HUMAN RIGHTS WATCH

"Chained Like Prisoners"

Abuses Against People with Psychosocial Disabilities in Somaliland

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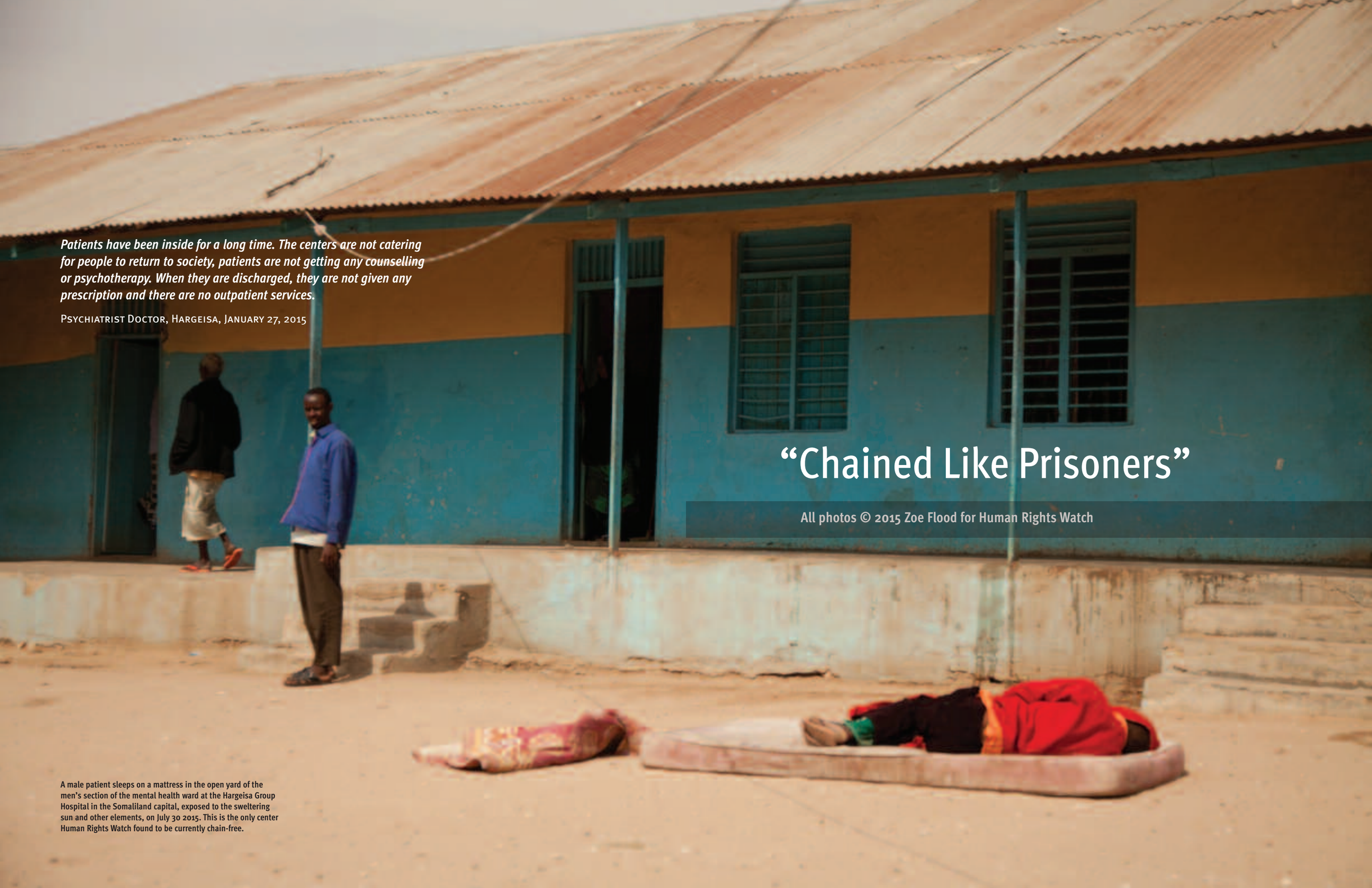
SUMMARY AND RECOMMENDATIONS



Patients have been inside for a long time. The centers are not catering for people to return to society, patients are not getting any counselling or psychotherapy. When they are discharged, they are not given any prescription and there are no outpatient services.

Psychiatrist Doctor, Hargeisa, January 27, 2015

"Chained Like Prisoners"

All photos © 2015 Zoe Flood for Human Rights Watch

A male patient sleeps on a mattress in the open yard of the men's section of the mental health ward at the Hargeisa Group Hospital in the Somaliland capital, exposed to the sweltering sun and other elements, on July 30 2015. This is the only center Human Rights Watch found to be currently chain-free.

Thirty-five year old Abdi spent 20 months in a privately-run residential center in Somaliland's capital Hargeisa. Abdi's family believed he was sick, maybe with a mental health condition, and they didn't know what to do. As a result, his sister who felt she couldn't care for him at home placed him in the center.

35-year-old Abdi, who was held for two years at the Macruuf Relief Organization, where he says he was taken against his will by his family and shackled for 14 months, puts away clothes in the small hut he now lives in next to his family home, Hargeisa, on July 27 2015.

Abdi – like many others in Somaliland who are perceived as having a psychosocial disability, or a mental health condition – then spent 14 months shackled at the ankles in the center, locked inside for almost the entire time. "It was very difficult to be inside all day long," he said. "I was counting the days until I got out."

The center's staff gave Abdi psychotropic medication but sought no consent from him nor offered any explanation about why he needed it or how it might affect him. "On admission I was prescribed olanzapine, and was on olanzapine for the whole time there, but the nurse didn't explain why." But he had no choice other than to take it.

A patient sleeps with his feet chained together at the Raywan private center in the Somaliland capital Hargeisa, on July 29 2015. As at other privately-run residential facilities for residents with actual or perceived psychosocial disabilities, patients are often chained for long periods of time.

"Sometimes if you refuse to take the medication or you become aggressive the guards beat you with a stick and slap you," Abdi said.

Abdi and his relatives were not given any information about his diagnosis. Abdi had no power to leave the center. His sister determined when he would ever be allowed to go home.

When Human Rights Watch met Abdi at his sister's home in Hargeisa, three days after he was discharged, his relief was palpable: "I was so happy to leave, I felt like a prisoner there, I felt like I was getting my freedom back when I left."

There is no official data on prevalence of mental health conditions in Somaliland. However, existing research points to alarmingly high levels, including severe conditions, caused by the violence of the civil war, widespread use of the amphetamine-like stimulant khat, entrenched unemployment and lack of health services. And yet people with psychosocial disabilities have been abandoned by the state, left to their own devices or reliant on often ill-informed relatives, who also have no place to turn for help on how to support a relative with psychosocial disabilities.

In addition to four under-resourced and dilapidated public mental health wards dotted across Somaliland, expensive privately-run residential centers with no legal mandate have mushroomed in the capital, Hargeisa. Far from offering residents' rest, rehabilitation or medical treatment, both public and private institutions are largely serving as places of confinement, and subject many residents to involuntary treatment and unlawful detention without free and informed consent.

Relatives and friends seek to gain entry to the Hargeisa Group Hospital mental health ward, which at the time held around 40 male and 25 female patients, in Hargeisa, on July 29, 2015.

Based on research in the towns of Hargeisa, Berbera and Gabiley, this report examines the abuses against people with actual or perceived mental health conditions or psychosocial disabilities in public and private institutions. Between October 2014 and July 2015 Human Rights Watch visited two public mental health wards, six privately-run residential centers and one facility that uses traditional and religious practice to treat and purportedly heal inpatients. Human Rights Watch interviewed 115 people, including 47 people with actual or perceived psychosocial disabilities currently or formerly within institutions, and found that most residents experience abuses. These include arbitrary detention, chaining, verbal and physical abuse, involuntary medication, overcrowding and poor conditions. Basic due process, judicial oversight and channels of redress are non-existent. Although women with psychosocial disabilities also suffer serious abuses in healing centers and in their communities, this reports focuses largely on men, because most of the centers hold men.

Families and relatives are the main support systems available to individuals with psychosocial disabilities, but often struggle to provide effective support, given the lack of community-support systems such as outpatient medical services and counselling based on free and informed consent. Family members are often ill-informed, with limited information about mental health conditions and what constitutes sound treatment and care, and must confront significant social stigma. Some rely on traditional

A female patient stands at the entrance of the women's section of the mental health ward at the Hargeisa Group Hospital in the Somaliland capital, on July 29, 2015.

Dr Mustafa Hassan Dahir and nurse Maryam Hassan Dahir attend to outpatients at the mental health ward, said to serve approximately 150 regular outpatients, at the Hargeisa Group Hospital in the Somaliland capital, on July 29 2015.

Islamic healers or over the counter medicines from unregulated and unlicensed pharmacies for sporadic help. As a result, individuals with psychosocial disabilities often end up being chained at home.

Human Rights Watch found a number of factors that are making people with actual or perceived psychosocial disabilities increasingly vulnerable to institutionalization and abuse. These include high prevalence of mental health conditions, the dearth of appropriate government-supported community-based services for families who are struggling with challenges that arise because of a relative with a psychosocial disability, and the lack of information about mental health. Given increasing demand for inpatient care, private centers, claiming to offer mental health treatment, are proliferating without appropriate legal framework, regulation or oversight.

Most people with psychosocial disabilities interviewed for this research were placed in the institutions against their will by their relatives. Regardless of how they enter, residents in both public and private institutions have no control over when they leave, yet do not go through any judicial process to authorize such detention. The Hargeisa district court has been endorsing admissions to three of the private centers, despite the lack of legal groundings for these admissions, without the person's informed consent or the individual ever appearing before the court, in addition to the lack of psychiatric assessment, or timeframe for "treatment".

Maryam Hassan Dahir, nurse at the Hargeisa Group Hospital mental health ward hands out medication to patients, on July 29 2015.

While a handful of residents said that there were some benefits to being at the centers, many residents told Human Rights Watch that they wanted to leave the public or private centers, but that their families had refused to bring them home or they had not seen a doctor competent to evaluate and discharge them. Some residents said that they had been held against their will for between one month and five years. None of the residents interviewed by Human Rights Watch had ever had access to a judge to challenge their detention.

The private centers hold residents in a heavily-controlled, often punitive, environment where guards and other staff subject residents to stringent timetables, protracted confinement and chaining.

Health workers and other support staff in the private centers Human Rights Watch visited chain residents as a form of restraint, frequently on admission, or because staff fear residents would be aggressive or try to escape. The widespread use of chaining creates a tense environment for residents, as one nurse at a private center explained: "Patients act aggressively as they feel that their freedom is being taken away from them, they feel the place is like a prison." Chaining is also used in the public Berbera General Hospital mental health ward. The common and prolonged use of chaining, and to a lesser extent seclusion, as documented in public and private centers in Somaliland, violates basic international standards prohibiting ill-treatment, and may constitute torture.

35-year-old Qasim, who had been in shackles for four months at the time of the photo and spent one week in an isolation room, sits with his feet chained together at the Horizon Social Assistance Development Organization, Hargeisa, on July 29 2015.

Some residents were subjected to involuntary medical treatment, through force and sedation. Medical staff regularly prescribes psychotropic medications without informing residents of their diagnosis, the reason they are being prescribed the drug, getting consent or offering them any alternatives. Only one out of 30 residents interviewed for this research knew his diagnosis. Only four, including Abdi, knew what psychotropic medication they had been prescribed.

Guards at the institutions on occasion punish residents who infringe rules or resist orders by beating them with sticks, slapping them or chaining them as punishment. Public facilities, as well as three of the private centers were unhygienic and dilapidated. In at least two private centers, residents' rooms are dark most of the time. Understaffing and lack of adequately trained staff was a problem in all of the private and public institutions Human Rights Watch visited. There are currently only two qualified psychiatric doctors in Somaliland for an estimated population of 3.5 million. For the everyday care of residents, the private centers in particular rely heavily on attendants and support staff, who are insufficiently trained, if at all.

Management of many of the centers provide very little, and often no, meaningful activities to residents, compounding their sense of imprisonment and hopelessness. Mowlid, who was detained for 15 months in one privately-run residential center, explained: "My family thought that place would help me, but in fact, it was too hard, I was constantly thinking, thinking, thinking. I just felt like I was in a prison." The services provided in both public and private centers largely fail to prepare the residents to return to their communities. Many people are readmitted by their families, sometimes on multiple occasions.

While people with certain psychosocial disabilities may benefit from care in medical facilities based on free and informed consent, many could clearly receive the necessary support and services – including healthcare and medical care – within their communities. In fact, many of those interviewed for this research said they would prefer to receive treatment on an outpatient basis while living with their families. A psychiatric doctor that has worked at both public and private institutions said that most patients in private centers should be dealt with on an out-patient basis.

The Somaliland authorities have recognized that mental health is a serious health problem but have so far failed to provide adequate support to public inpatient and outpatient services, oversight of the proliferating private sector or establish community-based services. The little money from the government budget going to mental health is going to institutions. International support for the health sector has overlooked mental health.

Addressing Somaliland's mental health crisis will require significant efforts. In the short term, the authorities should ensure that there is adequate regulation and monitoring of both public mental health wards and private centers, to prevent and respond to the serious abuses described in this report.

In the medium term, the Somaliland authorities, with support from their international partners and the Somaliland diaspora, should halt the increased institutionalization of mental health treatment and develop community-based mental health and support services. The government should work with people with psychosocial disabilities and their families and communities to tackle underlying stigma associated with mental disability, and find appropriate ways for individuals with psychosocial disabilities to live in a safe, independent and dignified manner in their community.

Somaliland needs to recruit and train more mental health professionals and social workers, mainstream mental health into primary care provision, guarantee access to treatment and counseling on the basis of free and informed consent, and ensure a steady, regulated supply of psychotropic medication. At the same time Somaliland, with the support of international partners, should strengthen existing mental health policies and move towards implementation of those plans, including by adopting mental health legislation in line with international human rights standards.

Given the apparent significant number of people institutionalized because of their consumption of khat, the authorities should consider providing similar services for people who use drugs at the community level.

Somaliland has an opportunity to build community support systems for people with psychosocial disabilities early on, regulate and monitor the private institutions who claim to offer mental health care treatment, stop the use of abusive and punitive chaining and thwart the move towards institutionalization.

KEY RECOMMENDATIONS

IMMEDIATE ACTIONS

- Mental health professionals, government health and judicial officials should review all cases of persons in public and private residential mental health centers and release those who are detained against their will;
- Release all persons who are held against their will in mental health centers because of their use of khat;
- Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in public and private mental health centers;
- Ban the use of chaining and the prolonged use of any measure designed to physically restrain an individual;
- Prohibit the use of seclusion;
- Permit the use of measures to physically restrain an individual or separate them from other persons only as measures of last resort, when necessary to prevent imminent and actual harm to self or others, imposed only for short periods and only to the extent strictly required for the purpose; such measures should not be justified on the basis of the existence of a disability and should be non-discriminatory, in line with the UN Convention on the Rights of Persons with Disabilities (CRPD);
- Prohibit the use of all restraints as a form of punishment, control, retaliation or as a measure of convenience for staff;
- Require admission and stays in public or private mental health centers be voluntary, based on free and informed consent;
- Ban medical intervention without free and informed consent; define exceptional circumstances in which a patient may be considered temporarily unable to give free and informed consent and in such circumstances, immediate medical treatment may be administered as it would be to any other patient without a disability incapable of consenting to treatment at that moment, provided that the treatment is strictly necessary to address a life-threatening condition or a condition of similar gravity;
- Ensure that all public and private institutions catering to persons with psychosocial disabilities are regularly monitored by the Ministry of Health, in coordination with the National Health Professions' Commission, as well as subject to independent monitoring including by the National Human Rights Commission and independent rights' organizations. Monitors should be granted unhindered access to facilities, residents and records documenting the use of restraints, and should focus on monitoring use of restraints, involuntary detention, seclusion and abusive punishment;
- Ensure that there will be no reprisals against any person in institutions who meets with monitors.

INTERMEDIATE AND LONG-TERM ACTIONS

- In collaboration with disability organizations, persons with psychosocial disabilities and the media, conduct a public information campaign to create awareness about persons with disabilities, particularly psychosocial disabilities. Target service providers, law enforcement agencies and the public;
- Make establishing, funding, and providing a wide range of community-based services for persons with psychosocial disabilities a top priority when designing mental health programs, including by integrating mental health into primary health care. These services should be based on values of equality, autonomy, and inclusion of individuals with psychosocial disabilities. Preventing institutionalization should be an important part of any planning for mental health care and key stakeholders including persons with psychosocial disabilities should be invited to participate in the formation of plans.

Methodology

Research into access to healthcare and abuses of people with psychosocial disabilities in institutions in Somaliland is scarce. There has been rare media reporting and a handful of assessments by local and international health organizations. Individuals with psychosocial disabilities and their families have very limited public channels through which to voice their experiences and concerns. This research seeks to help fill this void.

This report is based on almost four weeks of field research in Somaliland between October 2014 and August 2015 by two Human Rights Watch researchers and a psychologist who volunteered with Human Rights Watch for the research in the capital Hargeisa and in the towns of Berbera and Gabiley.

Human Rights Watch visited nine institutions offering services to people who were believed to have psychosocial disabilities – two mental health wards at the general hospitals in Hargeisa and Berbera, six privately-run residential centers as well as a facility which uses traditional and religious practice to treat and purportedly heal inpatients. The privately-run centers visited are Daryeel Psychosocial Center, Habwanaag Relief Organization, Horizon Social Assistance Development Organization, Macruuf Relief Organization, Raywan Advocacy Mental Organization and Sahan Mental Health and Psychosocial Centre. We also visited a religious center called Darul Shifo. With the exception of the two public mental health wards, Macruuf and Darul Shifo, all of the centers visited had only male patients and did not provide treatment to women.

Human Rights Watch research in the field of mental health has focused primarily on the conditions of people with psychosocial disabilities in private and public institutions. Given the increase in the numbers of privately-owned centers that hold persons with psychosocial disabilities in Hargeisa, as well as initial scoping work by Human Rights Watch that pointed to abusive practices, the focus on abuses in institutions was prioritized.

Human Rights Watch interviewed over 115 people in the course of the research. Forty-seven were with people with actual or perceived psychosocial disabilities (30 in institutions, the majority in private centers, and 17 living in their communities, receiving outpatient services or discharged from institutions). Of these 47 individuals, eight were women and 39 were

men. Human Rights Watch interviewed 20 family members and caregivers of persons with psychosocial disabilities.

Human Rights Watch also interviewed 16 individuals working for NGOs, UN agencies or donors working in the health sector, 10 government officials from the Ministry of Health, including the directors of the Hargeisa Group Hospital and Berbera General Hospital, from the National Health Professions Commission and the National Human Rights Commission, and 10 health professionals. Among the health professionals interviewed, two were psychiatric doctors, three were doctors with basic psychiatric training and nine were individuals with nursing training.[1] Five female community health workers were interviewed in Gabiley and surrounding villages. Human Rights Watch also interviewed 10 individuals managing private or public mental health facilities.

