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# THE CRIME OF ATTEMPTED SUICIDE IN UGANDA: THE NEED FOR REFORMS TO THE LAW

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## ABSTRACT

Much has been written on the subject of suicide in Uganda, in particular the need to decriminalise it. However, very little is devoted to the issue of whether, in the first place, this offence is grounded in the principles of criminal law. In addition, hardly any literature is devoted to the exploration of defences capable of being relied on to ensure that when persons who attempt suicide are charged, due regard is given to the mental health issues surrounding their conduct. The purpose of this article is twofold. First, to demonstrate that the offence of attempted suicide under Ugandan law lacks foundation in the principles of criminal law. This conclusion is based on the fact that the offence of suicide is not proscribed under Uganda's laws; therefore, the conduct of attempting to commit suicide cannot constitute an offence. Secondly, to argue that the defence of insanity in Uganda, if widened, could found a basis for persons who attempt suicide to be acquitted by reason of mental illness.

**Keywords:** attempted suicide; Uganda; defence of insanity; mental health

## INTRODUCTION

In June 2013, Innocent Muhangi, a 22-year-old Ugandan male, was arrested after he attempted to commit suicide. He intended to jump off the third floor of a building (*The New Vision* 2013). Muhangi was charged with the offence of attempting suicide in accordance with the penal laws of Uganda. During the trial, Muhangi confessed that he wanted to commit suicide. According to him, despite the fact that he had fulfilled

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every requirement to complete his vocational studies, the Uganda National Examination Board had not released his examination results. He was found guilty by the magistrate, convicted and sentenced to a jail term of six months. In handing down the six-month jail sentence, magistrate Rebecca Nasambu granted the request of the prosecutor, Betty Agalo, who prayed that Muhangi be imprisoned not only to "keep him in a safe place where he could not commit suicide", but also to have him "change his attitude about taking his life" (*The New Vision* 2013).

In another case, in 2007, Kalisti, a 19-year-old Ugandan male and bike rider, had earlier been arrested for allegedly stealing two mobile phones. On 6 June 2007, while in detention at a police station, he removed his long-sleeved shirt, made a noose and strapped it around his neck. Two policemen intervened to save his life. In court Kalisti testified that he was depressed on account of being detained for a crime he had not committed. Passing judgment, magistrate Gaster Mugoya ruled that "anyone who does not value life is not fit to be left loitering among right-thinking members of society. Being arrested over phone theft is not the end of the world" (Wendo 2007).

These and several other decisions have sparked a debate on this subject, with many advocates and scholars, both nationally and internationally, calling for the decriminalisation of the offence of attempted suicide.[1] The arguments and scientific research in support of decriminalisation are indeed sound. A number of jurisdictions have, on the basis of these arguments, been persuaded to decriminalise the offence of attempted suicide. In Uganda, however, the above cases confirm that attempting suicide remains an offence, one that is actively prosecuted. Some questions, however, remain unanswered regarding the position in Uganda. The first is this: Is this offence as proscribed under Ugandan law compatible with the principles of criminal law? Secondly, can the defence of insanity found a basis for acquitting persons who are charged with the offence of attempting suicide? The latter question warrants an answer in view of the fact that Uganda continues to criminalise attempted suicide. Therefore, in the event that the offence is not decriminalised, arguably, those accused could be acquitted based on a successful defence of insanity. Although this discussion places Uganda at the heart of the analysis, the conclusions drawn are of importance to other similarly situated jurisdictions, including Kenya (Penal Code, sections 12 and 226) and Tanzania (Penal Code, sections 15 and 217), whose penal laws mirror those of Uganda on the subjects of attempted suicide and the defence of insanity.

1 At the international level, the World Health Organisation (WHO) has taken a keen interest in decriminalising attempted suicide; and it has gone a step further to help countries at the national level to decriminalise it. In Uganda, as will be demonstrated subsequently in this article, there has been ongoing advocacy regarding the need for the offence of attempted suicide to be decriminalised.

## SCALE OF SUICIDE AND OFFENCE OF ATTEMPTED SUICIDE

The term "suicide" is derived from a Latin term *suicidium*, meaning "to kill oneself". According to Schlebusch (2005: 179), suicide denotes

> a wide range of self-destructive or self-damaging acts in which people engage, owing to varying degrees of levels of distress, psychopathology, … awareness and expectations of the deleterious consequences or outcome of the behaviour.

