AFRICA UNIVERSITY

(A United Methodist- Related Institution)

# EFFECTS OF INCARCERATION ON THE HUMAN RIGHTS OF FORENSIC PSYCHIATRIC PATIENTS IN ZIMBABWE

BY

BRIAN TAFADZWA HOVE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN HUMAN RIGHTS, PEACE AND DEVELOPMENT IN THE COLLEGE OF BUSINESS, PEACE, LEADERSHIP AND GOVERNANCE

2020

## Abstract

This study scrutinized the effects of human rights non-compliance for incarcerated forensic psychiatric patients in Zimbabwe. Literature was reviewed on forensic psychiatry patients' rehabilitation systems in special institutions, the benefits of prison detention on forensic psychiatric patients and the human rights compliance of special institutions towards forensic psychiatry patient care. The research design used for the study was an exploratory research design using a case study. The population and sampling included the Zimbabwe Prisons and Correctional Services medical caregivers working with the detained forensic psychiatric patients. Findings and results showed that the Zimbabwe Prison and Correctional Services as mandated by the law is failing to comply with human rights requirements on the management of detained mental health patients. Special institutions lacked basic human rights such as food, water, shelter, health, and clothing for forensic patients let alone the patients' rights to rehabilitation as a medical requirement. Medical carers brought to the fore lack of psycho tropical drugs, lack of mental health practitioners for mental health assessments, families not visiting inmates, families denying inmates home, communication difficulties with the inmates and special board taking a long time to make assessments as some of the detention challenges in special institutions. The government blames the lack of financial resources on its inability to provide for basic rights resulting in the ill-treatment of patients. Stakeholders from this study largely agree on the need for the reviewing of the Zimbabwe Mental Health Act 1996 No. 15, which is the principal law on the safeguarding of the patient rights. However, the Mental Health Act still emphasizes on the institutionalization of those who are mentally ill. There is consensus on the need for the testing of alternative models of care on the management of forensic psychiatric patients other than detention. Despite the need to protect the patient from self-harm, harm against others and being harmed by others because of mental illness vulnerability, the State through its practice is accused of blowing hot and cold as it protects from abuse and perpetuates abuse through institutionalization. The research discusses the findings in line with the objectives of the study and ends with recommendations for strengthening forensic psychiatric care and support in Zimbabwe from as being presently experienced punitive to a rehabilitative model of care for mental health patients. The recommendations include the reviewing of the Mental Health Act, prioritization on the funding of prisons and employment of more technical staff.



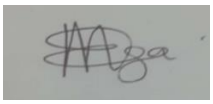
**Key Words**: Forensic Psychiatry, Human Rights, Detention, Zimbabwe Mental Health Act.

## Declaration

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree.

BRIAN TAFADZWA HOVE

Student's Full Name Student's Signature (April 8, 2020)



DR MAZVITA MACHINGA
Main Supervisor's Full Name Main Supervisor's Signature (April 8, 2020)

## Copyright

**Acknowledgements**

I thank the Lord God almighty for giving me the grace to reach this far. I would want to thank my supervisor, Dr Mazvita Machinga, for her guidance through each stage of the process. I would want to thank Mr Omer Abdalla for inspiring my interest in the field of forensic psychiatry. My wife Moreblessing Dupwa Hove, children Matidaishe and Waishe thank you for allowing me space to divert your time for studies. My English language editor Bianca Mapeta for the thorough work. My siblings, I have set the pace we can all do it.

## Dedication

I dedicate this work to my mother Barbra Khoza Hove. You have inspired us all that amid all challenges we can conquer. To my late father, George Vengai Hove, you should have lived to see this day; you have missed too many important events of my life. Continue to rest in peace.

## List of Acronyms and Abbreviations

| | |
|---|---|
| AUREC | Africa University Research Ethics Council |
| CMP | Criminal Mental Patients |
| DMP | Detained Mental Patients |
| ESCR | Economic Social Cultural Rights |
| MHRT | Mental Health Review Tribunal |
| MoHCC | Ministry of Health and Child Care |
| MSF | Medecins Sans Frontieres |
| UDHR | Universal Declaration of Human Rights |
| VSO | Volunteer Services Overseas |
| WHO | World Health Organizations |
| ZACRO | the Zimbabwe Association for Crime Prevention and Rehabilitation |
| ZHRC | Zimbabwe Human Rights Commission |
| ZIMNAMH | Zimbabwe National Association for Mental Health |
| ZPCS | Zimbabwe Prisons and Correctional Services |
| ZPSSO | Zimbabwe Prison Service Standing Orders |

## Definitions of Key Terms

| | |
|---|---|
| **Forensic Psychiatric Patient** | It refers to a person who has been acquitted, because of insanity, of a crime charged and thereupon found to be of substantial danger to other persons or to present a substantial likelihood of committing acts that jeopardize public safety or security unless kept under further control by the court or other persons or institutions. (Coutts, 2011) |
| **Forensic Psychiatry** | 'Forensic psychiatry' is defined by (Mullen, Burgess,Wallace,Palmer&Ruschena,2000) as rehabilitation interventions, treatment modalities and services that are provided by the judicial and medical teams to forensic psychiatric patients in special institutions to capacitate them to be as possible in fulfilling their usual roles and functions in society. |
| **Mental Health Review Tribunal** | It is a court established by the President of Zimbabwe to attend to appeals and applications made to it in terms of Sections 75-76 of the (Government of Zimbabwe, National Mental Health Policy 1996, 2004) Part 9 Sections 75-76. |

| | |
|---|---|
| **Prison** | It refers to a building that houses the special institution for rehabilitation purposes. (Dictionary of Contemporary English for Advanced Learners 2014) |
| **Rehabilitation** | (Dube, 2014) refers rehabilitation as the process of restoring forensic psychiatric patients by the multi-disciplinary medical and judicial teams towards the former's highest possible level of a bio-psychosocial function where they can fulfill their roles as independently as possible. |
| **Special Institutions** | According to Part 14, Section 107 of the (Government of Zimbabwe, Mental Health Act, 1996), a 'special institution' is a special psychiatric unit within a prison setting that is used for detaining patients. In this study the term 'special institutions' refers to the only two "units" or psychiatric hospitals" placed within prison settings in the Southern and Northern regions of Zimbabwe respectively. |

## Table of Contents


Abstract ..... ii
Declaration ..... iii
Copyright ..... iv
Acknowledgements ..... v
Dedication ..... vi
List of Acronyms and Abbreviations ..... vii
Definitions of Key Terms ..... viii
List of Tables ..... xiii
List of Figures ..... xiv
List of Appendices ..... xv
**CHAPTER 1 INTRODUCTION** ..... 1
1.2 Background of the Study ..... 1
1.3 Statement of the Problem ..... 7
1.4 Purpose of the Study ..... 8
1.5 Research Objectives ..... 8
1.6 Research Questions ..... 8
1.7 Justification of the Study ..... 8
1.8 Significance of the Study ..... 9
1.9 Delimitation of the Study ..... 9
1.9.1 Limitations of the Study ..... 10
1.10 Summary ..... 10
**CHAPTER 2 REVIEW OF RELATED LITERATURE** ..... 11
2.1 Introduction ..... 11
2.2 Theoretical Framework ..... 11
2.2.1 Human Rights-Based Approach ..... 11
2.3 The Relevance of the Theoretical Framework to the Study ..... 12
2.4 Forensic Psychiatric Patients' Rehabilitation ..... 14
2.4.1 Medicalization of Deviance ..... 16
2.5 The Benefits of Prison Detention on Forensic Psychiatric Patients ..... 19

2.5.1 Mental health in Prisons ..... 22
2.6 Human Rights in prisons and places of detention ..... 25
2.6.1 Mental health legislation ..... 29
2.7 Summary ..... 33
**CHAPTER 3 METHODOLOGY** ..... 34
3.1 Introduction ..... 34
3.2 The Research Design ..... 34
3.3 Population and Sampling ..... 34
3.4 Data Collection Instruments ..... 36
3.4.1 Interview Guides ..... 36
3.4.2 Self-administered Questionnaires ..... 37
3.4.3 Documentary Review ..... 37
3.5 Data Collection Procedure ..... 38
3.6 Analysis and Organization of Data ..... 38
3.7 Ethical Considerations ..... 39
3.8 Summary ..... 40
**CHAPTER 4 DATA PRESENTATION, ANALYSIS &INTERPRETATION** ..... 41
4.1 Introduction ..... 41
4.2 Data Presentation ..... 41
4.2.1 Rehabilitation Services Available for Forensic Psychiatric Patients ..... 41
4.3 Benefits of Prison Detention ..... 45
4.4 Human Rights Violations in Forensic Psychiatric Care ..... 49
4.5 Mental health laws in conflict with forensic psychiatric care ..... 55
4.6 Summary ..... 58
**CHAPTER 5 SUMMARY, CONCLUSIONS & RECOMMENDATIONS** ..... 60
5.1 Introduction ..... 60
5.2 Discussion ..... 60
5.3 Conclusions ..... 64
5.4 Implications ..... 65
5.5 Recommendations ..... 66
5.6 Suggestions for Further Research ..... 67

Reference ..... 68
Appendices ..... 74

## List of Tables

Table 1 Summary of Participants …….35

## List of Figures

Figure 1 Mental Health Facilities in Zimbabwe…….3

Figure 2 Prison Population in Zimbabwe…….24

## List of Appendices


Appendix 1 Data Collection Tools……...74

Appendix 2 Zimbabwe Human Rights Commission interview guide……..76

Appendix 3 Stakeholders Interview Guide……..77

Appendix 4 English Informed Consent…….……...78

Appendix 5 AUREC Approval Letter …….……....80

Appendix 6 Plagiarism Report ……81

Appendix 7 Zimbabwe Prisons and Correctional Services Approval letter…….82

# CHAPTER 1 INTRODUCTION

Forensic psychiatric services in Zimbabwe provide treatment and rehabilitation for mental health patients who commit a crime or pose a danger to themselves or others in the community. Treatment can be through the committing of the patient as prescribed by the (Government of Zimbabwe, Mental Health Act, 1996) in special institutions. The detention of patients in special institutions seeks to ensure treatment and rehabilitation, which is the primary goal of detention and is assumed to be in the best interest of the patient and the society. However, as some studies show and as will be discussed in this study special institution detention can exacerbate mental illness and limit the rehabilitation outcomes for the patient, which may result in unnecessary suffering of the patient. This study, therefore, seeks to examine the prison detention system, the rehabilitation system and its effects on the patient's human rights.

## 1.2 Background of the Study

Zimbabwe is a sub-Saharan country sharing borders with Zambia to the north, Mozambique to the East, Botswana to the West and South Africa along its southern border. According to the (Zimbabwe Demographic Health Survey, 2017), Zimbabwe has a population of over 13 million people, 40% of whom are below the age of 15. Zimbabwe has an agro-based economy and the majority of the population resides in non-urban areas. Zimbabwe is faced with significant disease burden of communicable and non-communicable disease and mental health disorders contribute significantly to this burden.

Historically, prior to independence in 1980, mental health care was a low priority and services were inaccessible to most of the population. Inguthseni was established in Bulawayo in 1908 as an asylum mainly for the black population and was changed into a mental health hospital in 1933 after a psychiatrist was assigned to run it from the United Kingdom. Training of a small number of specialist psychiatric nurses only started in 1970. At this time there was little mental health education included in general nurse training or the medical undergraduate curriculum (MoHCC, 2020). Independence came with significant changes to the structure of health services with emphasis on primary healthcare and improving access to healthcare for all.

From 1984, a program to decentralize healthcare was set up with upgrading of infrastructure at provincial and district level. In nine of the 10 provinces, a provincial hospital was built or refurbished and district hospitals were built or refurbished. Local clinics and rural health centers were established at primary health care level allowing a referral system to be set up. Mental health services were to be part of care at every level of care. Socioeconomic challenges interfered with the decentralization process however and only two Provincial units were established (MoHCC, 2020).

According to (Liang et al.,2016) Zimbabwe currently has four tertiary psychiatric units namely Inguthseni in Bulawayo, Sally Mugabe formerly Harare Hospital Psychiatric Unit and Parirenyatwa Annexe in Harare and Ngomahuru Hospital in Masvingo. There are four psychiatric units at provincial level in Chinhoyi, Gweru and Marondera as well as in the district of Mutoko. There are also two forensic psychiatric units, Chikurubi Special institution established in 2000 and Mlondolozi Special Institution established in 1978.

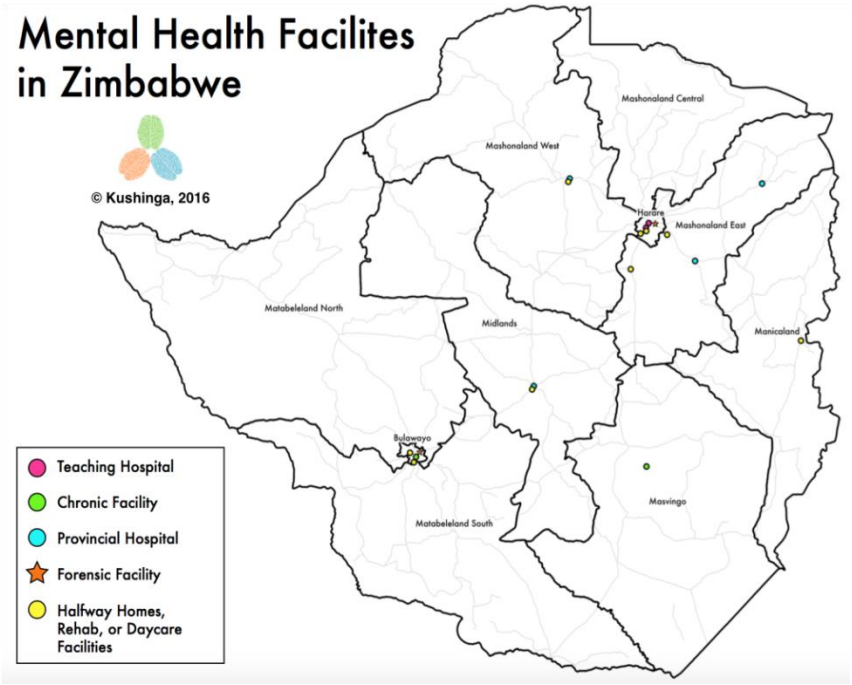



***Figure 1:*** Mental Health Facilities in Zimbabwe, (Liang et al.,2016)

All the other units except the Harare Psychiatric Hospital are however in dire need of refurbishment. There is a lack of admission facilities for children and adolescents, and lack of suitable services for effective occupational therapy. (MoHCC, 2020) reported that there is also need to improve the living conditions for forensic patients. There are currently nine hundred and seventeen registered mental health nurses in the country and seventeen psychiatrists. There are six Clinical psychologists, 13 Clinical Social Workers and 10 Occupational Therapists working in the government sector. There is high patient to staff ratio across all disciplines, highlighting a need to recruit and retain mental health professions.

According to the (WHO, 2003) one in four people globally is affected by a mental or neurological disease in their lifetime making mental health disorders one of the leading causes of the global health disease burden. In Zimbabwe the (Research Review Tribunal, 2009) estimates that ten percent of Zimbabwe's population suffer

from mental health problems. Patient numbers are currently high at tertiary units indicating possible recentralization of services. Major diagnoses reported include alcohol and substance related conditions, HIV and AIDS related conditions, schizophrenia, organic psychosis and depression with also a concerning number of attempted suicides also reported according to (MoHCC, 2020).