The research primarily focuses on the situation of men with psychosocial disabilities. Interviews and anecdotal evidence suggests that women and girls with psychosocial disabilities are more likely to be kept inside homes or sent to inpatient or outpatient traditional healers rather than public or private mental health facilities. Further research would be required to examine the specific abuses and serious problems facing women and girls with psychosocial disabilities within their communities and religious healing centers.

Human Rights Watch research indicates that both men and women with psychosocial disabilities often face abuse at the hands of spiritual and traditional healers. These practices and centers are however not the focus of the report and require further investigations to make conclusions or recommendations regarding protecting rights in those locations.

The vast majority of health service providers are located in large urban areas, particularly in Hargeisa. However, some interviewees reflected on the situation in rural Somaliland since they had come from rural areas to seek treatment in Hargeisa. Researchers spent a day in the town of Gabiley and nearby villages to get a brief insight into the challenges facing people with psychosocial disabilities outside of urban areas.

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[1] Several nurses working in the public and three in the private centers said they had received basic psychiatry teaching during their nursing courses. Human Rights Watch did not assess the scope or quality of this training.

Human Rights Watch informed interviewees of the purpose of the interview and the manner in which the information would be used. No remuneration or incentives were promised or provided to people interviewed. The interviews were conducted in person in English, or in Somali through an interpreter.

Persons with psychosocial disabilities were asked for their consent prior to and on multiple occasions during the interview and were informed they could decline to answer questions and end the interview at any time. Interviews were conducted individually when feasible. When within institutions, interviews with residents were conducted without the presence of staff and when feasible out of their hearing range. In order to respect confidentiality and protect residents from reprisals from family or from staff in institutions, they have been assigned pseudonyms and key identifying information has been withheld. In a few cases, names of staff members working at mental health institutions have also been withheld to protect their identity.

There are no statistics on prevalence of mental health conditions in Somaliland. In its 2010 situation analysis, the World Health Organization (WHO) provided basic information on the prevalence of different mental health conditions, based on data collected in mental health facilities across Somalia, including Somaliland, finding that men were diagnosed primarily with psychosis and schizophrenia whereas women primarily had depression and bipolar disorders.[2]

Diagnosis of mental health problems in Somaliland is extremely difficult. There are very limited qualified mental health personnel and limited diagnostic capacities in the public and private centers. The impact of chewing khat, an amphetamine-like stimulant, also interacts with underlying mental health problems in some people who use this drug.

Human Rights Watch did not attempt to determine the mental health conditions affecting interviewees. Based on discussions with mental health experts and observations during site visits, Human Rights Watch researchers identified the following groups of residents in institutions:

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[2] WHO, " A situation analysis of mental health in Somalia," October 2010, p.18, http://applications.emro.who.int/dsaf/EMROPUB_2010_EN_736.pdf (accessed August 19, 2015).

- Individuals who appeared to have severe mental disabilities, who showed signs of delusions, described hearing voices, or having lost hope and isolating themselves from the world;
- Individuals who described psychotic episodes, talking to themselves, becoming aggressive, escaping from their homes, often following a lot of continuous khat chewing, but who did not appear to have such episodes inside the centers;
- Individuals who described, or whose relatives described them as having behavior that was seen as socially unacceptable, including restlessness, talking too much, inability to hold on to a job, escaping from home, physical and verbal abuse and who may have less severe mental disabilities;
- Individuals, primarily originating from the diaspora, who had consumed drugs and substances, including alcohol, which are prohibited in Somali culture.

Given the limited credible information on individuals' diagnosis, in the report, the term "resident" is used to refer to people with actual or perceived mental disabilities in public and private mental health centers, including those who did not have or know their diagnosis, individuals who are merely perceived by their relatives as having a mental disability, as well as individuals with varying degrees of problems believed to be linked to khat usage.

Terms

Bipolar disorder: A mental health condition that brings severe disturbances in mood and activity levels and changes in sleep, energy, thinking, and behavior.

Chaining: Form of restraint in which the individual with psychosocial disabilities is chained including with just their hands and/ or legs bound or shackled together.

Institutions: Refers more generally to both state-run and privately-run mental health centers.

Jinn: A Somali word, from Islamic mythology, meaning spirits that can take possession of an individual.

Khat: A plant whose leaves are widely chewed throughout the Horn of Africa and contain an amphetamine-like stimulant.

Mental disability: Refers to mental health problems such as depression, bipolar disorder, and schizophrenia. This term is used interchangeably with psychosocial disability in this report.

Mental health ward: Refers to a state-run mental health ward linked to general hospitals that specifically treat persons with psychosocial disabilities.

Neurologist: Specialist who diagnoses and treats diseases of the nervous system.

Private center: A privately-run residential center that provides varying levels of medical assistance to inpatients. In Somaliland these hold people with mental disabilities as well as individuals with perceived drug dependence. Some also provide religious and traditional healing practices.

Psychosis: A mental health condition that can result in distortions of thinking and perception, inappropriate emotions, incoherent speech, hallucinations, delusions, and excessive suspicions.

Psychosocial disability: The preferred term to describe persons with mental health conditions such as depression, bipolar disorders, schizophrenia. This term expresses the interaction between psychological differences and social or cultural limits for behavior, as well as the stigma that the society attaches to persons with mental health conditions.[3]

Schizophrenia: A severe mental health condition that brings profound disruptions in thinking, affecting language, perception, sense of self as well as psychotic experiences, such as hearing voices or delusions.

Sheikh: From Arabic, an honorific title given to an Islamic scholar or elder.

Sixir: A Somali word for sorcery.

Traditional / Religious healing centers: Refers to healing centers, generally run by Islamic Sheikhs that use methods of treatment including Koranic recitation and herbal medicine including burning of herbs. These centers primarily cater for individuals with alleged spiritual problems such as *jinn* (evil spirits). Some centers offer inpatient facilities including for people with actual or perceived mental health conditions. These centers are often referred to as "Cilaaj" from the Arabic word for healing.

[3] World Network of Users and Survivors of Psychiatry, "Manual on Implementation of the Convention on the Rights of Persons with Disabilities,"2009, http://www.wnusp.net/documents/WNUSP_CRPD_Manual.pdf (accessed August 19,2015), p. 9.

I. Background

Political History of Somaliland

Somaliland was one of the areas most devastated by the initial years of Somalia's over two-decade long civil war. The Somali government's intelligence services arbitrarily detained, tortured, or murdered hundreds of civilians, particularly from Somaliland's dominant Isaaq clan, suspected of supporting the rebel Somali National Movement (SNM), from the early 1980s onward. The SNM was one of the most formidable armed groups to challenge the Somali government's power and when SNM captured parts of Hargeisa in 1988, the Somali government bombed the city and strafed columns of fleeing civilians.[4] The war claimed tens of thousands of civilian lives across Somaliland, drove at least a million people from their homes, many fleeing into neighboring Ethiopia, and left the region devastated.[5] By 1991 Hargeisa had been reduced to rubble and the town's basic infrastructure and public institutions had been destroyed.[6]

In May 1991 following the collapse of the central Somali government, leaders of the SNM and clan elders declared Somaliland's independence from Somalia.[7] A May 2001 popular referendum overwhelmingly approved a provisional constitution that reaffirmed Somaliland's independence.

Since declaring independence, Somaliland has been functioning largely as a weak but autonomous state, even though it has yet to be officially recognized. Much of the focus of the government since independence has been on securing recognition and maintaining security and stability.[8]

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[4] For a detailed account of abuses in northern Somalia during the war, see Africa Watch (now Human Rights Watch/Africa), Somalia - A Government at War With its Own People (New York: Human Rights Watch, 1990).

[5] Ibid.

[6] Mark Bradbury , *Becoming Somaliland*, (London: Progression, 2008), p. 3.

[7] For a detailed account of the consultative processes that led to the declaration of independence and formation of the Somaliland government, see Bradbury, *Becoming Somaliland*, p. 77-137.

[8] This focus and discourse has on occasion been used by those in power to legitimize efforts to postpone elections. Presidential elections were held in 2005 and then 2010 after significant delays. General elections were slated for June 2015 but have been delayed for technical and political reasons till March 2017. A significant proportion of government spending currently goes to the security sector.

According to the World Bank, Somaliland has one of the lowest Gross Domestic Product in the world and very high unemployment rates.[9] Youth unemployment is reported to be between 60 and 70 percent.[10] The economy relies largely on the livestock sector and trade.[11]

Health Sector

Somaliland's already weak and underfunded health infrastructure was not spared the impact of the civil war and the subsequent fragile stability of the 1990s. Many health workers died, were killed or fled, and the medical facilities were destroyed.[12]This has resulted in the proliferation of unregulated private health facilities. Much of the funding for health services comes from international assistance and organizations or the diaspora and remittances.[13]

Somaliland's government budget for 2015 was US$150 million for an estimated population of 3.5 million people.[14] Recently, allocations for health dropped as a percentage of the budget from approximately 3.9 percent to 3.3 percent.[15] Over sixty percent of this is spent on human resources.[16] Government funding also goes towards food and medication in the seven public hospitals, including the Hargeisa Group Hospital and Berbera General Hospital.[17]

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[9] World Bank, "New World Bank GDP and Poverty Estimates for Somaliland," Press Release, January 29, 2014, http://www.worldbank.org/en/news/press-release/2014/01/29/new-world-bank-gdp-and-poverty-estimates-for-somaliland (accessed July 4, 2015). The study found that Somaliland has very low employment-to-population ratios with 28% for males and 17% for females.

[10] IRIN, "Somaliland losing youth to lure of Europe," July 16, 2015.

[11] Ibid.

[12] See Mary-Jo Doyle & Caroline Morris, " Development of mental health nursing education and practice in Somaliland," Nurse Education in Practice 14, 2014, p. 1-3, file:///C:/Users/User/Downloads/mary%20Jo%20caroline%20NEIP%202014%20(3).pdf (accessed July 8, 2015).

[13] According to Oxfam, 40% of remittances to Somalia are going towards basic daily needs including health, see Oxfam, " As the cycle of crisis in Somalia continues, vital remittance pipelines risk being cut," Press Release, February 19, 2015, https://www.oxfam.org/en/pressroom/pressreleases/2015-02-19/cycle-crisis-continues-somalia-vital-remittance-pipelines-risk (accessed July 19, 2015); A 2013 study into how relatives share remittances and other income found that individuals in Somaliland spent 55% of the support on medical expenses see: " Family Ties: Remittances and Livelihoods Support in Puntland and Somaliland," Food Security and Nutrition Analysis Unit, June 5, 2013, file:///C:/Users/User/Downloads/Remittances-and-Livelihoods-Support-in-Puntland-and-Somaliland.pdf (accessed September 7, 2015).

[14] House of Representative, "Government Budget," undated, http://somalilandparliament.net/index.php/parliamentary-business/goverment-budget (accessed August 19, 2015).

[15] Ibid ; according to the DG for planning at the Ministry of Health, government contributions towards the health sector also include contributions to the National Health Professions' Commission and the National HIV/ AIDs Commission; Human Rights Watch email correspondence with Faisa Ibrahim, Director General for planning at Ministry of Health, July 10, 2015.

[16] House of Representative, "Government Budget. Budget Line 231," undated, http://somalilandparliament.net/index.php/parliamentary-business/goverment-budget ; In its Health Policy the Ministry of Health committed to pushing the government to increase public funding to the health sector to 15% as stipulated by the African Union Abuja agreement, see " National Health Policy", p.39, on file with Human Rights Watch.

[17]Human Rights Watch interview with Asha Aden Guled, director of Berbera General Hospital, Berbera, January, 24, 2015.

There is little information on the number of qualified health professionals in Somaliland. Staff shortages and limited qualified staffing is a problem across the public health sector. In 2013, the National Health Professions Commission (NHPC) was established with the mandate to regulate health providers across the public and private sectors. The work of the NHPC has so far been very limited and the commission is currently addressing a backlog of applications of health professionals. Many health professionals reportedly work in both the public and private sectors at the same time.[18]

The public health system in Somaliland comprises primary health care units, health centers, referral health centers and regional hospitals.[19] The World Health Organization (WHO) is currently piloting efforts to build a network of female community health workers to work within their local communities.[20]

Following the civil war, the private health sector proliferated. This sector is largely unregulated and the number of private clinics is unknown.[21] The NHPC has not started to register private health facilities. Estimates suggest that 60 percent of health care services are provided by the private sector.[22] According to the Somaliland Representative of Population Services International there are currently at least 1000 active pharmacies across Somaliland handing out medication, though none are actively regulated by any government body.[23]

Budgeting and Access to Mental Health Services

According to the WHO, more than 450 million people worldwide have psychosocial disabilities such as schizophrenia or bipolar disorder.[24] In conflict countries the rates are

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[18] Human Rights Watch interview with Dr Lula, head of the National Health Professions' Commission, Hargeisa, May 21, 2015; interview with Abdirisak Mohammed Warsame, GRT mental health project manager, Hargeisa, January 26,2015.

[19] Data on the numbers of active public health facilities is limited but according to the Ministry of Health there are at least 7 national hospitals and 97 health centers. Actual services available in health centers and posts varies greatly across Somaliland. Excel sheets sent by PSI, on file with Human Rights Watch; Human Rights Watch telephone interview with Faisa Ibrahim, Director General for planning at Ministry of Health, October 5, 2015.

[20] Human Rights Watch interview with Dr Humayun Rizwan, WHO primary health care doctor , Hargeisa, January 21, 2015.

[21] Joanna Buckley et al, " Assessment of the Private Health Sector in Somaliland, Puntland, and South Central," Health & Education Advice & Resource Team (HEART), March 2015, http://www.opml.co.uk/sites/default/files/Somalia%20Private%20Sector%20Assessment%20.pdf (accessed August 19, 2015).

[22] Fadwa A. Affara, "Operationalizing the Somaliland National Health Professions' Council," December 2011, p. 5 , http://hcsshare.org/uploads/documents/NHPCReport_Affara_December_2011.pdf (accessed August 19, 2015).

[23] Human Rights Watch phone interview with Farai Chieza, PSI Country Representative, July 8, 2015.

[24] WHO, " WHO Mental Health Gap Action Programme (mhGAP)," http://www.who.int/mental_health/mhgap/en/ (accessed August 19, 2015).

even higher and 20 percent of the population is affected by some kind of mental distress or problem.[25] While 14 percent of the global burden of disease is attributed to these conditions, most of the people affected – 75 percent in many low-income countries – do not have access to the treatment they need.[26]

There are no official estimates of the prevalence of psychosocial disabilities in Somaliland. Yet, small-scale studies carried out by international and local organizations point to high rates of mental disabilities.[27]

A 2002 study found that one in five households were caring for someone with mental health problems.[28] Twenty-one percent of the sampled households in Hargeisa were caring for at least one family member with severe mental health problems.[29] The research also found that veterans of the civil war were four times more likely than the general population, including survivors, to experience a severe mental health condition.[30]

Research points to the war, exposure to significant levels of violence and trauma,[31] poor health care systems,[32] as well as the widespread use of khat as key factors contributing to widespread mental health problems. Individuals interviewed by Human Rights Watch also pointed to high-levels of unemployment and financial dependency (especially of men) as additional contributing factors.

The Somaliland government has identified mental health as a priority area and has developed a mental health policy. Under the auspices of WHO and with Ministry of Health counterparts

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[25] WHO, " A situation analysis of mental health in Somalia," October 2010, http://applications.emro.who.int/dsaf/EMROPUB_2010_EN_736.pdf (accessed August 19, 2015).

[26] WHO, " WHO Mental Health Gap Action Programme (mhGAP)," http://www.who.int/mental_health/mhgap/en/ (accessed August 19, 2015).

[27] WHO," A situation analysis of mental health in Somalia," October 2010, p. 18.

[28] Human Rights Watch skype interview with Dr Michael Odenwald, Clinical Psychologist and author of VIVO study, January 15, 2015; King's College London, "Somaliland. KTSP Mental Health Group," http://www.kcl.ac.uk/lsm/research/divisions/global-health/partnerships/Somaliland/somaliland.aspx (accessed September 8, 2015).

[29] Michael Odenwald et al., " War Trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintregration Program Somaliland", 2002, http://www.mbali.info/doc136.htm (accessed July 6, 2015).

[30] Ibid.

[31] Michael Odenwald et al., " War Trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintregration Program Somaliland"; McGraw, D., & McDonald. C., "Somali Mental Health," *Bildhaan: An International Journal of Somali Studies*, 2004, http://digitalcommons.macalester.edu/cgi/viewcontent.cgi?article=1032&context=bildhaan (accessed August 19, 2015).

[32] King's College London, "Somaliland. KTSP Mental Health Group," http://www.kcl.ac.uk/lsm/research/divisions/global-health/partnerships/Somaliland/somaliland.aspx (accessed September 8, 2015).

in Somalia and Puntland, it has also developed a Somalia-wide mental health strategy. Both the policy and strategy underline the need to build community-based services, but these plans have never been implemented. For example, though the strategies recommend increasing staffing, there are currently only two psychiatric doctors in all of Somaliland and no psychiatric nurses for an estimated 3.5 million people.[33] Basic psychotropic medications are not currently included on the government's list of essential medicines.[34]

There is no clear disaggregated data on what portion of Somaliland's health budget is allocated for mental health care. The government's 2015 budget and Human Rights Watch interviews indicate that government support to the sector, like health spending more generally, largely goes to cover remuneration of staff in public institutions.[35]

In May 2015, Human Rights Watch visited a new mental health ward built at the Gabiley General Hospital. Initially built with support from the local business community, the ward resembles a prison, with rows of small cell-like rooms with steel doors and small, barred windows. Several rooms had metal hooks in the ground that would inevitably be used to chain residents. In the Ministry of Health 2015 budget seen by Human Rights Watch, $47500 of the ministry's funding is destined for the construction of this facility.[36]

Stigma and Discrimination

People with psychosocial disabilities face significant stigma within Somali society and are often socially isolated. Many Somalis believe that psychological disabilities are not the result of medical conditions but are the result of possession by a spirit known as "jinn," or evil eye, or due to witchcraft known as "sixir."[37]

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[33] Human Rights Watch phone interview with Mariam Dahir, THET programme officer, July 7, 2015.

[34] Human Rights Watch interview with Asia Ahmed Osman, officer in charge of WHO Hargeisa office, Hargeisa, May 13, 2015.