This definition not only underscores the deliberateness of the act of killing oneself; it also implicitly recognises the relationship between mental disorders and suicide. Suicidal behaviour is divided into fatal and non-fatal suicidal behaviour. Fatal suicidal behaviour refers to self-committed, completed suicidal behaviour that embodied the victim's intent or aim to die and where that person managed to achieve that predetermined intent or aim. Non-fatal suicidal behaviour, on the other hand, refers to self-inflicted suicidal behaviour that does not succeed in ending the victim's life and which embodies several manifestations such as those seen in attempted suicide (Schlebusch 2005: 179). Regarding the scale of suicide, a 2014 study by the World Health Organisation (WHO 2014) found that suicides take a high toll, to the extent that more than 800 000 people worldwide die from suicide every year and it is the second leading cause of death in 15–29-year-olds.

According to WHO (2014), the indications are that for each adult who died by suicide there may have been more than 20 others who attempted suicide. In the context of Uganda, there is a paucity of statistics on the true extent of the problem. A few studies have, however, cast some light on its scale. One notable study is that conducted by Kinyanda et al, who reported suicide rates of 15–20 per 100 000 for the period of 2005 to 2007 in northern Uganda (Kinyanda et al 2005: 468–477). In another study, a collaborative team from Uganda, Norway and Ghana surveyed the self-reported suicidal behaviour and attitudes towards suicide among psychology students in Ghana, Uganda and Norway (Hjelmeland et al 2008: 20–31). With respect to Uganda, the study found, among other things, that the most frequently reported problems preceding the suicidal act among the Ugandan patients were poverty, loneliness and feelings of shame.

At present, most countries across the world no longer proscribe attempted suicide, notably Australia, England, Finland, Ireland, New Zealand, Norway, Sweden, Switzerland and South Africa. As at 2012, WHO identified 59 countries worldwide that have decriminalised suicide (WHO 2012). Some of the arguments in favour of decriminalisation have been grounded on the potential of decriminalisation to reduce cases of suicide. With a decriminalisation approach, persons who attempt suicide would ideally seek psychiatric help without being wary of possible criminal prosecution

(Hjelmeland 2012: 148–151). Research also demonstrates mixed results regarding the deterrent impact of anti-suicide legislation.[2]

More recently, in 2014, India struck down section 309 of the Indian Penal Code Act, which encompassed the crime of attempted suicide.[3] India's penal law, as is the case with Uganda's, is a legacy of British influence, with the penal laws of both countries having been profoundly influenced by the English common law. Section 210 of the Penal Code Act of Uganda creates the offence of attempted suicide, providing that "any person who attempts to kill himself or herself commits a misdemeanour" (Penal Code Act of Uganda). Under section 22 of Uganda's Penal Code Act, misdemeanours are generally punishable with imprisonment for a period not exceeding two years. With the current debate on whether or not attempted suicide should be decriminalised in Uganda, it is imperative for the country not only to revisit the doctrinal foundation of this crime, but also to explore means of having due regard to the mental health needs of persons who attempt suicide, should the offence remain on Uganda's statute book. Before addressing the aforegoing two issues, the arguments for and against decriminalisation are discussed.

## DEBATE ABOUT WHETHER OR NOT ATTEMPTED SUICIDE SHOULD BE DECRIMINALISED

Decriminalisation connotes "the removal of criminal status from certain behavior or action" (Uitermark and Cohen 2005). The term "decriminalisation" has often been confused with "legalisation." Decriminalisation and legalisation may yield similar results, in that certain conduct is deemed not to be subject to criminal penalties. Despite this similarity, these two terms may differ in their aims. One of the many aims of legalisation is to maintain social order (Mossman 2007). Whereas this may hold true for decriminalisation, the latter often places emphasis on the human rights implications of the continued criminalisation of the conduct in issue (Mossman 2007). The bodily

2 Research on the deterrent impact of anti-suicide legislation has yielded mixed results. See eg Lester 1992: 738. Lester compared suicide rates in Canada in the ten-year periods before and after decriminalisation of suicide, and found no increase in the rate of suicide following decriminalisation (Lester 1993: 1050). In his study, Lester compared suicide rates in New Zealand in the ten-year periods before and after decriminalisation and found no increase in the country"s suicide rate following decriminalisation (Lester 2002: 898). In his third study, Lester compared the suicide rates in seven countries (Canada, England and Wales, Finland, Hong Kong, Ireland, New Zealand and Sweden) five years prior to and following decriminalisation and found an increase in the suicide rates for the period following the abrogation of criminalisation of suicide in all seven countries. The mixed results from the foregoing studies could suggest that an argument cannot be conclusively sustained to the effect that decriminalisation deters suicide.