According to the (Zimbabwe Mental Health Atlas, 2019) despite the mentally ill being entitled to free health services and the primary source of mental health financing being tax based there is no specific budget allocations for mental health in Zimbabwe. In addition to direct budget allocations, the Ministry of Health and Child care receives additional funding from development partners and statutory funds. (UNICEF, 2015), reported that 60.5% of the government funding goes to employment costs, the burden of programme spending and infrastructure has mainly fallen on development partners and individuals through out-of-pocket payments. For instance, as measured by facility sources of revenue, it can be noted that central government spending constitutes a small share of non-wage expenditure funding for district and primary level health facilities.

Due to shortages of foreign currency (Zimbabwe Mental Health Atlas, 2019) reported that there is a critical shortage of drugs countrywide. The Health Levy directed partly towards psychotropic drug procurement has had a limited effect on drug supplies as psychiatric units are reported to still have between 1 to 3 months stock of even the most basic drugs, primarily first-generation antipsychotics with minimal stocks of antidepressants and mood stabilizers.

Given the increased prevalence of mental illness in Zimbabwe, policies to regulate alcohol and substance use are necessary. Furthermore, the lack of funding for the mental health sector calls for an urgent need for public funding and partnership with private and non-governmental organizations.

Mental health management in Zimbabwe has a distinctive link with the criminal justice system and psychiatry structured together. In Zimbabwe legally committed mental health patients are admitted to what are called special institutions these are psychiatric hospitals situated inside a prison setting. (Zimbabwe Mental Health Act, 1996).

Commonly in the Zimbabwean prison system, there are two groups of mental health patients in special institutions. Namely, the Criminal Mental Patients (CMP) held on to be analyzed by the psychiatrist and the Detained Mental Patients (forensic mental patients) whom the specialist would have reviewed and confirmed to have a mental illness committed according to Section 8 of the (Zimbabwe Mental Health Act,1996) for treatment in special institutions. Despite the different mental health circumstances both patients are contained and managed together in the special institutions under the legal guardianship of the Prison Act.

The commitment of forensic psychiatric patients in special institutions for treatment has been criticized and often viewed as rather punitive for mental health patients. Dube (2014) cites that detained mental health patients experience life in the special institution just like a "detainee". The committing processes currently in place by which the patient is committed for detention are objectionable and condemning to this mental health patient right from the courtroom. In the court, the mental health patient is alluded to as an "accused person" by the prosecutors and is "detained" as is

alluded to admission to the special institution by the prosecutor. At the point when the patient arrives at the special institution, they are classified according to the prison classification as A, B, C or D as per the Zimbabwe Prison Service Standing Orders (1992).

In principle according to the (Mental Health Act, 1996) the detained mental health patient, is under ordered care in a special institution. However, in practice, the patient assumes a prison inmate status (a person captured and kept confined) Concise Oxford English Dictionary (2006) under the direct supervision and the custody of the Zimbabwe Prisons and Correctional Service. The patient can only be discharged from the special institution following the evaluation and recommendations of the Mental Health Review Tribunal (Mangezi & Chibanda, 2011).

Forensic psychiatric patients in special institutions population data is unclear with unofficial data suggesting that there are more than 600 patients in special institutions, despite the disputed unconfirmed figures, the Zimbabwe Prisons and Correctional Services (ZPCS) as cited in the (Independent Advisory Group on Country Information, 2017) acknowledged that its special health institutions are overcrowded as they have surpassed their holding capacity. The special institutions have a combined 465 patients against their holding capacity of 102 patients and some forensic psychiatric patients have spent more than 10 years in detention inside the special institution (Gwasira, 2019).

Despite the challenges within the special institutions ZPCS cannot by mandate refuse or turn away a committed patient and this poses conflicts generally involving admission criteria, space, care plan for patients, quality of care and access to medical

records. Njenga (2006) calls attention to the friction in forensic psychiatry as a more extensive issue that should be attended to in Africa, if not around the world.

Forensic psychiatry practice is generally shrouded in mystery and confusion, which then makes patients prone to injustices in the name of involuntary care. (Ogunlensi, 2012), reports that forensic psychiatry has remained underdeveloped within the context of pervasive neglect in the provision of mental health services and the situation is compounded by the dearth of information about forensic services in the African continent. According to the National Health Strategy for Zimbabwe 2009-2013, (2008), the care of forensic psychiatric patients in Zimbabwe presently is affected by the fact that the Special Boards and the Mental Health Review Tribunal are not able to carry out their duties as required due to financial limitations and incapacitation. These are the legal bodies responsible for the monitoring of patient progress and discharge from the special institutions.

## 1.3 Statement of the Problem

In Zimbabwe, the medico judicial relationship on the management of mental health patients is blurred and discordant with no public comprehension on the entry and exit process followed in the continuum of care for forensic psychiatric patients (Dube, 2014). Section 8 of Mental Health Act (1996) permits the detention of mental health patients in special institutions for involuntary treatment and rehabilitation; in principle and practice, the act as a mental health law in Zimbabwe violates the rights of mental health patients.

It is against this context that study seeks to answer the question if the Mental Health Act in Zimbabwe is violating patient's rights through the detention and institutionalization of mental health patients into prisons for medical treatment.

## 1.4 Purpose of the Study

The study's purpose is to examine the effects of forensic psychiatric patient's prison detention on human rights in Zimbabwe. The study will benefit society by generating information that contributes to thriving communities built upon resilience, reduced levels of mental ill health, less stigma and discrimination.

## 1.5 Research Objectives

The research objectives were to:

1.5.1 Explore the forensic psychiatry patients' rehabilitation system in special institutions

1.5.2 Analyze the benefits of prison detention on forensic psychiatric patients.

1.5.3 Assess the human rights compliance of special institutions towards forensic psychiatry patient care.

## 1.6 Research Questions

The main research questions that the study sought to answer are as follows:

1.6.1 How are forensic psychiatric patients rehabilitated in special institutions?

1.6.2 What are the benefits of prison detention on forensic psychiatric patients?

1.6.3 To what extent are special institutions complying with patients' rights?

## 1.7 Justification of the Study

This study seeks to create a reservoir for local relevant scientific knowledge and a new awareness of forensic psychiatric practice to realign forensic psychiatry to community rehabilitation and practice. The alignment of practice is critical, as the relationship between mental health and human rights is bidirectional. Human rights

violations negatively affect mental health and conversely, respecting human rights will improve mental health.

## 1.8 Significance of the Study

The study was significant in the promotion of patients' rights and the protection of human rights. The study raised awareness of the effects of forensic psychiatric patients' prison detention on human rights in Zimbabwe. For citizens, such awareness was intended to help curb stigma and discrimination of mental health. For policymakers the study was pertinent as the research findings revealed insights and dynamics relevant to their oversight role as human rights defenders and brought to their attention the need for policy review. From an academic perspective, the study sought to be a prelude to studies on mental health issues in Zimbabwe. This research also sought to inspire and enable readers and other stakeholders to appreciate the salient issues of mental health and its nexus with human rights. The study thus added to the body of mental health and human rights knowledge on existing literature in Zimbabwe.

## 1.9 Delimitation of the Study

This study was bordered in the ZPCS special institutions of Chikurubi in Harare and Mlondolozi in Bulawayo. These are by law high-security areas and the study topic subject centered on mental illness, which causes significant distress and impairment of functioning. With that in mind, the researcher set certain parameters to the study in terms of scope, methodology and respondents. The study adopted a qualitative method, as a case study using a purposive approach and thus consulted the psychiatric medical care providers, Zimbabwe Human Rights Commission and other

stakeholders as experts by experience using questionnaires and in-depth interviews. In terms of periodization, the study was confined to the period of the Mental Health Act use period 1996 to 2020. In terms of approach or paradigm, this study had a bias towards a human rights perspective for analysis.

### 1.9.1 Limitations of the Study

Resources, time and accessibility were identified as impediments during the study, nonetheless, the researcher managed to mitigate their impact in the following ways. Concerning resources, despite the high inflationary economic environment the researcher had saved enough for travelling to the prisons and stakeholders. In some instances, phone calls and emails were used to schedule appointments for formal interviews and ascertain status regarding written responses. With regards to time, the study involved persons whose work schedules were mostly busy and unpredictable, so the researcher opted for data collection tools and methods that saved on time. The questionnaires were simultaneously distributed to collect data at the same time across the medical careers as respondents. As for access, formal requests were sent to organizations and thereafter data was collected from willing respondents.

## 1.10 Summary

The chapter discussed forensic psychiatry in Zimbabwe and detention of patients in special institutions. The chapter provided a background to the study, statement of the problem and significance of the study on patients' rights. This chapter laid a foundation to the study by showing that mental health is a public health challenge, underfunded and neglected in Zimbabwe, the prevalence rate is on the increase, yet the service package is declining owing to the unavailability of resources.

# CHAPTER 2 REVIEW OF RELATED LITERATURE

## 2.1 Introduction

This chapter reviews the literature on the effects of forensic psychiatric patient's prison detention on human rights in Zimbabwe. The literature review also sought to shape the research questions and provide insight and reflective focus throughout this study. The review was conducted to appraise the existing knowledge regarding the focus of the current study, to identify gaps in the current literature, potential strategies and best practices on forensic psychiatry to contextualize the focus of this study as a potential contribution to generating new evidence. The literature search was carried out on electronic databases and hand searching of journals, policy documents and legislation related to the topic of study.

## 2.2 Theoretical Framework

### 2.2.1 Human Rights-Based Approach

The study was guided by the human rights-based approach to health. The WHO Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being." The understanding of health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.

The right to health is one of a set of internationally agreed human rights standards and is inseparable or 'indivisible' from other rights. This means achieving the right to health is both central to, and dependent upon, the realization of other human rights. Violations or lack of attention to human rights can have serious health consequences.

Mental ill health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions. Paradoxically, mental health is still given inadequate attention in public health, despite the high prevalence levels.

This research, therefore, sought to examine the effects of mental health patients' institutionalization in special institutions on human rights in Zimbabwe. The human rights framework was used also to measure if the duty bearers and those with the responsibility to implement the rights for the mental health patients are protecting and promoting the rights of the mentally ill who cannot independently claim for their rights. The nexus between the benefits of detention and human rights was also analyzed to ensure a balanced analysis.

## 2.3 The Relevance of the Theoretical Framework to the Study

The Human Rights Approach was embraced for the study on the basis that human rights are important in the relationships that exist between individual patients (claimant) and the government (duty bearer). The government should support the right to health through the allocation of maximum available resources to progressively realize adequate mental health care and in Zimbabwe; the right to health has been domesticated at law in the constitution of 2013. As such, human rights create a legal obligation on the state to ensure access to timely, acceptable, quality and affordable mental health care as well as to provide for the underlying determinants of health.

This approach resonates with the Universal Declaration of Human Rights (UNDHR) principles and the African Charter on the Human and People’s Rights article 16,

which reads as follows: "Every individual shall have the right to enjoy the best attainable state of physical and mental health." As such, the human rights approach to health requires that the domestic health policy and programs must prioritize the needs of those furthest behind first including the detained mental health patients towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage.

Based on the Human Rights based approach this study will not focus on all the human rights but will focus at the right to health, as achieving the right to health is both central to, and dependent upon, the realization of other human rights such as food and shelter in special institutions. Human rights instruments call for prisoners and detainees to receive health care at least equivalent to that available for the outside population.

On the one hand, "equivalence" rather than "equity" has been called for because a prison is a closed institution with a custodial role that does not always allow for the same provision of care available outside. Mental health patients are more likely to already be in a bad state of health when they are detained in special institutions, with the need to make the health services therein favorable, as the need for health care and treatments will often be greater in a prison than in an outside community.

The human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes in prisons. In pursuing a rights-based approach, health policy, strategies and programs are compelled in their design and implementation to explicitly improve the enjoyment of all people's right to health, with a focus on the furthest behind first.

The core principles of the human rights approach include accountability, equality, non-discrimination, and patients' participation (WHO, 2003).

## 2.4 Forensic Psychiatric Patients' Rehabilitation

Few papers have been published describing forensic psychiatric care in individual countries and the literature on international comparisons is scarce. However, these comparisons are important, particularly as discussions regarding service reorganization and as cost improvements become more imperative worldwide. International comparisons stimulate national debate and improve the development of best practices.

Rehabilitation is a comprehensive and multi-disciplinary treatment, which involves a wide variety of interventions. These interventions help the patient to reintegrate into the mainstream of society and improve his or her quality of life. Modern psychopharmacology, the assertion of patient rights and the positive results of the effectiveness of psychosocial rehabilitation have all contributed to the recent growth of this discipline.

According to (Rossler, 2006) the overall philosophy of psychiatric rehabilitation in mental disorders comprises of two intervention strategies. The first strategy is individual-centered and aims at developing the patient's skills in interacting with a stressful environment. The second strategy is ecological and is directed towards developing environmental resources to reduce potential stressors. Psychiatric rehabilitation should not be imposed; but should however concentrate on the individual's rights as a respected partner and endorse his or her involvement and self-determination concerning all aspects of the treatment and rehabilitation process.

Notably, the rehabilitation therapies available to the forensic psychiatric patient vary according to how developed a country is. According to (Dube, 2014) in developed countries at present the rehabilitation package include, Aggression Replacement Therapy, Aggression Control Therapy, Forensic Psychotherapy, Arts Therapy, Schema Focused Cognitive Therapy and Community reintegration.

Africa according (AU/NEPAD, 2009) most of the countries on the continent are economically developing which generally reflects a lack of resources which affect forensic psychiatric health financing as compared to other part of the developing world. According to Njenga (2006) most of the sub-Saharan Africa are still at a level where neither the medical nor prison systems have yet embraced responsibility for forensic psychiatric care and rehabilitation. Tunisia and Algeria are the only countries with substantive forensic psychiatric hospitals in Africa, Egypt for example, admits convicted patients to general hospitals while in North Africa certified programs in forensic psychiatry are non-existent and psychiatric care is largely legally imposed.

In Zimbabwe, the rehabilitation of forensic psychiatric patients is offered through special institutions (National Health Strategy for Zimbabwe 2009-2013, 2008). A special institution is a prison facility manned by guards and multi-disciplinary staff. Forensic psychiatric rehabilitation care requires a multi-sectoral approach, which includes the family and available social support systems, and a multidisciplinary medical care team who include psychiatrists, mental health nurses, physiotherapists, social workers and clinical psychologists to fully achieve its purpose (Dube, 2014). These multi- disciplinary medical care providers' compliments in their different areas of specialization with the detained mental health patient at the center of the

care they provide. The multidisciplinary teams in forensic psychiatric settings must coordinate with other stakeholders to ensure optimum patient support.

According to (Njenga, 2006), most of the African countries prison rehabilitation system; the multi-disciplinary medical caregivers are not trained to handle forensic psychiatric patients. This then has a negative impact on both the quality of rehabilitation care that is given to the patient and this in turn has a negative impact on patient recovery. In the Zimbabwean context special institutions have multi-disciplinary teams that provide the different rehabilitation functions. However in the Zimbabwean context (Dube, 2014) laments the unavailability of a rehabilitation protocol, which specifies whom in the rehabilitation service chain, does what for forensic psychiatric patients. There exists misperception on the nature of rehabilitation services, service accountability, equality, non-discrimination, and patients' participation.

