ECT is based on early treatments in which high doses of electricity were administered without anesthesia, leading to memory loss, fractured bones and other serious side effects.

During the study visit to Nairobi, Kenya, the Committee learnt that ECT is much safer today and is still in use even in the developed Countries. The Committee noted that although ECT still causes some side effects, it is given under anesthesia and uses electric currents given in a controlled setting to achieve the most benefit with the fewest possible risks.

Recommendation

The Committee recommends that;

- ***ECT is a viable method that should not be deleted from the bill; instead checks and balances should be put in place to cater for possible abuse and misuse of the treatment option. Such measures include ensuring that it should only be recommended for use by a highly trained and experienced psychiatrist in case of involuntary admission and for voluntary admission informed consent should be given.***
- ***A deterrent fine and sentence to be given to a person who performs ECT contrary to the law in order to deter would be offenders.***

- **The head note “treatment for involuntary patients” appearing before clause 11 should be deleted and substituted with ‘Treatment options’, since the treatments are not only for involuntary patients.**

b) Clause 12 provides for seclusion of patients: This is where a patient is placed alone in an isolated room for some time under observation.

Many stake holders expressed reservation towards the use of seclusion in the mental hospitals in Uganda; they informed the Committee that the current rooms used for seclusion in Uganda especially at Butabika National Referral and Teaching Mental Hospital are not up to standard. They informed the Committee that the rooms are cold, unpadded, and dark with no toilet facilities and minimal observance by medical practitioners for patients put under seclusion as required by the WHO guidelines.

The Committee noted that;

a) Seclusion should be in a room or area designed for that purpose and in a safe environment that fulfill the standard minimum conditions which include:

- adequate light, heat and ventilation;
- means to easily observe the patient that also allows the patient to see the head and shoulders of the observer;
- means for a secluded patient to call for attention;
- fittings recessed to avoid potential for harm; and
- Furnishings (other than bedding) that are fixed to avoid the potential for harm.

b) Seclusion should only be authorized under certain conditions for example;

- (i) the control of harmful behavior occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication;
 - (ii) disturbance of behavior as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgment;
 - (iii) to reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness; and
 - (iv) to prevent harmful or destructive behavior, using specific indicators of impending disturbance which may be identified by either the individual or the staff, and which should wherever possible be part of an agreed management plan.
- c) There should be regular (time) intervals under which a person under seclusion should be monitored by the Medical Practitioners.

Recommendations

The Committee recommends that:

- ***Seclusion is a treatment option that cannot be dealt away with; however as the WHO guidelines clearly state, government should ensure that the rooms for seclusion satisfy the standard required in order to ensure safety of the patients.***
- ***Seclusion should only be given as a last resort, under the prescribed circumstances and by recommendation of a psychiatrist.***
- ***Budgetary allocations should be specifically made towards funding the current National Referral Mental Hospital – Butabika and other mental health units with seclusion rooms or services to upgrade the seclusion rooms to a standard that is required for such a purpose.***
- ***A deterrent fine and sentence should be put in place for a person who keeps a person in seclusion contrary to the law in order to deter would be offenders.***

PROPOSED AMENDMENTS TO THE MENTAL HEALTH BILL, 2014

The Committee therefore recommends that;

The Bill entitled Mental Health Bill be passed into law subject to the following proposed amendments;

AMENDMENTS TO THE MENTAL HEALTH BILL, 2014

1. Clause 2. Interpretation.

Clause 2 is amended by;

- (i) Inserting the definition of the word “assisted treatment and care” immediately before the definition of the word ‘Board’ to read as follows;

“assisted treatment and care means the provision of health interventions to people incapable of making informed decisions due to their mental health status especially during episodes of mental illness”;

- (ii) Inserting the definition of the word “community mental health services” immediately after the definition of the word ‘bodily restraint’ to read as follows;

“community mental health services refer to a system of care in which the community of a person with mental illness, not a health unit or mental health unit, is the primary provider of care for the person with a mental illness”;