3 Section 309 of the Indian Penal Code, as struck down, stated: "Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine or both."

integrity of an individual as well as their right to dignity are issues that are accorded due regard in discussions pertaining to decriminalisation (Mossman 2007).

The terms "decriminalisation" and "legalisation" have featured prominently in discussions about whether or not marijuana should be legalised. In recent times, some states have been taking steps to decriminalise marijuana to the extent that an individual may consume it in the privacy of their home without being subjected to criminal sanctions (see eg *Prince & Others v Minister of Justice and Constitutional Development*).[4] By mapping out the contours of the conduct of cannabis consumption, these states are not per se legalising the use of cannabis; rather, they are regulating its use. The fact that the consumption of cannabis in the privacy of one"s home is beyond the reach of the arm of criminal law is not tantamount to legalisation of cannabis generally.

The same analogy may be invoked with regard to attempted suicide. Decriminalising attempted suicide does not make it legal. The decision to decriminalise may be based on the premise that the criminal law is not the best means of dealing with this issue or that invoking the criminal law is at odds with fundamental human rights, which are considered universal and an entitlement of everyone by virtue of their being human.

Arguments for the decriminalisation of attempted suicide have largely been grounded in the mental health needs of people with suicidal behaviour. In Uganda, just as the case has been for proponents in other jurisdictions, arguments for decriminalisation partly find basis in the fact that criminalisation constitutes cruel, inhuman and degrading treatment of persons who attempt suicide and an affront to their human dignity (Carlen 1994: 306–332; Hjelmeland 2012: 148–151). The foregoing position is supported by scientific research which shows that the presence of a mental disorder is a major risk factor for suicidal behaviour (Schotte and Clum 1987: 49–54; Shneidman 1993; Harris 1997: 205–228; Williams 1997, 2001; Clarke 1999: 457–462; Lönnqvist 2000: 107–120; O'Connor 2003: 279–308; Bertolote et al 2004: 147–155; Joiner 2005; Kinyanda et al 2005: 468–477; Ribeiro and Joiner 2009: 1291–1299; Khasakhala et al 2011: 134–139; Oliffe et al 2012: 505–514; Shilubane et al 2012: 177–189). It is generally estimated that more than 90 per cent of people who commit suicide will have had a psychiatric diagnosis at the time of death (Bertolote and Fleischmann 2001: 181–185). A more recent 2010 study by Izadinia et al found that up to 21 per cent of suicidal ideations were as a result of depression or what they preferred to refer to generally as "psychological problems". Also, an estimated 2–15 per cent of persons who have been diagnosed with major depression die by suicide (Bertolote and Fleischmann 2001: 181–185). The risk of suicide is highest in depressed individuals who feel hopeless about the future and who have attempted suicide in the past (Bertolote and Fleischmann 2001: 181–185).

Indeed, there is a plethora of empirical research demonstrating the nexus between mental disorders and suicidal behaviour.[5] In most of these studies, many people with

4 Case no 8760/2013, High Court of the Western Cape, 31 March 2017 at 102–110. Note, however, that this decision remains subject to confirmation by the Constitutional Court of South Africa.