### 2.4.1 Medicalization of Deviance

The medicalization of deviance refers to the process whereby non-normative or morally condemned appearance such as (obesity, unattractiveness, shortness), belief (mental disorder), and conduct (drinking, gambling, sexual practices) come under medical jurisdiction (Gonzalez & Connell, 2014). It seeks to find the root cause of deviance in an individual instead of looking at the external social structure around the person. Medicalization of deviances involves treating deviance with medicine and the medical personnel.

Most of the institutionalized forensic psychiatric patients are psychiatric diagnosed medical deviances with their crimes ranging from intention to commit a crime,

infractions, misdemeanours, and felonies.Medicalization of psychiatric patients therefore acts as social control of mental disorder deviance and the promotion of conformity to treatment and rehabilitation. Importantly the recognition of mental illness as a medical condition is important as it assists the patients to be provided with care and treatment.

The American Psychologist Association (as cited in Henderson, 2003) support medicalization of deviance as it labels specific behavior as diseases or disorders, importantly the removal of the stigmas from the individual experiencing the condition. For instance, if a person has a mental condition of generalized anxiety disorder, calling it an illness removes the blame from the individual because the term illness implies that the individual's anxiety is not due to a personal failing, but is brought about by a biological "malfunction" out of the individual's control.

Additionally, including a mental condition as an illness has practical advantages in that it helps the individual diagnosed with mental illnesses and disorders to get early treatment to alleviate negative symptoms. Likewise, the label can help individuals find support from others who have the same condition which then is the goal if special institution committing. However, the labels even medical labels link people to a set of undesirable characteristics that form stereotypes. According to Link (as cited in Rossler, 2006 ) labeled person experiences status loss and discrimination .Previous studies have shown that stigmatized groups are disadvantaged when it comes to life outcomes like income, education, psychological well-being, housing status, medical treatment, health and includes recidivism

However, medicalization of deviance has been criticized as diverting criminal liability through seeking insanity defense, in an insanity defense, the defendant

admits the action, but asserts a lack of culpability based on a mental illness. The insanity defense is classified as an excuse defense, rather than a justification defense. Although a defense known as "diminished capacity" bears some resemblance to the "reason of insanity" defense (in that both examine the mental competence of the defendant), there are important differences. The most fundamental of these is that, while "reason of insanity" is a full defense to a crime that is, pleading "reason of insanity" is the equivalent of pleading "not guilty", “diminished capacity" is merely pleading to a lesser crime (Slemon, Jenkins & Bungay, 2017).

An important procedural corollary to the insanity defense involves the establishment of legal competency, otherwise known as competence, to stand trial. In accordance with due process requirements, a criminal defendant cannot stand trial if he or she is deemed legally incompetent (Gonzalez & Connell, 2014). A defendant may move at any time for a hearing to determine competency, which involves the submission of supporting evidence and some form of a psychological evaluation. The threshold for establishing competency is often identified as notoriously low. So long as a defendant is deemed incompetent, the insanity defense becomes moot, as the defendant cannot stand trial.

However, detention of individuals with mental illness increases stigma as patients are labeled as criminals by society, which increase their recidivism. Stigma has traditionally been defined as an attribute that is deeply discrediting, and designates the labeled individual as tainted, or "discounted Goofman (cited in Dube, 2014). People who are stigmatized often experience negative psychological and social consequences such as stereotyping. A stereotype is a preconceived notion about specific types of individuals or certain ways of behavior that are thought to be

representative of a group as a whole. Furthermore, patients who are diagnosed as mentally unstable are sent to treatment facilities that tend to be either isolated or confined such the special institutions in Zimbabwe, which are in prison. Special institutions are by design medical institutions designed for medical deviants in principle however in the practice patients remain trapped in the system, revolving between courts, the special institution and the civil psychiatric hospital and back to the special institution (Dube, 2014).

## 2.5 The Benefits of Prison Detention on Forensic Psychiatric Patients

The purpose of prison detention is twofold: to offer care and treatment for the patient (i.e. to improve mental health and facilitate recovery) and protection of the public from harm from the offender (i.e. reduce the risk the patient poses). This dual function has been confused and cause tensions and dilemmas, which has potentially incompatible duties to the patient, medical caregivers and to the wider community.

The study recognizes the serious arguments of professionals who warn against a prohibition of forced treatment. Mental health patients cannot in principle consent to their treatment because of their medical condition. Some of the patients will be violent or delusional such that the medical caregivers cannot discuss the treatment plan with the patient hence there has to be someone who decides on behalf of the patient. The professionals insist on retaining legal permission to treat individuals with serious mental health conditions involuntarily in exceptional circumstances in ways that preserve dignity and autonomy, even the right to life. For some patients a restricted and safe environment is an essential feature of their mental health care

regime, at least at certain stages of their illness to maintain both their own and public safety, hence, the need and justification for detention, (Njenga, 2006).

Those against prison detention argue that the detention is a non-consensual imposition of mind and body altering drugs based on narrow conceptions of impairment. Poorly evidenced claims about "risk" and "necessity", and a limited range of alternatives, is incompatible with dignity and autonomy (Daniel, 2007).Detention in forensic care is generally not time-limited, and discharge depends on whether or not the individual is deemed to have made sufficient progress that they no longer present a risk. Discharge and transfer (e.g. to a less secure facility) is governed by a number of bodies (responsible clinician, hospital managers, mental health tribunals, Ministry of Justice) without further involvement of the sentencing court.

Whilst in detention the patients become less harmful to themselves, others and the environment, however despite the ongoing trends and debates on the benefits of psychiatric services and systems, which stress de-institutionalization and outpatient care the advantage of detention is that it allows access to psychiatric care for those in need at any time. On the other hand, the fact that individual with full criminal responsibility may be and often are held well beyond the time they would have been incarcerated had they received a prison sentence, as a non-mentally-disordered individual, and the involvement of a political body in decision-making about discharge, are ethically problematic.

Forensic psychiatric services must be provided in different levels of security high, medium and low secure as well as community forensic psychiatric services. High secure services cater for patients who 'require treatment under conditions of high

security on account of their dangerous, violent or criminal propensities, and ‘pose a grave and immediate danger’, medium secure services are for those presenting ‘a serious danger to the public and low secure services are for those ‘who pose a significant danger to themselves and others’ (Gonzalez & Connell, 2014).

In addition, ‘enhanced’ medium secure services are provided for women ‘who require enhanced levels of intervention and treatment. This tiered system has developed historically as described below; it allows in theory movement along a ‘treatment pathway’, where individuals move from more to less restrictive settings. Such provision in the least restrictive setting is essential not only for legal and ethical reasons but also for financial reasons. Forensic psychiatric services are high cost, low volume services.

Scholars in diverse fields, including philosophy, neuroscience, psychology and economics, are increasingly challenging the grounds for the “exceptions” that legitimize coercion in mental health care (Puras &Gooding, 2019). The Convention on the Rights of Persons with Disabilities (CRPD) has elevated this challenge to the level of international human rights law. Indeed, the CRPD challenges centuries of legally sanctioned prejudice. However, the exceptions remain at the domestic level, in law, policy and practice, and they filter into the norm, fostering power asymmetries, the overuse of biomedical interventions, and the disempowerment of an already marginalized population.

According to the (United Nations, 2012), compulsory detention raise human rights issues and threaten the health of detainees, including through increased vulnerability to HIV and tuberculosis (TB) infection. Criteria for detention of individuals in these centers vary within and among countries. However, such detention often takes place

without the benefit of sufficient due process, legal safeguards or judicial review. The deprivation of liberty without due process is an unacceptable violation of internationally recognized human rights standards. Furthermore, detention in these centers has been reported to involve physical and sexual violence, sub-standard conditions, denial of health care, and other measures that violate human rights.

Nonetheless, free and informed consent should form the basis of the treatment and rehabilitation of most people with mental disorders. All patients must be assumed initially to have capacity and every effort should be made to enable a person to accept voluntary admission or treatment, as appropriate, before implementing involuntary procedures.

### 2.5.1 Mental health in Prisons

According to the (National Mental Health Alliance, 2019), 2 million people with mental illness are booked into prisons each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition. The disproportionately high rate of mental illness in prisons is related to several factors: the widespread misconception that all people with mental disorders are a danger to the public; the general intolerance of many societies to difficult or disturbing behavior; the failure to promote treatment, care and rehabilitation, and, above all, the lack of, or poor access to, mental health services in many countries. Many of these disorders may be present before admission to prison, and may be further exacerbated by the stress of imprisonment. However, mental illness may also develop during imprisonment itself as a consequence of prevailing conditions and also possibly due to torture or other human rights violations.

Once detained in prison, many individuals do not receive the treatment they need and end up getting worse, not better. They stay longer than their counterparts without mental illness stay in prison. They are at risk of victimization and often their mental health conditions get worse. According to the International Committee of the Red Cross (ICRC) (cited in Hans, Harald & Kief, 2007) there are factors in many prisons globally that have negative effects on mental health, including: overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from the outside world and social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental health services, in prisons. The increased risk of suicide in prisons (often related to depression) is, unfortunately, one common manifestation of the cumulative effects of these factors.

After leaving detention, many no longer have access to need employment and shelter, as criminal records often make it hard for discharged patients to get a job or housing. Many individuals, especially without access to mental health services and supports, wind up homeless, in emergency rooms and often re-arrested creating a revolving door scenario (Dube, 2014). Shockingly least 83% of jail inmates with a mental illness did not have access to needed treatment.

In some countries according to the (World Health Organisation, 2010) people with severe mental disorders are inappropriately locked up in prisons simply because of the lack of mental health services. People with substance abuse disorders or people who, at least in part due to a mental disorder, have committed minor offences are often sent to prison rather than treated for their disorder. These disorders therefore continue to go unnoticed, undiagnosed and untreated.

Detaining people with mental illness creates huge burdens on law enforcement, corrections and state and local budgets. It does not protect public safety. In addition, people who could be helped are being ignored. Rather in the best interest of the patient, they should be more interaction with medical care than law. In countries like Zimbabwe, the distance between mental health referral centers also acts as a deterrent on the accessibility and availability of medical services. In most communities, police services are easily available as compared to mental health services.

In Zimbabwe, with different countries adopting different models, responsibility for mental health services in prisons is split between the Ministry of Health and the Ministry of Justice, leading to complex funding streams and neither party taking full responsibility. According to the Institute of Crime and Justice Policy Research (2019), the Zimbabwean Prison population was at 19382 as of April 2019.

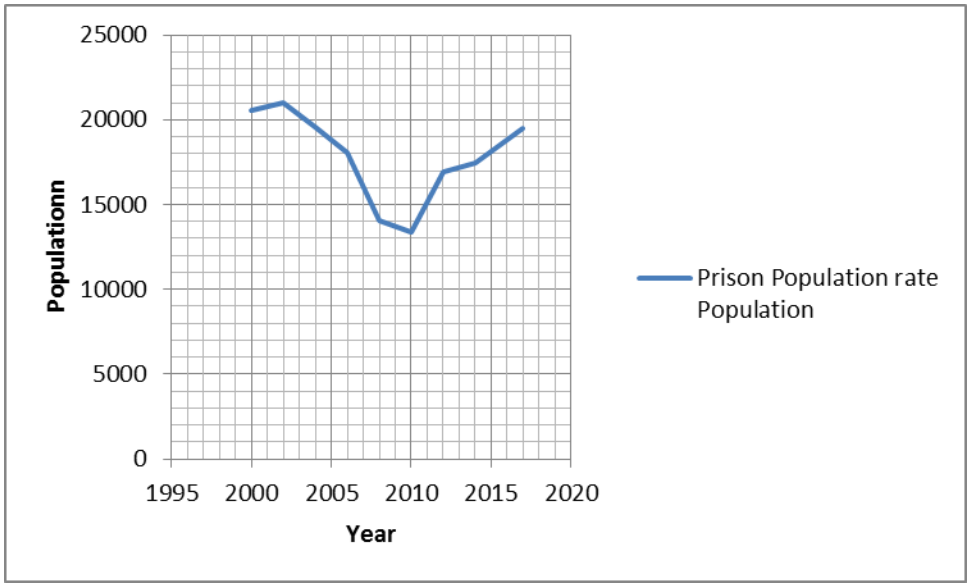



***Figure2:*** Prison Population in Zimbabwe

(Institute of Crime and Justice Policy Research, 2019)

## 2.6 Human Rights in prisons and places of detention

There is consensus in international law that the state has an obligation to protect the lives and well-being of people it holds in custody. Prisoners have the right to health, including medical care, mental health care and living conditions that do not jeopardize their health or promote disease. As will be discussed below, the international jurisprudence exhibits clear areas of consensus, and therefore direction to states, on the minimum legal standards they must meet to remain human rights compliant.

The right to health of prisoners is enshrined under both economic, social and cultural rights as well as civil and political rights. Primarily located within legal frameworks that focus on civil and political rights, the right to health is more frequently being used to challenge abuses of health by invoking social and economic rights, even though this places the right to health on slippery terrain that is not as internationally accepted as civil and political rights. The right to health in prisons according to (Lines, 2008) includes a right to medical care, a right to timely medical attention, a right to preventative health, a right to mental health care, a right to a professional standard of care, a right to informed consent and to refuse treatment, a right to environmental health, a right to adequate living space, a right to hygienic living conditions, and a right to food and water.

Indeed, the issue of the right to health of prisoners offers a unique intersection of these two groups of rights, and one might argue is an illustration of interconnectedness of these rights that highlights the artificial separation of them into different categories. A comparison of the jurisprudence from United Nations and regional human rights bodies, as well as key national case law, shows that the

different systems have adopted a remarkably similar approach when engaging the right to health of persons in detention. Yet despite this legal direction, it is clear from the investigations of human rights monitors and non-governmental organizations that the failure to fulfill the right to health of prisoners affects millions of people worldwide.

Despite the availability of numerous conventions and treaties that protect human rights (Hunt, 2004) argues that respect for the basic human rights have traditionally been a problem in prisons and places of detention. In the human rights discourse and practice, the right to health has been and continues to be a contentious arena. Human rights violations in the mental health context remain significant throughout the world, including in high, middle and low-income countries

Likewise, access to healthcare is often incorrectly cast as synonymous with the right to health. However, while this remains true in some ways (particularly when it comes to social and economic inequities in healthcare access) the right to healthcare should not be viewed as categorically the same. In practice, the right to health is often favored, as the right to health care is seen as too narrow in focus. At the same time, the right to health is also seen as too demanding, because for some it implies a right to be perpetually healthy, which is an impossible standard. In turn, the right to health care is too narrow to include important factors like safe environmental conditions or adequate sanitation. Thus, the right to health is an umbrella term that implies a variety of practical requirements.

Despite the Sustainable Development Goals and international guidelines, conditions pertaining to the ill treatment of mental health patients in criminal justice systems across the world continue to warrant attention, with systemic abuse of detained

mental health patients, and deplorable conditions continuing to exist. The prevalence of rights abuse cannot be explained by a mere lack of resources. (Puras & Gooding, 2019), concurs that in the relatively wealthy European region, for example, funds continue to be invested in the renovation and expansion of large-scale residential and psychiatric institutions.

Although the right to health of prisoners is broadly protected under human rights norms, exercising these guarantees within the context of prisons is difficult. As described by Rieter, (cited by Lines., 2008), apart from being especially vulnerable by virtue of being detained, detainees generally are an unpopular political cause. The consideration of the rights of the detained mental health patients is not normally included in the political process hence not a priority for the political leaders or the general public leaders or the general public. Complicating this situation is the fact that none of the relevant international or regional conventions define humane or inhumane treatment'' As a result, the generalized language used in the international treaties allows for significant discretion in interpreting standards of humane treatment of prisoners, such as the provision of medical care.