- (iii) Inserting the definition of the word “court” immediately after the definition of the word ‘concerned person’ to read as follows;

“court” means a court with competent jurisdiction”;

- iv) Inserting the definition of the word “mental capacity” immediately after the definition of the word ‘medical practitioner’ to read as follows;

“mental capacity means the independent and informed cognitive ability to understand the nature and effects of one's decisions and actions”;

- (iv) Substituting the definition of the word “mental illness” with the following;

“mental illness means a diagnosis of a mental health condition in terms of accepted diagnostic criteria made by a mental health practitioner or medical practitioner authorized to make such diagnosis, mental health conditions include but are not are limited to depression, bipolar, anxiety disorders, schizophrenia and addictive behavior due to alcohol/substance abuse among others”;

- (v) Deleting the definition of the word “mental disorder”

- (vi) Inserting the definition of the word “mental health services” immediately after the definition of the word ‘medical health practitioner’ to read as follows;

“mental health services refers to assessment, diagnosis, treatment, care counseling or advice given to an individual or group of individuals with mental illness or disorders”;

- (vii) Inserting the definition of the word “mental health service user” immediately after the definition of the word ‘mental health services’ to read as follows;

“mental health service user refers to any person receiving either continuous or non-continuous mental health care and treatment services from a health unit, mental health unit or community aimed at enhancing his or her mental health status regardless of age, gender, social or economic standing”;

- (viii) substituting the definition of the word “primary health center” with the following;

“primary health Centre” means a government primary health centre II, III or IV or equivalent health unit in the private sector”;

- (ix) Inserting the definition of the word “treatment and care” immediately after the definition of the word ‘senior mental health practitioner’ to read as follows;

“treatment and care” means the provision of interventions whether medical or otherwise to a person with mental illness”.

Justification

For clarity and to enhance understanding and of the words used in the bill

2. **Clause 3. Object of the Act**

Clause 3 is amended

(x) by deleting in paragraph (c) the word “voluntarily”.

Justification

To provide for access to mental health care services whether voluntarily, involuntarily or under emergency care.

(ii) by inserting a new sub-clause to read as follows;

“ensure that community mental health services are integrated in the treatment and care of persons with mental illness.”

Justification

To offer a holistic approach to the treatment of mental illness

3. Insert a new clause immediately after clause 3 to read as follows;

Clause 4: District Mental Health Focal Person.

“(1) The Chief Administrative Officer of every district shall appoint from among district staff a district mental health focal person who shall work under the supervision of the District Health officer.

(2) The district mental health focal person shall have knowledge or experience in the field of medicine, social work or human rights.

(3) The district mental health focal person shall co-ordinate the mental health services and community mental health services in the district.

(4) The district mental health focal person may receive such facilitation as is necessary to facilitate co-ordination.

Justification

To ensure that mental health services are delivered to the people in their communities.

4. Clause 5. Treatment and care of out-patients at primary health centers.

Clause 5 is amended –

(i) by substituting sub-clause (1) with the following;

“(1) A primary health centre shall provide treatment for mental illness to all patients taken to the health facility for treatment or care.”

Justification

To avail treatment and care to all patients taken to health facilities without discrimination as to whether the patient is resident in that area or not, this will cater for majority patients with mental illness who do not have health facilities in their areas.

(ii) by inserting in sub-clause (2) the word “informed” immediately after the word ‘gives’;

Justification

To ensure that the consent given by the patient is informed and therefore the patient understands the consequences of his or her choices.

(iii) by inserting a new sub-clause immediately after sub-clause (2) to read as follows;

“A patient who is willing to receive treatment and care under this part, but is not in position to give informed consent by him/her self, shall be entitled to assisted care and treatment in accordance with this Act”

Justification

To allow patients who desire for treatment and care but are incapable of giving informed consent due to their prevailing mental status at the time when the decision is required, to receive treatment and care.

(iv) by substituting sub-clause (7) with the following;

“(7) The treatment and care administered under this section shall be appropriate for the person with mental illness.”

