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Judiciarisation of the mentally ill and/or mentally incapacitated in the Malawi criminal justice system: Gaps and flaws of human rights protection

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ABSTRACT

Rates (where recorded) of mental illness, intellectual disabilities and co-morbidities are disproportionately high and rising among global prison populations. There is little data on the extent of mental illness and/or mental incapacity in prison populations in the Global South. Criminal justice systems are generally under-resourced, with a lack of adequate forensic monitoring, availability of specialist psychological and psychiatric expertise, and system coordination with mental health treatment and support services.

Very little is known with regard to the judiciarisation of the mentally ill and/or mentally incapacitated in African criminal justice systems. In this *Commentary* we focus on Malawi, as a least developed country in sub-Saharan Africa. We present the international human rights framework pertinent to the judiciarisation of people with disability, the global discourse around disability-neutral doctrines and the contentiousness of the link between mental and legal capacity. We discuss challenges and procedural complexities in the Malawi criminal justice system as it relates to how people with mental illness and/or mental incapacity navigate the process and to what extent their basic human rights are upheld.

Mental health legislation and policies to uphold the rights of the mentally ill and/or mentally incapacitated in the criminal justice system are underdeveloped (and under-resourced). There are backlogs in forensic assessments to determine competency to stand trial and criminal responsibility; inadequate availability of forensic beds; and insufficient coverage of community and prison based mental health services. Lengthy detention periods in overcrowded unsafe conditions are common, with little or no access to specialist medical care.

We present medico-legal and clinical recommendations for enhanced human rights monitoring and protections cognisant of the various challenges in ensuring the implementation of human rights and of due process in Malawi. We encourage the government to consider formal diversion options via mental health courts and invest in the capacity of forensic specialists and hospitals to support court assessments and community care. Oversight mechanisms preventing human rights abuses of these very vulnerable individuals are crucial in all mental health settings in Malawi, not limited to police custody, remand detention facilities and prisons. Ratification of the Optional Protocol of the Convention against Torture is imperative.

1. Background

The global prison population has reached its highest level to date, with over 11.5 million deprived of their liberty on any given day (Penal Reform International, 2023). Lack of prison system resourcing, high pre-trial rates and consequent overcrowding remain a challenge in many countries, with 121 countries currently operating over capacity (in some African countries over 200%) (Penal Reform International, 2023). Marginalised, minority and Indigenous communities represent a substantial share of the prison population (Penal Reform International,

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2023; United Nations Office on Drugs and Crime, 2018:2022). Reoffending rates in many countries continue to be high (at times over 70%) (Fazel & Wolf, 2015; United Nations Office on Drugs and Crime, 2018; Yukhnenko et al., 2020).

Rates (where recorded) of mental illness, intellectual disabilities and co-morbidities are disproportionately high and rising among the prison population (Fazel & Seewald, 2012; Fazel et al., 2016; Jack et al., 2018; Penal Reform International, 2023; World Health Organization- European Region, 2023). COVID-19 restriction measures (including solitary confinement for lengthy durations) have exacerbated levels of mental illness in prisons (Amnesty International, 2021; Heard, 2021; Johnson et al., 2021). Screening, diagnosis and treatment, and competency of criminal justice actors to deal with mentally unwell or impaired detainees is generally only available in high income countries (Butler et al., 2022; Penal Reform International, 2023). Criminalisation, detention and incarceration of the mentally ill and/or mentally incapacitated often occurs where lack of suitable facilities exist in the community, and can include continued arbitrary detention at the end of a sentence or despite acquittal (Boyd-Caine & Chappell, 2005). Individuals with mental illness experience substantial vulnerabilities and challenges navigating criminal justice systems, and this contributes strongly to the global revolving door of incarceration (Barnett et al., 2014; Fazel & Seewald, 2012; Fazel & Wolf, 2015; Houston & Butler, 2019; Mundt & Baranyi, 2020; Zhang et al., 2011).