[35] House of Representative, "Government Budget. Budget Line 231," undated, http://somalilandparliament.net/index.php/parliamentary-business/goverment-budget, (accessed August 19, 2015); Human Rights Watch interview with Faisa Ibrahim, Director General for planning at Ministry of Health, May 23, 2015, Hargeisa; interview with Asha Aden Guled, director of Berbera hospital, Berbera, January 24, 2015; interview with former head of Non-Communicable Diseases unit at Ministry of Health, January 26, 2015. Several credible sources told Human Rights Watch that one private institution, the Sahan private center, was receiving government assistance.

[36] House of Representative, "Government Budget. Budget Line 231," undated, http://somalilandparliament.net/index.php/parliamentary-business/goverment-budget.

[37] See Wedel, Johan, "Mental Health Problems and Healing among Somalis in Sweden," *Bildhaan: An International Journal of Somali Studies*, Vol. 11, Article 11, 2012, http://digitalcommons.macalester.edu/bildhaan/vol11/iss1/11/(accessed September 8, 2015) ; McGraw, D., & McDonald. C., "Somali Mental Health," *Bildhaan: An International Journal of Somali Studies*, 2004, http://digitalcommons.macalester.edu/cgi/viewcontent.cgi?article=1032&context=bildhaan (accessed August 19, 2015).

In Somali language, there are limited terms to differentiate between various mental health conditions.[38] Either people have "waalli" (madness) or they do not. People with psychosocial disabilities are often referred to with derogatory terms such as "ninka waalan" (the mad man), exacerbating stigma and marginalization. Somalis generally believe that serious mental health conditions are incurable.[39]

Given the lack of clear terminology as well as limited understanding of mental health conditions, Somalis often describe mental health problems as somatic – physical pains such as headaches.[40] Relatives interviewed described the "symptoms" and signs of mental health problems as restlessness, disorientation and confusing speech, or escaping from the home, throwing stones at people and objects, refusing food, or lack of hygiene, in other words, as socially unacceptable behavior rather than as a medical condition.[41] They also often said that the person was "thinking too much."[42]

With the exception of one Italian NGO, Gruppo per le Relazioni Transculturali (GRT), and a local human rights organization, the Human Rights Centre, there are no local or international organizations currently working to promote the rights of people with psychosocial disabilities and no local support groups of persons with psychosocial disabilities.[43] Organizations working on disability rights have tended to overlook issues relating to mental health.[44]

Khat and Its Impact on Mental Health

The chewing of khat – a plant that contains an amphetamine-like stimulant – is a crucial social activity in many parts of the Horn of Africa. Khat consumption was reportedly

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[38] Somalis do have terms to describe different forms of distress, generally linked to a person's context (lovesickness, homesickness and worry about those back in Somalia, distress because of their inability to migrate…) but these are not seen as medical conditions. See Wedel, Johan, "Mental Health Problems and Healing among Somalis in Sweden," p.76-77.

[39] IRIN, " Addressing Mental Health Illness in the Somali Diaspora," July 25, 2011, http://www.irinnews.org/report/93319/health-addressing-mental-illness-stigma-in-somali-diaspora (accessed August 19, 2015).

[40] See Wedel, Johan, "Mental Health Problems and Healing among Somalis in Sweden," p.74.

[41] WHO, "A situation analysis of mental health in Somalia," October 2010, p. 22 citing GRT, "Assessment Report and feasibility Study on Mental Health in Merka, 2004. Human Rights Watch interviews with relatives of residents, Hargeisa, throughout the course of the research.

[42] Ibid.

[43] The Human Rights Centre has reported on abuses in privately-run centers in their annual reports.

[44] Human Rights Watch interview with Zahra Dahir, Handicap International field coordinator, Hargeisa, October 9, 2014.

widespread in the pre-war years in Somaliland,[45] but its usage has increased since the civil war.[46] Previously, khat consumption was regulated by socio-cultural norms; consumption was generally kept for certain days of the week or special occasions, and women and youth did not consume khat.[47]

Scientific research on the impact of khat both in terms of dependency and relationship to mental health conditions remains inconclusive. Some existing research suggests that while khat consumption – particularly large quantities and frequent use – can trigger or exacerbate existing mental health problems, there is no clear evidence which indicates that khat use is a catalyst for the development of mental health conditions.[48]

Khat has been found to induce psychosis in some users but such episodes are likely to end if consumption stops.[49] Certain patterns of use of khat may lead to psychosis. In particular, researchers point to individuals with pre-existing psychosocial disabilities, notably depression, self-medicating with khat which can in turn result in psychotic conditions.[50] A 2002 study by a team of psychiatric experts in Somaliland found that individuals with forms of post-traumatic stress disorder, particularly war veterans, were prone to chewing a lot of khat, which results in long lasting, in some instances chronic psychosis.[51] There is also ongoing scientific debate on whether khat is addictive.[52]

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[45] See Elmi A.S., Ahmed Y.A., Samatar, M.S, " Experience in the control of khat-chewing in Somalia," *Bulletin of Narcotics*, Vol. XXX1X, N.2, 1987, pp.51-57.

[46] For an assessment of the positive and negative economic, social and political impacts of Khat in Somaliland, see Hansen, P. "The ambiguity of Khat in Somaliland," *Journal of Ethnopharmacology*, 132 , 2010, ,3, pp. 590-599, http://www.ncbi.nlm.nih.gov/pubmed/20211235 (accessed August 19, 2015); khat consumed in Somaliland is grown on farms and plantations in eastern Ethiopia.

[47] Neil Carrier, " Khat: A lingering Controversy," *Afrikan Sarvi*, http://afrikansarvi.fi/42-artikkeli/117-khat-a-lingering-controversy (accessed June 30, 2015) ; see Hansen, "The ambiguity of Khat in Somaliland," *Journal of Ethnopharmacology*, p.591.

[48] Human Rights Watch skype interview with Dr Michael Odenwald, Clinical Psychologist and author of VIVO study, January 15, 2015.

[49] Corckery, J.M, Schifano, F., Oyefeso, A., et al, " Overview of literature and information on "khat-related" mortality: a call for recognition for the issue and further research," Ann Ist Super Sanita 2011, Vol. 47, No.4: 445-464, http://www.iss.it/binary/publ/cont/ANN_11_04_17.pdf (accessed July 17, 2015); for a summary of the impact of khat on physical and mental health, see WHO, "Assessment of Khat," 34th ECDD **2006**/4.4 **khat**., http://www.who.int/medicines/areas/quality_safety/4.4KhatCritReview.pdf (accessed September 8, 2015).

[50] News Medical, " Link between Khat use and mental illness," June 5, 2007, http://www.news-medical.net/news/2007/06/05/26041.aspx (accessed August 19, 2015); Human Rights Watch skype interview with Dr Michael Odenwald, Clinical Psychologist and author of VIVO study, January 15, 2015.

[51] Odenwald et al., " War Trauma, Khat Abuse and Psychosis: Mental Health in the Demobilization and Reintregration Program Somaliland".

[52] Corckery, J.M, Schifano, F., Oyefeso, A., et al, "Overview of literature and information on "khat-related" mortality: a call for recognition for the issue and further research," Ann Ist Super Sanita 2011.

Health practitioners in Somaliland told Human Rights Watch that khat undermines the effectiveness of anti-psychotic medication.[53]

Regardless of the chemical connections between khat abuse and mental health conditions, in the minds and narratives of individuals with psychosocial disabilities and their families in Somaliland, the two are intricately linked. A recent study on the impact of the war on Somali men conducted across south-central Somalia, Somaliland, Puntland, and among the Somali refugee community in Kenya, identified khat "addiction" and mental health conditions as both a symptom and a cause of men's failure to live up to the significant responsibilities placed on men in Somali culture and society.[54] Khat use is perceived as contributing to idleness and unemployment, and many family members interviewed by Human Rights Watch linked their relatives' mental health problems with unemployment and what they considered khat "dependence." Others noticed that khat clearly triggered existing problems, mentioning that the individual reacted to khat in a way that many other people do not.

Mental Health Service Options in Somaliland

Most people with psychosocial disabilities in Somaliland are unlikely to receive any formal medical assistance. Individuals who receive some form of treatment generally have four care options and many utilize more than one and sometimes several at the same time.

Traditional /Religious Healing Centers (known as *Cilaaj*)

Traditional healing centers offer different treatment including Koranic recitation and the burning of plants, particularly herbs, (known as *Dawo* in Somali). Some centers include inpatient facilities.[55]

Services in the Community

Public community-based mental health services, including outpatient care, are non-existent or severely limited. Both the Hargeisa Group Hospital and Berbera General Hospital mental

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[53] Human Rights Watch interview with manager of Habiba outpatient center, Hargeisa, May 22, 2015.

[54] Judith Gardner, Judy El-Bushra et al., "The Impact of War on Somali Men. An inception study," May 2015, p.30 http://www.logica-wb.org/PDFs/LOGICA_The_Impact_of_War_on_Somali_Men.pdf (accessed August 19).

[55] Estimates suggest that 60 percent of the population seeks health care with traditional healers before resorting to formal health care practitioners. See Fadwa A. Affara, "Operationalizing the Somaliland National Health Professions' Council," p. 5.

health wards provide outpatient services but neither conduct outreach activities. The Hargeisa Group Hospital mental health ward currently reportedly serves approximately 150 regular outpatients and the Berbera ward serves 55.[56] Medical supplies at both wards have been erratic and rely on supplies from international organizations.[57] There are at present no local or international NGOs providing free services in the community.

General Hospitals with a Mental Health Ward

There are four health wards linked to general hospitals across Somaliland.[58] Their inpatient capacity is limited.[59] Medication supplies are largely dependent on support from international organizations and at times erratic.

Privately-Run Centers

There are currently at least nine privately-run residential centers in Hargeisa, several of which have multiple branches. They have no legal powers. These centers promote themselves as offering a place for rest, medical assistance and rehabilitation. Residents generally pay between USD $100- $130 per month, which often goes towards covering medication costs.

Inadequate Services

Families and relatives of people with psychosocial disabilities play a vital part in care and support for individuals and generally decide whether to seek formal medical treatment or to place an individual in an institution, although in reality the options available to them, as described above are severely limited.[60] The concept of free and informed consent of the person with the perceived mental health condition is routinely ignored.

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[56] Human Rights Watch email communication with Yassmin Mohamed, Sahil Programme Manager, Health Poverty Action (HPA), July 7, 2015.

[57] According to GRT, the Italian NGO that has been working with the Hargeisa Group Hospital mental health ward, the lack of a regular supply of drugs has resulted in a significant drop in the number of regular outpatients from approximately 500 to 150. Human Rights Watch email exchange with Abdirisak Warsame, GRT mental health project manager, July 12, 2015. The INGO, Health Poverty Action, has been supply the Berbera General Hospital mental health ward with drugs since August 2014. Human Rights Watch email with Rohit Odari and Yassmin Mohamed, HPA, July 7, 2015.

[58] Human Rights Watch did not visit the wards linked to the Borama and Burao general hospitals and therefore has not linked into their capacity, services and conditions.

[59] The Hargeisa ward was built in 1971 and the Berbera ward was built by the British as a prison in the 1950s.

[60] Human Rights Watch skype interview with Dr Michael Odenwald, Clinical Psychologist and author of VIVO study, January 15, 2015.

While there is scant research into the treatment of psychosocial disabilities in Somaliland, traditional healers, generally a sheikh, are often the first place where individuals are taken to for help. When relatives' decide to take someone to a more formal medical practitioner, they generally go to local private pharmacies or "neurologists."[61] Yet these are largely unregulated and there is currently no quality control of the medicines.[62] Individuals with actual or perceived psychosocial disabilities are often taken to the same traditional healer, pharmacist or "neurologist," on multiple occasions even if there have been no improvement in their well-being.[63]

Inpatient treatment by formal health care providers is generally a last resort, once the individual's condition is believed by family members to be chronic. Most families who spoke to Human Rights Watch described feeling despair, after a particularly difficult incident, or because what other limited care options were available, had failed, as having pushed them to finally take their relative to a public or private center.[64]

Public inpatient and outpatient facilities are limited and largely substandard. Conditions for patients in the main mental health ward in Hargeisa have improved somewhat thanks to support from an INGO, which has helped to reduce overcrowding in the ward, train staff and also end the practice of chaining. However staff numbers and qualifications remain a problem in all the institutions.

Privately-run residential centers have proliferated in Hargeisa in recent years. While more research is required to understand the factors driving this, high prevalence rates of mental health conditions and families' burden of care, combined with the absence of public community-based services, poor quality and unregulated private outpatient services and limited understanding of mental health, and what represents quality care, all contribute to increasing demand for privately-run inpatient facilities.

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[61] Human Rights Watch multiple interviews with relatives of people with psychosocial disabilities, Hargeisa; WHO, " A situation analysis of mental health in Somalia," October 2010, p.24. Human Rights Watch did not assess whether these were qualified neurologists.

[62] Joanna Buckley et al,, " Assessment of the Private Health Sector in Somaliland, Puntland, and South Central," V ; "Hamza Mohamed, "Counterfeit Medicine Endangering Somali Lives," *Aljazeera*, July 3, 2015, http://www.aljazeera.com/indepth/features/2015/06/counterfeit-medicine-endangering-somali-lives-150625100645962.html (accessed September 8, 2015).

[63] WHO, "A situation analysis of mental health in Somalia," October 2010.

[64] Human Rights Watch interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015.

Diaspora and Mental Health

In addition to support via remittances to individuals and families in Somaliland, the diaspora contributes funding for upkeep of public mental health facilities,[65] including food, clothing and beds.[66] Medical staff from the diaspora has also provided direct assistance to public facilities.[67]

The diaspora also appear to be contributing to the proliferation of privately-run centers. Academic research documents the practice of the diaspora sending relatives back to Somaliland to seek care and treatment when they behave in a manner that is considered socially unacceptable, including having a mental health problem or heavily using drugs.[68] A number of residents in the private centers visited by Human Rights Watch were from the diaspora.[69]

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[65] Human Rights Watch interview with Zahra Dahir, Handicap International field coordinator, Hargeisa, October 9, 2014; interview with psychiatric doctor Hargeisa, January 21, 2015; GRT, "Rapid Assessment in Mental Health. Somaliland," 2012, on file with Human Rights Watch.

[66] One of the diaspora organizations contributing is UK based Somaliland Mental Health Support Organization see website: http://www.somalilandmentalhealth.com/ ; Human Rights Watch interview with Abdirashid Gulaid, London, February 25, 2014.

[67] Human Rights Watch interview with Asha Aden Guled, director of Berbera hospital, Berbera, January 24, 2015.

[68] For a more detailed assessment of this phenomenon see Marja Tiilikainen, " Failed Diaspora: Experiences of Dhaqan Celis and Mentally Ill Returnees in Somaliland," *Nordic Journal of African Studies*, 20 (1): 71-89 (2011) , http://www.njas.helsinki.fi/pdf-files/vol20num1/tiilikainen.pdf (accessed July 19, 2015).

[69] Human Rights Watch interviews in Macruuf, Sahan, Raywan, Habwanaag and Daryeel private centers.

II. Abuses in Institutions

Instead of providing people with actual or perceived psychosocial disabilities with care and evidence-based treatment both public and particularly the private institutions are largely places of confinement. Most residents interviewed experienced abuses including arbitrary detention, chaining, verbal and physical abuse and unhygienic conditions. Few are asked for their consent with regard to admission, treatment or release. People institutionalized against their will or subjected to other abuses do not have access to channels of redress.

While some residents said that there were some benefits to being at the centers, most residents said they felt incarcerated and longed to be taken home.

Restraints and Seclusion

The abuse of restraints in psychiatric institutions remains a widespread problem across the world. International standards make clear that physical restraints or measures to separate an individual from others should only be used when they are the only means available to prevent immediate or imminent harm to the patient or others, and then only as long as that harm is imminent. In these limited instances when restraint is permitted, specific compliance criteria should be defined, including who has the authority to restrain another person.

The international human rights legal framework and standards are however constantly evolving and the rights of people with psychosocial disabilities should be placed at the heart of policies and practices.

The former UN special rapporteur on torture has stated that seclusion or solitary confinement as a form of control or medical treatment "cannot be justified for therapeutic reasons, or as a form of punishment."[70] The expert also underlines that "there can be no

[70] Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (SR Torture Interim Report), 28 July 2008, UN Doc A/63/175, para. 56, http://daccess-ods.un.org/TMP/886408.537626266.html (accessed August 19, 2015).

therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment."[71] The UN special rapporteur on torture stated that in certain circumstances the restraint of an individual with mental disabilities for even a short period of time may constitute torture and ill-treatment.[72]

Chaining

> The patients are acting aggressively as they feel that their freedom is being taken away. They feel the place is like a prison.
>
> – Former nurse at private center, Hargeisa, May 20, 2015[73]

Shackling residents with metal chains as a form of treatment or punishment and restricting their movement is common in all of the private centers visited by Human Rights Watch and, although to a lesser extent, in the Berbera General Hospital mental health ward. People are chained with thin metallic chains at the ankles which significantly restricts their movement. In three centers, Human Rights Watch saw men chained to window grates and structural columns in their rooms or the facility's courtyard and at the ankles with thick chains.[74] Importantly, the Hargeisa Group Hospital mental health ward is currently chain-free.[75]

The reliance on chaining and to a lesser extent, seclusion, documented in public and private centers in Somaliland violates basic international standards. Health workers' justification for the use of chains did not fall within the scope of the exceptions for temporary measures of restraints recognized by international standards.[76] Staff argued for

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[71] Ibid para. 55.

[72] UN Human Rights Council, Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment, Juan Mendez, A/HRC/22/53, February 1, 2013, para. 63, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed August 19, 2015).

[73] Human Rights Watch interview with a nurse at the Hargeisa Group Hospital mental health ward ,Hargeisa, May 20, 2015.

[74] Human Rights Watch visit to Raywan, Horizon and Berbera General Hospital mental health ward.

[75] Conditions for patients in the main mental health ward in Hargeisa have reportedly improved in recent years somewhat thanks to support from an INGO, which has helped to reduce overcrowding in the ward, provide basic training to staff, and also end chaining.

[76] See WHO, " WHO resource book on Mental Health, Human Rights and Legislation," 2005; the section on " Seclusion and Restraint," states that: "Restraints and seclusion may be allowed when they are the *only* means available to prevent immediate or imminent harm to self or others, and then used for the shortest period of time necessary. They may only be authorized by an accredited mental health practitioner. If used, there needs to be ongoing active and personal contact with the person subject to seclusion or restraint, which goes beyond passive monitoring," p.64, http://www.who.int/entity/mental_health/policy/who_rb_mnh_hr_leg_FINAL_11_07_05.pdf?ua=1 (accessed August 26, 2015).

the use of chains as restraints, because they feared that residents would escape or "become aggressive."[77] The use of restraints is not monitored or recorded.[78]

Chaining upon admission is widespread.[79] Twenty-seven year old Samatar, who was placed by his father in a private center, Daryeel, for two months in early 2015, after he had chewed large quantities of khat and disappeared from his home, said:

> It's the rule for all the new arrivals to have chains. I was in chains the whole two months I was there. I felt as though my freedom was taken away. Around 30 others [of approximately 105 patients] were also in chains.[80]

In addition, chaining was used for prolonged periods. Certain individuals are chained indefinitely.[81]

Human Rights Watch researchers found two residents in Raywan, chained to the windows in the front room of the facility in exactly the same place they were during a research trip four months earlier. According to staff at the facility, one of these residents, Warsame a 32-year-old man diagnosed with schizophrenia, had been in the facility for eight months by the time of the second visit.[82]

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[77] Human Rights Watch interview with two nurses at Macruuf private center, Hargeisa, May 14, 2015; interview with nurse at Berbera General Hospital mental health ward, Berbera, January 24, 2015; interview with former nurse at Sahan private center, Hargeisa, May 20, 2015; Human Rights Watch interview with manager of Horizon private center, Hargeisa, October 9, 2014.