5 For example, the study by Madelyn et al (1998: 915–923) sought to identify the independent and

suicidal behaviour often suffered from a mental disorder in accordance with the definition of a mental disorder[6] in the fifth edition of the *Diagnostic and Statistical*

differential diagnostic and symptom correlates of suicidal ideation and suicide attempts and to determine whether there are gender- and age-specific diagnostic profiles. The relationships between suicidal ideation, suicide attempts and psychiatric disorders were examined in 1 285 randomly selected children and adolescents, aged 9–17 years, of whom 42 had attempted suicide and 67 had expressed suicidal ideation only. The study found that mood, anxiety and substance abuse/dependence disorders independently increased the risk of suicide attempts. Bertolote and Fleischmann (2001: 181–185) conducted a study in which they reviewed 31 published papers on suicidal behaviour and mental disorders. All the diagnoses of mental disorders in the 31 publications were made on the basis of ICD or DSM III, IIIR or IV. The study found that in all the 31 studies, 98% of those who committed suicide had a diagnosable mental disorder. Some of the disorders identified by the study include mood disorders, schizophrenia and personality disorders. Notably, ICD stands for "International Statistical Classification of Diseases and Related Health Problems." It constitutes a medical classification list by the World Health Organization. DSM stands for the Diagnostic Statistical annual of Mental Disorders. It is a classification of psychiatric diagnoses and related problems. It is authored by the American Psychiatric Association.

A study by Lopez et al (2006: 1747–1757) found that psychiatric disorders were present in at least 90% of suicides, and up to 80% of such cases had gone untreated at the time of death.

King et al (2008: 117) focused on suicidal behaviour among lesbian, gay and bisexual (LGB) people. Data was extracted on 214 344 heterosexuals and 11 971 non-heterosexual people. The meta-analyses revealed a twofold excess in suicide attempts in LGB people. The risk for depression and anxiety disorders (over a period of 12 months or a lifetime) on meta-analyses was at least 1.5 times higher in LGB people. The study concluded that LGB people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm than heterosexual people.

Appleby et al (1998: 209–211) conducted a study which found that between 8 per cent and 15 per cent of women suffer postpartum depression, and that the condition is usually mild and manageable. Severe postpartum depression, however, is linked to an elevated suicide risk, with those who are admitted to hospital up to 70 times as likely to die by suicide.

WHO (2001: 265) reports that approximately 24 million people worldwide suffer from schizophrenia, with most of them being at risk for suicide.

Henriksson et al (1993: 935–940) investigated the prevalence and comorbidity of current mental disorders defined by DSM-III-R (among a random sample of suicide victims from a nationwide suicide population. Using a psychological autopsy method, the authors collected comprehensive data on all suicide victims in Finland during one year. Retrospective axis I–III consensus diagnoses were assigned to 229 (172 male, 57 female) victims. It was found that one or more diagnoses on axis I were made for 93 per cent of the victims. The most prevalent disorders were depressive disorders (59%) and alcohol dependence or abuse (43%). The prevalence of major depression was higher among females (46%) than among males (26%). Alcohol dependence was more common among the males (39% versus 18% for females). A diagnosis on axis II was made for 31 per cent and at least one diagnosis on axis III for 46 per cent of the cases. Only 12 per cent of the victims received one axis I diagnosis without any comorbidity. The study concluded that the majority of suicide victims suffered from comorbid mental disorders. Notably, the term axis is referred to under the DSM. A clinician uses axes (axes is the plural of axis) to diagnose a patient. There are different axes a clinician can rely on under the DSM. In addition, there are different editions of the DSM. Researchers and clinicians always make reference to the edition in place at the time of publication. Henriksson et al referred to DSM-III-R because it was the prevailing edition in 1993.

6 Under the DSM-5, "[a] syndrome characterized by clinically significant disturbance in an individual's

*Manual of Mental Disorders* (*DSM-5*). In terms of the mental disorders recognised by the *DSM-5*, suicidal behaviour is a major risk among people diagnosed with the various mental disorders.[7] Generally, the mental disorders recognised by the *DSM-5* identify suicidal behaviour as one of the risks. Notable mental disorders associated with the risk of suicide include disruptive mood dysregulation disorder, major depressive disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, separation anxiety disorder, selective mutism, panic disorder and post-traumatic stress disorder.