Justification

The words “and shall have scientific evidence of safety and effectiveness” seems redundant since treatment is expected to have scientific evidence of safety.

(v) in sub-clause (10)-

(a) by inserting the word “or tortures” immediately after the word ‘ill-treats’

Justification

To protect persons with mental illness from torture.

(b) by substituting the word “thirty” with “**one hundred eighty**” and the word ‘fifteen’ with “**eighteen**”.

Justification

To deter would be offenders by providing for a stringent fine and sentence.

5. Clause 6. Admission, treatment and care at primary health centres.

Clause 6 is amended by substituting sub-clause (1) with the following:-

“(1) Subject to subsection (2), a person with mental illness shall be admitted at a primary health centre within his or her reach.”

Justification

To give allowance to patients to be admitted at a primary health centre which they can easily access

6. Clause 7. Emergency admission and treatment

Clause 7 is amended -

(i) by substituting sub clause (6) with the following;

"(6) A person who is admitted under subsection (4) and (5) shall be assessed within twelve hours and the emergency treatment shall be for a period of not more than seventy two hours after assessment."

Justification

To protect the rights of persons with mental health so as to be assessed as soon as possible

- (ii) by inserting a new sub-clause (10) immediately after sub clause (9) to read;

"(10) The mental health practitioner or medical practitioner shall where possible obtain consent for emergency treatment for competent patients and where consent cannot be obtained, the mental health practitioner or medical practitioner shall provide medical treatment that is in the patient's best interest to save life or prevent the deterioration of the patient's health."

Justification

To ensure that treatment given is accepted by the patient or is in the best interest of the patient as the case may be.

- (iii) by inserting a new sub-clause immediately before sub-clause (10) to read;

"(11) A police officer or any other person shall where there is a person with mental illness who is discharged but has nowhere to go or is cruelly treated or neglected by a person having charge over him / her immediately report that fact to the District Community Development officer."

- (iv) by inserting a new sub-clause immediately before sub-clause (10) to read;

"The District Community Development officer may, after receiving the report, cause a social assessment to be conducted and work with available mental health facilities to improve social support structures for the person with mental illness."

Justification

To cater for a person with mental illness who receives mental health treatment and care but has nowhere to go after.

7. Clause 9- Involuntary admission and treatment

Clause 9 is amended -

- (i) by substituting the head note with the following;

"Involuntary admission and treatment"

Justification

To cater for involuntary treatment.

- (ii) by substituting clause 9 with the following;

"(1) A person with mental illness and prima facie requires treatment and care from a mental health unit but is for the time being incapable of expressing himself/herself to receive treatment, may on a written request under this section, be received in a mental health unit as an involuntary patient for treatment and care."

(2) Involuntary examination, admission and treatment shall only be carried out at a mental health unit.

(3) The request under subsection (1) (a) shall be in writing, addressed to the officer in charge of the mental health unit where the admission, treatment and care is being sought and shall-

(a) be made by the by a relative of the person to whom it relates; or

(b) if there is no relative available or willing to make a request, by a concerned person who shall state in his/ her application the reason why it is not made as provided in paragraph (a), the connection of the requestor with the person to whom the request relates and the circumstances in which the request is made.

(c) if the requestor is not a relative, what steps were taken to locate the relatives in order to determine their inability to make the request;

(d) set out the grounds on which the requestor believes that admission, treatment and care are required; and

(e) state the date, time and place where the person was last seen by the requestor before making the request.