Although specific entitlements, including health guidelines, are codified in numerous international resolutions and model standards, none enjoys the status of international law, and are rather non-binding ''soft law'' instruments. Concerns have been raised globally in Europe particularly; there have been major attempts to protect prisoners from violations of their basic rights, as evidenced for example by the European Convention against Torture. The Council of Europe has created a specific body, the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, known as the CPT, to monitor ill treatment and the conditions of prisoners, including health issues. Many other non-governmental organizations also

monitor prisoners' conditions, in particular all aspects of health within prisons (Irish Mental Health Commission, 2011).

In sub Saharan African, prisons overcrowding is severe. In study by (Keehn & Nevin, 2018) to study to address HIV and Tuberculosis in Prisons which health co-morbidities. The study shows that eighty six percent of countries for which data were available had prison occupancy rates over hundred percent. Overcrowding and poor ventilation contribute to the risk of airborne TB infection. The African Commission on Human Rights has found that such poor environmental conditions in prisons can violate the right to health under the African Charter. In Malawi African Association and others v. Mauritania, a violation of Article 16 was found, in part, due to inadequate hygiene in the prison.

Poor conditions can also heighten tension among inmates and fuel violence, including rape, which heightens the risk of blood-borne and sexually transmitted infections, including HIV. These realities are a reflection of how many prisons in the region are operated against a background of severe infrastructural constraints, under-prioritization, and relative poverty. The African Charter also requires that states parties ''take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick''. Within the African system, the right to health of prisoners has also been engaged under the right to life and the prohibition of cruel, inhuman or degrading treatment.

It should be realized that the detained mental health patients will have to re-join society as reformed citizens. On the contrary, the human rights violations present conditions in the special institutions that worsen patient's medical conditions. Although these patients committed crimes, they are still human beings who deserve

dignified treatment. After all, anybody can be candidate for these institutions due to mental illness.

The study by (RAU, 2019) revealed that Zimbabwe prison's physical structures are in remorseful state exposing prisoners to inhuman and degrading living conditions. The prisons are overcrowded, food shortages and an unequal proportion between the Prison staff and inmates resultantly the Zimbabwe Prisons and Correctional Society cut down the hour's inmates can spend outside their cells in violation of the inmates' rights The prison system in Zimbabwe is not structured to handle vulnerable groups such as women, children and people with disabilities and unfortunately. For female inmates in Zimbabwe, Mtetwa (2017) revealed that women in prison indicated that they did not have adequate undergarments; there is inadequate sanitary wear, and other sexual reproductive health rights services.

The ZHRC (2016), report on the visit to Chikurubi Maximum Prison (Male section) on the 18th of March 2015 Riot, revealed that inmates are treated from rooms with no privacy or from buildings with inadequate storage space for medication. The report also noted that prisons had shortages of staff including ordinary staff clinical staff, let alone specialists such as psychologists, social workers, specialist doctors, and psychiatrists and essential drugs.

### 2.6.1 Mental health legislation

The purpose of mental health legislation is to protect the rights of those affected by mental illness as they are often faced with stigma, discrimination and prone to abuse (WHO, 2003). Legislation also serves to govern involuntary care and forensic psychiatry. Forensic psychiatry represents the interface of two worlds, which identify

and regulate deviance, which are medicine and the law. The law is primarily concerned with regulating human behavior and psychiatry with understanding human behavior.

Many anomalies continue to exist in the laws as it relates to the practice of forensic psychiatry globally. The problems inherent in the defenses of insanity and sane and insane automatism, as well as in their outcomes are difficult. Many ethical-conceptual issues in relation to psychiatry still need clarification. For example, what counts as a mental illness, and how does mental illness excuse responsibility for criminal actions? This question is particularly difficult to answer in relation to personality disorder, and its sister concept, psychopath.

From time to time psychiatrists are called upon to determine whether a defendant is fit to be tried. The task of determining whether in a realistic sense, a person can understand legal proceedings and of playing a role in them can pose its practical clinical difficulties. Not least among them, of course, is the fact that defendants' mental states can be constantly shifting, and the processes of a court appearance affect the patients.

Respect for justice usually requires that we treat similar people in similar ways. Presently and arguably, there is a difference in how detained mental health patients and other offenders are treated at law. Forensic patients are vulnerable to exploitation and injustices. For example, mentally ill offenders are detained longer in prison detentions than their counterparts who have committed exactly the same offence, but do not have a mental disorder. This may do justice to the victims of the patient’s deviance, but at the expense of the offender patient's welfare; so that the patient's claim to justice is set against another's claim in an adversarial way. It is arguable that

because forensic patients are vulnerable, there is an increased duty of care on professionals to respect their claims to justice.

Although legislation may provide many rights to persons with mental disorders, they are frequently unaware of their rights and thus unable to exercise them. It is therefore essential that legislation include a provision for informing patients of their rights when interacting with mental health services. This review covers important areas that need to be incorporated into mental health legislation. Frequently, such legislation focuses only on involuntary admission and treatment, and neglects or omits equally important concerns related to persons with mental disorders. Laws related to mental health can satisfactorily be dispersed in several different legislative measures or contained in a single statute. The type or form of the legislative text will vary from country to country. For example, some countries may choose to spell out only the key principles in a mental health act, and use regulations to specify the procedural details for translating legislative intent into action; others may include the procedural aspects within the main body of the mental health law

The criteria for involuntary mental health patient institutionalization and the regulation of special treatments are critical issues along with other legal issues that confront the forensic psychiatrist, such as psychiatric impairment and the concept of competence. The law regulates psychiatry, as a branch of medicine, and the specific practices that are most vulnerable to legal attention are discussed along with psychiatry's own unique position of advice to regulators on the capacity of other practitioners to practice safely and competently. This latter problem is discussed from the perspective of confidentiality, and criminal responsibility, competencies, and insanity. Countries need to decide how broadly or narrowly to define the

beneficiaries or target group of the legislation. Choosing between a broader definition and a narrow one is complex. If mental health legislation covers purely "care and treatment", most mental health users, advocates and human rights activists prefer a narrower definition. On the other hand, if such legislation is aimed at protecting a broad range of rights of persons with mental health problems and includes, for example, anti-discrimination clauses and protection from abuse, a more inclusive definition of mental health problems appears preferable.

In addition the (World Health Organisation, 2010) states that Mental health legislation can be a powerful tool to protect the rights of people with a mental illness, including detained mental health patients, yet in many countries mental health laws are outdated and fail to address the mental health needs of the prison population. The development of legal provisions that address these needs can help to promote the rights of mental health patients, including the right to quality treatment and care, to refuse treatment, to appeal decisions of involuntary treatment, to confidentiality, to protection from discrimination and violence, and to protection from torture and other cruel, inhuman and degrading treatment (including abusive use of seclusion, restraints and medication, and non-consensual scientific or medical experimentation), among others.

Legislation should provide prisoners with mental disorders with procedural protections within the criminal justice system equivalent to those granted other prisoners. The protection, through legislation, of other basic rights of prisoners, such as acceptable living conditions, adequate food, access to the open air, meaningful activity, and contact with the family are also important and can further contribute to the promotion of good mental health. Independent inspection mechanism such as

mental health visiting boards can also be established through legislation, to inspect prisons as well as other mental health facilities in order to monitor conditions for people with mental disorders.

In Zimbabwe, the (Mental Health Act, 1996) guides both general psychiatry and forensic psychiatry in Zimbabwe and guided by the Mental Health Policy of 2007. However, the act has been criticized as the act legalizes the institutionalization of forensic psychiatric patients in Zimbabwe. The National mental health laws and policies are further criticized to have failed to encompass the mental health needs of the detained mental health patient's population.

According to the ZIMNAMH there is a need to review the (Mental Health Act, 1996) to bring it in line with contemporary approaches to mental health care and protection of human rights enhanced by an appropriate prison management act that promotes and protects human rights. Attention to areas such as sanitation, food, meaningful occupation, and physical activity, prevention of discrimination and violence, and promotion of social networks will be essential.

## 2.7 Summary

Literature related to forensic psychiatry was reviewed to discuss forensic psychiatric practice in the developed world, in the African region, and Zimbabwe. Forensic psychiatric practice is reflected as being highly developed in Europe while it is perceived as inconsistent in other parts of the developed world. On the African continent, including Zimbabwe, literature has shown that there are efforts related to the protection of patients with legal instruments in the process of committing patients to forensic psychiatric institutions.

# CHAPTER 3 METHODOLOGY

## 3.1 Introduction

This chapter presents the research design used by the researcher with the influence of methodological frameworks, which also informed the data collection methods. The population in which the study drew its sample is also presented in this chapter. In this chapter, the study presents the sampling methods, the sample size, instruments used for data collection. Data analysis methods are also considered again as pertinent in this chapter and combined to that are some ethical considerations.

## 3.2 The Research Design

The study adopted an exploratory research design using a case study to allow for an in-depth investigation into the effects of forensic psychiatric patient's detention in prisons. The exploratory research design helped to establish data collection methods, analysis and the selection of research participants in this study.

## 3.3 Population and Sampling

The total population of the study of 14 participants came from Zimbabwe Prison and Correctional Services (ZPCS), The Zimbabwe Human Rights Commission (ZHRC), and Stakeholders from Volunteer Services Organization (VSO), the Zimbabwe Association for Crime Prevention and Rehabilitation (ZACRO), and Zimbabwe National Mental Health Association (ZIMNAMH).

.

10 questionnaires out of a total of 34 (20 Chikurubi, 14 Mlondolozi) multi-disciplinary members were distributed for data collection in the Chikurubi and Mlondolozi Psychiatric hospitals. The medical multi-disciplinary team members who voluntarily participated in this study included mental health nurses, physiotherapists, a psychiatrist and a registered general nurse. 4 in-depth interviews were carried out with stakeholders from VSO, ZACRO, ZIMNAMH and the ZHRC.

Participants were identified through purposive sampling, a non-probability sampling method based on the populations' knowledge and the researcher's aims and objectives to elicit free-flowing data on the effects of forensic psychiatric prison detention on human rights in Zimbabwe. The participants represented perspectives within the population before data saturation was reached. Formal permission to carry out this study and interviews was obtained from the Zimbabwe Prisons and Correctional Services (ZPCS).

**Table 1: Summary of participants**

| **Code** | **Language** | **Institution** | **The professional background of the respondent** |
|---|---|---|---|
| A | English | Chikurubi | Mental Health Nurse |
| B | English | Chikurubi | Physiotherapist |
| C | English | Chikurubi | Social Worker |
| D | English | Mlondolozi & Chikurubi | Psychiatrist |
| E | English | Mlondolozi | Mental Health Nurse |
| F | English | Mlondolozi | Mental Health Nurse |

| | | | |
|---|---|---|---|
| G | English | Chikurubi | Mental Health Nurse |
| H | English | Chikurubi | Mental Health Nurse |
| I | English | Chikurubi | Social Worker |
| K | English | Chikurubi | Register General Nurse |
| K | English | ZHRC | Human Rights Officer |
| L | English | ZIMNAMH | Programs Manager |
| M | English | VSO | Program Officer |
| N | English | ZACRO | Director |

### 3.4 Data Collection Instruments

To obtain necessary data about the effects of forensic psychiatry psychiatric patients' prison detention in Zimbabwe this study employed 3 main instruments to collect data.

#### 3.4.1 Interview Guides

Interviews were scheduled held with 5 key informants namely the Parliamentary Portfolio Committee on Health, ZHRC, ZIMNAMH, VSO and ZACRO, and 4 were completed with ZHRC, ZACRO, ZIMNAMH and VSO. An interview guide from whom discussions were held with informants guided the interviews. None among the informants consented to audio recording; therefore, notes were jotted down when it was convenient or permissible. The interviews were priceless in exploring intimate perspectives by respondents to some seemingly sensitive questions. In some instances, the interview enabled the researcher to probe further on clarifications and

exploration of the responses. The face to face aspect helped the researcher to notice the respondent's non-verbal cues.

### 3.4.2 Self-administered Questionnaires

Due to the controlled nature of prisons, this research also relied comprehensively on hybrid self-administered questionnaires that asked the same set of questions in a predetermined order for reliable responses. These yielded standard data which was easily analyzed into themes. The questionnaires checked against digression by having closed questions with predetermined responses. However, other questions incorporated open-ended section to record other views. The self-administered aspect, ethical section and anonymity principles encouraged free and objective reliable responses and recording of 'sensitive' data from the respondents. Questionnaires were considered for their versatility and cost-effectiveness as well as the quick response rate since they were concurrently administered to several respondents at the same time.

### 3.4.3 Documentary Review

The use of obtainable literature helped the researcher to understand the depth of forensic psychiatry, its effects on patients' human rights and to identify areas of research by other scholars who contributed to the topic. These documents reviewed included research work by other scholars, policies, journals, and publications. The obtaining data documents were both qualitative and quantitative research paradigms and provided a holistic appreciation of the subject. The rationale for using a combination lay in their individual and collective capacity to decipher, describe and present perspectives and attitudes

## 3.5 Data Collection Procedure

For data collection, the researcher used a semi-structured guide for key informant interviews, these were meant to initiate and allow the flow of the interviews in the direction of participants while focusing on the rights of mental health patients within the justice system. Drafting and testing of the interview guide were done before it was launched to the respondents. All questionnaires were in English and were tested to guarantee that they efficiently and effectively served their purpose.

## 3.6 Analysis and Organization of Data

Data gathered in this research was categorized into themes emerging from the responses to questions. The questionnaires were first categorized according to the respondents as revealed by the information on organizational affiliation. This enabled the researcher to have a general perspective of what kind of responses came from a particular group of respondents. The researcher also made further classifications according to responses to certain questions; this was essential in identifying and deducing trends relating to certain aspects in the questions.

The information from the questionnaires that had bimodal or specific static values was fed into Microsoft Excel and Microsoft Access database programmes to generate descriptive statistical data. These two programmes are easy to use, especially with small volumes of statistical data. They are compatible with Microsoft Word thereby enabling easy navigation between the programmes. Microsoft Excel is also adaptable in generating simple visual data presentation tools such as tables, graphs, charts from trend analysis of numerical data relating to sex, age and other numerical or bimodal information.

### 3.7 Ethical Considerations

The entire research design and conduct were based on ethical standards reviewed and approved from the Africa University Research Ethics Council (AUREC). Permission to conduct the study was obtained from the Zimbabwe Prison and Correction Services office of the Commissioner-General (Department of Research and Development).

The research was bound by research ethics on respect for persons according to the Ethical Guidelines for Health Research Involving Human Participants in Zimbabwe (2011), ethical principles should promote the respect of persons. Individuals must be treated as autonomous agents. In this study, the multidisciplinary health and stakeholder's teams were considered as autonomous individuals.

Confidentiality was important for most respondents in giving their opinions on a subject involving the prisons and Official Secrets Act [Chapter 11:09] which prohibits the communication of certain information so, before the research, the informed consent was sought at both organizational and individual levels. The researcher highlighted the importance of voluntary participation and that the information was solely for academic research and reiterated the right to withdrawal. The researcher also stressed the beneficence of such a study towards improving human rights for the forensic psychiatry information after finding out that respondents were also keen to know the possible benefit.