2. Judiciarisation of the mentally ill and/or incapacitated in Africa

There is little data available on the extent of mental illness and/or mental incapacity in prison populations in the Global South (Baranyi et al., 2019; Fazel et al., 2016; Fazel & Seewald, 2012; Jack et al., 2018; Penal Reform International, 2023). Prevalence rates in these prisons are speculated to be far greater than in high income developed countries (Fazel et al., 2016; Fazel & Seewald, 2012). Reviews indicate high pooled prevalence of mental illness in prisons, including high rates of detention without charge in non-prison settings (forensic hospitals, youth institutions), often for lengthy periods (Baranyi et al., 2019; Lovett et al., 2019).

African criminal justice and penal systems are generally under-resourced and operating over-capacity, with a lack of adequate forensic health monitoring, and specialist psychological/psychiatric expertise. There is poor system coordination with community mental health services (Alem et al., 2008; Mundt et al., 2022; Pienaar, 2021; World Health Organization, 2018). Competency to stand trial and criminal responsibility are not put under scrutiny (Schwikkard & Van Der Merwe, 2016; Van Hout & Wessels, 2021). Various studies from South Africa, Nigeria, Ghana, Ethiopia, Zambia, Malawi, Zimbabwe and Kenya illustrate over-representation of mental illness and impairment in justice pathways; often due to lack of forensic hospitals, backlogs in determining competency to stand trial and criminal responsibility and lengthy periods awaiting forensic assessment in prisons with little or no access to specialist medical care (Abdulmalik et al., 2014; Agboola et al., 2017; Armiya'u, et al., 2013; Armiya'u, et al., 2013; Beyen et al., 2017; Calitz et al., 2006; Dejene-Tolla & Sisay-Taddese, 2021; Hayward et al., 2010; Ibrahim et al., 2015; Kanyanya et al., 2007; Menezes et al., 2007; Modupi et al., 2020; Naidoo & Mkize, 2012; Nseluke, 2011; Osasona & Koleoso, 2015; Pienaar, 2021; Prinsloo, 2013; Prinsloo & Hesselink, 2014; Telisinghe et al., 2016; Van Hout, 2022).

Extant literature on the judiciarisation of the mentally ill and/or mentally incapacitated in African criminal justice systems mostly originates from South Africa (Allan, 2005; Allan & Meintjes-Van der Walt, 2006; Pillay, 2014a,b; Pienaar, 2021; Schutte & Subramaney, 2013; Solomons, 2004; Van Hout & Wessels, 2021). In this *Commentary* we focus on Malawi, classified as a least developed country by the Organisation for Economic Co-operation and Development (2022). We present the international human rights framework pertinent to the judiciarisation of people with disability, the global discourse around disability-neutral doctrines and the contentiousness of the link between mental and legal capacity (Craigie, 2015; McNamara, 2018). We discuss challenges and procedural complexities in the Malawi criminal justice system as it relates to how people with mental illness and/or mental incapacity navigate the process and to what extent their basic human rights are upheld. We conclude with a series of medico-legal and clinical recommendations for enhanced human rights monitoring and protections.

3. Global critique of the judicial-psychiatric interface

Debate around the concept of judiciarisation of the mentally ill and/or mentally incapacitated occurs within a global call for wider recognition of legal capacity both as duty bearer, and as rights holder relating to personal decisions and criminal activity (Craigie, 2015; MacDonald & Dumais-Michaud, 2015; Paradis-Gagné & Jacob, 2021; Sugie & Turney, 2017). Access to justice (systems, information, procedures, locations) as a basic rule of law principle is crucial for these vulnerable detainees as in its absence, they are *"unable to have their voice heard, exercise their rights, challenge discrimination or hold decision-makers accountable"* (Arzani, 2019). Judiciarisation exacerbates their marginalisation and stigma (Arzani, 2019; Chaimowitz, 2012; Lamb et al., 2004; Paradis-Gagné & Holmes, 2020; Paradis-Gagné & Jacob, 2021; Rogers & Pilgrim, 2014; Talbot, 2009; Van Hout & Wessels, 2021).