- (4) An application referred to in subsection (1) may be withdrawn any time before a decision is taken."
- (5) On receipt of the request, the officer in charge of the mental health unit to whom the request is addressed, shall within three days make a written response, specifying the procedures to be followed for the examination, admission and treatment and thereafter shall cause the person to be brought to the mental health unit for examination.
- (6) The officer in charge shall approve the request only if it satisfies the conditions for involuntary admission and shall, in writing inform the applicant whether the person should be admitted for involuntary treatment and care or not.
- (7) An examination under this section shall be carried out as soon as practicable by two mental health practitioners, one of who should be a psychiatrist or where a psychiatrist is not available, a senior mental health practitioner.
- (8) On completion of the examination, the mental health practitioners shall submit to the officer in charge their written findings on whether the person has mental illness and qualifies under subsection (1) to be admitted as an involuntary patient.
- (9) Where the officer in charge approves involuntary treatment and care, he or she shall-
- (a) within forty eight hours after approval cause the person to be admitted to the mental health unit for treatment;
- (b) with the concurrence of any other mental health unit with the appropriate facilities, refer the person to that mental health unit."
- (10) Where a person examined under this section can be treated at a primary health centre, a senior mental health practitioner shall issue a community treatment order, in respect of that person.
- (11) A person shall only be admitted as an involuntary patient where involuntary admission is the only means by which that person may be provided with care, treatment and rehabilitation that will benefit him or her.
- (12) Involuntary admission shall be for a period of not more than three months, unless the Board authorizes extension of the period.

(13) *An involuntary patient may be discharged at any time as may be determined appropriate by the mental health practitioner who attended to the patient.*

(14) *A person who willfully assists a person with mental illness-*

(a) Who is being conveyed to or from a mental health unit for; or involuntary examination, admission and treatment, to escape

Commits an offence and is liable on conviction to a fine not exceeding one hundred twenty currency points or to imprisonment for a term not exceeding six months, or both.

Justification

To provide for a clear procedure to be followed for voluntary examination, admission and treatment.

8. Substitute the sub-title immediately after clause 10 with the following;

"Special Treatment options".

Justification

The treatments provided in clauses 11 and 12 are treatment options given to patients admitted under the different types of admission as long as the mental health practitioner deems the treatment to be in the best interest of the patient.

9. insert a new clause immediately after the sub-title to read as follows;

"(1) The special treatment options such as electroconvulsive therapy, seclusion, psychosurgery and bodily restraint shall be provided only after exhaustion of all other treatment options."

"(2) These procedures shall be applied under the authorization and supervision of a psychiatrist."

Justification

To eliminate possible abuse of the special treatment options.

10. **Clause 11: Electroconvulsive therapy.**

Clause 11 is amended in sub-clause (5) by deleting the word 'thirty' appearing immediately after exceeding and substituting the word 'one hundred eighty' and for the words 'fifteen months' the word 'eighteen months'.

Justification

To ensure safety of the patients by giving a deterrent sentence.

11. Clause 12. Seclusion

Clause 12 is amended-

- (i) by substituting sub-clause (5) with the following-

"A patient shall not be kept in seclusion consecutively for more than twenty four hours."

Justification

To protect the patient from negligent behavior of the medical practitioners.

- (ii) by substituting in sub-clause (8) the words "thirty" appearing immediately after exceeding with the words "one hundred eighty" and for the word 'fifteen' with the word "eighteen".

Justification

To ensure safety of the patients by giving a deterrent sentence.

Note:

Transfer clauses 11, 12, 13 and 14 of the bill and place them immediately before part III for sequential flow of the Bill.

12. Clause 16. Absence without leave.

Clause 16 is amended by substituting the last three lines with the following;

'.....commits an offence and is liable on conviction to a fine not exceeding one hundred twenty currency points or to imprisonment for a term not exceeding six months, or both'.

Justification

To deter possible offenders from assisting patients to escape before they receive full treatment.

13. **Clause 17. Staff of mental health unit permitting escape of patient.**

Clause 17 (5) is amended by substituting for the word 'thirty' immediately after exceeding with the word "one hundred eighty".

Justification.

To deter staff of mental health units from abusing their authority by conniving to permit a patient leave the mental health unit without following the proper procedures.

14. **Clause 18. Voluntary admission and treatment**

Clause 18 is amended by substituting the clause with the following;

"(1) A person with mental illness who has attained the apparent age of eighteen years, and submits voluntarily to a health unit or a mental health unit shall be received or admitted as a voluntary patient by that health unit or mental unit, and is entitled to voluntary treatment."