[78] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment underlines the safeguards that need to be in place when restraints are used: "Given the serious nature of restraining patients with mental disorders, effective safeguards must be in place to prevent abuse of restraint measures. A legal basis, authorisation by medical doctors only, meticulous record-keeping, supervision and effective complaint procedures are all important elements in this respect. It should also be required that whenever someone is subjected to restraints, the patient must be continuously supervised by staff and also seen by a medical doctor at reasonable intervals. In many countries such safeguards are already guaranteed in the legislation. "http://www.cpt.coe.int/En/working-documents/CPT-2012-28-eng.pdf (accessed June 30, 2015).

[79] Human Rights Watch interview with Bilan, 24-years-old sister of former resident of Sahan private center, Hargeisa May 17, 2015;interview with Burhan, 54-year-old former resident of Raywan, Hargeisa, May 21, 2015; interview with manager of Horizon private center, Hargeisa, October 9, 2015; and ; interview with nurse at Berbera General Hospital mental health ward, Berbera, January 24, 2015.

[80] Human Rights Watch interview with Samatar27-years-old former resident of Daryeel private center, Hargeisa, May 22, 2015.

[81] Human Rights Watch visits to the Raywan private center, Hargeisa, January 24 & May 17, 2015; interview with Abdi, 35-years-old former resident of Macruuf private center, May 18, 2015

[82] Human Rights Watch visit to the Raywan private center, Hargeisa, January 24, 2015; when Human Rights Watch visited Raywan in July 2015, Warsame was in the courtyard for a short break but was visibly physically and psychologically significantly affected by the months he had spent chained inside.

Staff said they removed the chains when the residents are bathing and sometimes when they go to the toilets,[83] leaving people to sleep, eat, and pray while chained. However, Human Rights Watch found that some residents are forced to urinate and defecate while still chained. Warsame who said he had been ill for over a decade, described being forced to urinate on the floor inside his room.[84] Human Rights Watch researchers could smell the stench of urine even when standing several meters away.[85] Similarly, during a visit to the Berbera General Hospital mental health ward, Human Rights Watch researchers witnessed a man chained to a thick pillar in the middle of the courtyard who was surrounded by his own excrement and urine.[86] According to a nurse, he had schizophrenia and had been abandoned by his family at the ward.[87]

Residents told Human Rights Watch that staff at the private centers and the Berbera General Hospital mental health ward chain residents to punish them when they refuse to follow orders, exhibit aggressive behavior or fight with other residents or staff. [88] Samatar went on to describe the punishments guards subjected him to there as particularly harsh:

> It was a place that chained people, whenever you had a small argument. They do this as a punishment. There is a hall between the rooms that they use as the punishment area.
>
> First time I was chained, it was just at the ankles and then another chain that connected my ankles to a metal hook on ground. I had had a fight with

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[83] Human Rights Watch interview with Barre , 29-years-old resident of Daryeel private center, Hargeisa May 17, 2015 ;interview with Aden, 26-year-old resident of Raywan, Hargeisa, May 17, 2015; interview with manager of Horizon private center, Hargeisa, October 9, 2015.

[84] Human Rights Watch visit to Raywan private center, Hargeisa, January 20, 2015.

[85] Human Rights Watch visit to Raywan private center, Hargeisa, January 20, 2015.

[86] Human Rights Watch visit of the Berbera General Hospital mental health ward, Berbera, January 24, 2015.

[87] Ibid.

[88] Human Rights Watch interview with Halane, 50-years-old man resident of Daryeel private center, May 20, 2015; visit to the Raywan private center, Hargeisa, January 24, 2015; interview with Jibril, 50-years-old resident of Raywan private center, May 17, 2015; interview with Mursal, 45-year-old resident of Horizon private center , May 17, 2015; interview with manager of Horizon private center, Hargeisa, October 9, 2015; with Tawane, 29 years-old former resident of Sahan private center, Hargeisa, May 16, 2015; interview with Samatar, 27-years-old former resident of Daryeel private center, May 22, 2015; interview with Mursal, 45-year-old resident of Horizon private center, May 17, 2015; visit of the Berbera General Hospital mental health ward, Berbera, January 24, 2015.

> another resident, so I was restrained for 6 hours. I was also chained with my ankles upwards for around 30 minutes.[89]

> I couldn't handle it, it was painful, so hard, it was so painful to be in that position to have my head on the ground and it made me have a headache. It was hard to move my head in that position.[90]

The common use of chaining contributes to the further use of restraints and physical abuse: "Yesterday, one of the patients fought with the security guard – then they used a belt to hit him. He wanted them to remove his chains. They hit him five or six times with the belt."[91]

While, as will be described below, families take responsibility for their relatives upon admission, private centers fear escape and staff in private centers regularly chain residents who they fear will escape or punish other residents if one does escape.[92] As the manager of Habwanaag explained: "It would be a big problem if a patient escapes, anything can happen, they could get into an accident, and in Somali culture you are responsible for it."[93]

A 35-year-old man diagnosed with psychosis, who had been at the Horizon center for three months after his family committed him, told us:

> I have been wearing them [the chains] for 45 days. Someone escaped from the center and they chained several of us after this as they said we might escape too. One patient is chained to the window now. They [the staff] said he tried to escape, so they chained him.[94]

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[89] Anecdotally, another former resident of Daryeel told Human Rights Watch that during his last confinement at Daryeel in April-May 2015, management had scolded the guards for using this form of punishment ordering them to stop punishing residents in this way. Human Rights Watch interview with 38-year-old former resident of Daryeel private center, July 29, 2015.

[90] Human Rights Watch interview with Samatar, 27-years-old former resident of Daryeel private center, May 22, 2015.

[91] Human Rights Watch interview with Barre , 29-years-old resident of Daryeel private center, Hargeisa May 17, 2015.

[92] Human Rights Watch interview with Ali, 31-year-old former resident of Sahan private center, Hargeisa, January, 25, 2015; visit to Berbera General Hospital mental health ward, January 24, 2015; meeting with Ahmed Omar Hersi, head of GAVO, October 8, 2014; interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015.

[93] Human Rights Watch meeting with manager of Habwanaag private center, Hargeisa, January 23, 2015.

[94] Human Rights Watch interview with Tariq, 35-years-old resident of Horizon, Hargeisa, May 20, 2015.

Two managers of private centers also told Human Rights Watch that they chained residents to punish them or prevent them from destroying property and "wasting resources."[95]

Some family members were concerned about the impact chaining would have on residents.[96]The mother of a 38-year-old man who had been repeatedly admitted to the private center, Daryeel, after he showed signs of restlessness and spoke a language his family could not understand, said: "Whenever I saw all the people chained around him, I thought, my son would never get better if he is surrounded by people in chains."[97]

Forced Seclusion

While Human Rights Watch did not witness widespread seclusion, based on interviews we are concerned that prolonged isolation is being used as a form of restraint and punishment.

In Hargeisa Group Hospital and Berbera General Hospital mental health ward and at least two of the private centers, Human Rights Watch found that people were held in isolation for varying periods ranging from two days up to one week.[98]

During a visit to the Hargeisa Group Hospital mental health ward, Human Rights Watch saw two isolation cells for women and three for men, although the rooms were empty at the time.[99] Staff at the center said that when residents "exhibit aggressive behavior" they keep them there for two to three days and administer sedatives without informed consent.[100]

Similarly, the manager of Horizon center said: "There is a separate room for those who are aggressive, we lock them in there. It's for the security of others, they can be harmed. There is someone in there now. We keep them there for 2 to 3 days."[101] Yet, Qasim, a 35-year-old man who had been in Horizon for four months after his mother and uncle committed him when he was unable to sleep at night and couldn't maintain his job as a mechanic, said he

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[95] Human Rights Watch interview with manager of Sahan private center, January 22, 2015; interview with manager of Horizon private center, Hargeisa, October 9, 2014.

[96] Human Rights Watch interview with Idil, elderly mother of former resident of Daryeel, May 22, 2015.

[97]Human Rights Watch interview with Zainaba, mother of former resident of Daryeel, May 22, 2015.

[98] Human Rights Watch interview with Yassin, former resident of Raywan, May 21, 2015; interview with Mowlid, 33 years-old former resident of Horizon, May 20, 2015.

[99] Human Rights Watch visit to Hargeisa Group Hospital mental health ward, Hargeisa, January 26, 2015.

[100] Ibid.

[101] Human Rights Watch interview with manager of Horizon private center, Hargeisa, October 9, 2015.

spent a week in isolation: "I was there for two Fridays in a row. I was chained to the window. I even hurt myself with the chains as I was walking around."[102] He told Human Rights Watch that he had damaged property at the facility, insulted staff and tried to escape on several occasions as reasons for his isolation.

In some centers, residents are locked up in their rooms for 24 hours a day for extended periods of time, although not in isolation. The manager of a private center, Sahan, told Human Rights Watch: "We do not chain usually, but it's difficult to control. We keep the aggressive patients in their rooms."[103] A nurse that had worked at Sahan confirmed this practice: "Some patients are not allowed outside their rooms, they stay locked inside all day."[104]

Physical and Verbal Abuse

Rather than a rehabilitative or restorative setting, residents of the private centers in particular live in a punitive environment. Guards occasionally beat residents for trying to escape as well as for infringing rules and resisting orders.[105]

Four interviewees told Human Rights Watch that they were slapped or hit with a stick by guards and many others described seeing guards beating residents to force those reluctant back inside their rooms, to get residents to take their medicine or to eat, but also when residents exhibited aggressive behavior or tried to escape.[106]

One man who spent 10 months at Horizon said: "Two weeks ago, I escaped but they caught me outside and brought me back and they beat me with a stick. They beat me for two to three days."[107]

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[102] Human Rights Watch interview with Qasim, 35-years-old resident of Horizon, Hargeisa, May 20, 2015.

[103] Human Rights Watch interview with manager of Sahan private center, Hargeisa, January 22, 2015.

[104] Human Rights Watch interview with Khalid, former nurse from Sahan, May 20, 2015 ; interview with Bulle, former nurse from Sahan, May 20, 2015.

[105] Human Rights Watch interview with psychiatric doctor, Hargeisa, January 27, 2015 ; interview with Burhan, 54-year-old former resident of Raywan private center, May 21, 2015; interview with Tawane, 29 years-old former resident of Sahan private center, May 16, 2015.

[106] Human Rights Watch interview withMansur, 39 year-old- resident of Horizon private center, May 20, 2015; interview with Ali, 31-year-old former resident of Sahan private center, Hargeisa, January, 25, 2015; interview with Burhan, 54-year-old former resident of Raywan private center, May 21, 2015; interview with Yassin, former resident of Raywan, May 21, 2015; interview with Nur Ahmed Hassan, brother of former resident of Raywan private center, May 21, 2015; interview with Qasim, 35-years-old resident of Horizon, Hargeisa, May 20, 2015.

[107] Human Rights Watch interview with Mansur, 39 year-old- resident of Horizon private center, May 20, 2015.

One resident, diagnosed with acute psychosis, who had been chained throughout his five months at Raywan, told Human Rights Watch:

> One security guard hit me. I lost my tooth [has a front tooth missing]. I told the management and they said that my family would discuss it with the family of the guard, that is was not their problem.
>
> I was beaten again, one month ago. [108]

While mistreatment is harder to conceal at the Hargeisa Group Hospital mental health ward, given that relatives are allowed to visit more frequently than at private centers where visiting days are generally limited, an outpatient at Hargeisa Group Hospital mental health ward raised concerns about staff mistreatment of patients: "I've seen it myself, I've seen the staff fight with the patients. I've seen them beating the patients.[109]

Religious Healing Centers, "Cilaaj"

Human Rights Watch visited one inpatient facility, Darul Shifo, run by a religious healer who was treating approximately 70 residents. The visit points to several issues of concern which require further investigation.

The conditions in the facilities were poor. Women residents were locked-up in an underground hall, with very limited daylight and air. Male patients appeared unclean and described poor hygienic conditions in the male section.[110] As in private centers, movement of residents was severely limited, residents interviewed had been held for prolonged periods of time and apart from the ritual healing sessions, there are no activities for residents.[111] Patients are chained in both the female and male wards.[112]

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[108] Human Rights Watch interview with Barre , 29-years-old resident of Daryeel private center, Hargeisa May 17, 2015.

[109] Interview with Batuulo, female outpatient in her twenties from Hargeisa Group Hospital January 21, 2015.

[110] Human Rights Watch interview with Kulmiye, 50-year-old resident of Darul Shifo religious healing center, Hargeisa, May 16, 2015; Human Rights Watch was not allowed to visit the male sections of the center.

[111] Human Rights Watch interview with Zeitun, 36-year-old female resident of Darul Shifo; religious healing center, Hargeisa, May 16, 2015; interview with Ramla, 35-year-old female resident of Darul Shifo religious healing center May 16, 2015.

[112] Human Rights Watch interview with Ashkiro, female resident of Darul Shifo religious healing center, Hargeisa, May 16, 2015.

Residents described how some of the rituals carried out in the center including the burning of herbs resulted in injuries.[113] Two of the female residents told Human Rights Watch that they were beaten with hose pipes during Koranic reading ceremonies; as one resident explained: "Yesterday the sheikh hit me with a hose pipe. They say I have a jinn [spirit]. As I fainted while they were reading the Koran to me, they hit me on my back to wake me up."[114] Another patient had significant bruising all down her left leg where the staff had hit her during a Koranic reading session.[115]

Due Process Violations

The Somaliland Constitution protects against arbitrary detention,[116] and prohibits detention in facilities which are not designated as detention centers by law (non-gazetted). The private centers have no legal mandate to receive or detain individuals. Government and judicial oversight of mental health institutions is currently severely limited.

Involuntary Admission and Arbitrary Detention

Involuntary Detention and Human Rights Law

Human rights law guarantees to persons with disabilities, on an equal basis with others, the right to liberty. In narrow circumstances, human rights law allows for deprivation of liberty, as long as it is lawful and not arbitrary and subject to prompt and regular judicial review. Such deprivation should not be discriminatory and should never be justified on the basis of the existence of a disability.[117]

According to the CRPD Committee, the involuntary detention of people with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the

[113] Human Rights Watch interview with Zeitun, 36-year-old female resident of Darul Shifo religious healing center, Hargeisa, May 16, 2015.

[114] Human Rights Watch interview with Ashkiro, female resident of Darul Shifo religious healing center, Hargeisa, May 16, 2015.

[115] Human Rights Watch interview with Xadiyo, 30-year-old resident of Darul Shifo religious healing center, Hargeisa, May 16, 2015.

[116] Constitution of the Republic of Somaliland, artcs 25 (1) & (2), 27 (4), http://www.somalilandlaw.com/somaliland_constitution.htm (accessed August 20, 2015).

[117] Office of High Commissioner for Human Rights, Information Note No.4: Persons with Disabilities, "Dignity and Justice for Detainees Week," p. 1, http://www.ohchr.org/EN/UDHR/Documents/60UDHR/detention_infonote_4.pdf (accessed August 20, 2015).

right to liberty.[118] International law also underlines the legal capacity of individuals with psychosocial disabilities, guaranteeing their right to challenge the lawfulness of their detention and the right for a review of their detention [119]

The UN special rapporteur on torture has noted that the "severity of the mental illness is not by itself sufficient to justify detention."[120]

The UN special rapporteur on torture has stated involuntary admission on the basis of a disability which inflicts pain and suffering may constitute torture and ill-treatment, and states that assessments should take into account "factors such as fear and anxiety produced by the indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community…"[121]

Involuntary admission and arbitrary detention is the norm in Somaliland. A majority of the people with psychosocial disabilities interviewed by Human Rights Watch were committed without their consent or any judicial oversight. The district court has been granting admissions to three of the private centers without the individual being present, any psychiatric assessments, based solely on witness testimonies and seemingly irrelevant medical tests.[122] Occasionally, the authorities also institutionalize people that they find on the streets.[123]

In the private centers, residents' relatives sign a notarized agreement with the facility in order to admit the individual. The relatives have to claim responsibility for them and any damage or harm they may commit while confined. The resident's consent is entirely

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[118] OHCHR, "Statement on Article 14 of the Convention on the Rights of Persons with Disabilities," September 2014, http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E#sthash.ECHAfoA5.dpuf (accessed August 20, 2015).

[119] Office of High Commissioner for Human Rights, Information Note No.4: Persons with Disabilities, "Dignity and Justice for Detainees Week," p. 3. CRPD, Article 12.

[120] A/HRC/22/53, para. 68.

[121] Ibid, para. 69.

[122] Human Rights Watch interview with lawyer from Human Rights Center Hana Mohammed, Hargeisa, October 11, 2015; interview with Abdi, 35-years-old former resident of Macruuf private center, May 18, 2015.

[123] Human Rights Watch interview with manager of Sahan private center, Hargeisa, January 22, 2015;; visit of the Berbera General Hospital mental health ward, Berbera, January 24, 2015.

overlooked, as the manager of one private center said: "Patients don't have a say in whether they are admitted or not. Relatives approach us and decide."[124]

Abdi, who had been admitted to a private center, Macruuf, for almost two years explained: "My family forced me. They took me there against my will. I was not taken to court."[125]

Some relatives forcefully bring residents to the private centers.[126] Thirty-nine year old Mansur, who was diagnosed with psychosis and had already been detained for 10 months in Horizon when Human Rights Watch met with him, said "My father ordered my brother to bring me here. They told me I'm mad but I do not want to be here and I do not like to be here."[127]

Human Rights Watch only spoke to one individual who said the police forcibly admitted him. Aden, a 26-year-old man who had been chewing a lot of khat was brought to Daryeel from his home: "I was brought here by two policemen and one guard of the center. They took me by force. My mother paid the center and then they explained what to do."[128]

Many of the individuals involuntarily admitted were perceived by their families to be a danger to themselves,[129] their families[130] and communities,[131] or to property. Sometimes all these factors combined. Several families said they could no longer afford to compensate community members for the damage done by the individual. The mother of a 19-year-old who was admitted to a private center in 2012 said: "I was very scared as he was hanging out with gangs. He had started stealing mobile phones – he stole three – I had to refund the price, one was 300 USD. And instead of having to deal with that, I preferred to take him to

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[124] Human Rights Watch interview with manager of Horizon private center, Hargeisa, October 9, 2015.