Studies have also illustrated that mental disorders are often triggered by a wide range of risk factors, some of which are beyond the control of individuals. Notable risk factors include poverty, medical conditions, frustration in love, financial setbacks, a psychosocial state of mind such as hopelessness and depression, among others (Lester 1989; Baumeister 1990: 90–113; Ajzen 1991: 179–211; Bearman 1991: 501–524; Kral 1994: 245–255; Maris 1997: 519–550; Pillay and Wassenaar 1997: 155–162; Pollock and Williams 1998: 375–387; Eshun 2003: 165–171; Katarina and Agneta 2003: 193–206; Anderson et al 2005: 317–331; Masango et al 2008 25–29; Schlebusch 2012). This makes suicidal behaviour a multifaceted issue that cannot exclusively be addressed through criminalisation and penalisation. Kwesiga, a Ugandan counsellor and psychologist, has, for instance, aptly observed that

> if a person has an illness which causes them to have thoughts of suicide, even after imprisonment that illness can come back from time-to-time, and with it, the suicidal ideas come back even stronger than before (*The New Vision* 2013).

Kwesiga adds that "if it is social or economic or other such problems causing them to have suicidal tendencies, again those problems will not go away with imprisonment."

Arguments for decriminalisation have also rationally been grounded in the negative implications of criminalising attempted suicide. Notably, a criminalisation approach could push the suicidal behaviour underground, therefore exacerbating the challenges that persons who attempt to commit suicide have to contend with (Latha and Geetha 2004: 343–347; Hjelmeland 2012: 148–151). Similarly, the health rights of people with suicidal behaviour may be affected negatively as patients would avoid seeking mental treatment and counselling for fear of being punished (Latha and Geetha 2004: 343–347; Hjelmeland 2012: 148–151). Across the literature, various viable options have been suggested as alternatives to criminalisation. These include public health messages about suicide and media coverage of suicide issues; school-based programmes that focus on raising awareness about suicide; family support for families facing stress and difficulty; community-based mental health services and support services; the improvement of

cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental process underlying mental findings. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities …"

7 See generally the risks of mental disorders under the *DSM-5*.

control over substance and alcohol use; support for family and friends bereaved by suicide; encouragement of responsible media coverage of suicide; crisis centres and crisis counselling; screening for depression and suicide risk; public awareness education and mental health literacy; psychotherapy and psychosocial interventions for mental illness; pharmacotherapy for mental illness; support after suicide attempts; restriction of access to means of suicide; and training of various stakeholders in how to support people with suicidal behaviour (Lester 1995: 79–84; Madelyn and Rachel 2001: 6–31; Mann et al 2005: 2064–2074; Beautrais et al 2007: 67–79; Burrows and Schlebusch 2008: 173–193, 2009: 755–757; Van der Fletz-Cornelis et al 2011: 319–333).

For opponents of decriminalisation, the crux of their argument is the deterrent role of penal laws as a response to suicidal behaviour. In the context of Uganda, as the case has been in other jurisdictions, the deterrence argument stands out as a major justification for the continued criminalisation of attempted suicide. Since, in the opponents' view, there is a universal condemnation of suicide on account of a belief in the sanctity of human life, it is argued that the criminalisation of attempted suicide is morally justified as it affirms the unlawfulness of suicide (Wendo 2007). It is argued, therefore, that criminal prosecution of suicidal behaviour generally has a deterrent effect (Wendo 2007). The opponents of decriminalisation are also of the opinion that people make rational decisions to engage in suicidal behaviour by weighing the potential benefits and consequences of their actions. Repealing laws proscribing the conduct of attempting suicide would, it is argued, encourage suicidal behaviour and lead to a rise in suicide rates (Wendo 2007).

In a study conducted by Hjemeland et al (2012: 148–151) on the views of Ugandan mental health professionals towards the criminalisation of attempted suicide, it was found that although the majority of mental health professionals were in favour of decriminalisation, some felt very strongly that the law needs to be retained because it would deter people from attempting suicide. In this study, some mental health professionals expressed confidence in the power of severe punitive measures to deter persons who attempt suicide. The study by Hjemeland et al (2012) also found that within the juridical community there is great resistance to decriminalising the conduct of attempting suicide because many legal professionals believe that retaining the law serves a deterrent role. The foregoing arguments, may, however, crumble when measured against the formidable body of research on the mental state of persons who attempt suicide. Having briefly dealt with these preliminary views, it is now apt to delve into the two overarching issues of this article.