(2) A person with mental illness who has not attained the apparent age of eighteen years and whose parent or guardian by application desires to submit him or her for treatment to a health unit or a mental health unit, shall be received or admitted as a voluntary patient by that health unit or mental health unit and is entitled to voluntary treatment.

(3) The application mentioned under subsection (2) may be verbal or written.

(3) A person received as a voluntary patient under this section may leave the health unit or mental health unit, upon giving the person in charge seventy two hours' notice of his intention to leave and if he or she is a person who has not attained the apparent age of eighteen years, upon such notice being given by his parent or guardian, and the release shall be at the discretion of the person in charge of the health unit or mental health unit.

(4) A voluntary patient shall only receive treatment after giving informed consent to the treatment."

15. **Clause 36. Respect, human dignity and privacy.**

Clause 36 is amended -

- (i) by inserting immediately after sub clause (1) the following new sub clauses, to read;

"(2) Subject to such limitations as are prescribed by law, a person with mental illness shall not be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment."

Justification.

To protect persons with mental illness from abuse and ill-treatment.

"(3) Subject to such limitations as are prescribed by law, a person with mental illness has the right to protection from physical, economic, social, sexual and other forms of exploitation and abuse."

Justification.

To ensure the protection of the mentioned rights of persons with mental illness.

16. **Clause 37. Non-discrimination of persons with mental illness**

Clause 37 is amended -

- (i) by deleting in the headnote the word 'prohibited' appearing at the end;
- (ii) by substituting in sub clause (2) for the word 'similar' the word "equitable";

Justification

For clarity.

- (iii) by inserting immediately after sub clause (4) a new sub-clause to read;

"Appropriate action under subsection (4) shall be in accordance with the employment laws and other laws of Uganda."

Justification

To ensure fair treatment to persons with mental health and protection of their employment.

17. **Clause 38: Exploitation and abuse.**

Clause 38 (2) is amended by substituting the sub-clause with the following;

*"(2) An employee of a mental health unit who contravenes this **section** commits an offence and is liable on conviction to a fine not **exceeding one hundred and twenty** currency points or to imprisonment for a term not exceeding **six** months, or both."*

Justification

To ensure that the rights stated in the clause are granted to the patients by putting a deterrent sentence to whoever contravenes the provision.

18. **Clause 39. Determination of mental health status.**

Clause 39 is amended -

- (i) by deleting in sub-clause (2) the word 'another' appearing on the last line.

Justification

For grammatical correction.

- (ii) by substituting in sub-clause (5) the last three lines with the following;

"A person, who carries out a determination of the mental health status of a person contrary to this section, commits an offence and is liable on conviction to a fine not exceeding one hundred twenty currency points or to imprisonment for a term not exceeding six months, or both."

Justification

The deterrent sentence protects the rights of persons with mental health from abuse by practitioners.



Clause 44 is amended-

- “A person with mental illness has the right to enjoy legal capacity on equal basis with others in all aspects of life.”*

Persons with mental health are human beings in all aspects and so deserve to enjoy all legal rights accorded to humans.

- For clarity purposes

- To augment the right of a person with mental illness to manage his or her affairs.

Clause 45 is amended by inserting a new sub-clause, immediately after sub-clause (2) to read;

"The personal representative under sub section (1) may be a relative, a concerned person, mental health practitioner or a lawyer appointed through advance directive when the person with mental illness is capable to make the appointment."

Justification

To clearly state the category of persons who can be appointed as personal representative in order to avoid abuse by persons alleging to have been appointed whereas not.

21. Clause 46. Appointment of personal representative by court.

Amend clause 46 -

- (i) by substituting sub-clause (5) with the following;

*"The personal representative **or public trustee** shall act in the best interest of the person with mental illness, to the extent determined by court to-*

Justification.

To provide for a situation where the Public Trustee is managing the estate of a person with mental illness.