[125] Human Rights Watch interview with Abdi, 35-years-old former resident of Macruuf private center, May 18, 2015.

[126] Human Rights Watch interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015; interview with Iftin, niece of female outpatient at Hargeisa Group Hospital mental health ward Hargeisa, January 24, 2015; interview with two nieces of patient of Raywan, Hargeisa, January 23, 2015.

[127] interview with Mansur, 39 year-old- resident of Horizon private center, May 20, 2015.

[128] interview with Aden, 26-year-old resident of Raywan, Hargeisa, May 17, 2015.

[129] Human Rights Watch interview with Idil, elderly mother of former resident of Daryeel, May 22, 2015 ; interview with Roble, 45-year-old relative of three former residents of the Sahan private center, Hargeisa, January 25, 2015.

[130] Human Rights Watch interview with Lul, mother of former resident of Sahan private center, January 25, 2015 ; interview with Idil, elderly mother of former resident of Daryeel, May 22, 2015.

[131] Human Rights Watch interview with Bilan, 24-years-old sister of former resident of Sahan private center, May 17, 2015 ; interview with 35-year-old male outpatient of Hargeisa Group Hospital mental health ward Hassan, and his brother Burale, January 21, 2015.

Sahan."[132] Female heads of household often raised the lack of male presence in the house who may have been able to deal with the individual's condition as the reason why they had to have a relative involuntarily admitted.[133] The absence of community support mechanisms for families who are struggling with challenges that arise because of a relative with a psychosocial disability leaves relatives little scope but to turn to institutions for help.

Many also had or were perceived as having a negative reaction to consuming khat and so relatives admitted them to stop them from chewing khat.[134]

Human Rights Watch identified only one privately-run center – Daryeel – where individuals are seen before admission by a medical doctor with significant training in psychiatry. Yet, once again the family's decision is paramount, also given the profit-driven motivations of the private centers, as the doctor complained: "The family brings the patient to the facility. I decide if the patient is suitable or not, but my decision is also affected by the parent's wish. Even if some are not clinically right for admission, some parents get their way."[135]

Family members interviewed readily acknowledged that they had sought admission without the consent of the individual, as the brother of Kulmiye, a 40-year-old man with a psychosocial disability said: "I went to the Horizon office, they asked me who was responsible for him. We signed an agreement and then two men from Horizon came with me to get my brother. We took my brother by force with the two men."[136]

Arbitrary Institutionalization without Recourse

Arbitrary institutionalization, without the person's free and informed consent, proper medical evaluation by a skilled practitioner, judicial review, or right to appeal their confinement, was widespread among the people with whom Human Rights Watch spoke.

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[132] Human Rights Watch interview with Quman, mother of outpatient of Hargeisa Group Hospital mental health ward, Hargeisa, January 21, 2015.

[133] Human Rights Watch interview with Lul, mother of former resident of Sahan private center, January 25, 2015 ; interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015.

[134] Human Rights Watch interviews with two nieces of patient of Raywan, Hargeisa, January 23, 2015.

[135] Human Rights Watch interview with former head of Non-Commnicable Diseases unit at Ministry of Health, May 13, 2015.

[136] Human Rights Watch interview with Bile, brother of former patient from Horizon private center, May 18, 2015.

The Hargeisa district court has been sanctioning admissions to at least three private residential centers.[137] According to court documents seen by Human Rights Watch, the court has been endorsing the admission on the basis of two witness testimonies, generally clan relatives asked to vouch for the veracity of the perceived disability, without the individual being present and able to give their consent, without any psychiatric assessment, seemingly irrelevant medical tests and without specifying the timeframe of the confinement.[138]

Human Rights Watch only heard of one case in which the individual himself was brought before the court and in this instance, the patient was not asked a single question by the judge.[139] In May 2015, the new head of the district court, Judge Yusuf Dalad, told Human Rights Watch that he had made an official request to the regional appeal's court, head of the supreme court and justice committee to stop receiving cases of admission due to perceived psychosocial disabilities until clear guidelines and policies were developed to prevent the abuse of the rights of those being committed.[140] Between May and September admissions by the court stopped. This judge was dismissed in September 2015; Human Rights Watch was not able to clarify whether the involvement of the court in admissions has been reassessed.[141]

Residents interviewed by Human Rights Watch had been held against their will for between one month and five years.[142] Many interviewees told Human Rights Watch that they wanted to leave the hospital or private center but their families refused to take them home. A significant proportion had been repeatedly admitted to public and private centers as their conditions were not improving or the reasons their families initial committed them, returned.

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[137] Human Rights Watch interview with manager of Sahan private center, Hargeisa, January 22, 2015;interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015; ; interview with manager of Habwanaag private center, Hargeisa, January 23, 2015 interview with Yusuf Dalal Abdi, head of district court, Hargeisa, January 20, 2015.

[138] Human Rights Watch interview with lawyer from the Human Rights Center, Guleid Ahmed Jama, Hargeisa, January 23, 2015.

[139] Human Rights Watch interview with financial officer at Sahan, Hargeisa, January 25, 2015; interview with Roble, 45-year-old relative of three former residents of the Sahan private center, Hargeisa, January 25, 2015.

[140] Human Rights Watch interview with Yusuf Dalal Abdi, head of district court, Hargeisa, January 20, 2015.

[141] Human Rights Watch telephone interview with Yusuf Dalal Abdi, September 8, 2015.

[142] Human Rights Watch interview with Qalanjo, 38 -year-old former resident of Sahan, January 21, 2015; interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015; interview with Halane, 50-year-old resident of Daryeel private center, May 20, 2015.

Families often have the last word on when a resident is discharged and residents' views are not taken into consideration.[143] Bilan, whose brother was held for a year in Sahan, said: "He was sometimes complaining about Sahan, but we didn't listen to him as we thought it was the best place for him to be."[144] Families occasionally refuse to come to pick-up their relatives even after the medical staff have requested for the residents to be discharged.[145]

Other families abandon their relatives inside the institutions.[146] The manager of Horizon told Human Rights Watch:

> Families are not taking responsibility and are refusing to take our calls, some say the patient has to stay here. We tell our doctors to write to the relatives to tell them the patient is ready to be discharged. But often they put the patient here with their own hands, so we cannot discharge without the family.[147]

A doctor expressed his frustration with the current status quo: "We have called for the discharge of many patients at Sahan, but then many are not discharged. We are told that the family wants them to stay, but the system should not listen to the families."

Overcrowding and limited numbers of trained doctors also appear to contribute to long delays in discharge and prolonged arbitrary detention as doctors meet residents very rarely. In addition, facilities lack clear protocols and criteria for discharge.

Prolonged arbitrary detention is particularly a problem in the private centers, given the financial incentives to the owners,[148] as one resident held for 20 months said: "The period of admission should be shorter. The government should follow-up on periods of detention,

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[143] Human Rights Watch interview with Jibril, 50-year-old resident of Raywan private center, May, 17, 2015; interview with Hared, 44-year-old resident of Raywan private center, May, 17, 2015; interview with manager of Habwanaag private center, Hargeisa, January 23, 2015.

[144] Human Rights Watch interview with Bilan, sister of former resident of Sahan private center, May 17, 2015.

[145] Human Rights Watch interview with Khalid, former nurse from Sahan, May 20, 2015 ; Human Rights Watch interview with psychiatric doctor Hargeisa, January 21, 2015; Human Rights Watch interview with psychiatric doctor Hargeisa, May 15, 2015; interview with manager of Horizon private center, Hargeisa, October 9, 2015; interview with Mohammed, manager of Daryeel private center , May 20, 2015.

[146] Human Rights Watch interview with Asha Aden Guled, director of Berbera hospital, Berbera, January 24, 2015.

[147] Human Rights Watch interview with manager of Habwanaag private center, Hargeisa, January 23, 2015.

[148] Human Rights Watch interview with nurse at the Hargeisa Group Hospital mental health ward and consultant at Macruuf, Hargeisa, May 15, 2015.

because our relatives are paying these centers. They don't care about how long people have been in the place."[149] A resident, who told Human Rights Watch he had been diagnosed as bipolar and had already spent 10 months at Daryeel when he spoke to Human Rights Watch, complained: "My family wants me to stay here but I want my freedom back. The time here is too long."[150]

This lack of avenues to return home has a detrimental impact on individuals' state of mind and leaves them feeling powerless to control their situation. Samatar, who spent two months chained in Daryeel in early 2015 said: "I was counting the days to go home. And all the time I was there, I was just in fear."[151]

A nurse at one of the private centers highlighted the impact of the prolonged arbitrary detention on residents' state of mind: "One patient I saw had been there for seven years. Of course someone like that would try to escape, any wall, given half a chance."[152]

Involuntary Treatment

Informed consent is a bedrock principle of medical ethics and international human rights law, and forcing individuals to take medication without their knowledge or consent violates their rights.[153] The former special rapporteur on torture, Manfred Nowak, said "protocols for informed consent need to be developed to ensure that accurate and unbiased information is provided to individuals who are considering treatment with psychiatric drugs, including information about less intrusive alternatives."[154]

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[149] Human Rights Watch interview with Abdi, 35-years-old former resident of Macruuf private center, Hargeisa May 18, 2015.

[150] Human Rights Watch interview with Gamadid, 45-year-old resident of Daryeel private center, May 21, 2015.

[151] Human Rights Watch interview with Samatar, 27-years-old former resident of Daryeel private center, Hargeisa, May 22, 2015.

[152] Human Rights Watch interview with Khalid, former nurse from Sahan, May 20, 2015.

[153] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, arts. 7 17 (1).International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI),21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 12; Beijing Declaration and Platform for Action, Fourth World Conference on Women, September 15, 1995, A/CONF.177/20 (1995), art.108(e); United Nations Educational, Scientific, and Cultural Organization (UNESCO), Universal Declaration on Bioethics and Human Rights, adopted October 2005, SHS/EST/05/CONF.204/3 REV, arts. 6 and 9.

[154] Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (SR Torture Interim Report), 28 July 2008, UN Doc A/63/175.

The majority of patients in both the private and public centers interviewed by Human Rights Watch were on psychotropic medication.[155] Doctors regularly prescribe psychotropic medication without any explanation and without offering any alternatives. Only one out of 30 residents interviewed for this research knew his diagnosis.[156]Only four knew what psychotropic medication they had been prescribed.[157]

Some doctors prescribe the medication based on very quick and minimal assessments. An NGO staff that has been working in the field of mental health for over a decade commented that diagnosis and intake assessments appear to have improved somewhat at the Hargeisa Group Hospital mental health ward since the arrival in 2014 of two newly trained psychiatric doctors.[158]

Misdiagnosis and over-sedation appear to be a significant problem. Human Rights Watch researchers interviewed several residents that appeared heavily sedated.[159]The younger brother of a 52-year-old war veteran who is deaf and whose family repeatedly committed him to stop him from chewing khat complained about the systematic administration of drugs at Raywan:

> At Raywan, Dr Mustafa gave my brother some drugs but then his skin became so dry. He also gave him sedatives to make him sleep, but I told him to stop. They misunderstood his diagnosis. I told them that there was nothing wrong with him, that I just took him there to take some rest. They just give the same medication to everyone.[160]

A handful of residents were forced to take the medication against their will.[161]

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[155] Human Rights Watch assessment of patients' files and prescriptions highlighted that doctors often prescribe several psychotropic medications at the same time, which is generally not recommended.

[156] Human Rights Watch interview with Gamadid, 45-year-old resident of Daryeel private center, May 21, 2015.

[157] Human Rights Watch interview with 28-year-old resident of Sahan private center, January 26, 2015; interview with Hared, 44-year-old resident of Raywan, June 17, 2015; interview with 50-year-old resident of Daryeel private center, May 20, 2015.

[158] Human Rights Watch interview with Abdirisak Mohammed Warsame, GRT mental health project manager, Hargeisa, January 26,2015.

[159] Human Rights Watch interview with Tariq, 35-year-old resident of Horizon private center, May 20, 2015; interview with 28-year-old resident of Sahan private center, January 26; 2015.

[160] Human Rights Watch interview with brother of former resident of Raywan private center, Hargeisa, January 21, 2015;

[161] Human Rights Watch interview with Ali, 31-year-old former resident of Sahan private center, Hargeisa, January, 25, 2015

Nineteen-year-old Cabdi, who was an outpatient at the Hargeisa Group Hospital mental health ward when Human Rights Watch interviewed him, described being forced to take medication that gave him side effects when he spent four months at Sahan in 2012: "They [the staff] would force us to take medication. I did not often refuse, but when the tablets were giving me problems [side-effects], I was refusing to take them, and they would hit me."[162]

The notion that residents should be consulted appeared anathema to some of the medical staff. A nurse at one private center said regarding residents who refuse to take their medication: "The patient is sick so they don't know what they are talking about. People need to be here until they are better. Two days ago a patient with schizophrenia refused to take his medication and so we give him an injection. I have only seen this twice."[163]

Conditions of Confinement and Treatment

A lack of alternatives including the absence of community support mechanisms combined with families' lack of understanding of what constitutes adequate and quality medical treatment and care contributes to increasing institutionalization and reliance on private centers. Many relatives mentioned the fact that the residents were eating and looked clean as the sign of good medical treatment, but as one psychiatric doctor ironically pointed out: "When the relatives see people getting fatter again, they think that they are healthy but they are just 'places to get fat'" – referring to the lack of exercise and the food given to residents at all the centers.[164]

Overcrowding, Poor Hygiene

Conditions of hygiene and physical maintenance varied across the different facilities.[165] In both public mental health wards, Human Rights Watch researchers witnessed several toilets that were completely blocked and others surrounded by feces, a significant health hazard to patients. Staff at both wards raised concerns about water shortages and sewage

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[162] Human Rights Watch interview with Cabdi 19-year-old male outpatient at Hargeisa Group Hospital mental health ward, January 21, 2015; when Human Rights Watch visited Cabdi at his home on a subsequent visit, he showed visible signs of side-effects, very drowsy, with significant stiffness in his right arm.

[163] Idris, January 20, 2015

[164] Human Rights Watch interview with psychiatric doctor, Hargeisa, January 27, 2015.

[165] Human Rights Watch found that the conditions and hygiene of the facilities visited at Habwanaag private center and the new Macruuf private center facilities were good. Human Rights Watch was not able to visit the whole of Sahan but found the conditions in the entrance and courtyard areas good.

problems.[166] Hygiene in a section of the male ward of the Berbera General Hospital mental health ward was poor.[167] In addition to unhygienic latrines, the sewage system was not functioning, and a handful of patients were urinating and defecating in and around their rooms, or on the floor near where they were chained.

During visits to at least three of the privately-run centers in the afternoon or very early mornings, Human Rights Watch researchers found the hygiene conditions worse, with pungent smell of urine, as most of the cleaning occurs in the mornings.

Five of the facilities that Human Rights Watch visited were in a decrepit state of maintenance. At both public hospitals, Human Rights Watch saw detritus – including rusty pieces of metal – laying around the ward compounds' and inside some of the rooms. In at least two of the private centers, the houses in which residents were confined were in disrepair, including with parts of the roofing of the rooms caving in and bars on windows broken and sticking out into the room.[168]

Four of the private centers are housed in normal houses resulting in overcrowding in the rooms and very limited space to move around in compound.

In two of the private centers, Sahan and Macruuf, up to 30 residents were being held in some of the rooms.[169] Residents complained about the lack of space inside their rooms.[170] Ali, a 31-year-old man taken to Sahan who spent 10 months there was badly affected by the overcrowding: "It was difficult to sleep in Sahan: so noisy, with people talking. The rooms were very small and crowded."[171]

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[166] Human Rights Watch visit of Hargeisa Group Hospital mental ward, January 26, 2015.

[167] Human Rights Watch visit of the Berbera General Hospital mental health ward, Berbera, January 24, 2015.

[168] Human Rights Watch visit to Horizon, October 9, 2014; visit to Raywan, May 21, 2015. On a subsequent visit to Horizon private center in July 2015, Human Rights Watch noticed repairs to the facilities and a reduction in the number of patients.

[169] Human Rights Watch interview with Qalanjo, 38 -year-old former resident of Sahan, Hargeisa, January 21, 2015; Human Rights Watch was not given access inside the rooms at Sahan but interviewed three former residents that described certain rooms with up to 30 residents.

[170] Human Rights Watch with Hussein, 28-years-old man, Hargeisa, May 20, 2015; interview with Yassin, former resident of Raywan, May 21, 2015; interview with Mowlid, 33 years-old former resident of Horizon, May 20, 2015.

[171] Human Rights Watch interview with Ali, 31-year-old former resident of Sahan private center, Hargeisa, January, 25, 2015.

Residents' personal hygiene also suffers due to congested living quarters, the water shortages, and small staff numbers. Most residents are only allowed to bathe twice sometimes three times a week.

With the exception of Hargeisa Group Hospital mental health ward, and certain sections of the Berbera General Hospital mental health ward, none of the facilities allow residents to have beds; time and again, residents complained about the lack of beddings and fact they were forced to spend their days and nights on straw mats on the ground.

Restrictions on Freedom of Movement

> When I was in Sahan, my dream was to go outside. Having limited freedom made me feel worse.
>
> – Ali, Hargeisa, former resident of Sahan private center, January, 25, 2015[172]

Management and staff significantly restrict residents' freedoms and mobility to such an extent that it is like they are in a prison. In all of the private facilities visited by Human Rights Watch staff prohibit residents from leaving the premises and restrict their movement around the institution's compound.

Staff in the private centers impose restrictions on residents both through restraints, as described above, but also through strict schedules which regulate when residents are allowed out of their rooms, just as in most prison systems. All the private centers allow residents out into the courtyard for a couple of hours in the morning, then again before the evening prayer. This varied from three to nine hours a day.[173] The rest of the time, residents are kept inside of their rooms, often locked in.[174]

In at least two private centers, residents are kept in their rooms in darkness. A man who had been repeatedly admitted to Daryeel described the daily routine:

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[172] Human Rights Watch interview with Ali, 31-year-old man, Hargeisa, January 25, 2015.

[173] Human Rights Watch interview with Barre , 29-years-old resident of Daryeel private center, Hargeisa May 17, 2015.

[174] Human Rights Watch interview with Mowlid, 33 years-old former resident of Horizon, May 20, 2015; interview with Qalanjo, 38 -year-old former resident of Sahan, January 21, 2015; interview with Qasim, 35-years-old resident of Horizon, Hargeisa, May 20, 2015.