## FUNDAMENTAL FLAW IN OFFENCE OF ATTEMPTING SUICIDE UNDER UGANDA'S PENAL CODE ACT

In Uganda, the offence of attempting suicide is explicitly proscribed under the Penal Code Act as follows: "[a]ny person who attempts to kill himself or herself commits

a misdemeanor" (section 210, Chapter 120). As a misdemeanour, this offence is dealt with in accordance with the provisions on misdemeanours under Uganda's laws. The Penal Code Act offers a vague definition of the term "misdemeanour." Under section 1, it means "any offence which is not a felony." The term "felony" is also accorded a vague definition – "an offence which is declared by law to be a felony or, if not declared to be a misdemeanour, is punishable, without proof of previous conviction, with death or with imprisonment for three years or more" (Penal Code Act 1950, section 1). It could be deduced from these vague provisions – in particular, that pertaining to a "felony" – that the term "misdemeanour" is generally used to refer to less serious offences that carry lesser penalties than felonies. In accordance with section 22 of the Penal Code Act, the general punishment for misdemeanours is imprisonment for a period not exceeding two years. With the offence of attempting suicide being categorised as a misdemeanour, the rules applicable to misdemeanours, including the nature of the punishment to be handed down by courts, are to be invoked. Therefore, a person found guilty of attempting suicide could be sentenced to imprisonment for a period of up to two years.

Suffice it to note that most of Uganda's laws, including its criminal laws, are a legacy of colonialism. Uganda, being a former British colony, derived most of its laws, including its criminal laws, from Britain. Even though the country has since attained independence, these laws have been inherited and have hardly undergone any amendment since the 1960s. From a religious perspective, this crime was deemed necessary because the sanctity of life had to be protected (Aquila 2007). Even though in cases of attempted suicide the person takes their own life as opposed to others', this is still considered offensive based on the premise that only God can give or take away life (Aquila 2007). Of course, suicide itself was not proscribed under British laws at the time; however, attempting to commit suicide was.

Persons are not only held criminally liable when a crime has been completed. Certain forms of conduct prior to the completion of the crime, such as conspiracy and attempt, are also considered crimes for the purposes of criminal liability (Snyman 2008: 283; Burchell 2013: 535). The need to punish this type of conduct does not fall strictly within the ambit of the retributive theory of justice (Snyman 2008: 283). It is, however, supported by other theories of justice such as the reformative and preventive theories (Snyman 2008: 283). For one to be held guilty of an attempt to commit a given crime, it has to be proved that the person intends or intended to commit that crime and, as Snyman (2008: 285) puts it, the person, in addition, "unlawfully engages in conduct that is not merely preparatory but has reached at least the commencement of the execution of the intended crime." In the light of these elements, it can be deduced that for conduct to constitute an attempt, in the first place, there has to be a crime. It stands to reason that a person cannot be found guilty of attempt if the conduct they attempt to engage in does not constitute a crime.

Burchell (2013: 535–553) also makes reference to the term "crime" in substantiating conduct amounting to an attempt. He is of the opinion that

> to amount to an attempt, the steps taken by the accused must have reached the point when they themselves indicate beyond reasonable doubt that he or she intended to commit a crime he or she is charged with attempting.

The emphasis again is to be placed on the words "intended to commit a crime." This conceptualisation buttresses the view that attempts are with respect to crimes already proscribed. Therefore, even if society may find certain conduct undesirable, a person cannot be found guilty of attempt unless the attempt pertains to conduct that is already proscribed as a crime.

The question then arises: Is the crime of attempting suicide in Uganda grounded in the principles of criminal law? As already alluded to, Uganda does not criminalise suicide, for the obvious reason that the victim, who is also the perpetrator, cannot be prosecuted by reason of death. Yet, despite the fact that suicide is not an offence under Ugandan law, this country's Penal Code Act criminalises the conduct of attempting to commit suicide. By categorising this conduct as an attempt, it is to be assumed reasonably that the crime of attempting suicide would have to be dealt with in accordance with the principles of attempt under criminal law. This, however, is not the case because there is no crime of suicide in the first place. On the basis of this gap, it follows logically that an attempt to commit suicide under Ugandan law is doctrinally flawed. Therefore, it is fair to conclude that the crime of attempting suicide under Ugandan law does not have proper grounding in the principles of criminal law.