- (ii) by substituting sub-clause (6) with the following;

"Where, upon review, a person with mental illness is found capable of managing his or her affairs, the court shall revoke the order made to the personal representative or Public Trustee."

Justification.

For clarity and to provide for a situation when the Public Trustee is the manager and the order is revoked by court when the person recovers and has the ability to manage his or her own affairs.

22. Power to order transfer of property of person with mental illness residing out of Uganda.

Part IV is amended by immediately after clause 48 inserting a new clause to read;

"Where any movable or immovable property is in the name of or vested in any person residing out of Uganda, the Board or court may, upon being satisfied that such person is with mental illness and that a personal representative or Public Trustees has been appointed for his or her estate according to the law of the

place where he or she is residing, order a fit person to pay, deliver or transfer the property, or any part of it, to the name of the personal representative or Public trustee so appointed, as the court may think fit."

Justification

To provide for a situation where a person with mental illness owns property outside Uganda.

23. Clause 52. Periodic reviews of mental health status of prisoners with mental illness.

Clause 52 (1) is amended by substituting for the word 'once' the word **"twice"**.

Justification

To ensure safety and availability of medical care and treatment to a prisoner with mental illness.

24. Clause 53. Recovery of prisoner with mental illness.

Clause 53 is amended -

- (i) in the headnote by substituting for the word 'mentally' the word **"mental"**.

Justification

For grammatical correction

- (ii) in paragraph (c) by substituting for the word 'magistrate' the word **"court"**.

Justification

For consistency with other provisions within the bill.

25. Clause 55. Expiry of term of imprisonment of prisoner with mental illness.

Clause 55 is amended -

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- (i) by inserting in sub-clause (2) the word **'to'** immediately after the word prisoner.
- (ii) by substituting in sub-clause (3) for the word 'for' the word **'from'**

Justification

For grammatical correction.

26. Clause 56. Duties of local authorities.

Clause 56 (1) is amended by substituting for the word 'do' appearing on the second last line the word **'does'**.

Justification

For grammatical correction.

Clause 58. Composition of the Board.

Clause 58 is amended -

(a) by substituting in sub-clause (1) for the word 'ten' the word **'six'** so that it reads;

Justification

A smaller board is more efficient and easier to manage financially.

(b) by substituting sub-clause (3) with the following;

"(3) The members shall include-

(a) The Chairperson

(b) The Director General of medical services or his or her representative;

(c) a consultant psychiatrist;

(d) a police officer at the rank of Commissioner of Police

(e) a mental health service user nominated by the recognized an duly registered Association for mental health service users;

(f) a representative from the Ministry of Gender, Labor and Social Development;

(g) A lawyer specialized in human rights advocacy, nominated by Uganda Law society; and

Justification.

To ensure relevancy of the members to the Board through their experience.

(c) by substituting sub clause (4) with the following;

"The national mental health coordinator shall be an ex-officio member and secretary of the Board."

(d) by substituting sub clause (5) with the following

"(5) The chairperson and members referred to in subsection (3) (c) and (e) shall be appointed by the Minister who shall, in making the appointments, take into consideration the principle of equal opportunity and gender."

Justification

To ensure gender and equity in making the appointments.

(e) by substituting sub clause (6) with the following;

"The member referred to in subsection (3) (c) shall be nominated by the Minister for Internal Affairs."

Justification

The Minister for Internal Affairs supervises Police.

27. Clause 59. Tenure of Board

Clause 59 is amended by substituting in sub-clause (1) with the following;

"(1) The chairperson and members of the Board except those in subsection (3) (b) and subsection (4) shall hold office for four years and are eligible for re-appointment for one further term."

Justification

For clarity as to the term of office of the different Members of the Board

Note:

**Transfer part VI of the Bill to part II for sequential flow of the Bill.
Renumber the parts accordingly.**

28. Clause 73. Powers of the Minister to make regulations

Clause 73 (1) is amended -

- (i) by inserting a new paragraph immediately after paragraph (a) to read;

"To designate and appoint mental health units and hospitals;

- (ii) by inserting a new paragraph immediately after paragraph (d) to read;

"Prescribing the procedure for treatment of women, children and youths with mental illness."