There are increasing implications for the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2007) regarding the rights of persons with disabilities in the criminal justice system and attributions of criminal responsibility. Article 13 CRPD provides for the equal right to access to justice of persons with disabilities (United Nations, 2007). The invisible nature of many cognitive, intellectual or mental disabilities, traumatic brain injuries and literacy and cognitive impairments however creates various problems (Blanck, 2017; Nowak & Zarraluqui, 2009). Of the 183 states which have ratified the CRPD, only a minority are making progress to ensure equal access to justice with procedural safeguards for people with intellectual disabilities, and only half report on the implementation of disability awareness for security personnel (Gulati et al., 2021).

The CRPD has substantial implications for criminal defenses based on mental incapacity (Bach, 2009; Loughnan, 2011, 2012; Peay, 2015). Legal capacity defined as the ability to hold rights and duties (legal standing) and exercise these rights and duties (legal agency) is a requirement for criminal responsibility and all persons are presumed to have legal capacity (United Nations, 2014). Article 12 requires *"that legal capacity* ***should not be limited*** *on the basis of mental disability: persons with mental disabilities, including mental disorders, must be recognized as persons before the law o****n an equal basis to others*** *and must be* supported *in the exercise of their legal capacity"* (United Nations, 2014). General Comment on Article 12 CRDP by the Committee on the Rights of Persons with Disabilities further establishes that; *"the Convention affirms that* ***all persons with disabilities have full legal capacity****"* and that *"perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity"* (United Nations, 2014).

Hence, the legitimacy of the link between mental and legal capacity remains contentious (Craigie, 2015). Defense based on the inability of the individual to appreciate the wrongfulness of their actions or to act in accordance with such appreciation due to mental or intellectual disability, is regarded as a substantive law defense, with the burden of proof on the person raising the defense (Schwikkard & Van Der Merwe, 2016). However, the inability to understand court proceedings raises the question around mental fitness to stand trial and triability. It is not a substantive law defense, nor does not give rise to criminal responsibility, and the burden of proof remains with the prosecution (Schwikkard & Van Der Merwe, 2016).

Debate continues with respect of Article 12 of CRPD and its impact on criminal law (Bach, 2009; Bartlett, 2012; Craigie, 2015;

Paradis-Gagné & Jacob, 2021; Slobogin, 2015). In 2009, the United Nations High Commissioner called for the CRPD to replace criminal defenses based on mental or intellectual disability with disability-neutral doctrines (para 47), inferring that defenses based on diminished responsibility and insanity could be in violation of the CRPD (Bartlett, 2012; Flynn & Arstein-Kerslake, 2014; Peay, 2015; Slobogin, 2015). McNamara (2018) has argued that "*States Parties may need to consider introducing a **disability neutral approach**, which does not seek to distinguish between persons based on the existence of a disability. …. if a person with a psychosocial disability has been found to have committed the crime (**actus reus**) and had formed the necessary intention to commit the crime (**mens rea**), then they can be found culpable on an equal basis with others*"

Finally, minimum standards of detention and the upholding of the rights of all people deprived of the liberty apply to all without discrimination (United Nations, 2016). Article 14 of the CRPD supports this by providing that States Parties must ensure that persons with disabilities are not unlawfully or arbitrarily detained, that any deprivation of liberty occurs in conformity with the law, and that their disability shall not justify a deprivation of liberty. They must further respect and uphold their rights to minimum standards of detention, including reasonable accommodation and access to free, equivalence of care (United Nations, 2007).

4. African regional human rights frameworks and the Malawi politico-legal context

There are a broad range of African regional human rights frameworks, instruments and normative standards which align to the CRPD and the United Nations normative standards of detention. The African Commission on Human and Peoples' Rights' Principles and Guidelines on the Rights to a Fair Trial and Legal Assistance in Africa (1999) refer to disability and provide for "*equality of all persons before any judicial body **without any distinction***" (Article 2(b)). Whilst the African Charter on Human and Peoples' Rights' (Organization of African Unity, 1981) does not specifically provide for the rights of people deprived of their liberty, the African Commission on Human and Peoples' Rights' (2002) notes the obligation of the State to prohibit torture and other cruel, inhuman or degrading treatment or punishment, and protect the rights of ***all*** detainees, and that obligations of the state are heightened due to the reliance of the detainee on the state. In addition, Articles (4), 4 (1) and 17 of the African Disability Rights Protocol oblige States Parties to ensure the rights of the disabled are upheld and respected on an equal basis with others; including as it relates to legislative, administrative and any other measures.