> We would sit in the room all day long. In the morning we would go out for two hours, from 7-9am, and we would just sit on chairs. Then again from 15h30-17h.
>
> The rest of the time we were inside the room. The door to the room is locked and you had to ask the guards to open it. They don't open the door or the windows, and so it's just a dark room. No lights in the room. We just had small torches.[175]

Abdi who spent 20 months in Macruuf said: "We slept all day long. We were allowed outside for a short time but most of the time we were in our rooms. One of the rules is that the door of the room has to be shut and the windows as well." When asked why the windows were open during Human Rights Watch's visit he answered: "because that was visiting day [when relatives visit], it was Thursday."[176]

While two of the private centers had toilets within the rooms, residents in others had to ask for permission to the guards to go to the toilets. Samatar said: "We were locked in our room, if you wanted to go to the toilet, you called the guards, and they would come. If they don't hear you, you go to the toilet in the room, there is a bucket. The smell was bad."[177]

Lack of Adequately Trained Staff

Understaffing and lack of adequately trained staff was a problem in all of the private and public institutions visited by Human Rights Watch. The private centers in particular rely heavily on attendants and support staff for the everyday care of residents who are insufficiently trained, if at all.

There is little or no information on actual qualification and capacity of staff in the public and private health care sectors given the current lack of government accreditation of health care professionals, as described above.[178] Interviewees told Human Rights Watch that there are

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[175] Human Rights Watch interview with Mowlid, 33 years-old former resident of Horizon, May 20, 2015.

[176] Human Rights Watch interview with Abdi, 35-years-old former resident of Macruuf private center, Hargeisa May 18, 2015.

[177] Human Rights Watch interview with Samatar, 27-years-old former resident of Daryeel private center, Hargeisa, May 22, 2015.

[178] Human Rights Watch interview with Dr Lula, head of the National Health Professions' Commission, Hargeisa, May 21, 2015; Joanna Buckley et al, " Assessment of the Private Health Sector in Somaliland, Puntland, and South Central," p. 26.

currently no trained psychiatric nurses in Somaliland,[179] and only two psychiatric doctors for an estimated population of 3.5 million.[180] Several of those currently working in public and private centers, including those taking on medical responsibilities, have been working in this field to fill a vacuum and yet have only received basic, sporadic training.[181]

There are currently only four doctors, two psychiatric doctors who recently graduated, and two others that have received basic psychiatric training that are working in all the public and private centers visited by Human Rights Watch.[182] In the two public wards and three of the private centers, doctors visit several days a week for a couple of hours. In three of the private centers one of these doctors and a nurse visit sporadically. During these visits the doctors are expected to see inpatients and outpatients (in the public centers) and admit new patients.[183] There are no counsellors or therapists in any of the public and private centers.

While the UN World Health Organization (WHO) and an Italian NGO, Gruppo per le Relazioni Transculturali (GRT), have provided trainings for medical staff and social workers, these trainings have been irregular and depend largely on access to donor funding.[184] In 2012, WHO provided a training on Mental Health Gap Action Programme – a program aimed at scaling-up basic mental health care services in low and middle-income countries – for five medical staff from Somaliland; no follow-up trainings have taken place.[185]

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[179] Human Rights Watch phone interview with Mariam Dahir, THET programme officer, July 7, 2015. These rates are much lower than the global median. The WHO 2014 World Mental Health Atlas finds that "the global median is 9 per 100,000 population, or less than one mental health worker for every 10,000 people." WHO, "World Mental Health Atlas 2014," p. 34.

[180] In May 2015, a Somalia wide population census was released based on work by UNFPA, which led to significant outcry in Somaliland. The Census was based on pre-conflict regions of the country, thereby lumping the five regions of Somaliland with the rest of Somalia. See: "Somaliland Country included in an UNFPA/UNHCR Sponsored Somalia Population Census," *Somaliland Sun*, May 26, 2015, http://somalilandsun.com/index.php/development-aid/7456-somaliland-country-included-in-an-unfpa-unhcr-sponsored-somalia-population-census (accessed September 8, 2015).

[181] Human Rights Watch interview with Abdirisak Mohammed Warsame, GRT mental health project manager, Hargeisa, January 26,2015; interview with nurse at the Hargeisa Group Hospital mental health ward and consultant at Macruuf, Hargeisa, May 15, 2015.

[182] Dr Abdirisak Baraco, who works at Daryeel private center, and Dr Mustafa Hussein Hersi who works at the Hargeisa Group Hospital mental health ward, Raywan and Sahan private centers, received training by WHO as trainers in the Mental Health Gap Action Programme (mhGAP).

[183] The Hargeisa Group Hospital has the highest number of trained medical staff.

[184] Human Rights Watch interview with Dr Humayun Rizwan, WHO primary health care doctor , Hargeisa, January 21, 2015; interview with former head of Non-Communicable Diseases unit at Ministry of Health, Hargeisa, May 13, 2015.

[185] Meeting with Asia Ahmed Osman, officer in charge of WHO Hargeisa office, with two of her colleagues, LB and GP, 13/05/2015 ; interview with former head of Non-Communicable Diseases unit at Ministry of Health, Hargeisa, May 13, 2015.

Facilities lack nursing staff. A nurse that had previously worked at Sahan which has at least 400 in-patients and only four nurses said "It was very difficult to monitor all the patients as the place is over-crowded. We were only four medical workers working there."[186] A psychiatric doctor raised concerns that given the lack of training, the staff was unable to identify residents that required follow-up.[187]

Mental health professionals and others engaged in this field said that the stigma around mental health deters new health professionals from entering this sphere.188 As the manager of a private residential center pointed out:

> Dealing with patients who are psychotic is new in our country, and our culture. Even those of us working on these issues, we face problems. They call me 'Mr Cilaaj' [the healer] and they make jokes about me. They don't want to talk to us. There are a lot of beliefs that someone who is psychotic never recovers.[189]

A nurse that has been working for three years at the Berbera General Hospital mental health ward said, laughing: "My community thinks I'm mad too. They are always asking why I'm working here."[190]

In most of the facilities, particularly the privately-run centers, medical staff were scarce and most of the staff working at the centers on a daily basis were untrained support staff such as cleaners, guards and cooks.[191] In the afternoons in particular, there is very limited medical staff at both public and private facilities. When Human Rights Watch visited centers in the afternoon, they often encountered just one or two support staff on call, a nurse and residents all locked in their rooms.[192]

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[186] Human Rights Watch interview with Khalid, former nurse from Sahan, May 20, 2015.

[187] Human Rights Watch interview with psychiatric doctor Hargeisa, January 27, 2015.

[188] Human Rights Watch interview with psychiatric doctor Hargeisa, January 21, 2015; interview with manager of Habiba, an outpatient private mental health center, Hargeisa, January 26, 2015.

[189] Human Rights Watch interview with manager of Habwanaag private center, Hargeisa, January 23, 2015.

[190] Human Rights Watch interview with nurse at Berbera General Hospital mental health ward, Berbera, January 24, 2015.

[191] Human Rights Watch interview with Massimiliano Reggi, GRT regional representative, Nairobi, October 13, 2015; Human Rights Watch meeting with Ahmed Omar Hersi, head of GAVO, October 8, 2014.

[192] Human Rights Watch visits to Berbera General Hospital mental health ward, Horizon private center and Daryeel private center.

Staff at both public and private facilities said dealing with aggressive residents is their biggest challenge. While some staff, particularly in the public wards, had received training aimed at helping them to calm residents who experience anxiety or exhibit aggressive behavior, such as techniques to speak to the individual calmly, most said the automatic response was to isolate the patient, chain them and inject them.[193]

The lack of trained staffing also undermines residents' chances of re-integration once they are discharged. A psychiatric doctor who has worked in a private center summarized the problems: "Patients have been inside for a long time. The centers are not catering for people to return to society, patients are not getting any counselling or psychotherapy. When they are discharged, they are not given any prescription and there are no outpatient services."[194] None of the institutions visited by Human Rights Watch provide counselling for residents or their caregivers.

As described above, medical staff generally do not give residents or their relatives the diagnosis nor explain the prescription, making ongoing support very difficult.[195] Former residents and their relatives told Human Rights Watch that the staff at centers would stop the prescription when the person was discharged, without explanation. Staff on occasion discharge residents without any explanation.[196]

The Hargeisa Group Hospital mental health ward is at present the only facility where Human Rights Watch found some efforts to support community living. Support by the Italian NGO, GRT, has enabled the ward to stop relying on chaining resident and encourage the discharge of patients who can be treated on an outpatient basis, which staff said has offered them better opportunities for follow-up.

Relatives noted that at the Hargeisa Group Hospital mental health ward, where they can visit more regularly compared to the private centers where visits are often confined to once

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[193] Human Rights Watch visit to Macruuf private center, Hargeisa, May 14, 2015 ; interview with manager of Habwanaag private center, Hargeisa, January 23, 2015.

[194] Human Rights Watch interview with psychiatric doctor Hargeisa, January 27, 2015.

[195] Human Rights Watch interview with Iftin, niece of female outpatient of Hargeisa Group Hospital mental health ward Hargeisa, January 24, 2015; interview with Halima, female outpatient at Hargeisa Group Hospital mental health ward and her daughter, January 21, 2015; interview with Mursal, 25-year-old male outpatient at Hargeisa Group Hospital mental health ward and his relatives , January 21, 2015.

[196] Human Rights Watch interview with Cabdi, 19-year-old male outpatient at Hargeisa Group Hospital mental health ward with his relatives, May 18, 2015.

a week, they have better access to medical staff.[197] Yet, a nurse who has worked for many years at the Hargeisa Group Hospital mental health ward admitted:

> I don't have enough knowledge to classify and explain the disease, but I am also not taking the time to learn. We get a lot of training, but it's all theoretical not practical. And I am the most trained so I am lucky.[198]

Lack of Stimulation and Education

One major problem in the public and private institutions visited was the lack of meaningful activities to stimulate both the residents' physical as well as intellectual and psychological wellbeing and to keep them occupied.

Human Rights Watch would routinely arrive at both the public and private centers to find residents either locked inside their rooms or sitting or wandering aimlessly around the institutions' compound.[199]

A patient with perceived mental disabilities who spent 20 months in Daryeel said:

> It was difficult to be inside all day long. I was counting the days until I got out. We didn't do any gardening, the garden was already in place when we arrived. There were some classes for those that don't know how to read and write.[200]

For Mowlid, who spent 15 months in Horizon before his mother took him out because she wanted to admit his brother and couldn't pay for both, the lack of activities was deadening and contributed to a sense of imprisonment. He told Human Rights Watch researchers who visited him at his home three months after his release: "My family thought that place would help me, but in fact, it was too hard, I was constantly thinking, thinking, thinking. I just felt like I was in a prison."[201]

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[197] Human Rights Watch interview with nurse at the Hargeisa Group Hospital mental health ward and consultant at Macruuf, Hargeisa, May 15, 2015.

[199] Human Rights Watch interview with a nurse at the Hargeisa Group Hospital mental health ward, Hargeisa, May 20, 2015.

[199]Human Rights Watch visit of Berbera General Hospital mental health ward Berbera, January 24, 2015.

[200] Human Rights Watch interview with Abdi, 35-years-old former resident of Macruuf private center, Hargeisa May 18, 2015.

[201] Human Rights Watch interview with Mowlid, 33 years-old former resident of Horizon, May 20, 2015.

Hajir who spent 3 months at Horizon said he was happy when given the chance to clean his room: "We don't do anything, on some days, every two days, we are given cleaning material and told to clean our room. We enjoy it, because at least it's an activity."[202]

At best, institutions provide basic Koranic and literacy classes, some vocational training activities, or provided televisions in the rooms.[203] The Hargeisa mental health ward offered the most activities to residents including literacy classes, English, sewing for women and electrical classes for men. Several residents who had been admitted to several centers commended the practice of allowing residents to play football at Sahan for an hour in the morning, the facility with the biggest compound.[204]

Yet, while Human Rights Watch researchers were shown facilities for literacy teaching and sewing, researchers only witnessed residents taking part in activities at the Hargeisa Group Hospital mental health, where researchers saw a very short literacy class taking place for male patients.[205]

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[202] Human Rights Watch interview with Hajir, 39-year-old male, May 20, 2015.

[203] Human Rights Watch interview with Hibaaq, sister of former resident of Sahan private center, January 25, 2015; Human Rights Watch visits to Macruuf and Habwanaag.

[204] Human Rights Watch interview with Hussein, 28-year-old resident pf Daryeel, May 20, 2015.

[205] Human Rights Watch multimedia visit to Hargeisa Group Hospital mental health ward, July 29, 2015.

III. National and International Legal and Policy Framework

> Here is like a prison, we are chained like prisoners. The Ministry of Health should have a policy to monitor and follow-up on these places, to identify those that are good, and those that are not.
> – Barre, 29-year-old resident of Raywan private center, May 17, 2015[206]

The Somaliland constitution provides protection for the rights of people with psychosocial disabilities, as do applicable international and regional standards. Somaliland has also identified mental health as one of its key areas and adopted policies that seek to improve the conditions of people with psychosocial disabilities in the community and in institutions. Yet to date the Somaliland authorities have done little to ensure these protections are implemented and oversight is guaranteed.

International Obligations

Somaliland lacks international recognition as a state and as such cannot be party to international human rights treaties and is not a member of the United Nations. However, in governing the population in areas over which it has effective control, the Somaliland government is bound by customary international human rights law.[207] This includes non-discrimination, the prohibitions on arbitrary detention and torture and the right to liberty and security.

Moreover, Somaliland's constitution provides that the government shall act in conformity with international law and respect the Universal Declaration on Human Rights and commits to observing treaties signed by Somalia prior to independence, which would include both

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[206] Human Rights Watch interview with Barre , 29-years-old resident of Daryeel private center, Hargeisa May 17, 2015.

[207] According to the Human Rights Committee, the expert body that monitors compliance with the International Covenant on Civil and Political Rights, "The rights enshrined in the Covenant belong to the people living in the territory of the State party. The Human Rights Committee has consistently taken the view, as evidenced by its long-standing practice, that once the people are accorded the protection of the rights under the Covenant, such protection devolves with territory and continues to belong to them, notwithstanding change in Government of the State party, including dismemberment in more than one State or State succession or any subsequent action of the State party designed to divest them of the rights guaranteed by the Covenant." Human Rights Committee, General Comment 26 (61), General Comments under art. 40, para. 4 of the International Covenant on Civil and Political Rights, Adopted by the Committee at its 1631st meeting, para. 4. See also Human Rights Committee, Concluding Observations on Kosovo (Serbia), CCPR/C/UNK/CO/1, August 14, 2006, para 4.

the International Covenant on Economic, Social and Cultural Rights (ICESCR), International Covenant on Civil and Political Rights (ICCPR), and the African Charter on Human and Peoples' Rights (ACHPR).[208]

Right to Non-Discrimination

The ICESCR, ICCPR and ACHPR expressly prohibit discrimination and require States Parties to take steps to eliminate discrimination in the enjoyment and exercise of rights guaranteed by the treaties.[209] The Committee on Economic, Social and Cultural Rights, the body charged with monitoring compliance with the ICESCR, has said that while the Covenant does not explicitly include disability as a protected ground against discrimination, the rights recognized in the Covenant apply to persons with disability, and persons with disabilities are protected from any form of discrimination on grounds of their disability in progressive realization of the rights laid out in the Covenant.[210]

Freedom from Torture or Cruel, Inhuman, or Degrading Treatment or Punishment and Right to Protection of Personal, Mental, and Physical Integrity

The prohibition against torture is firmly embedded in customary international law. The ICCPR, and the ACHPR prohibit subjecting any person to torture or cruel, inhuman, or degrading treatment or punishment, including non-consensual medical or scientific experimentation.[211]

The Convention against Torture defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as… intimidating or coercing him or a third person, or for any reason based on discrimination of any kind." Cruel, inhuman, or degrading treatment or punishment is defined as those acts that cause grievous harm but do not amount to torture.[212] In either

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[208] Constitution of the Republic of Somaliland, art. 10. (1)& (2). In 1990, Somalia ratified the International Covenant on Civil and Political Rights (ICCPR) , the Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and the International Covenant on Economic, Social and Cultural Rights (IESCR) and ratified the African Charter on Human and People's Rights (ACHPR) in 1985.

[209] ICESCR, art. 2 (1). ICCPR, art. 2(1). ACHPR, art. 18 (4) and 28.

[210] CESCR, Persons with Disabilities 12/09/1994, CESCR General Comment 5 (General Comments), 11th session 1994, para. 5, http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/4b0c449a9ab4ff72c12563ed0054f17d?Opendocument, (accessed October 12, 2015).

[211] ICCPR, art. 7; ACHPR, art.5.

[212] CAT, art. 1(1).

case, the pain, suffering, or harm must be instigated with the consent or acquiescence of a public official or other person acting in an official capacity.[213]

The prohibition against torture or cruel, inhuman, or degrading treatment "relates not only to public officials, such as law enforcement agents in the strictest sense, but may apply to doctors, health professionals and social workers, including those working in private hospitals, other institutions and detention centers."[214] Governments are required to "prevent, investigate, prosecute and punish such non-State officials or private actors."[215]

Right to Liberty and Security of the Person

The right to protection from arbitrary detention is contained in article 9 of the ICCPR and article 6 of the ACHPR. Article 9 of the ICCPR states, "No one shall be subjected to arbitrary arrest or detention" and "no one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law."[216] Article 9 also mandates that an individual have the opportunity to challenge his or her detention, such that "[a]nyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."[217]

According to the UN Human Rights Committee, these provisions apply not only to those accused of crimes, but also "to all persons deprived of their liberty by arrest or detention" including those detained because of, "for example, mental health difficulties, vagrancy, drug addiction, immigration control, etc."[218]

For individuals with psychosocial disabilities, in cases where the person is not an imminent danger to himself/herself or others, or is not detained because of pending

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[213] CAT, art. 1(1).

[214] See General Comment No. 2 (2008) of the Committee against Torture on the implementation of article 2 of the Convention (CAT/C/GC/2), para. 17. See also U.N. Commission on Human Rights, Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment, Session 7, A/HRC/7/3, para. 31.

[215] U.N. Commission on Human Rights, Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment, E/CN.4/1986/15, para. 119.

[216] ICCPR, art 9.

[217] ICCPR, art 9.

[218] UN Human Rights Committee, General Comment 8, art. 9, U.N. Doc HRI/GEN/1/Rev.1 at 8 (1994), para. 1.

criminal charges, this may result in arbitrary and prolonged detention, in contravention of the ACHPR.

The UN Special Rapporteur on Torture has stated that the institutionalization of individuals who do not meet even basic admission criteria may amount to ill-treatment or torture: [219]

> The effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight, raise particular questions under prohibition of torture and ill-treatment. Inappropriate or unnecessary non-consensual institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary.