For quite some time, arguments for decriminalising the crime of attempting suicide have been grounded on the mental health needs of persons who attempt suicide. With the analysis in this section, arguably, the lack of foundation in the principles of criminal law is another ground for challenging this crime.

This crime, however, continues to sit uncomfortably alongside the principles of criminal law on attempts. Despite the arguments advanced by the adherents of decriminalisation, thus far, Uganda's criminal justice system has not been persuaded to decriminalise attempted suicide. The ideal solution, of course, would be for this crime to be decriminalised. Criminal law should not be concerned with cases of attempted suicide in the light of the fact that individuals enjoy the right to personal liberty and dignity. Suffice it to note that the Constitution of Uganda of 1995 guarantees these rights in very strong terms (articles 23 and 24); therefore, one could take the debate to its logical conclusion – that the offence of attempting suicide is at odds with the Constitution, a law that is considered supreme in this country (article 2).

However, the fact that the conduct of attempting suicide remains an offence after decades of advocacy for decriminalisation suggests that persons who attempt suicide continue to face the risk of prosecution and imprisonment. How, then, can the existing laws be applied with a view to guaranteeing the right to a fair trial of persons charged with attempting suicide? The next section discusses the defence of insanity with a view to assessing whether it can be invoked to ensure that the accused in a case of attempting suicide is acquitted by reason of suffering from a disease of the mind.

## DEFENCE OF INSANITY AS BASIS FOR ACQUITTAL OF PERSONS FOUND GUILTY OF ATTEMPTING SUICIDE

A person cannot be held criminally liable if they are insane. The defence of insanity is two-legged. The first leg of the insanity defence was the *M'Naghten rule,* which was issued by a British court in 1843 (*R v M'Naghten*).[8] According to the *M'Naghten rule,* a person is legally insane and therefore not guilty of the crime with which he is accused if, at the time of the crime, he was

> labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know that what he was doing was wrong.

So, under the *M'Naghten* rule, a person is considered insane and therefore not criminally responsible if, at the time of the alleged crime, the person had a mental disorder or a disease of the mind; the person's mental disorder caused him to suffer from severe ignorance; and this ignorance took one of two forms – either ignorance of what the person was doing or ignorance of the fact that what they were doing was wrong. Essentially, the *M'Naghten* criteria are based on the accused person's ability to distinguish between "good" and "evil" or "right" and "wrong." Many criminal justice systems, including Uganda's, still apply the one-legged approach to the defence of insanity. This is evident is section 11 of the Ugandan Penal Code Act, which reads as follows:

> A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he or she is through any disease affecting his or her mind incapable of understanding what he or she is doing or of knowing that he or she ought not to do the act or make the omission; but a person may be criminally responsible for an act or omission, although his or her mind is affected by disease, if that disease does not in fact produce upon his or her mind one or other of the effects mentioned in this section in reference to that act or omission.

The general principle in criminal law is that a person who attempts suicide is not criminally responsible if by reason of a mental illness they are incapable of appreciating the wrongfulness of their act or omission. Therefore, section 11 above is in accord with this general principle. As noted in the section above on the debate on whether or not attempted suicide should be decriminalised, studies show that suicide is one of the major risks of the mental disorders categorised under the *DSM-5*. Since Uganda continues to criminalise the act of attempting suicide despite the studies mentioned above, arguably, the defence of insanity under section 11 could be relied on to provide relief to those accused of attempting suicide. In this regard, expert evidence (in particular evidence of mental health professionals) on the mental state of mind of the accused can be led with a view to proving that the accused was labouring under a defect of reason arising from a

8 This traditional formulation found its basis in the so-called *M'Naghten* rules. These rules were named after *M'Naghten*, the accused person in the case of *R v M'Naghten.*

disease of the mind and that by reason of this defect the person attempting suicide was "incapable of understanding what he or she [was] doing or of knowing that he or she ought not to do the act or make the omission."

If the person accused of attempting suicide successfully raises the defence of insanity, then they would have to be dealt with in terms of section 48(1) of Uganda's Trial on Indictment Act. This section provides as follows:

> Where any act or omission is charged against any person as an offence, and it is given in evidence on the trial of that person for that offence that he or she was insane so as not to be responsible for his or her action at the time when the act was done or omission made, then if it appears to the High Court that that person did the act or made the omission charged but was insane as aforesaid at the time when he or she did the act or made the omission, the court shall make a special finding to the effect that the accused is not guilty of the act or omission charged by reason of insanity.