The transcripts are locked in the safe in the principal researchers' office. Identifiable information such as interview transcripts are not kept on the researchers' personal computer. The data regarding this study will be destroyed when it is no longer of functional value and this is projected to be five years from the date of publication of

this study. The researcher will personally delete the audio recordings used during the semi structures interviews. The USB will be physically destroyed. A record stating when, how and which records were destroyed by the researcher will be kept.

## 3.8 Summary

In this chapter, the researcher presented the research methodology, and the research design used for the study was an exploratory research design using a case study. The population and sampling included the ZPCS medical caregivers working with the detained forensic psychiatric patients. The Chapter also discussed data collection tools used which included the semi-structured interview guides, data collection procedures, analysis of data and ethical considerations including confidentiality, data handling, and data management, which were adopted by the study.

# CHAPTER 4 DATA PRESENTATION, ANALYSIS &INTERPRETATION

## 4.1 Introduction

This chapter presents the research findings, which emanated from the research. The findings that emerged from the interviews are presented, analyzed and interpreted with the existing literature related to the topic of the study. Further to the discussion in Chapters 1 and 2, this study followed a qualitative research approach to develop an in-depth understanding of the effects of forensic psychiatric patient's prison detention on human rights in Zimbabwe.

The objectives of this research study, as highlighted in Chapter 1 (section 1.4) were to explore and describe the effects of the psychiatric patient's prison detention on human rights in Zimbabwe. Semi-structured interviews were conducted with ZPCS Special institutions medical caregivers, Zimbabwe Human Rights Commission and Stakeholders working with forensic psychiatric patients to collect data from participants.

## 4.2 Data Presentation

### 4.2.1 Rehabilitation Services Available for Forensic Psychiatric Patients

The medical caregiver's respondents from the self-administered questionnaires in response to the researcher's question on the understanding of rehabilitation and its interpretation in the context of special institutions from participants are varied. Rehabilitation in the special institution's context is defined differently because of the double-barrel function of the special institutions its first a prison then a psychiatric hospital, according to the professional background; medical caregivers defined rehabilitation differently, Interestingly 70% interpreted it more as restorative whilst 30% interpreted it related with the correctional functions of the prison.

The rehabilitation meaning according Participant A and B, mental health nurse and physiotherapists, can reveal the disconnection of the rehabilitation concept;

Participant A

> "….activities of daily living such as bathing, washing, grooming, cooking, and cleaning the cells, Social skills, recreational activities such as music and dance, playing soccer, volleyball, board-games e.g. chess and draft…"

Participant B

> "…..Occupational therapy based assessments primarily support diagnostic processes, then to ascertain the level and types of impact of a person's illness/situation on their ability to perform activities of daily living. Chief among this is also determining the risks to self and others that the inmate presents…."

The interpretive disjuncture on rehabilitation presented also the confusion brought about by having a hospital in a prison setting. The researcher noted how this confusion also impacted on this how at times during the interviews the medical caregivers deliberately called the detained mental health patients "musungwa" prisoners.

This is also a culmination of lack of coordination on rehabilitation of patients present in special institutions caused by the absence of standard operating procedures to standardize rehabilitation in care. When a single phenomenon means different things to different people it prone to personal interpretations that can cause harm to the intended beneficiary. The other point of interest emanating from the unavailability of a forensic psychiatric rehabilitation standard operating procedures is the over-

reliance on psycho–pharmacotherapy compared to the possible treatment modalities like occupational therapy and psychotherapy.

The shortage of multi-disciplinary staff key to rehabilitation was also recorded as affecting rehabilitation services. Rehabilitation is a specialized skill, which requires special training. However, special institutions have shortages of general and specialist medical personnel. For instance, the Mlondolozi special institution has a 56% percent staff compliment against the needs.

This translated to fourteen medical caregivers against a recommended number of 25 professionals; presently there is one (1) Psychiatrist against a recommended number of two (2); one (1) Rehabilitation officer against a recommended number of two (2); one (1) Physiotherapist against a recommended number of two (2); and had no Psychologist against a recommended number of one (1). These figures fell short of the WHO guidelines and government obligation to ensure that attention is given to prisoners with special health care needs or issues that prevent their rehabilitation. The shortage has a negative impact on the quality of care that the patients are receiving.

Despite the shortages in staff, the positive aspects as a best practice are the rehabilitation of forensic psychiatric patients in Zimbabwe. When comparing the Zimbabwean forensic psychiatric care model against other African countries on the multi-disciplinary teams for the rehabilitation of patients. Zimbabwe has a trained forensic psychiatric multi-disciplinary team; with the multi-disciplinary professionals affiliated to different professional bodies for authorization and continued education.

Rehabilitation however in the Zimbabwe context is not structured. Zimbabwe being a developing country does not prioritize funding for rehabilitation, the concept of rehabilitation is in special institutions more centered on cleaning, singing and dancing. These rehabilitation techniques are more ART therapy techniques and negate other packages such as Aggression Replacement Therapy, Aggression Control Therapy, Forensic Psychotherapy, Arts Therapy, Schema Focused Cognitive Therapy and Community reintegration.

Despondently, one realization was that in detention, rehabilitation is not prioritized as a right for patients but a privilege for patients. Upon prison detention, prison assigns a class A, B, C, D according to the crimes they committed. The detained D class inmate is considered a high risk to the medical caregiver is considered dangerous patients not allowed leaving their ward cum prison cell. The patient is not entitled to rehabilitation because of the nature of the crime that they committed and is confined.

Mental illness is itself a medicalized deviance; as such, there should be promotion of conformity to treatment and rehabilitation of the patient. The recognition of mental illness as a medical condition should remove some of the stigmas for the individual experiencing the condition including rehabilitation denial. This patient because of the mental illness would have committed a crime but because they are being treated and as part of the treatment plan, there is, no point to deny the patient rehabilitation as part of the patient care plan and treatment based on crime committed because of an illness being now treated.

From this study on rehabilitation for psychiatric patients, rehabilitation in Zimbabwe should focus on maximizing the function of these patients so that they fit into the environments of their respective societies. The study found that the rehabilitation for forensic psychiatric patients was biased towards drugs instead of having a general rehabilitative approach that is specific to patients. This study further asserts that

forensic psychiatric patients have healthcare needs that are specific to them in view of the complexity of the setting in which they are cared for and the inherent challenges related to their psychiatric, medical, and social circumstances.

The rehabilitation system in special institutions is not coordinated by standard operating procedures or policy. Despite the efforts by ZPCS to involve multi-disciplinary teams there is need to regulate standards so as to effectively assist detained mental health patients. This coordination in the absence of resources to recruit more staff boosts task shifting of disciplines to create a polyvalent medical caregiver in the best interest of patients.

### 4.3 Benefits of Prison Detention

From the study findings 60% of the respondents, responded that there are benefits in institutionalization. These benefits mostly are security benefits. The medical caregivers argued in their justification for detention that mandatory treatment by the government in special institutions was important as this patient would have no mental capacity to determine what would be best for themselves, according to the medical caregivers this improved the mental health status and reduced the risk of violence to self and others.

According to Key Informant A,

> "….detention offers a safe environment and allows enough time for monitoring of patients who would have committed a crime and are a danger to the society…."

This reliance on detention for security should be looked at holistically; security should be looked at from a one-side point of view as beneficial to the society and medical caregivers only. Security should include the patient's perspective also. To overcome the risk-related challenges described above, Reed (as cited in Seppaneni, 2018), distinguishes three aspects of security: physical security, relational security, and procedural security. Physical security ensures aspects of the environmental and building design that include safety and restraint in this regard the prison detention physical resembles security with maximum restraint.

Whilst incarcerated mental health medical caregivers face difficulties in relation to the autonomy of their patients. (Labelle, 2008), concurs that some of these difficulties are the familiar ones relating to legal coercion of people with mental illnesses, and the impairment of autonomy by mental illness. In such cases, restrictions of autonomy may be justified with respect to the patient's own welfare. However, in forensic settings, as in prison, other people's welfare can also become a justification for restrictions on autonomy as a benefit for detention.

It is hard not to perceive that the interests of mentally health offenders come at the bottom of almost any list of priorities; partly because such patients are vulnerable and can be exploited, but also because they are "guilty" as charged individuals, and can thus claim less moral or legal protection. Some of the ethical dilemmas in managing patients in forensic psychiatry services may arise from the fact that the patients are highly stigmatized, and often deemed as "valueless" by the rest of society.

Miserably observed during the study visit was the fact that for medical caregivers to perform their duties, the presence of a Prison guard was mandatory. According to the

Zimbabwe Prison Act (1996) it is mandatory for a prison guard and it was operationalized by the Zimbabwe Prison Service Standing Orders of 1992, Part IX, Section 164, subsection 4 (1992). Notably also was the level of command that the guards demanded, guards in prisons are demigods because of the authority in prisons.

40% of the respondents who responded against detention believed the practice of committing psychiatric patients is special institutions for security purposes is inhumane and does not benefit the patient. As was reviewed in the related literature the mistreatment in detention has led to deaths, though the number of casualties is unclear a similar question was posed to the Prison authorities and unfortunately, prisons classify the deaths in various ways.

There are many concerns within forensic psychiatry about not doing harm to patients. First, the pharmacological management of violence makes use of sedating drugs, which decrease the risk of violence, but may increase a risk to the health of the patient. Second, it is not clear who should be judging the harm suffered; patients may experience the use of seclusion or other types of behavior modification as unjustified harm, as opposed to staff who perceive it as justified. In usual clinical settings, the patient's view should prevail (Adshead, 2000). However, it may also be argued that the loss of physical autonomy caused by drugs or seclusion is harmful.

According to (Daniel, 2007) in developed contexts, the three-tier detention system is used for detention of forensic psychiatric patients with classification from low, medium and high risk. However, from the study forensic psychiatric care in Zimbabwe is offered at Chikurubi Maximum prison and Mlondolozi prison, which are high security zones. The institutions have armed guards forming the bulk of its main staff. This put an emphasis on external benefits than the patient care benefits.

There are alternative care models opposed to detention (institutionalization) with growing concerns on keeping people with mental health problems out of correctional facilities. There was a deliberate attempt to discuss alternatives models, respondents largely from ZIMNAM a Non-Governmental Organizations working with psychiatric patients and ZACRO a Non-Government working to help rehabilitate offenders there was consensus on the need to shift from the model of care based on the traditional institutions of care to modern comprehensive community-based models of care, and the main reasons for this shift being on a human rights perspective.

Community-based models according to the findings of the study provide social support systems, which form a critical role in the rehabilitation of mental health patients. Support systems according to (Dube, 2014) refer to the people within the patient's social circle who can look out for the forensic psychiatric patient before, during and after admission to a special institution. The support could be in the form of adherence support.

ZIMNAMH corroborated the importance of the support system for patients "…. the least expensive option of all is to make sure seriously mentally ill individuals receive proper psychiatric care in the community so they do not end up in the special institutions, those who are on medication are less likely to be arrested and this will save the Government less comparing the cost of detention as opposed to treatment…" (H. Mayuni, personal communication, 18 February 2020)

Prison detention of forensic psychiatric patients raise human rights issues and threatens the health of detainees, including through increased vulnerability to HIV and tuberculosis (TB) infection. However, revealed from this study is that the detention in practice does not due benefit the patient as there is no evidence that

special institutions represent a favorable or effective environment for the treatment of mental illness or the rehabilitation of individuals with mental illness in Zimbabwe. The deprivation of liberty without due process is an unacceptable violation of internationally recognized human rights standards. Furthermore, detention in these special institutions has been reported to involve physical and sexual violence, sub-standard conditions, denial of health care, and other measures that violate human rights.

From this study in Zimbabwe, it can be therefore concluded that there are no benefits of prison detention on forensic psychiatric patients. The purpose of prison detention, which is to offer care and treatment for the patient (i.e. to improve mental health and facilitate recovery), is being failed due to the right to health violations prevalent in the prisons in Zimbabwe. The protection of the public from harm from the offender (i.e. reduce the risk the patient poses), this function has been confused and cause tensions on patient care with prisons being relegated to holding centers for psychiatric patients.

As was discovered that some patients have stayed for longer periods in prisons there is need to review the detention of those in the centers to ensure that there is no arbitrary detention and that any detention is conducted according to relevant international standards of due process and provides alternatives to imprisonment. This review will allow the identification of those who should be released immediately and those who should be referred for voluntary, evidence-informed treatment programs within the community.

### 4.4 Human Rights Violations in Forensic Psychiatric Care

Concerning the assessment and identifying applicable international and domestic standards on prisons and conditions of detention. This study largely relied on primary and secondary sources from the Zimbabwe Human Rights Commission (ZHRC) to assess compliance of special institutions to the key human rights for detained mental health patients. From the review of the ZHRC reports, it was apparent that the topical issues also in the special institutions included; the right to health care for the preservation of health and life.

The ZHRC has according to its constitutional mandate made considerable efforts to fulfill the general obligation to monitor and inspect institutions of mentally disordered persons to ensure the observance of human rights and humane treatment of patients in relation to recognized national and international standards. However, despite being an independent institution, there are challenges that threaten the institution in effectively discharging its mandate. There is need according to the findings of this study to ensure that the Commission is adequately funded to ensure that it can discharge its constitutional mandate without any hindrance.

From the study it was established that the Commission is underfunded, and this has affected its operations and constitutional mandate to constantly assess places where mentally disordered or intellectually persons are detained. The frequency of assessment visits is rather slow as compared to the assessment needs to make the ZHRC effective and efficient. Considering the enormous challenges that were noted during the prisons visit there is a need for stronger institution like the ZHRC through its parliamentary oversight role to advocate for better conditions for detained mental health patients.

In its previous reports the ZHRC has made recommendations that are directed to specific Government Ministries and Departments on areas that need to be addressed in relation to enjoyment of basic human rights by people who are detained in institutions where the mentally handicapped are detained. Unfortunately, these recommendations from the ZHRC commission on human rights compliance in special institutions are not being taken seriously, as most of the challenges despite being recommended for action still exist in the special institutions. There is therefore need for the commission to relook at its strategies towards protecting the human rights of detained mental health patients. For example on the recommendation that ZHRC made in its report on the visit to Chikurubi Prison on the 18th of March 2015 there was need for ZPCS staff to receive human rights training so as to use the human rights based approach in dealing with their patients.

Timelines should be put in together with the recommendations so that there is monitoring on the recommendations being put into practice as up to the time of the study interview the recommendation had not been put into practice. As an independent institution, ZHRC should take the government to task to hold it to deliver on its mandate. It is time that the ZHRC can also take the legal route to ensure rights compliance as opposed to recommendations diplomacy.

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991 which are relevant in providing the rights to be enjoyed by persons with mental illness particularly those who are institutionalized. In Article 1, provides that all persons have the right to the best available mental health care, which shall be part of the health and social care system.

At domestic level, the Zimbabwean Constitution provides for every citizen and permanent resident's right to have access to basic health care and reproductive health care services; including access to basic health care for chronic illnesses. Further, section 50(5)(d) of the Constitution provides for detained persons' right to conditions of detention that are consistent with human dignity, including the provision of medical treatment at the State's expense. Thus, the right to medical treatment for detained persons does not appear to be subject to progressive realization in special institutions.

The right to health care services from the discussions with careers Chikurubi in Harare has more needs than Mlondolozi in Bulawayo. Mlondolozi has a visiting psychiatrist 3 days a week and patients seem to be well managed with appropriate diagnoses and have quite a lot of stimulation generally with different activities as compared to their counterparts in Harare. The difference speaks to the absence of standard operating procedures affecting the patient's right to health.