Malawi signed the CRPD (United Nations, 2007) and later ratified it on August 27, 2009. It has also ratified international human rights treaties which recognise right to health as an essential right (Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights). Regionally, it is a signatory to the African Disability Rights Protocol since February 6, 2022. These are reflected in the 1994 Constitution of Malawi which provides for the right to dignity (Section 19), equal treatment and access to justice (Section 20), right to access justice and other legal remedies before any court of law or tribunal (Section 41), and the specific rights of the accused (Section 42), which includes the right to legal representation (42)(1)(c)) and right to be informed in a language which he/she understands (42(2)(f)(ix).

Right to health is not directly enshrined in the Constitution of Malawi of 1966, however Section 12(d) establishes the fundamental principles upon which the Constitution was founded and includes that all persons have equal status before the law. Section 13 provides for principles of national policy, concerning, inter alia, gender equality, persons with disabilities, children, and the elderly; and enjoins the state to "*actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation.*" This includes ensuring that there is enough provision of health care (including mental health treatment) commensurate with Malawian needs as well as aligned to international standards.

Mental health disorders are recognized as a disability under the Disability Act (No. 8 of 2012) which defines disability as a long-term physical, mental, intellectual or sensory impairment, and which recognises that this impairment, in interaction with various barriers, may hinder the full and effective participation in society of a person on equal basis with other persons (Section 2). The 1948 Mental Treatment Act (Chapter 34:02 of the Laws of Malawi) is a general public provision which provides for the care of persons who are "*suffering from mental disorder or mental defect*" in mental hospitals in Malawi. Of note is that whilst there is a distinction with regard to referral on own initiative or by the court, the Act does not provide for specific treatment for any particular group (for example people in contact with the criminal justice system) once they are admitted.

Notwithstanding these fundamental rights provisions at both regional and domestic levels in Malawi, the situation on the ground for persons with mental illness and/or intellectual disability is precarious. The National Mental Health Policy which was developed in 2000 has had little traction on improving mental health service delivery. The policy has been going through a revision since 2014 (Malawi Human Rights Commission, 2022). It remains in draft form to date. There is one state operated mental hospital (*Zomba* Mental Hospital) and one large private psychiatrist hospital (St John of God Centre). Mental health screening and treatment services are provided in some prisons (*Maula Prison* in the Central Region; *Mzuzu Prison* in the Northern Region) on an ad hoc basis. In 2022 the Malawi Human Rights Commission raised concerns around a broad range of human rights violations and discrimination in the country, including in mental health care settings (referring to over-emphasis on biomedical treatment approaches and use of involuntary psychiatric interventions) and in the criminal justice and penal continuum.

There is no official data on the number or characteristics of detainees with mental illness or mental impairment in police custody or in the Malawi prison system. A joint civil society exercise (including by authors of this *Commentary*) reported in November 2021, the presence of 30 prisoners at Chichiri Prison and 20 prisoners at Maula Prison with various mental health conditions (depression, psychosis and others) (Mental Health Users and Carers, Centre for Human Rights Education, Advice and Assistance, Irish Rule of Law, 2021). Limited access to psychotropic drugs, and inadequate capacity and specialist expertise to detect, treat and manage mental health conditions and/or intellectual disabilities was documented across the criminal justice continuum (arrest, remand, sentence). A later Joint Civil Society Submission to the United Nations Committee on Economic, Social and Cultural Rights in 2023 has outlined substantial concerns regarding criminal justice processes (access to justice) in the country, prison conditions (food insecurity, water and electricity shortages, severe overcrowding, inadequate healthcare coverage) and use of the death penalty (including the impact of *'death row phenomenon'* on mental health) (Centre for Human Rights Education, Advice and Assistance, Irish Rule of Law International, Reprieve and the World Coalition Against the Death Penalty, 2023).