Justification

Adolescents and youth constitute the majority of the population and so need to clearly be catered for in addition to the other special categories of persons who need special care at the mental health units.

- (iii) by inserting a new paragraph immediately before paragraph (e) to read;

"Prescribing the procedure for integration of community mental health services and psychosocial support in treating and caring for persons with mental illness."

Justification

To implement government's desired policy of integrating community based care in treatment of patients.

29. Clause 74: Repeal

Clause 74 is amended by substituting the clause with the following.

The following laws are repealed-

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(a) Mental Treatment Act, Cap 279

(b) Administration of Estates of persons of unsound mind Act, Cap 155

Justification

The procedure of dealing with the estate of persons of unsound mind has been incorporated in the bill.

30. Clause 75. Saving provisions.

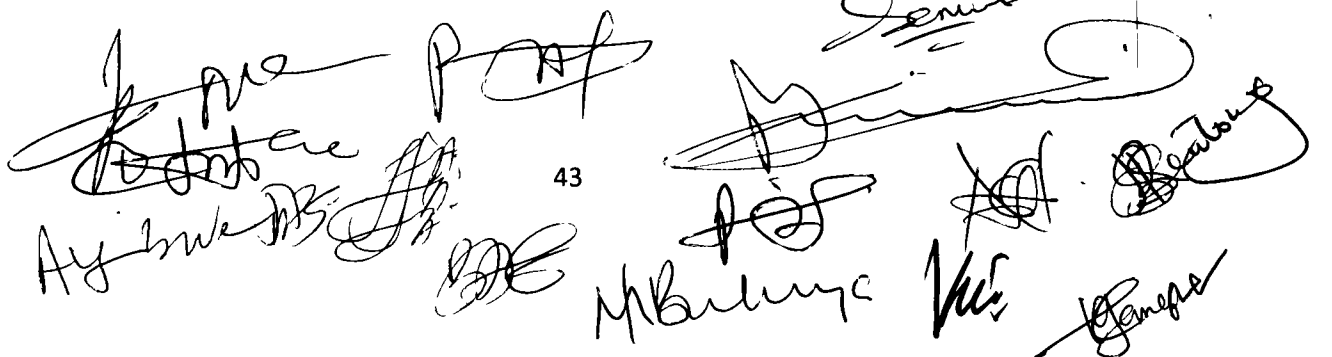
Clause 75 is amended substituting the clause with the following;

- (1) The provisions of this Act and any regulations made under it shall apply to a person received or admitted to a mental health facility or otherwise dealt with under the Mental Treatment Act, Cap 279 as if that person were admitted or dealt with under this Act.*
- (2) A building appointed by the Minister as a mental hospital under the Mental Treatment Act, Cap 279 shall be deemed to be mental health unit under this Act.*
- (3) Movable and immovable properties in use by mental health facilities under the Mental Treatment Act, Cap 279 shall on the commencement of this Act be considered properties under this Act.*
- (4) Staff of mental health facilities under the Mental Treatment Act, Cap 279 shall, on the commencement of this act, be considered to be staff of mental health units or health units created under this Act.*
- (5) Any action taken or document executed under the Administration of Estates of persons of unsound mind Act, Cap 155 and which is subsisting at the date of commencement of this Act is deemed to be an action taken under this Act."*