Noted also from the interviews with the medical caregivers and substantiated by the ZHRC was the lack of some essential psychotropic drugs. The ZHRC responded that

> "….drugs shortages are also on record from monitoring visits, we have recommended the MoHCC to assist with the provision of the drugs, there are shortages of essential anti-psychotic drugs at Special institutions and this affects both the patient and the staff as they may be unable to work safely if acute mental health patients are not sedated. The drugs in shortage are the critical drugs such as the Chrorpromazine, Fluphenazine-Deconate and Benzhezol and this also can result in deterioration of patients' condition…"

Despite the Universal Declaration of Human Rights (UNDHR) being instrumental in enshrining the notion of human dignity in international law, providing a legal and moral grounding for improved standards of care based on our basic responsibilities towards each other as members of the "human family", and giving important guidance on critical social, legal and ethical issues. There still remains a great deal of work to be done to clarify the relationship between human rights and right to health, including patient rights in the Zimbabwean special institutions, The health facilities do not have a designated place for confidential treatment of patients, with a general problem of privacy in the facilities.

The ZHRC response to the health infrastructure in special institutions, the commission remarked that

> "…the infrastructure and furniture in the special institutions is dilapidated and there is need to ensure that there are proper consultation rooms, this has an impact on the Zimbabwe Patient Charter which guides health care providers and states that the patients have a right to access the health system at the time of need, both as paying or non-paying and the general rights to access and treatment deals with hospitality, confidentiality, privacy, choice and redress grievances…"

Interestingly, despite all patients having a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures. In the special institutions the patients are attended to medically under the watch of an

armed guard and due involuntary nature of patient institutionalization to the prison context patients cannot refuse treatment.

Mental health service provision in special institutions is generally consisted of prescribing and supplying psychotropic medicines, which were reported to be "sometimes available". Complementary treatment, such as cognitive behavioral therapy, was not available, staff reported personnel shortages owing to resources challenge, and attributed to the inability by the ZPCS to uphold patient's rights in institutions.

Shocking on the patient right to health was the disregard of prescribed drug timetables, in special institutions the ZPS Act overrides any other Act even on the right to health. The prison system in Zimbabwe starts the day at 0800hrs and ends at 1530hrs; if the mental health patient has to take medication 3 times a day the system does not allow the 8hrs intervals of prescription as after 1530hrs the patients have to be in their ward cum cell locked up. In case the patient falls ill or has an urgent medical need to be attended to, they will have to wait until the morning meaning that adherence will be compromised.

In the special institutions, the study also discovered that medical caregivers working in special institutions are faced ethical challenges stemming from the inherent tension between the role of the prison as a place of punishment and their role as protectors and promoters of health. They need to provide care in an environment that is geared toward security, to patients who are held involuntarily in conditions that greatly diminish their personal freedoms, and they are faced with high workloads coupled with limited resources.

These ethical challenges are particularly acute in solitary confinement units, where health professionals are required to provide care to individuals who are isolated in conditions that are known to be detrimental to health and well-being and where prison authorities place a particularly high emphasis on security and control in the management of prisoners.

Some of the right to health violations has a trickle effect on the other rights such as on the right to dignity of patients. The resource shortages presented serious violations to patients the special institutions buildings are dilapidated; many windows are broken. The ZHRC reported that bedbugs infested the institutions with an urgent need for fumigation. Some resident patients sleep on the floor due to the overcrowding in the special institutions. There is no privacy in bathrooms, no toilet paper, no towels, no toothpaste, and no sanitary products for
women patients of women inmates, as there is a shortage of sanitary wear.

While the "right to health" in international law is often defined as "the right to the highest attainable standard of health, from the above the study exposed that the right to health in detention for forensic psychiatric patients are being violated in prison. There is a critical shortage of drugs in special institutions, human resources due to socio economic instability, brain drain; there is burnout of staff and high burden of mental illness in special institutions due to overcrowding.

### 4.5 Mental health laws in conflict with forensic psychiatric care

There is a one hundred percent consensus from stakeholders working mental health patients including forensic psychiatric patients all agreed during the study on the need to amend the Mental Health Act. The (WHO, 1996) recommended on the need to continuously review and improve mental health legislation to keep it in line with contemporary approaches to mental health. Mental health law should include aspects that promote less restrictive types of mental health care such as detention of patients.

Mental Health Care in Zimbabwe is governed by the Mental Health Act of 1996 and guided by the Mental Health Policy of 2007. The Mental Health Act of 1996 in Zimbabwe blows hot and cold. The act safeguards the rights of the patient with the rights and emphasizes the judiciary institutionalization of mentally ill patients in the special institution according to sections 26 -36 of the Act. The engagement of the judiciary on the management of psychiatric care is inconsistent with patient recovery; patients spend more time frequenting courtrooms as opposed to medical facilities.

Revealed during the study was the need to amend the Mental Health Act section 120 to ensure that the ZHRC gets access as and when necessary to monitor the situation at the special institutions for the fulfillment of the rights of mental patients as enunciated in the Constitution and international human rights instruments. Presently the monitoring is jointly done with the Prisons visit. Technically this has an impact on the mental health patients, the patients are not treated as a separate group with different needs.

On the laws as an impediment to care for forensic patient care the Zimbabwe National Association for Mental Health (ZIMNAMH) commented during the interviews that;

> "…The Zimbabwe Mental Health Act of 1996 has been fully implemented, resulting in the shoddy treatment and exclusion of the mentally ill. The act can be criticized as being too vague or outright insensitive on gender issues relating to mental illness, the organization argues that despite the government being a signatory to a host of conventions on the rights of mentally ill, mental health still is not a priority in the national public health policy formulation due to laws…."

In a report by the Zimbabwe Human Rights NGO Forum, entitled Rights behind Bars report in 2018, the report also recommended that it is necessary to amend the Prisons Act and the regulations to ensure that they are compliant with the dictates of both the constitution of 2013 and international law. The Parliament, however, has drafted the Prisons and correctional Service Act of 2016, which is yet to come to the law. The ZPCS draft Bill is centered on having correctional services systems and moves away from the current punitive prison system. Human rights are enshrined in the Constitution are reflected as the bill seeks to balance concerns about security, safety, and human rights. However unexpectedly the ZPCS bill is not among the list of acts that are to be prioritized for enactment in 2020.

It is the state's responsibility to put in place policies, laws and resources for the right to basic health care to be enjoyed in Zimbabwe. The Zimbabwean government has put in place policies however due to funding challenges for mental health activities there is an implementation gap for mental health policies. There is also need to review the Mental Health Act to bring it in line with contemporary approaches to mental health care and protection of human rights

## 4.6 Summary

The chapter has presented the main findings of the study with the goal of exploring the forensic psychiatric patients' rehabilitation system in special institutions forensic psychiatric practice has all along been, and is still, providing forensic psychiatric rehabilitation from an uncoordinated prison system supremacy which doesn't comprehensively provide rehabilitation.

The benefits of forensic psychiatry continue to look at the security of the patient from self, others and to others. In as much as security is important the study presented that the perceived benefits are not in the best interest of the patients as there is no proper rehabilitation plans, no defined exit criteria with some patients spending more than a lifetime in the special institutions. There are alternative care models that are proposed for the proper care with evidence of implementation that the government can adopt as a model of psychiatric model of care.

The third objective was to assess the human rights compliance in special institutions. From the study, the ZHRC acknowledged the massive violations of patients' rights to health in the special institutions including. The human rights violations were largely attributed to the lack of funding of the Zimbabwe Prisons and Correctional Services by government and were cited as the major barrier towards the fulfillment of patient's human rights and an impediment on rehabilitation in special institutions. Given that the violations are noticed and discussed this amounts to the state's failure to comply to human rights standards.

The detained mental health patients are entitled to the right of access to health care services as protected in the Constitution of Zimbabwe section 76, Regional laws in

the African Charter on Human and Peoples' Rights, and international law International Covenant on Economic, Social and Cultural Rights. As interpreted from this study there is need for improvement in the provision of health care services for the treatment and rehabilitation of detained mental health patient's rights. In the special institutions, patients are treated from rooms with no privacy or from buildings with inadequate storage space for medication. Virtually all special institutions visited had a shortage of ordinary clinical staff, let alone specialist staff such as psychologists, social workers, psychiatrists, mental health nurses and occupational therapists.

In line with the objectives of this study to assess the human rights compliance of special institutions towards forensic psychiatry patient care with international and domestic standards on conditions of detention as provided for in international instruments, the Constitution and the Prisons Act [Chapter 7:11]. Relating to the human rights framework and the prevailing human rights situation in the Zimbabwean special institutions from this study it is concluded that there is no human rights compliance in the special institutions, the prison conditions do not meet either the Zimbabwean constitution or the international law.

# CHAPTER 5 SUMMARY, CONCLUSIONS & RECOMMENDATIONS

## 5.1 Introduction

This chapter articulates on the conclusions deciphered from analyzing research results about the effects of forensic psychiatric prison detention on human rights in the Zimbabwean context. It discusses the implications, identified areas for further research and offered recommendations.

## 5.2 Discussion

This study focused on the effects of forensic psychiatric patients' prison detention on human rights in Zimbabwe. The key respondents where medical caregivers who included psychiatrists, occupational therapists, social workers, psychologists, and mental health nurses as well as stakeholders ZACRO, ZIMNAMH, VSO and the Zimbabwe Human Rights Commission.

Conversely, the findings and results pointed out there was a need for patient's rehabilitation to focus more on maximizing the function of these patients so that they fit into the environments of their respective societies. The study found that rehabilitation for forensic psychiatric patients was biased towards drugs instead of having a general rehabilitative approach that is specific to patients. The acquired skills would then keep the patients busy, therefore facilitating recovery and self-sustenance.

The attitude of the public towards psychiatry is mostly influenced by what rehabilitation accomplishes or not. In fact, helping affected persons to achieve functional recovery is the main purpose of the mental health care system. From the

study it is obvious that current treatment and rehabilitation practice has to be substantially improved in the light of the rehabilitation research available. The refinement of psychiatric rehabilitation has to achieve a point where it should be made readily available for every patient in Zimbabwe as opposed to the current model of rehabilitation care in special institutions. Psychiatric rehabilitation is by its very nature multidisciplinary, because of the many different competencies required however due to the present resources challenges there is need for studies to research on task shifting as a rehabilitation innovation to mental health care.

The need for security of the patient against self and others as explained by most of the medical careers and other stakeholders cannot be underplayed; the discourse of safety has informed the care of persons with mental illness through institutionalization. Detention of mental patients arose from safety out of both societal stigma and fear for public safety as well as benevolently paternalistic aims to protect patients from self-harm. It should be noted also in the context of the discussion that health safety includes also patient safety, quality assurance and quality improvements however; the need for safety in Zimbabwe has taken precedence over the other facets of health safety.

The belief that individuals with mental illness are violent, unpredictable and dangerous is a pervasive stigmatizing view Camuccio cited by (Slemon, Jenkins & Bungay, 2017) negatively affect medical caregiver's perceptions of their personal safety. Patient seclusion in locked rooms as a violence risk management strategy is widespread, serving as a risk prevention and containment intervention .To change the conceptualization and management of risk in psychiatric inpatient care, the concept of safety itself must be reframed, and other care practices and frameworks

prioritized. While safety is a crucial component of inpatient psychiatric care, its framing and use must shift in order to create environments perceived as truly safe and to support meaningful therapeutic engagement and treatment.

The effects of prison detention of forensic psychiatric patients on human rights in Zimbabwe are multi-pronged, these include prison detention being used as a dumping ground for mental health patients, stigma and discrimination, physical and sexual violence, drug overdose for control, food shortages, overcrowding, limited to access with the outside world, limited and outdated rehabilitation equipment despite the human rights violations in the mental health being significant globally. The prevalence of rights abuse cannot be explained by mere lack of resources as in the case of Zimbabwe, the government blames the lack of finance to the ill-treatment of patients perpetuating a vicious circle of exclusion and despair. The continued rise of involuntary psychiatric intervention in prisons suggests that something is wrong.

Mental health in Zimbabwe is emerging from the shadows; human rights are on the national agenda after the promulgation of Zimbabwe's constitution in 2013 however despite the advocate's increased call for parity on funding and a reduction of the treatment for vulnerable populations. There is from the study an agreement on the need for good mental health policy and promotion to prevention, treatment, and rehabilitation in Zimbabwe. Protection of human rights is a key issue in the delivery of care to patients suffering from chronic mental health disorders. The principles set by UN Human Rights systems play a key role in advocating for the de-institutionalization. The right to the highest attainable standard of health is particularly important including dimensions such as

1. Access to appropriate services
2. The right to individualized treatment
3. The right to rehabilitation and treatment promoting autonomy;
4. The right to community-based services
5. The right to least restrictive services
6. The right to human dignity

The right to community-based services expressly recognized in Article 19 of the United Nations Convention on the Rights of people with disabilities (CRPD), has significant implications for the organization of mental health services.

A rights-based approach can provide a pathway to the future of forensic psychiatry care to challenge the status quo where prison law in the case of forensic psychiatric overrides public health law, it should be emphasized that mental health is not a criminal case but a public health challenge. The effects of prison detention in Zimbabwe are multi-pronged, despite the effects on basic human rights such as involuntary institutionalization, lack of food, squalid living conditions, and food and drug shortages.

For medical careers, a pivot towards human rights calls for the substitution of decision making and offers person-centered support to offer treatment according to a person's will and preferences just like any other medical condition. It should be acknowledged that there are no simple solutions and debating this will help open new opportunities and roles for psychiatry in Zimbabwe. The shift will diminish the formal power currently afforded to the judiciary and the medical careers and spread it according to between the patients (primarily), medical careers (secondary) and the judiciary (tertiary level). There are multiple benefits of shifting the power to center

more on the patient. It should be in the best interest of the patient and on the judiciary reduces reliance on coercion to treatment.

In Zimbabwe, forensic psychiatry is a highly stigmatized condition both at the societal level and at institutional levels, coercion in psychiatry and broader mental health. This study, therefore, seeks also to stimulate the chance for all stakeholders to rethink and address long-standing power imbalances and implement innovative models of care.

Mental health should not be criminalized, as it is a non-communicable medical condition that can be treated. Institutionalization of non-communicable medical conditions is archaic and a human rights violation as compared to the nineteenth century, patients diagnosed with leprosy were detained, isolated and institutionalized. The management of leprosy, which is a communicable disease, has conformed to changing ethical imperatives even in Zimbabwe. The continued institutionalization of forensic psychiatric patients constitutes an inhuman disregard for the person afflicted with the disease.

## 5.3 Conclusions

The study embraced exploratory design using a case study to populate and sample the ZPCS medical caregivers, the Zimbabwe Human Rights Commission and other Stakeholders working with the detained forensic psychiatric patients. The data were collected using semi-structured interview guides.

Consequently, this research noted that the rehabilitation systems in special institutions are "principle desires" to escape responsibility through prison institutionalization of mental health patients to protect the society of mental illness

annoyance. The reality presents a rehabilitation practice that is outdated, uncoordinated and not patient-centered.

The study findings highlighted the need to have a pro-medical team that is accessible to forensic psychiatric patients. This team would transact rehabilitation. It is obvious that the more limited the access patients have to the team, the less likely they are to recover. This accessibility would be covered both at forensic psychiatric hospital (special institution) level. The increase of access to the multidisciplinary team would lead to an increase in the forensic psychiatric patients' specific capital for rehabilitation.