There are 30 prisons in the system which is operating at 234% capacity (17.6% in pre-trial detention) (October 2022) (World Prison Brief, 2023). Conditions of detention are historically harsh (see *Gable Masangano v Attorney General, Minister of Home Affairs and the Commissioner of Prisons, 2009*) and worsening in recent times due to food insecurity, dated infrastructure and inadequate sanitation (Centre for Human Rights Education, Advice and Assistance, Irish Rule of Law International, Reprieve and the World Coalition Against the Death Penalty, 2023; Gadama et al., 2020; Gauld, 2021; Jumbe et al., 2022; Malawi Inspectorate of Prisons, 2019; Malawi Inspectorate of Prisons, 2021; Malawi Law Commission, 2018; United States Department of State, 2020; Van Hout, 2022; Van Hout et al., 2022b; Van Hout et al., 2023).

5. Triability and procedural complexities in the Malawi criminal justice system

Both the Constitution of Malawi and the Criminal Procedure and Evidence Code (Act 36 of 1967) provide that those arrested must be brought before the court within 48 h of their arrest. Compliance with this provision is low (roughly 40%) (Vizsolvi, 2021). The maximum period that a person may be held in preventive detention is 30 days (Criminal Procedure and Evidence Code 161D). There is an exception, whereby in the case of homicide or where mental illness is suspected the State is required to undertake a mental assessment to determine whether to proceed with charging and prosecuting, or withdrawing the case. The process of transferring the file from lower courts to the High Court (known as *Committal proceedings*) level as in the case of homicide should be completed within 30 days (Criminal Procedure and Evidence Code, Part VIII), and the trial, at the maximum should be commenced within 90 days from the date of committal (Criminal Procedure and Evidence Code Section 161E).

With regard to capacity to commit offences, in Malawi; *"Every person is presumed to be of sound mind, and to have been of sound mind at any time which comes in question, until the contrary is proved."* (Section 11 of the Penal Code (Amendment) Act, 2023 (Act 8 of 2023), with Section 12 exempting people who are deemed "*mentally unsound through any disease affecting his mind incapable of understanding what he is doing, or of knowing that he ought not to do the act or make the omission"* at the time of commission of an offence from criminal liability. The wording is clear in that it does not refer to a specific mental disease or mental illness, but rather any disease that affects the mind, whether permanent or temporary. It is therefore not limited to known forms of mental illnesses or abnormalities, to the exclusion of others (Bande, 2017).

It is required for an accused person to be mentally competent to make a defence. In the ruling of the 2015 case of *Republic versus Lutepo* the court emphasised the relevance of an accused person being of sound mind, whereby this protects the right to fair trial. The court quoted with approval a prior statement by Birgden and Thomson (1990): *"In the criminal justice process, a defendant must be fit to stand trial so that the criminal procedure is dignified, the results are reliable and the punishment is morally justified, i.e. a fair trial."* The court further quoted Schiffer (1977); "*The idea that persons of unsound mind should not be made to stand trial is rooted in old age concepts of fair play and fundamental justice. … the fitness requirement is both the product of the traditional right of an accused to make fuller answer and defence … and a logical extension of the rule which evolved at common law prohibiting trial in absentia."*

In instances where the accused person has not been assessed, evidence presented at trial by the prosecution can infer that they do not have the capacity to be held responsible, where mental health was deemed instrumental in the crime or defence, resulting in acquittal. The mere fact that a person suffers from a mental illness does not suffice as evidence of unfitness to stand trial. The court must find that the person is incapable of understanding the charges, entering their defence or following trial.

In court, the magistrate or the judge may request a psychiatric assessment prior to the trial commencement, and require law enforcement, the prosecution or the defence to progress the matter (Section 133 Criminal Procedure and Evidence Code). This generally occurs as preliminary issue in order to determine whether the accused person can stand trial. Section 133 of the Criminal Procedure and Evidence Code provides guidance on dealing with accused persons with mental illness and incapacity, when "*the court has reason to believe that the accused may be of unsound mind so as to be incapable of making his defence*" (Subsection 1). These include an adjournment once the court is doubtful of the mental status of the accused person, where the accused is held in custody (or equivalent) for observation and treatment, and the Court direction of a medical practitioner to examine the accused "*with particular reference to his capability of making his defence"* (and included as evidence).