Right to Health

The human right to the highest attainable standard of health is enshrined in numerous international and regional human rights instruments. The ICESCR obligates governments to take steps individually and through international cooperation to progressively realize this right.[220]

According to the Committee on Economic, Social and Cultural Rights (CESCR), governments should ensure that health services are available, accessible, acceptable, and of good quality.[221] Availability comprises the availability of functioning healthcare services, medical personnel, and drugs, as well as safe water and sanitation. Accessibility means that health facilities should be accessible for everyone, without discrimination, and located within safe physical reach and economically affordable for all; it also comprises the right to seek and receive information on health services. Acceptability means that all health facilities need to adhere to ethical standards, including the principle of confidentiality.[222]The Committee states that access to health facilities, goods and services

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[219] A/HRC/22/53, para. 70.

[220] ICESCR, art. 12.

[221] Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C 12/2000/4, (2000), para. 12, http://www.refworld.org/docid/4538838d0.html (accessed August 24, 2015).

[222] Ibid.

should be non-discriminatory, especially for "the most vulnerable or marginalized sections of the population"[223] including individuals with disabilities.[224]

The right to health includes the principle of treatment following informed consent. The CESCR has interpreted Article 12 to include "the right to be free from... non-consensual medical treatment and experimentation."[225] The UN Special Rapporteur on the Right to Health has stated that: "Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.[226]

Convention on the Rights of Persons with Disabilities (CRPD)

The UN Convention on the Rights of Persons with Disabilities (CRPD) came into force in 2008 and so it was not ratified by Somalia before Somaliland sought independence. While it is not binding on Somaliland, the CRPD codified the human rights enumerated in other major conventions regarding individuals with disabilities and provides authoritative guidance. The Somaliland government has endorsed policies that commit to implementing legislation in line with the CRPD.[227]

Non-discrimination is one of the cardinal principles upon which the CRPD is grounded.[228] The CRPD sets minimum guiding standards on how to realize equality and non-discrimination, including by recognizing that all persons are equal before and under the law and are entitled without discrimination to the equal protection and equal benefit of the law.[229]

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[223] CESCR, General Comment No. 14, para 12(b).

[224] Ibid, para. 18.

[225] General Comment No. 14, para. 34.

[226] UN General Assembly, Report by the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/64/272, August 10, 2009, para. 9, http://www.refworld.org/pdfid/4aa762e30.pdf (accessed August 24, 2015).

[227] Somaliland mental health policy, Edition 1, p. 18, on file with Human Rights Watch; Somalia Mental Health Strategy 2014-2020, on file with Human Rights Watch.

[228] CRPD, art. 3(b).

[229] Ibid., art. 5.

The CRPD provides that persons with disabilities should be recognized as persons before the law who enjoy legal capacity on an equal basis with others[230] and that support may be needed to exercise one's legal capacity.[231]

Article 14 of the CPRD, provides even greater protections against deprivations of liberty to persons with disabilities. Article 14 not only forbids arbitrary detention but also states that detention cannot be justified on the basis of the existence of a disability. There should therefore be some basis underlying the deprivation of liberty that does not discriminate based on disability.

Governments should ensure that health professionals "provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care."[232]

The Committee on the Rights of Persons with Disabilities, a group of independent experts which monitors implementation of the CRPD, considers that community living, as oppose to institutionalization is an internationally recognized right, and not just a favorable policy development,[233] and has called for institutional-based care for people with disabilities to be phased out and eliminated.[234]

Somaliland Laws and Policies

Somaliland's constitution contains several human rights guarantees that are found in international law, including right to liberty[235] and non-discrimination,[236] and provides that these guarantees be interpreted in a manner consistent with international human rights conventions.[237] It prohibits detention in places not designated for that purpose by

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[230] CRPD, art. 14.
[231] CRPD, art.12 (3).
[232] Ibid.
[233] CRPD/C/CHN/CO/1 and Corr.1, paras. 92-93.
[234] See CRPD/C/CHN/CO/1, para. 32.
[235] Constitution of the Republic of Somaliland, art. 25 (1) & (2).
[236] Constitution of the Republic of Somaliland, art. 8.
[237] Constitution of the Republic of Somaliland, arts. 8, 21-36.

law.[238] Under the Somaliland Constitution, the government is responsible for "the promotion and the extension of healthcare and private health centers."[239] It also underlines government responsibility for providing health care and education to people with psychosocial disabilities, although undermines their legal capacity by upholding legal guardianship[240] The outdated 1973 civil code also includes several provisions which remove legal capacity and impose legal guardianship.[241]

There is currently no mental health legislation and no legal basis for placement of people with psychosocial disabilities in institutions.

Policies and National Strategy Plans on Mental Health

A general disabilities policy was drafted in consultation with disability groups under the Ministry of Labour and Social Affairs. This policy was at time of writing still awaiting parliamentary approval.[242]

The Ministry of Health, along with the Italian NGO, GRT, developed a mental health policy, which was passed as an annex of the general health policy in March 2014, and a basic implementation plan for the policy. In addition, spearheaded by the World Health Organization (WHO), the Ministry of Health, along with counterpart ministries in Puntland and south-central Somalia, developed a mental health strategy for the three zones of Somalia.

The policy[243] and the strategy contain positive provisions. Both the policy and strategy prioritize the development of a community-based approach towards mental health.[244]

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[238] Constitution of the Republic of Somaliland, art. 27 (4).

[239] Constitution of the Republic of Somaliland, art. 17 (2).

[240] Constitution of the Republic of Somaliland, art.19 states: "The state shall be responsible for the health, care, development and education of the mother, the child, the disabled who have no one to care for them, and the mentally handicapped persons who are not able and have no one to care for them."

[241] Somali Civil Code (1973), art. 47, http://www.somalilandlaw.com/Civil_Code_Italian_1973.pdf (accessed July 23, 2015). According to legal expert, Ibrahim Hashi Jama, the civil procedure code spells out the circumstances in which an individual can be deprived of their right to exercise their legal capacity and requires the involvement of the attorney general, court and medical expertise after which a legal guardian can be appointed. Human Rights Watch email correspondence with Ibrahim Hashi Jama, July 20, 2015.

[242] Human Rights Watch email correspondence with Zahra Dahir, Handicap International field coordinator, July 6, 2015.

[243] Somaliland mental health policy, Edition 1, p. 18, on file with Human Rights Watch.

[244] The mental health policy focuses on the need to strengthen community-based services, notably by integrating mental health into primary health care, including through the establishment of a community mental health workforce.

They identify activities which will be important to ensuring greater engagement by the government in this sphere, mainstreaming mental health into primary healthcare programming, and putting in place mechanisms to better safeguard the rights of people with psychosocial disabilities in institutions and the community.[245]

Some of the policy's most noteworthy features are its effort to establish structures within the Ministry of Health, and other line ministries, to implement the policy and improve oversight over mental health services, plans to mainstream mental health into health structures and legislation aimed at improving the rights and treatment of people with psychosocial disabilities. The WHO-led strategy includes basic action plans with short, medium and long-term activities to implement between 2014-2020 with a focus on capacity building in the sphere of mental health and building community-services.[246]

Somaliland's mental health policy and strategy call for the passing of legislation in line with international standards, including the UN Convention of Rights for Persons with Disabilities. The policy however also calls for the establishment of protocols on involuntary detention treatment and discharge, and states that "involuntary admission" will require the authorization of two mental health practitioners. Any protocols on admissions or treatment need to ensure that they are based on principles of free and informed consent, the right to liberty and protection against arbitrary detention, and that any "involuntary admission" is limited to exceptional circumstances, for a temporary period, and always subject to prompt and regular review, with a right of the person detained to challenge the detention before a judicial body and that this detention should not be discriminatory and should never be justified on the basis of the existence of a disability.

To date the government has not implemented either the policy or strategy. The former Director General of the Ministry of Health said quite frankly: "The mental health policy is an aspirational document at this point."[247]

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[245] The policy also establishes tribunals and review committees at the local level to "independently monitor standards, review detention orders and hear appeals and complaints". Both the policy and strategy call for the drafting of mental health legislation in line with the CRPD.

[246] Somalia Mental Health Strategy 2014-2020, on file with Human Rights Watch.

[247] Human Rights Watch interview with then Director General of Ministry of Health, Osman Hussein Warsame , Hargeisa, October 8, 2014.

It is not clear if the policy or the strategy will be prioritized for implementation.[248] While each includes implementation plans, these do not clarify responsibility for implementation and do not have detailed timeframes and indicators which would facilitate implementation and oversight. While both make several references to community-based services, they do not explicitly call for a shift away from institutionalization. In addition, neither includes concrete activities aimed at improving support in the community – apart from improving access to localized healthcare and efforts to target widespread stigma around mental health. While the policy in particular calls for the establishment of redress mechanisms for abuses, neither explicitly call for the development of clear guidelines and protocols on issues of restraints that would contribute to improving conditions in existing facilities.

[248] In a July 28, 2015 meeting with the Director General of the Ministry of Health among other staff from the Ministry, Ministry staff told Human Rights Watch that the policy was the priority.

IV. Oversight and Monitoring Efforts

There are several government bodies mandated to oversee mental health services and work towards protecting the rights of persons with psychosocial disabilities. Yet government oversight, particularly of privately-run centers, is at present missing. In addition, judicial review over mental health detentions is at present also lacking.

The Ministry of Health

The Ministry of Health is the ministry in charge of mental health and has registered all of the private facilities visited by Human Rights Watch; yet, support for and oversight of the public and private mental health services by the ministry is almost inexistent. In addition, registration by the Ministry does not impose any legal standards.

There is currently no one staffing the mental health unit within the Ministry of Health- tasked under the mental health policy with overseeing the implementation of much of the policy.

The Ministry of Health has registered all of the privately-run centers and the two religious centers visited by Human Rights Watch.[249] Yet, Ministry of Health oversight of the private centers is almost non-existent. The centers are required to report on a yearly basis to the Ministry of Planning to renew their licenses as NGOs, but this reporting does not include any real oversight of treatment and care. The ministry had organized coordination meetings with managers of private centers, largely thanks to GRT, but these stopped in the course of 2014. A focal point for non-communicable diseases has been established at the Ministry of Health,[250] but it was not functioning for most of the course of Human Rights Watch's research. A new focal point was appointed in April 2015 and held an initial coordination meeting on mental health in May 2015.

While the Ministry of Health has started to roll out a data tracking system known as the Health Management Information System (HMIS) – that seeks to collect patient information

[249] Human Rights Watch interview with manager of Sahan private center, Hargeisa, January 22, 2015

[250] Human Rights Watch email correspondence with Dr Bashir Jaamac, July 2015.

from health centers – which could help reduce involuntary and prolonged detentions. So far this does not include mental health indicators.[251]

The National Health Professions' Commission

The National Health Professions' Commission (NHPC) is a regulatory body that was officially established in 2013 and is mandated to register and license health professionals and public and private health care facilities.[252] The Commission currently lacks funding, human resources and enforcement capacity.[253] Dr Lula, the head of the commission raised concerns about the limited legal mandate of the commission to enforce disciplinary action if and when required.[254]

While the commission has developed guidelines for the assessment of health care institutions, actual assessments have been irregular.[255] The commission has not yet started to register or assess private health facilities, and still has a backlog of hundreds of applications from health professionals.[256]

The National Human Rights Commission

The National Human Rights Commission has been carrying out monitoring visits to public, private and religious healing centers. In a meeting with Human Rights Watch, commissioners raised serious concerns about the abuses they documented in these centers including the widespread use of chaining, overcrowding, and admission of patients for purely private reasons.[257] However, in the last annual report, the Commission only reported on issues of access to drugs and other medication, without reporting on more serious physical rights abuses; although it did call for oversight of religious healing centers.[258]

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[251] Human Rights Watch interview with manager of Horizon private center, Hargeisa, October 9, 2015.

[252] See website of the National Health Professions Commission at http://www.nhpcsomaliland.org/ (accessed August 8, 2015). The legal act setting up the Commission is available in Somali at http://www.nhpcsomaliland.org/documents/Xeerka_Guddida_Mihnadlayaasha_Caafimaadka.pdf.

[253] Human Rights Watch interview with Dr Lula, head of the National Health Professions' Commission, Hargeisa, May 21, 2015; Joanna Buckley et al,, " Assessment of the Private Health Sector in Somaliland, Puntland, and South Central."

[254] Human Rights Watch interview with Dr Lula, head of the National Health Professions' Commission, Hargeisa, May 21, 2015; Joanna Buckley et al, " Assessment of the Private Health Sector in Somaliland, Puntland, and South Central."

[255] Ibid.

[256] Human Rights Watch interview with Dr Lula, head of the National Health Professions' Commission, Hargeisa, May 21, 2015.

[257] Human Rights Watch interview with Fathia Hussein Ahmed, Chairperson, and Abdisamad Saad Hassan, January 22, 2015.

[258] Somaliland National Human Rights Commission Annual Report 2014, on file with Human Rights Watch, p 57.

Channels of Redress

As described above, the court system in so far as it is involved at all in involuntary admissions has until recently primarily been serving the interests of relatives and guardians of individuals with psychosocial disabilities as well as protecting owners of private centers from liability, rather than protecting the rights of individuals with psychosocial disabilities.

The government's mental health policy establishes tribunals and review committees at the local level to "independently monitor standards, review detention orders and hear appeals and complaints;" however, these mechanisms have not been established.

As detailed above, none of the individuals interviewed by Human Rights Watch with actual or perceived psychosocial disabilities had been before a judge to review or challenge their detention or seek redress for other abuses faced inside the centers. As one doctor who has worked at both the private and public centers said, "Their [patient's] right to stand before the law is taken by their guardian."[259] Human Rights Watch received only one report of a former resident that had been able to challenge abuses he had suffered whilst confined in a private center in 2010.[260]

[259] Human Rights Watch interview with former head of Non-Communicable Diseases unit at Ministry of Health, Hargeisa, May 13, 2015.

[260] According to the lawyer of Macruuf, the private center that was sued in a civil case by the former resident, the individual accused guards at the center of having physically mistreated him. The case was settled out of court, with Macruuf paying the former resident compensation. Human Rights Watch telephone interview with lawyer, August 8, 2015.

V. International Actors

Given Somaliland's lack of international recognition, it does not receive bilateral financial assistance. However it has been receiving donor support notably since 2012 through the Somaliland Trust Fund, a development initiative carried out jointly by the Danish and UK governments' aid agencies, along with Norway and the Netherlands.[261]

Somaliland is also currently receiving significant contributions to the health sector through Somalia-wide health initiatives.[262] Despite the estimated high levels of mental disabilities, partners have not invested in mental health.[263]

Most multilateral donor funding to the health sector currently being implemented across Somalia, including Somaliland, is being channeled to the Joint Health and Nutrition Programme (JHNP), a five year program to strengthen the national health systems and the Essential Package for Health Services (EPHS) focusing on reducing maternal and new-born deaths through increased access to basic services.[264] EPHS is currently being implemented by Ministries of Health in Somaliland, Puntland and Somalia in conjunction with three UN organizations- WHO, UNICEF and UNFPA.

International donors, currently led by the UK's Department for International Development (DFID), along with the Swedish International Development Agency (SIDA), Australian Agency for International Development (AusAID), Finland's Ministry of Foreign Affairs (Formin), Swiss Agency for Development and Cooperation (SDC), and United States Agency

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[261] Somaliland Development Fund, "Donors and Funding," http://somalilanddevelopmentfund.org/donors-and-funding.

[262] The Economist, " Somaliland sets its 2014 Budget," November 5, 2014, http://country.eiu.com/article.aspx?articleid=1601139944&Country=Somalia&topic=Economy&subtopic=Forecast&subsubtopic=Fiscal+policy+outlook&u=1&pid=413119625&oid=413119625&uid=1 (accessed July 6, 2015).

[263] UNICEF, " Essential Package of Health Services Launched in Somalia to Improve Maternal and Child Health," Joint Press Release, May 6, 2014, http://www.unicef.org/somalia/media_14657.html (accessed August 20, 2015); Human Rights Watch interview with Dr Humayun Rizwan, WHO primary health care doctor , Hargeisa, January 21, 2015.

[264] JHNP, " Essential Package of Health Services (EPHS) launched in Somalia," June 3, 2014, http://jhnp.org/?news_data=essential-package-of-health-services-launched-in-somalia-to-improve-maternal-and-child-health (accessed July 20, 2015) The JHNP focusses on reproductive, maternal and neonatal health, family planning and nutrition and seeks to strengthen the national health systems.

for International Development (USAID)[265] have been providing support to JHNP.[266] The JHNS which runs between 2012 and 2016 has a budget of USD $236 million although actual funds contributed are reportedly much lower.[267]

Funding needs for the last phase of the program have however not been met.[268] In June 2015, the UN's resident humanitarian coordinator held a donor conference to look at next steps in health programming and to push for new contributions to the health sector.

Under EPHS, UNICEF is the lead UN agency in charge of procuring drugs for the public sector, however psychotropic medications have not been included in Somaliland's list of essential medicines. In May 2015, WHO and the Ministry of Health met to discuss the idea of expanding the list of essential medicines to include basic psychotropic medications; at time of writing, no decision had been taken.[269]

WHO identifies mental health among its priorities in Somalia but has not provided basic support notably training or drug supplies to Somaliland in the field of mental health since 2012.[270]

Donors have been funding small piecemeal mental health projects run by INGOs.

For example, between 2012 and 2014, the EU-funded GRT, which has been involved in the field for many years to carry out advocacy on mental health issues, work that contributed

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[265] USAID does not contribute funds through the JHNP pool-funding mechanism.

[266] http://jhnp.org/; In addition to DFID funding, other donors have contributed the following amounts: Sweden: US$ 10.36 million (2012–2014); DFAT: US$ 3.13 million (2012–2013); and the United States Agency for International Development (USAID): US$ 2.54 million (2012–2015). The new commitments from donors are: Sweden: US$ 31.5 million (2014–2016); Finland: US$ 8.16 million (2014–2016); and Swiss Agency for Development and Cooperation (SDC): US$ 5.58 million (2014–2016). See DFID report quoting DFID (2014b) 2nd Annual Review. Joint Health and Nutrition Programme; see http://jhnp.org/.

[267] Human Rights Watch interview with Barni Nor, Swedish-SIDA, Nairobi, June 29, 2015 ; See also, JHNP, " Fact Sheet," http://jhnp.org/ (accessed July 20, 2015).

[268] Human Rights Watch interview with Barni Nor, Swedish-SIDA, Nairobi, June 29, 2015; interview with with Katie Bigmore, DFID Human Development lead, Nairobi, June 25, 2015; interview with Dr Humayun Rizwan, WHO primary health care doctor , Hargeisa, January 21, 2015.

[269] Joanna Buckley et al,, "Assessment of the Private Health Sector in Somaliland, Puntland, and South Central;" interview with with Katie Bigmore, DFID Human Development lead, Nairobi, June 25, 2015; Due to cuts in funding for humanitarian assistance and UNICEF, there have reportedly been cuts in supplies of some of the drugs on the list.