The analysis of the benefits of prison detention can be inferred as lacking evidential merits and increasing stigma and discrimination of mental health patients in Zimbabwe. The benefits are more centered on others than the mental health patient and as such the benefits need to be reexamined taking into account the availability of better treatment régimes with better treatment outcomes for mental health patients.

On human rights compliance, there is a two-pronged combination, lack of financial resources that has given rise to human rights violations as special institutions are overcrowded, have little food, poor living conditions, poor medical care, and minimum psychiatric care. The other contributory factor is the continued use of laws that are not human rights centered but rather punitive as evidenced in the research the (Mental Health Act, 1996) is now irrelevant and inadequate to protect patient's rights.

## 5.4 Implications

This study has both practical and deleterious implications, the research will have an impact on the knowledge it has generated for future research on forensic psychiatry and on policy, it adds on the voices for the adoption of the ZPCS bill into Act as it is

pro-human rights. This research also is relevant for the lobbying and advocacy for the reviewing of the Mental Health Act of 1996.

The deleterious implication of the study includes that the study information can be used against the objectives and ethical requirements of the Africa University Ethics Review Committee and Zimbabwe Prisons and Correctional Services, due to the interest in the human rights of prison inmates subject especially by the media.

## 5.5 Recommendations

5.5.1 The reviewing of the Mental Health Act of 1996 as it is now inadequate as law; it is not patient-centered and promotes institutionalization against international best practices of chronic care facilities and community-based care programs.

5.5.2 Documentation and development of standard operating procedures of rehabilitation to further clarify and define the roles and responsibilities of medical caregivers and task shifting at the facility level.

5.5.3 Continuous capacity building of mental health caregivers and prison officers on human rights.

5.5.4 The separation of detained mental health patients and criminal patients both are medical patients but have different extenuating factors, the former is detained for being mentally ill and needing treatment and rehabilitation whilst the latter is detained initially for criminal nuisance and however develops mental conditions needing treatment and rehabilitation.

5.5.5 The increase of budgetary allocations provided to the ZPCS by the Central Government to allow it to fully fund its mandate and obligations to fulfill human rights being violated due to the lack of government funding of prisons.

## 5.6 Suggestions for Further Research

5.6.1 From this research, I suggest for the furtherance of the mental health in prison research as a priority building upon the findings of the study.

5.6.2 For the addressing of the limitations of this study on time, more time should be afforded by the University for the Study and for the prompt response of institutions such as the Zimbabwe Prison and Correctional Services whose bureaucracy is time-consuming.

5.6.3 This research has also to be carried out in psychiatric hospitals in future studies to compare the human rights impact on hospitalization contrasted with the special institutions.

5.6.4 Suggest the reassessing of the human rights theory to address the effects of prison detention of forensic psychiatric patients on human rights in Zimbabwe.

## Reference


Abdalla-Filho.E, Manoel Bertolote.L.,. (2006). Forensic psychiatric systems of the world. *Brazilian Journal of Psychiatry*(Suppl 2:S56-61.). doi:10.1590/s1516-44462006000600002

Adshead, G. (2000). Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, 23 -24. Retrieved from http://jme.bmj.com/

AU/NEPAD. (2009). *New Partnership for Africa's Development Action Plan 2010-2015.* Addis Ababa: Africa Union.

Baasher, T. (2001). Islam and mental health. *Islam and Mental Health. EMHJ - Eastern Mediterranean Health Journal*. Retrieved from 2001 https://apps.who.int/iris/handle/10665/119027

Bloom, D.E, Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl,. (2011). *The Global Economic Burden of Non Communicable Diseases.* Geneva: World Economic Forum.

Center for Mental Health. (2013). *Guidance for Commisioners of forensic mental health services.* Adelaide: Rafertys.

Country Policy Information Note. (2019). *Zimbabwe - Medical and health care issues.* Harare: Country Policy and Information Note.

Coutts, S. (2011). Care or Custody Where should mentally disordered offenders be placed? *International Journal of Criminology*, 11. Retrieved from https://958be75a-da42-4a45-aafa-549955018b18.filesusr.com/ugd/b93dd4_686ddfd5f5a044d9ab4657e97172f7a7.pdf

Daniel, A. (2007). Care for the Mentally ill in Prisons. *Journal of the American Academy of Psychiatry and the Law Online December 2007, 35 (4) 406-410;, Volume 47, Number 4, 2019*. Retrieved from http://jaapl.org/sites/default/files/JAAPL_0.png

Dube, V. (2014). *Medico-Judicial framework for rehabilitation of forensic Psychiatric patients in Zimbabwe.* Pretoria: University of South Africa.

European Commision Final Report. (2005). *Placement and treatment of mentally ill offenders - legislation and practice in EU member states.* Mannheim: Central Institute of Mental Health.

Gonzalez, J.M.R., Connell,N.M.,. (2014). Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and medication continuity. *American Public Health Association*, 2328–2333. doi:10.2105/AJPH.2014.302043

Government of Zimbabwe. (1996). *Prison Act Chapter 7:11.* Harare: Government Printer.

Government of Zimbabwe. (1996). *Zimbabwe Mental Health Act.* Harare: Goverment Printers.

Government of Zimbabwe. (2004). *National Mental Health Policy.* Harare: MoHCC.

Government of Zimbabwe. (2008). *National Health Strategy for Zimbabwe 2009-2013, Equity and quality.* Government Printers.

Government of Zimbabwe. (2013). *Zimbabwe Constitution.* Harare: Government Printers.

Government of Zimbabwe. (2016). *Zimbabwe Prisons and Correctional Service Bill.* Harare: Government Printers.

Gwasira, M. (2019, July 23). *300 mentally ill inmates trapped in Zimbabwe Prisona*. Retrieved from Health times.

Hans,J.S, Harald.D, Kief,C. (2007). *Mentally disordered persons in European prison systems Needs; Programs and Outcome(EUPRIS).* Mannheim: Central Institute of Mental Health.

Henderson, S. (2003). *Mental illness and the Criminal Justice Sysyem.* Mental Health Coordinating Council.

Hendler, R., Khamee,K., Machando,D., Crooks,M,.Mangezi,W.,Abas.M, Katz,C., Thornicroft,.G. (2016). We Are Not Really Marketing mental health, Mental health Advocasy in Zimbabwe. *PLOS-One*.

Hunt, P. (2004). *Human Rights and Health.* Essex: University of Essex, UK. Retrieved from https://www.du.edu/korbel/hrhw/researchdigest/health/health.pdf

Independent Advisory Group on Country Information. (2017). *Country Policy and Information Note Zimbabwe: Prison conditions.* London: Independent Advisory Group on Country Information,.

Irish Mental Health Commission. (2011). *Forensic Mental Health Services for adults in Ireland.* Irish Mentah Health Commision.

Jack.H., Kidia.K,Lovett.A.,Kwon.H.R.,. (2019). *Mental Health of incarcerated people in Africa.* London: The Mental Health Innovation Network and The Department of Mental Health and Substance abuse WHO.

Jackson, L. (1991). Gendered disorder in colonial Zimbabwe: Case analysis of African female inmates at Ingutsheni Mental Hospital, 1932 -1957. *Institute of Commonwealth Studies, Symposium of madness and colonialism.* Societies of Southern Africa in the 19th and 20th centuries, Vol.19. Retrieved from https://www.google.com/search?sxsrf=ALeKk02vGCe_lVBPZF-cEn7w3UafAQ1BiA:1591197986796&source=univ&tbm=isch&q=Jackson,+L.+(1991).+Gendered+disorder+in+colonial+Zimbabwe:+Case+analysis+of+African+female+inmates+at+Ingutsheni+Mental+Hospital,+1932+-1957.+Inst

Keehn, J.D,Nevin. A,. (2018). Health human Rights, and the Transformation of punishment. *Health human Rights Journal*, 213-218. Retrieved from no. 1 (2018): 213-24. Accessed February 3, 2020. www.jstor.org/stable/90023065

Kleinman.A, P. (2003). Poverty and common mental health disorders in developing countries. *London School of Hygiene and Tropical Medicine*.

Labelle, D. (2008). Bringing Human rights home to the world of detention. *COLUMBIA HUMAN RIGHTS LAW REVIEW*, [40:79. Retrieved from http://www.corteidh.or.cr/tablas/r21711.pdf

Lee, D. (2003). Community-treated and discharged forensic patients: an 11 year follow. *International Journal of Law and Psychiatry*. doi:10.1016/S0160-2527(03)00039-6

Liang, M. Machando,D. Mangezi,W. Hendler,R. Crooks,M. Kats,C. Abas,M. (2016). , *Mental Health in Zimbabwe.* Harare, Zimbabwe: Kushinga.

Lines. P. (2008). The right to health ofprisoners in international human rights law. *International Journal of Prisoner Health*, 3 -53. Retrieved from https://www.google.co.zw/search?hl=en&q=Lines.+P.+(2008).+The+right+to+health+of+prisoners+in+international+human+rights+law.+International+Journal+of+Prisoner+Health,+3+-53.&spell=1&sa=X&ved=2ahUKEwiowc3E9uXpAhUpQEEAHU2_BJMQBSgAegQIDBAk&biw=1920&bih=910

*Longman Dictionary of Contemporary English (6th edition) for advanced learners (LDOCE6).* (2014). published by Pearson Education 2014.

Makgoba, M. (2016). *The report into the circumstatnces surrounding the deaths of mentally ill patients: Gauteng Province No Guns: 94 Silent deaths and still counting.* Johannesburg: Office of the Health Ombudsman.

Mangezi, W., & Chibanda, D. (2010). Mental health in Zimbabwe. *International psychiatry : bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, 93-94. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ca

d=rja&uact=8&ved=2ahUKEwiHq8fI--XpAhWMVBUIHSJoBQYQFjAAegQIAxAB&url=https%3A%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F31508055&authuser=1&usg=AOvVaw2Qyr9kKbuFR0vI6q4tSBye

Matanhike, R. (2019, June 24). Mental Patients over detained at Chikurubi and Mlondolozi. *Newsday*. Harare, Zimbabwe. Retrieved November 23, 2019

Mawerewere-Dube, V. (2015). The Dinosaur of Judicial Disjuncture with Forensic Psychiatric Rehabilitation Processes in Zimbabwe. *International Journal of Emergence Mental Health and Human Resilence*.

MoHCC. (2020, February 20). *Mental Health*. Retrieved from http://www.mohcc.gov.zw/: https://www.google.co.zw/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjhhKCWudPpAhXjuXEKHcw9DgsQFjAAegQIARAB&url=http%3A%2F%2Fwww.mohcc.gov.zw%2F&authuser=1&usg=AOvVaw1kGBPnrA58V0M3urIaSUzU

Muchinako, G.A., Mabvurira,V.,Chinyenze,P. (2012). Mental illness and the Shona People of Zimbabwe. *International Journal of Advances Research in Management and Social Sciences*. Retrieved from http://www.garph.co.uk/IJARMSS/Mar2013/13.pdf

Mullen P.E, Burgess.P, Wallace.C, Palmer.S, Ruschena.D,. (2000). Community Care and Criminal Offending in Schizophrenia. doi:10.1016/S0140-6736(99)05082-5

National Mental Health Alliance. (2019). *Jailing People with Mental Illness.* Arlington, VA 22203: National Mental Health Alliance.

Ncube-Sibanda, S. D. (2009). Mental Health and the Justice System in Zimbabwe An Interpretative Phenomelogical Analysis. *International Journal of Nusing Science* .

Njenga, F. (2006). Forensic psychiatry: the African experience. *World Psychiatry*. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj7jKW1gObpAhXUuHEKHRoZCSUQFjADegQIAxAB&url=https%3A%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F16946948&usg=AOvVaw1KISpU0XFGRGogivFM1bTd

Ogunlensi.O.A, Ogunwalei.A, De Wet.P, Ross.L. *Forensic psychiatry in Africa; prospects and challenges.* African Journal of Psychiatry. doi:: 10.4314/ajpsy.v15i1.1

Pitorak, H. M. (2012). *There is no Health without Mental Health and HiV services intergration in Zimbabwe Situational analysis.* Arlington: USAID's Aids Support and Technical support resources.

Puras, D., Gooding,P. (2019). Mental health and human rights in the 21st centurt. *World Psychiatry*, 42-43. doi: https://doi.org/10.1002/wps.20599

Research Review Tribunal. (2009). *Refugee Review Tribunal - Zimbabwe.* Australia RRT Research Response.

Rossler.W. (2006). Psychiaitric rehabilitation today: an overview. *World Psychiatry*, 151-157. Retrieved from PMID: 17139342

Safaids. (2015). *Prisons in Southern Africa.* Harare: Safaids.

Seppaneni, A. Tormanen,I. Shaw,C. Kennedy.H. (2018, 2018 Oct 20. ). Modern forensic psychiatric hospital design: Clinical, legal and structural aspects. *International Journal of Mental Health Systems*. doi: 10.1186/s13033-018-0238-7

Shae- Leigh, V. Nagesh, P. (2012). The measurement of burden of care in serious mental illness, A qualitative review. *Australian & New Zealand Journal of Psychiatry*, 4. doi: DOI: 10.1177/0004867412468494

Slemon.A, Jenkins.E,Bungay.V. (2017). Safety in Psychiatric Inpatient Care: The Impact of Risk management Culture on Mental Health Nursing Practice. *Nursing Inquiry*, 24. doi: 10.1111/nin.12199

Tzeferakos, G.A, Douzenis,A.I. (2017). Islam, mental health and law ageneral overview. *Annals of General psychiatry*. doi: 10.1186/s12991-017-0150-6

UNICEF. (2015). *Zimbabwe 2016 Health and Child Care Budget Brief.* Harare: UNICEF ZCO.

United Nations. (2005). *Human Rights and Prisons.* New York and Geneva: United Nations.

United Nations. (2012). *Compulsory drug detention and rehabilitation centres.* Geneva: UN.

Völlm, B. Edworthy,J.H, Talbot.E, Majid.S, Duggan.C , Weaver.T, McDonald,R. (2017). A mixed-methods study exploring the characteristics and needs of long-stay patients in high and medium secure settings in England: implications for service organisation. *Southhampton (UK): NIHR Jornals Library*, 11-18. doi:10.3310/hsdr05110

WHO. (2003). *THe Mental Health Context (Mental health policy and service guidance package).* Geneva: World Health Organisation.

Wintersteen, R. M. (1995). Zimbabwean families of the mentally ill: experiences and support needs. *Journal of Social Development*. Retrieved from http://digital.lib.msu.edu/projects/africanjournals/

World Bank. (2017). *World Bank Annual Report.* Washington: World Bank.

World Health Organisation. (2010). *World Health Report: Mental Health: New Understanding , New Hope.* Geneva: WHO.

Zimbabwe Demographic Health Survey. (2017). *Zimbabwe Demographic Health Survey.* Harare: Ministry of Health and Child Care.

Zimbabwe Human Rights Commission. (2015). *Report on the visit to Chikurubi Maximum Prison (Male section) on the 18th of March 2015 Riot.* Harare: ZHRC.

Zimbabwe Human Rights NGO Forum. (2018). *Rights behind bars, a study of prison conditions in Zimbabwe.* Harare: Zimbabwe Human Rights NGO Forum.

Zimbabwe Mental Health Atlas. (2019). *Mental Health Atlas.* World Health Organisation.