The period of adjournment must be at the discretion of the court, but it cannot exceed one month. During this adjournment period, the accused must be kept either in custody or at such other "*appropriate place as the court may direct*". Ordinarily this place must be a forensic hospital (*Zomba Mental Hospital*). Under Section 133(1) (c) the court must give the medical practitioner the reasons for its directions. The matter is then adjourned for psychiatric assessment by the medical practitioner for them to furnish the court with a report. When the report is ready, its copies must be provided for prosecution and the accused person (or their legal practitioner if any) either at the hearing, or if practicable, before the hearing (Section 133(3)). At its discretion the court may call upon the medical practitioner who furnished the report to testify orally. After considering the report and all evidence adduced by either the accused person or the prosecution, the court must make its decision whether the accused is of unsound mind and therefore either capable or incapable of making their defence.

Where the adjournment is made for reason that the accused person is of unsound mind, the court may at any time resume the proceedings and call for the accused person to be brought before the court for assessment regarding their capability to make their defence (Section 133(6)). An adjournment is a stop to a proceeding to continue on an already set date or date to be set, mostly instigated where there is a need for further information or evidence or where the court has run out of time to continue with a proceeding on that day. A discontinuance is similar to a withdrawal where in most instances there is an option to recommence the matter where circumstances permit. And then the procedure regarding assessment of fitness to stand trial is repeated.

When the court finds that the accused person is of sound mind, the matter proceeds to trial. If it is found otherwise, the proceedings are adjourned to an unspecified date (Section 133(6)). The court may also release the accused person on bail subject to sufficient security being given that he/she will properly be taken care of and prevented from doing injury to himself or any other person and for their appearance before the court or such other officer as the court may appoint in their behalf (Section 133(4)). If the court decides that bail should not be granted or if after being given bail sufficient security is not given, the court must make a "*reception order*" for the admission of the accused to a mental hospital (Section 133(5)). The person is to remain admitted in the *Zomba Mental Hospital* until such time as the court orders otherwise or unless a discontinuance is entered discontinuing the proceedings in the course of which the reception order was made. If such a discontinuance is entered, its copy must be served on the Secretary for Health and the person detained may be discharged from the *Zomba Mental Hospital* upon an order in writing by the Secretary for Health or by three of the visitors of the *Zomba Mental Hospital*, one of whom shall be a medical practitioner. During the period of discontinuance, the Secretary for Health is obliged to provide the court with monthly reports in the prescribed form on the status of the person detained until such person is discharged from hospital (Section 133(9)).

6. Gaps and flaws in due process and human rights protections

Malawi encounters substantial challenges in the due process of managing mental illness and mental incapacity when it comes to the criminal justice system. Such challenges include arrest without investigation; lack of access to legal representation; use of torture to extract confessions; partially completed or incomplete investigations; incomplete medical assessments; courts ignoring medical assessment reports; various forms of arbitrary detention (pre-trial, remand and post sentence) including for long durations (years in some cases); and detention in congested, inhumane, impoverished and highly stressful conditions (see *Gable Masangano v Attorney General, Minister of Home Affairs and the Commissioner of Prisons, 2009*) (Centre for Human Rights Education, Advice and Assistance, 2021; 2022; Centre for Human Rights Education, Advice and Assistance, Irish Rule of Law International, Reprieve and the World Coalition Against the Death Penalty, 2023; Malawi Human Rights Commission, 2022; Malawi Inspectorate of Prisons, 2019; Malawi

Inspectorate of Prisons, 2021; Van Hout et al., 2022a; Vizsolvi, 2021).

Criminal justice officials including law enforcement are observed to lack sensitivity toward persons with mental illness or intellectual disability, and lack knowledge of how to deal with them or when to refer them for mental assessment (Centre for Human Rights Education, Advice and Assistance, 2021; 2022). There are complications regarding whether law enforcement or prison resources should be used to coordinate transportation for psychiatric assessment at the Zomba Mental Hospital. Police in particular lack adequate resources to facilitate medical referral logistics for transfer to the Zomba Mental Hospital, timely mental assessment and adequate care of the arrested (Centre for Human Rights Education, Advice and Assistance, 2021; Centre for Human Rights, Education, Advice and Assistance, 2022; Vizsolvi, 2021).