[270] WHO," Country Cooperation Strategy at a Glance. Somalia," http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_som_en.pdf (accessed 20 August , 2015).

to the drafting of the government's mental health policy.[271] The EU has since pulled out of the health sector and this funding is coming to an end.[272] So far, no donor has stepped up to take over this support.

The UK has contributed to funding training by the Tropical Health and Education Trust (THET), in conjunction with King's College Hospital in London that has since the late-2000s worked to include mental health training into nursing and medical curriculum at Amoud Medical School at Boroma University and at Hargeisa University, and other medical teaching institutions.[273]

More recently, the DFID-funded Health Consortium for the Somali People, an INGO-led initiative aimed at implementing the EPHS through public and private initiatives,[274] has started to include mental health within its pilot project in the Sahil region of Somaliland.[275] In August 2014, the NGO Health Poverty Action started providing essential drugs and basic training for staff at the Berbera General Hospital mental health ward.[276]

All of the key health sector programs are scheduled to end in 2016, offering donors and the government the opportunity to include non-communicable diseases, including mental health, within programs going forward. At the June 2015 high level forum for the Somali health sector, the lack of investment on non-communicable diseases including mental health was identified as a key challenge in the health sector.[277]

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[271] See Funding Line, 27:http://www.eeas.europa.eu/delegations/somalia/documents/projects/20140430_ec_development_programme_april_2014_en.pdf, (accessed October 12, 2015);

[272] The funding was extended into 2015 but has now finished. Human Rights Watch interview with Massimiliano Reggi, GRT regional representative, Hargeisa, May 15, 2015.

[273] See Doyle & Morris, "Development of mental health nursing education and practice in Somaliland," Nurse Education in p. 1-3;Kings-THET Somaliland Partnership, "Health Partnership Scheme," http://www.thet.org/health-partnership-scheme/health-partnerships/rachscho (accessed August 19, 2015) ; King's College London, "Somaliland. KTSP Mental Health Group," http://www.kcl.ac.uk/lsm/research/divisions/global-health/partnerships/Somaliland/somaliland.aspx (accessed September 8, 2015); also Handuleh, Jibril I M et al. "Mental Health Services Provision in Somaliland," The *Lancet Psychiatry*, Volume 1, N.2, p106-108, July 2014, http://www.download.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(14)70241-X.pdf (accessed July 19, 2015). In 2014 a well-known psychologist from Somaliland, Dr Hussein Bulhan, set-up a new university in Hargeisa which offers undergraduate and post-graduate courses in Psychiatry and Psychology, the first of its kind in Somaliland. See Frantz Fanon University, "Degree Programs," http://fanonuniversity.org/?page_id=148(accessed August 19, 2015).

[274] The Consortium includes five INGOs, led by Population Services International (PSI), and focusses on EPHS aimed at reducing mother and new-born mortality rates. The program has run from 2010 and funding runs through to March 2016 see http://devtracker.dfid.gov.uk/projects/GB-1-200842/documents/ (accessed August 20, 2015).

[275] Human Rights Watch interview with Katie Bigmore, DFID Human Development lead, Nairobi, June 25, 2015; email exchange with Rohit Odari, Country Representative for HPA, July 6, 2015.

[276] Human Rights Watch email exchange with Rohit Odari, Country Representative for HPA, July 6, 2015.

[277] High-Level Forum pamphlet, on file with HRW.

VI. Recommendations

To the Ministry of Health

- Immediately improve conditions in mental hospitals including privately-run residential centers to ensure the human rights of persons with psychosocial disabilities are respected by:
    1. Reviewing, with mental health professionals and judicial officials, all cases of persons who reside in public mental health wards and privately-run residential centers and releasing those who are detained against their will;
    2. Releasing all persons who are held against their will in mental health centers because of their use of khat;
    3. Conducting prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in public and private mental health centers;
    4. Banning the use of chaining and the prolonged use of any measure designed to physically restrain an individual;
    5. Prohibiting the use of seclusion;
    6. Permitting the use of measures to physically restrain an individual or separate them from other persons only as measures of last resort, when necessary to prevent imminent and actual harm to self or others, imposed only for short periods and only to the extent strictly required for the purpose; such measures should not be justified on the basis of the existence of a disability and should be non-discriminatory, in line with the CRPD;
    7. Prohibiting the use of all restraints as a form of punishment, control, retaliation or as a measure of convenience for staff;
    8. Requiring admission and detention in public or private mental health institutions be voluntary, based on free and informed consent;
    9. Requiring that any detention on an non-voluntary basis be possible only following a determination by an independent judicial authority, following due process, that is based on behavior that poses imminent actual harm to self or others and not on the basis of the existence of a disability; it should be limited

to short periods of time as specified by law, and subject to continuous full judicial review;

10. Banning medical intervention without free and informed consent; define exceptional circumstances in which a patient may be considered temporarily unable to give free and informed consent and in such circumstances, immediate medical treatment may be administered as it would be to any other patient without a disability incapable of consenting to treatment at that moment, provided that the treatment is strictly necessary to address a life-threatening condition or a condition of similar gravity;
11. Developing strict guidelines on the use of temporary restraint measures other than chaining and seclusion; ensure that the physical restraint of a person is not justified on the basis of the existence of a disability, in line with the CRPD, but based on conduct posing an imminent and actual harm to self or others; all incidents in which measures are taken to physically restrain a person should be recorded and reviewed to ensure consistency with the guidelines;
12. Consulting with the National Human Rights Commission, persons with psychosocial disabilities, and other experts in disability rights on the development of such guidelines. Implementation of these guidelines should be a precondition for centers being registered and licensed by the National Health Professions' Commission;
13. Ensuring that all public and private institutions catering for people with psychosocial disabilities enforce the law on involuntary detention and guidelines on use of restraints through record keeping, trainings, supervision, reviews, investigations and holding staff accountable for violating these guidelines;
14. Ensuring that the Ministry of Health non-communicable diseases unit has adequate funding and staff, meets regularly, including with private health practitioners and includes a mental health focal point.

- Improve the infrastructure in public mental health wards, including repairing dilapidated buildings, broken water supply systems and sanitation facilities; ensure that space is available for de-escalation efforts;

- Significantly restructure the facilities of the new Gabiley General Hospital mental health ward before it is opened;
- Progressively develop voluntary community-based mental health services and other social forms of support to allow persons with psychosocial disabilities to live independently and in the community;
- Train primary health care providers to recognize and manage common mental health problems, particularly on de-escalation techniques such as verbal interventions. This can be done by ensuring that mental health is included within all current health sector programming;
- Include mental health components into the trainings of community health workers;
- Train and recruit more mental health professionals to improve the doctor/nurse patient ratio;
- Take measures to promote retention of trained and skilled staff;
- Guarantee availability of psychotropic medications in the public mental health wards for inpatient and outpatients to enhance access to persons with psychosocial disabilities, especially those living in the community;
- Ensure that persons with psychosocial disabilities are provided with support and accessible information to make informed choices and decisions regarding medical procedures and interventions;
- Facilitate adequate, confidential and appropriate legal aid to persons with disabilities living in institutions;
- Require all government and privately-run institutions to provide accessible information to persons with psychosocial disabilities and inform them about their rights and complaint procedures;
- Include mental health indicators into the Health Management Information System and ensure that data collection is rolled out to all health centers, including private centers. Ensure that the information is stored and shared with relevant stakeholders including regulatory and accountability mechanisms;
- In collaboration with disabled person's organizations, people with psychosocial disabilities, other NGOs and the media, conduct a public information campaign to

create awareness about persons with disabilities, particularly psychosocial disabilities. Target service providers, law enforcement agencies and the public;

- Update existing mental health strategies including by specifying the budget and timeframe and the roles of different stakeholders involved in implementing activities or programs;
- Formulate and implement a national policy on formal and informal service provision, which should regulate the use of private centers and religious healing centers for persons with psychosocial disabilities; the policy should spell out clear referral procedures among formal and informal health centers; ensure that the policy spells out that no involuntary admissions on the basis of disability is permitted;
- In addition, work to establish access to voluntary, community-based drug dependency treatment and ensure that such treatment is medically appropriate, based on free and informed consent, and comports with international standards.

To the National Health Professions' Commission

- Develop and maintain a register of privately-run residential centers and traditional healing centers that house or interact with persons with psychosocial disabilities;
- Ensure that health facilities comply with guidelines on the use of restraints; compliance should be a precondition for centers being registered and licensed.

To the Judicial Commission and the Chief Justice

- Prohibit the district court in Hargeisa from endorsing admissions to private centers without the consent of individuals concerned, and require the court to stipulate that anyone so admitted is free to leave the center at a time of their choosing;
- Ensure any court to which an application for involuntary detention of a person at a private or public hospital is made requires that the person be present and have legal representation for the hearing, that detention is sought based on behavior that poses imminent actual harm to self or others and not on the basis of the existence of a disability; that psychiatric assessment is available, and any detention is limited to short periods of time and subject to continuous full judicial review;

- Cooperate so that judicial officers, together with mental health professionals and government health officials review all cases of persons who reside in public mental health wards and privately-run residential centers and release those who are detained against their will.

To the National Human Rights Commission

- Continue to carry out independent monitoring visits to all places of detention, including public and private mental health institutions; the visits should be regular, unannounced and commission staff should be granted unhindered and confidential access to all patients, records and facilities; the commission should follow-up to ensure that there will be no reprisals against any person in institutions who meets with them. The commission should publicly report on the findings of these visits;
- Ensure that commission staff receive appropriate and regular training on carrying out research into abuses against people with psychosocial disabilities.

To the Government of Somaliland

- Publicly commit to adhering to the basic principles outlined in the United Nations Convention on the Rights of Persons with Disabilities and to working towards including the rights outlined in the convention into domestic law;
- Ensure effective collaboration between key government stakeholders, including the Ministry of Health and National Health Professions' Commission, in the areas of monitoring and oversight over all health facilities housing people with psychosocial disabilities;
- Make establishing, funding, and providing a wide range of community-based services for persons with psychosocial disabilities a top priority when designing mental health programs, including by integrating mental health into primary health care. These services should be based on values of equality, autonomy, and inclusion of individuals with psychosocial disabilities. Preventing institutionalization should be an important part of any planning for mental health care and key stakeholders including persons with psychosocial disabilities, should be invited to participate in the formation of plans;

- Establish an effective monitoring framework, including designating a special independent body to oversee conditions of persons with psychosocial disabilities whose right to personal liberty is restricted. This body can be under the Ministry of Health or elsewhere but should have a special mandate to monitor compliance by the community and privately-run centers and traditional healers. Monitors should be granted unhindered access to facilities and residents and should focus on monitoring use of restraints, involuntary detention, punishment and seclusion. Ensure that there will be no reprisals against any person in institutions who meets with monitors. The findings should be shared with other relevant bodies, including complaints mechanisms such as the National Human Rights Commission;
- Invite the UN special rapporteurs on torture and other cruel, inhumane and degrading punishment, on the rights of persons with disabilities, and on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Working Group on Arbitrary Detention to visit. Allow them unhindered, confidential access to all private centers and public hospitals and to residents, while ensuring that there will be no reprisals against any person in institutions who meets with them;
- Ensure that persons with psychosocial disabilities and their representative organizations are involved and participate fully in planning, carrying out, and monitoring government programs that promote employment, social welfare and independent living;
- In consultation with persons with psychosocial disabilities and their representative organizations, improve census data collection on persons with psychosocial and other disabilities to better inform policy decisions.

To the Management of Mental Health Wards

- Implement guidelines on free and informed consent and use of restraints; ensure that detention without free and informed consent and use of restraints are never justified on the basis of disability;
- Train staff, including support staff and security personnel, on human rights-based approaches to psychiatric treatment, including on free and informed consent;
- Train staff on de-escalation techniques. Staff should make every reasonable effort to use alternatives to restraints, including through the use of "cooling off" periods

and verbal persuasion and negotiation strategies to defuse and de-escalate volatile situations; management should ensure that preferred strategies are discussed with residents upon admission;

- Monitor compliance with guidelines on and restraints other than chaining; keep clear records and regularly review incidents in which they are used;
- Staff who do not comply with policies on restraints and involuntary detention should be subject to appropriate disciplinary sanctions up to and including dismissal and if they commit acts of criminal abuse against patients for criminal prosecution;
- Facilitate adequate, confidential and appropriate legal aid to persons with disabilities living in institutions;
- Develop and implement guidelines that prioritize making the institutional environment accessible and making medical forms, specifically consent forms, available in easy-to-read formats;
- Provide appropriate and adequate activities and access to education within institutions;
- Ensure appropriate and regular counseling for inpatients and outpatients, on the basis of free and informed consent;
- Educate families to the needs and rights of persons with psychosocial disabilities and involve them in caring for relatives;
- Continue to progressively move toward Outpatient Department, daycare services and short-term, voluntary in-patient care in the community rather than long-term admission.

To The Judiciary, Police and Prison Officials

- Strengthen existing structures to effectively address legal concerns of persons with psychosocial disabilities. This should include continuous training for the officials of the judiciary, police, and prisons and improve access of persons with psychosocial disabilities to the police and courts to ensure that their admission is based on free and informed consent, challenge detention and lodge allegations about abuses. Ensure the investigation and prosecution of alleged human rights violations. Protect individuals who report abuses from reprisals;

- Centers found guilty of serious abuses should be sanctioned and closed;
- Require that any detention on a non-voluntary basis be possible only following a determination by an independent judicial authority, following due process, based on behavior that poses imminent actual harm to self or others and is not justified on the basis of the existence of a disability; detention should be limited to short periods of time as specified by law, and subject to continuous full judicial review.

To The Parliament of Somaliland

- Adopt mental health legislation that complies with international standards, including the UN Convention on the Rights of Persons with Disabilities;
- Recognize the legal capacity of all persons with disabilities on an equal basis with others and the right to exercise it;
- Recognize institutionalization based on disability as a form of discrimination and institutionalization without consent of the individual as a form of arbitrary detention;
- Adopt legislation banning practices in public and private psychiatric hospitals that are identified as violating human rights standards, including chaining, treatment without free and informed consent, the use of restraints and seclusion as punishment, for convenience, or justified on the basis of disability; legislation may outline the exceptional circumstances when temporary measures to physically restrain an individual or separate them from other persons can be used, and this should be applied equally regardless of whether the person has a disability or not;
- Remove pejorative language such people of "unsound mind" and other similar phrases from all government legislation and documentation.

To the Management of Privately-Run Centers for Persons with Psychosocial Disabilities

- Immediately stop and prohibit the practice of chaining;
- Ensure residents in the center are there voluntarily and can freely enter and leave at will, give free and informed consent to treatment and can refuse treatment with

no negative repercussions, and ensure that all persons in institutions are fully aware of their rights;

- Increase the number of qualified staff at centers to the extent possible and ensure that all staff, including security personnel, receive appropriate and adequate training on how to be attentive and responsive to the concerns and needs of persons with psychosocial disabilities, on the principle of free and informed consent;
- Train staff on de-escalation techniques. Staff should make every reasonable effort to use alternatives to restraints, including through the use of "cooling off" periods and verbal persuasion and negotiation strategies to defuse and de-escalate volatile situations; management should ensure that preferred strategies are discussed with residents upon admission;
- Enforce strict guidelines on the exceptional circumstances when restraints other than chaining and seclusion may be used and keep clear records and regularly review incidents in which they are used; ensure that detention without free and informed consent and use of restraints are never justified on the basis of disability;
- Facilitate access to adequate, confidential and appropriate legal aid to persons with disabilities living in institutions;
- Provide appropriate and adequate activities and access to education within institutions. Develop creative techniques to motivate persons with disabilities to learn skills;
- Move toward Outpatient Department, daycare services and short-term, voluntary in-patient care rather than long-term admission;
- Ensure access to appropriate and regular counseling for inpatients and outpatients;
- Educate families to the needs and rights of persons with psychosocial disabilities and involve them in caring for relatives.

To Donors and Multilateral Agencies Working in the Health Sector

- Support the government of Somaliland and disabled persons' organizations through funding and providing technical assistance as needed to safeguard and raise awareness of the rights of persons with psychosocial disabilities;

- Support efforts to mainstream mental health into current and future primary health care programming;
- Encourage the government of Somaliland to allocate appropriate resources to the mental health sector including funds to support national mental health wards, build capacity at the primary health care level and build community support initiatives;
- Support efforts to prohibit chaining across public and private institutions in Somaliland by assisting in appropriate training of staff in institutions, pushing for an increase in staff numbers, helping to ensure a steady supply of essential medication and supporting efforts to build community support initiatives;
- Support the development of disability rights organizations, including organizations of people with psychosocial disabilities.

To The United Nations World Health Organisation (WHO)

- Carry out regular training on mental health in Somaliland;
- Include mental health components into the trainings of community health workers, including the WHO trained lady-health workers;
- Support efforts to ensure that psychotropic medications are readily available within mental health wards of general hospitals throughout Somaliland;
- Encourage the government of Somaliland to allocate adequate resources to the mental health sector including funds to support national mental health wards, build capacity at the primary health care level and build community support initiatives.

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“Chained Like Prisoners”

Abuses Against People with Psychosocial Disabilities in Somaliland

Violence and trauma of the civil war, lack of health services and widespread use of the amphetamine-like stimulant khat are all factors driving a pressing need for quality mental health care in Somaliland. Yet people with psychosocial disabilities and other mental health needs are often abandoned by the state, left on their own or reliant on usually ill-informed relatives, who also have no place to turn for help on how to support a relative with a psychosocial disability.

In recent years, in addition to four under-resourced and dilapidated public mental health wards dotted across Somaliland, expensive privately-run residential centers have mushroomed in the capital, Hargeisa. To date, there has been no scrutiny by authorities of the treatment of residents inside these centers.

Chained like Prisoners documents how men with actual or perceived psychosocial disabilities, or who chew large amounts of khat, are involuntarily confined to public mental hospitals or privately-run residential centers, where they face various forms of abuse.

Rather than receiving care or rehabilitation on the basis of informed consent, residents are subjected to forced medical treatment, prolonged arbitrary confinement, physical abuses, including beatings, overcrowding and poor hygiene conditions. Basic due process, judicial oversight and channels of redress are non-existent. Most of these centers provide very little, and often no meaningful activities to residents, compounding their sense of imprisonment and hopelessness.

Somaliland authorities should immediately prohibit abusive practices, such as chaining, and monitor mental health facilities for abuse. In the longer-term the government, with the support of its international partners, should establish voluntary community-based services for people with psychosocial disabilities.

(above) Chains hang from a barred window leading to a room in which residents are chained as punishment, at the Horizon Social Assistance Development Organization, Hargeisa on July 29 2015.

(front cover) A resident sits with his foot chained in the courtyard of the Raywan private center in the Somaliland capital Hargeisa, on July 29 2015.

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