## Appendices

### APPENDIX 1 Data Collection Tools

My name is Brian Tafadzwa Hove I am a Masters in Human Rights, Peace, and Development student with Africa University, I am currently conducting a study for my dissertation on the effects of forensic psychiatric prison detention on human rights in Zimbabwe. The main goal of the research studies is to gain knowledge that may add to the body of knowledge on forensic psychiatry in Zimbabwe.

**Interview Guide for the Multidisciplinary Health Team**

1.

| The professional background of the respondent |
| --- |
| |

2.

| The professional background of the respondent |
| --- |
| |

3. What rehabilitation services do you offer to the forensic psychiatric patients during admission at this institution?

4. Which medical procedures are involved in the rehabilitation of forensic psychiatric patients to this institution? [For health team]

5. What are the benefits of detaining forensic psychiatric patients from this institution?

6. Which resources help to rehabilitate forensic psychiatric patients at this institution?

7. Which resources make it difficult to rehabilitate forensic psychiatric patients at this institution?

8. What community services do you utilize for forensic psychiatric patients beyond the special institution?

9. How do you think the medical and judicial teams can work together to improve the rehabilitation of forensic psychiatric patients?

10. What challenges exist in the discharging of forensic psychiatric patients from institutions?

11. Which challenges do you think prison detention bring for patients as compared to other care models. Such as hospital, halfway homes, and community-based rehabilitation?

12. As experts by practice, what recommendations do you suggest on the management of detained forensic psychiatric patients in Zimbabwe?

**Thank you for participating**

## APPENDIX 2 Zimbabwe Human Rights Commission Interview Guide

The Zimbabwe Human Rights Commission (ZHRC) is amongst the Chapter 12 Independent Commissions which seek to promote human rights and democracy in Zimbabwe. The mandate of the ZHRC is to promote, protect and enforce human rights and fundamental freedoms in Zimbabwe. The establishment of the ZHRC is in terms of section 242 and its functions as outlined in Section 243 of the Constitution of Zimbabwe, 2013. The Constitution mandates the ZHRC to promote, protect and enforce human rights in Zimbabwe through embracing various strategies inter alia stated in section 243(k) (ii) of the Constitution which is to "visit and inspect places where mentally disordered or intellectually handicapped persons are detained".

1. How frequent are the visits to inspect places where mentally disordered or intellectually handicapped persons are detained?
2. When was the last time that the ZHRC visited the Special institutions at Chikurubi and Mlondolozi?
3. What are the benefits of forensic psychiatric patient's prison detention from a human rights perspective?
4. How are the Staffing Levels, in line with the Forensic Patient Population ratio?
5. In special institutions is there a patients separation mechanism (forensic patients versus criminal patients)
6. Describe access to the right to health in special institutions in line with the constitution (availability of essential and critical anti-psychotic drugs at the institution such as the Chlorpromazine, Fluphenazine, Deconate).
7. Are the resource constraints affecting forensic psychiatric rehabilitation in Special institutions in Zimbabwe, if Yes
   - What are the constraints concerning forensic psychiatric patients?
8. What are the areas of good practice in Special institutions in Zimbabwe?
9. What is the relationship between the ZHRC and the Mental Health Review Tribunal

**Thank you for answering**

**APPENDIX 3 Stakeholders Interview Guide**

1. Name of Organization
2. Interest in Forensic Psychiatry?
3. Present or Previous work with Prison detained forensic psychiatric patients?
4. From your Organizational point of view what are the benefits of detaining Forensic psychiatric patients?
5. What alternatives to care, exist of benefit to both the patients and the community?
6. How do you think the medical and judicial teams can work together to improve the rehabilitation of forensic psychiatric patients?
7. What challenges exist in the discharging of forensic psychiatric patients from institutions?
8. What challenges exist on the discharged forensic psychiatric patients in communities which can be mitigated by institutionalization?
9. Are there discrepancies between the Mental Health and the Prisons Act or the ZPCS bill?

**Thank you for your participation**

**APPENDIX 4 English Informed Consent**

My name is Brian Tafadzwa Hove I am a Masters in Human Rights, Peace, and Development student with Africa University, I am currently conducting a study for my dissertation on the effects of forensic psychiatric prison detention on human rights in Zimbabwe. The main goal of the research studies is to gain knowledge that may add to the body of knowledge on forensic psychiatry in Zimbabwe. I am kindly asking you to participate in this study, in an interview. I am also asking to record your views on an audio recording machine to correctly capture your views.

---

**What you should know about the study:**

**Purpose of the study**

The main goal of the research studies is to gain knowledge that may add to the body of knowledge on forensic psychiatry in Zimbabwe.

**Procedures and duration**

If you decide to participate you will be involved in an interview/ focus group discussion where you will respond to questions that I have. It is expected that this discussion will take about thirty to forty - five minutes.

**Risks and discomforts**

It is possible that you may fear that disclosing the truth may affect your position, relations with others or result in punishment

**Benefits and/or compensation**

You will not be compensated or there are no monetary benefits given for participating in this study. The study will, however, benefit mental health patients.

**Confidentiality**

Your participation in this study will be upheld in confidence. Any traceable information obtained in the study that could identify you, or family will be kept confidential. The results of the research will not divulge any information which will identify you. Names and any other identification will not be asked or disclosed. Pseudo names will be used to hide your identity.

**Voluntary Participation**

Participation in this study is voluntary.

**Offer to Answer Questions**

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**Feedback**

On completion of the study, I intend to communicate the results. This will be done through a presentation to the participants

**Authorization**

If you have decided to participate in this study, please sign this form in the space provided below as an indication that you have read and understood the information provided above and have agreed to participate.

---------- ----------

**Signature of Research Participant** **Date**

If you have any questions concerning this study or consent form beyond those answered by the researcher including questions about the research, your rights as a research participant, or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Africa University Research Ethics Committee on telephone (020) 60075 or 60026 extension 1156 email aurec@africau.edu

**APPENDIX 5 AUREC Approval Letter**

AFRICA UNIVERSITY
(A United Methodist-Related Institution)
INVESTING IN AFRICA'S FUTURE

**AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE (AUREC)**

P.O. Box 1320 Mutare, Zimbabwe, Off Nyanga Road, Old Mutare-Tel (+263-20) 60075/60026/61611 Fax: (+263 20) 61785 website: www.africau.edu

Ref: AU1298/19

8 January, 2020

Brian Hove
C/O CBPLG
Africa University
Box 1320
**Mutare**

**RE: THE EFFECTS OF FORENSIC PSYCHIATRIC PATIENTS PRISON DETENTION ON HUMAN RIGHTS IN ZIMBABWE**

Thank you for the above titled proposal that you submitted to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and approved your application to conduct the above research.

AFRICA UNIVERSITY
RESEARCH ETHICS COMMITTEE (AUREC)
0 8 JAN 2020
APPROVED
P.O. BOX 1320, MUTARE, ZIMBABWE

The approval is based on the following.

a) Research proposal
b) Questionnaires
c) Informed consent form

- **APPROVAL NUMBER** AUREC1298/19

This number should be used on all correspondences, consent forms, and appropriate documents.

- **AUREC MEETING DATE** NA
- **APPROVAL DATE** January 8, 2020
- **EXPIRATION DATE** January 8, 2021
- **TYPE OF MEETING** Expedited

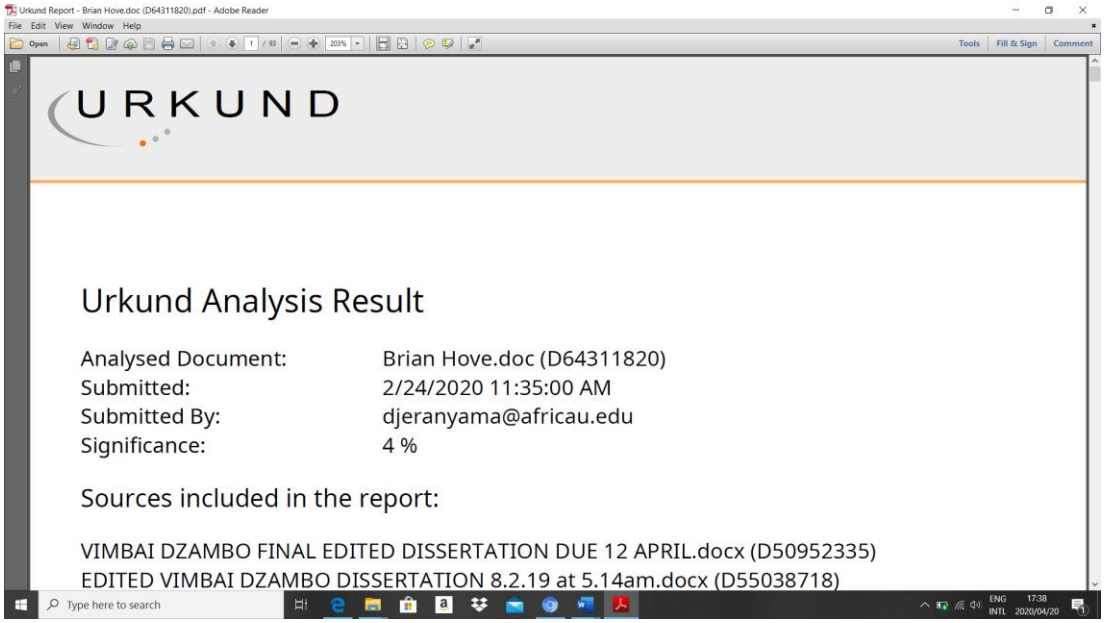
After the expiration date this research may only continue upon renewal. For purposes of renewal, a progress report on a standard AUREC form should be submitted a month before expiration date.

- **SERIOUS ADVERSE EVENTS** All serious problems having to do with subject safety must be reported to AUREC within 3 working days on standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

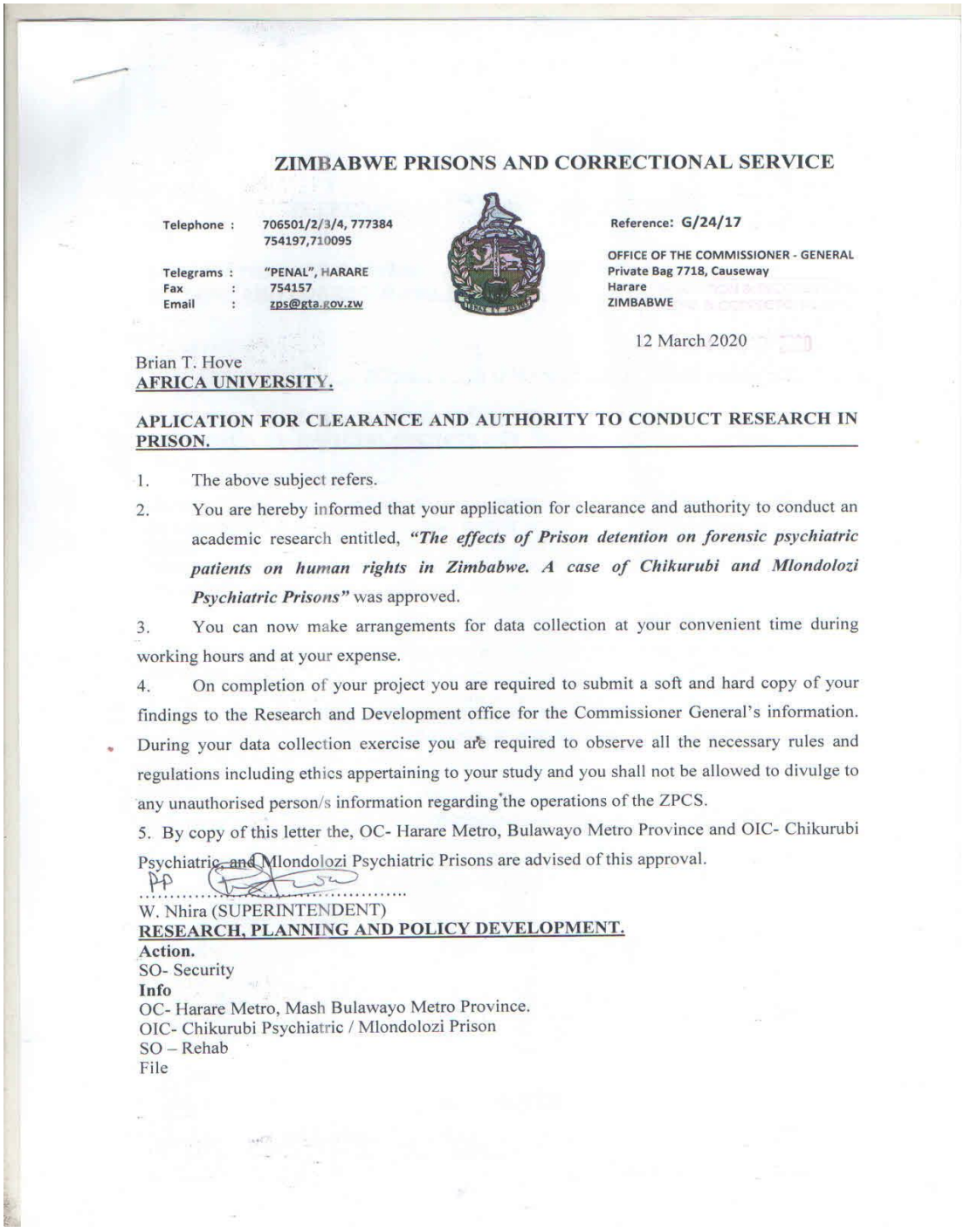
**Yours Faithfully**

**MARY CHINZOU – A/AUREC ADMINISTRATOR**
**FOR CHAIRPERSON, AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE**

## APPENDIX 6 Plagiarism check report



**APPENDIX 7 Approval Letter from ZPCS**



ZIMBABWE PRISONS AND CORRECTIONAL SERVICE

Telephone : 706501/2/3/4, 777384
754197,710095

Telegrams : "PENAL", HARARE
Fax : 754157
Email : zps@gta.gov.zw

Reference: G/24/17

OFFICE OF THE COMMISSIONER - GENERAL
Private Bag 7718, Causeway
Harare
ZIMBABWE

12 March 2020

Brian T. Hove
**AFRICA UNIVERSITY.**

**APLICATION FOR CLEARANCE AND AUTHORITY TO CONDUCT RESEARCH IN PRISON.**

1. The above subject refers.
2. You are hereby informed that your application for clearance and authority to conduct an academic research entitled, ***"The effects of Prison detention on forensic psychiatric patients on human rights in Zimbabwe. A case of Chikurubi and Mlondolozi Psychiatric Prisons"*** was approved.
3. You can now make arrangements for data collection at your convenient time during working hours and at your expense.
4. On completion of your project you are required to submit a soft and hard copy of your findings to the Research and Development office for the Commissioner General's information. During your data collection exercise you are required to observe all the necessary rules and regulations including ethics appertaining to your study and you shall not be allowed to divulge to any unauthorised person/s information regarding the operations of the ZPCS.
5. By copy of this letter the, OC- Harare Metro, Bulawayo Metro Province and OIC- Chikurubi Psychiatric and Mlondolozi Psychiatric Prisons are advised of this approval.

PP .....
W. Nhira (SUPERINTENDENT)
**RESEARCH, PLANNING AND POLICY DEVELOPMENT.**
**Action.**
SO- Security
**Info**
OC- Harare Metro, Mash Bulawayo Metro Province.
OIC- Chikurubi Psychiatric / Mlondolozi Prison
SO – Rehab
File