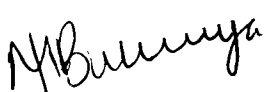
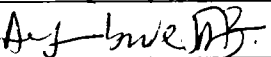
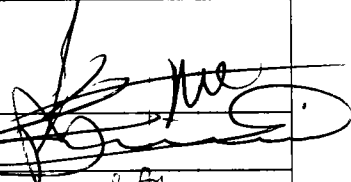
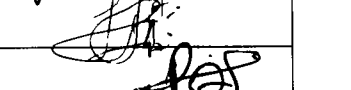
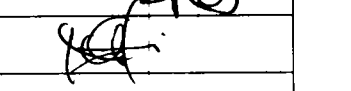
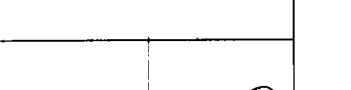
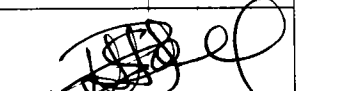
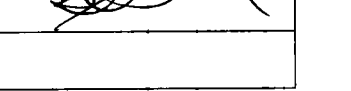
Justification

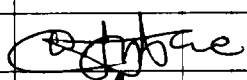
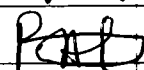
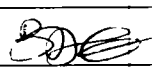
To protect property, staff, action or documents executed under the Mental Treatment Act and Administration of Estates of persons of unsound mind Act since they are repealed by this Act.

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The bottom of the page features several handwritten signatures and initials in black ink. On the left, there are signatures that appear to be 'J. M. A.', 'P. A.', and 'A. J. M.'. In the center, there is a signature that looks like 'M. B. M.'. On the right, there are more signatures, including one that appears to be 'J. M. A.' and another that looks like 'J. M. A.'. The signatures are written in a cursive, handwritten style.

**SIGNATURE SHEET FOR MEMBERS ON THE REPORT
OF THE SECTORAL COMMITTEE ON HEALTH ON THE
MENTAL HEALTH BILL, 2014**

NO	NAME	CONSTITUENCY	PARTY	SIGNATURE
1	Hon. Dr. Bukenya Micheal (Chair person)	Bukuya County	NRM	
2	Hon. Kahunde Hellen- (Vice Chairperson)	DWR Kiryandongo	NRM	
3	Hon. Adoa Hellen	DWR Serere	NRM	
4	Hon. Ayebazibwe Justine	DWR Isingiro	NRM	
5	Hon. Babirye Kityo Sarah	Youth Rep.	NRM	
6	Hon. Bebona Babungi. J	DWR Bundibugyo	NRM	
7	Hon. Kemirembe Pauline	DWR Lyantode	NRM	
8	Hon. Mbwaterkamwa Gaffa	Kasambya County	NRM	
9	Hon. Kajungu Mutambi	DWR Mbarara	NRM	
10	Hon. Kamusiime Innocent P	Butembe county	NRM	
11	Hon. Muheirwe M Daniel	Buhaguzi county	NRM	
12	Hon. Ndamira Catherine	DWR Kabale	NRM	
13	Hon. Ayaka Rose Atim	DWR Karacha	NRM	
14	Hon. Nayeabale Sylvia	DWR Gomba	NRM	
15	Hon. Alyek Judith	DWR Kole	NRM	
16	Hon. Lyomoki Sam	Workers Rep	NRM	
17	Hon. Ssebikaali Yoweri Joel	Ntwetwe County	NRM	
18	Hon. Ssembatya Edward N	Katikamu South	NRM	

19	Hon. Rwakimari Beatrice	DWR Ntungamo County	NRM	
20	Hon. Mbabazi Kyomuhendo Janepher	DWR Kagadi	NRM	
21	Hon. Baguma Spellanza	DWR Kyenjojo	NRM	
22	Hon. Atyanga Stella	DWR Moroto	NRM	
23	Hon. Mirembe Lydia Daphine	DWR Butambala	INDEP	
24	Hon. Baseke Fred	Ntenjeru south	INDEP	
25	Hon. Kinobere Herbert Tom	Kibuku county	INDEP	
26	Hon. Aol Ocan Betty	DWR Gulu	FDC	
27	Hon. Sizomu Gershomu	Bungokho North	FDC	
28	Hon. Atim Joy Ongom	DWR Lira	UPC	
29	Hon. Asimwe Everlyne Buregyeya (Cpt.)	UPDF	Army	
30	Hon. Ssentongo Robina Nakasirye	DWR Kyotera	DP	