Procedural processes are further compounded by complexities around psychiatric assessment within the court processes, whereby the 1948 Mental Treatment Act does not specifically state the requisite specific qualifications regarding the appropriate specialist assessment. It simply refers to a '*medical practitioner in charge of a mental hospital*.' This refers to a medical practitioner who is registered or licensed under any law in force in Malawi governing the registration of medical practitioners (Section 2). The Criminal Procedure and Evidence Code also refers to the same. Assessments are generally conducted by medical practitioners at the *Zomba Mental Hospital*, although assessments on fitness to stand trial are (at times) conducted at District Government Hospitals upon an order of the court (under Section 303(6) of the Criminal Procedure and Evidence Code). Medical assessment specialist capacity is however limited in the Zomba Mental Hospital, including in cases of homicide where the prosecution has applied for an order of the court for psychiatric assessment (see Section 133 of the Criminal Procedure and Evidence Code).

Poor compliance whereby court ordered psychiatric assessments are ignored, overlooked, or are even incomplete can occur (see *Republic versus Lutepo 2015)*. The process is also not watertight and despite qualified medical assessment, the court can ignore an expert opinion suggesting that an accused is not fit to stand trial; "*despite what medical witnesses may say as to the mental condition the court may, rejecting that evidence, still find the accused fit to stand trial."* (as was the case in *Republic v Lutepo 2015)*.

Lengthy detention periods of the mentally ill and/or mentally incapacitated are common, many lasting several months, and even years before any progress on their matter (see *Republic V Lutepo 2015*) (Centre for Human Rights Education, Advice and Assistance, 2021; Centre for Human Rights Education, Advice and Assistance, 2022). Without robust psychiatric assessment the accused person may not be included on the court listing for trial, and remains in limbo in prison or in police custody. For example, when the assessment is completed, and even if it is deemed that a person is unfit to stand trial, but if the Zomba mental hospital certifies that the person need not be institutionalised at the hospital but can receive treatment in the community, then practically, they are sent back to be remanded in prison. This is mainly due to the fact that there are no appropriate rehabilitation centres for such persons. Once assessed at the Zomba Mental Hospital, if the accused person is deemed not medically fit to stand trial, this does not necessarily translate into immediate release from custody. There are reports of accused persons being held in police custody for further months even post-discharge from Zomba Mental Hospital (Centre for Human Rights Education, Advice and Assistance, 2021; Centre for Human Rights Education, Advice and Assistance, 2022; Vizsolvi, 2021). They are also not permitted to enter prison as the Malawi prison system cannot cater for their health care and other needs (Centre for Human Rights Education, Advice and Assistance, 2021; Centre for Human Rights Education, Advice and Assistance, 2022; Vizsolvi, 2021).

Prolonged detention also occurs after court proceedings, for example in the case of further waiting for medical assessment processes to determine fitness to stand trial or determine criminal capacity. Delays can occur whereby the accused person is transferred back to police custody post assessment to wait for his/her trial date, and with no urgency placed on the fact that they have been determined not fit to stand trial. For example, an accused person is remanded to prison where he has entered plea before a competent court, or where in cases that require the person to be committed to the High Court, the accused is informed of the allegations against him/her and is remanded to prison awaiting *Committal proceedings*, or where *Committal proceedings* have been done but plea taking is yet to be done (Part IVA of the Criminal Procedure and Evidence Code). This can result in the accused person staying in detention for months or even years before appearing in court again and the further deterioration of mental health conditions, often exacerbated by congested conditions of detention.

7. Conclusion

It is evident that even though Malawi has legal instruments that attempt to deal with issues surrounding persons with mental illness or are mentally incapacitated in contact with the criminal justice system, there are inadequate provisions to manage these individuals adequately and in a humane manner throughout the process. Current provisions in Section 133 of the Criminal Procedure and Evidence Code, and Section 12 of the Malawi Penal Code combined still do not comply adequately with the CRPD nor the Protocol to the African Charter on the Rights of Person with Disabilities in criminal proceedings. An urgent review of due process is warranted.

Mental health legislation and policies to uphold the basic human rights of the mentally ill and/or mentally incapacitated within the criminal justice system are underdeveloped (and under-resourced). There are flaws in due diligence in the Malawi criminal justice pathway, and a broad range of basic human rights violations of the mentally ill or intellectually disabled when accused, remanded or sentenced for committing a crime are observed. Such violations concern basic rights around normative standards of detention, right to humane treatment and prohibition of torture, and fair trial rights (right to comprehend the charges against them, right to silence) (Centre for Human Rights Education, Advice and Assistance. Irish Rule of Law International, Reprieve and the World Coalition Against the Death Penalty, 2023; Vizsolvi, 2021). An urgent review of due process is warranted in the following areas; police referral of arrestees for medical assessment; follow through on court-directed assessments; arbitrary detention (arrest, remand, without formal charge, sentenced); monitoring of conditions of detention; provision of reinsertion supports and appropriate psychiatric services in the community and in prison.

Of key importance is that both pre-trial and prison detention facilities lack sufficient specialist clinical care and logistical supports and are unable to comply with the CRPD, and the UN norms and standards of detention and equivalence of care. There are insufficient trained medical specialists in the Zomba Mental Hospital, and in the country. There are backlogs in forensic assessments to determine competency to stand trial and criminal responsibility; inadequate availability of forensic beds; and insufficient coverage of community based mental health services. Skilled law enforcement to refer to the Zomba Mental Health hospital on arrest, availability of competent medical personnel for validated psychiatric assessments, robust medical pathways for therapeutic and psychosocial treatment, adequate medical supplies and reinsertion supports are needed.

Challenges also arise where at times the issue of fitness to stand trial and criminal culpability at the time of committing the offence are not clearly separated, and where medical reports are ignored by the court. Recommendations centre on the imperatives of consistency in mental capacity or illness assessment using validated screening tools, timely access to psychiatric assessment, that specialist expert reports provided to the court comply with the general requirements of expert evidence, and that courts respect the medical assessments themselves (Van Hout & Wessels, 2021).

Similar to other African countries (Pienaar, 2021; Van Hout &

Wessels, 2021), persons with mental illness or who are mentally incapacitated in the Malawi criminal justice system endure lengthy durations of detention awaiting and after forensic assessment. We encourage Malawi to consider (piloting) formal diversion options from the criminal justice system via mental health courts (see Pienaar, 2021). Mental health courts supported by medico-legal expertise can support the court in addressing mental illness as the underpinning driver for contact with the criminal justice system (see Bernstein & Seltzer, 2003; Pienaar, 2021). This can be incorporated into law by amendment of the relevant legislation (for example the Criminal Procedure and Evidence Code).

Given the deplorable conditions in Malawi prisons, an inter-departmental government response (Health, Justice and Correctional Services) is recommended to alleviate prison (and police holding cell0 congestion, by addressing criminalisation of the mentally ill and incapacitated, the lack of comprehensive forensic psychiatric services and by developing a centralised data base on mentally ill prisoners. Oversight mechanisms preventing human rights abuses of these very vulnerable individuals are crucial in all mental health settings in Malawi, not limited to police custody, remand detention facilities and prisons. Ratification of the Optional Protocol of the Convention against Torture is imperative. Arbitrary and lengthy detention for people with mental illness and/or intellectual disability is potentially classed as inhumane and constitutes an excessive sanction (Goomany & Dickinson, 2015; Gulati & Kelly, 2023; Pienaar, 2021; Van Hout and Wessels, 2021).

Further multi-stakeholder research is warranted to explore and raise awareness around the situation of the mentally ill and incapacitated in the Malawi criminal justice system. Research informed advocacy and sensitisation can support continued prison decongestion measures, including Presidential pardons, government debate around the rights of the mentally ill, surveillance, resourcing of community and prison based psychiatric screening and treatment services, training of law enforcement and prison staff and assist in developing diversionary and reinsertion supports in the community.

Declaration of competing interest

The authors declares that they have no conflict of interest to declare and has no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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