Worthy of note, however, is that section 11 may, in some respects, be limited in affording a defence to accused persons who attempt suicide. It is also notable that, for the defence of insanity under section 11 to found a basis for acquittal, the test is the person's "incapability of appreciating the wrongfulness of the proscribed conduct." Therefore, where a person who attempts suicide appreciates the wrongfulness of attempting suicide under Ugandan law but by reason of a mental illness they cannot exercise self-control to avoid the act of suicide, they are criminally responsible. In this regard it must be pointed out that most often persons who attempt suicide – such as Muhangi and Kalisti in the introductory cases – even by reason of a mental disorder may be capable of appreciating the wrongfulness of attempting suicide. They may be cognitively and socially intelligent, able to communicate as normal human beings, do not suffer from any illusions (like many schizophrenics) and are quite adept at practical reasoning (that is, to the extent of finding the means to satisfy their need to commit suicide) (Michel et al 1994: 172–178; Fairbairn 1995; Shneidman 1996; Hjelmeland and Knizek 1999: 277–283; Konrad and Ladislav 2001: 231–254; ). Many people who display suicidal behaviour, however, proceed to attempt suicide because, despite their appreciation of the wrongfulness of suicide, they are incapable of acting in accordance with such appreciation. In the light of section 11 above, persons who attempt suicide and who, by reason of a mental disorder cannot act in accordance with the appreciation of the wrongfulness of suicide, proceed to commit suicide, may not benefit from the defence of insanity. They are criminally responsible because they do not fall within the narrow ambit of Uganda's insanity defence.

However, on account of the limitations of the insanity defence in accordance with the *M'Naghten* rule, some jurisdictions have supplemented the *M'Naghten* version of the insanity defence with what is typically known as the "irresistible impulse rule" (IIR) (Burchell 2013: 271–272). This is the second leg of the insanity defence. According to IIR, accused persons are legally insane and therefore not criminally responsible or punishable for their otherwise criminal conduct if a mental defect or disorder made it impossible for them to control their behaviour and avoid committing the criminal act

for which they are being prosecuted (Burchell 2013: 271–272). Burchell offers a useful insight into the content of the second version of the insanity defence and explains (2013: 287) that a person can fall within the ambit of the insanity definition if by reason of their mental illness they lack "self-control" and they cannot "resist" committing or "refrain" from committing an offence. Burchell (2013: 287) also explains that the determining factor is the question of capacity for self-control. For persons who attempt suicide, the issue is whether, in addition to appreciating the wrongfulness of suicide, the person who attempts suicide could refrain from attempting suicide. The import of this is that if by reason of a mental disorder a person who attempts suicide cannot refrain from doing so, then they fall within the ambit of the insanity defence and ought not to be held criminally responsible. Under the second version of the insanity defence, the action of the person who attempts suicide does not have to be "physically irresistible or based on sudden unplanned action" (Burchell 2013: 382). In fact, the action of the person who attempts suicide could even arise out of "brooding or reflection over a lengthy period of time" (Burchell 2013: 382). Yet with the narrowness of Uganda's insanity defence in the light of Uganda's failure to adopt the IIR approach, persons who attempt suicide and who, by reason of mental disorder, are legally insane, are still criminally responsible for attempted suicide.

Unlike Uganda, South Africa has a provision that embraces the two versions of the insanity defence and, accordingly, would make room for the mental health needs of persons who attempt suicide to be given due regard. Section 78 of South Africa's Criminal Procedure Act reads as follows:

1. A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable–

   (*a*) of appreciating the wrongfulness of his or her act or omission; or

   (*b*) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

   shall not be criminally responsible for such act or omission.

What distinguishes South Africa's provision from the penal provision of Uganda is section 78(1)(*b*): it makes provision for the element of self-control. Contrary to the provision of Uganda, which is one-legged, South Africa"s current formulation of the defence of insanity is two-legged. The first leg is incapability to appreciate the wrongfulness of an act or omission and the second leg is incapability to act in accordance with an appreciation of the wrongfulness of the wrongful act or omission. Of course, neither suicide nor attempting suicide are crimes in South Africa. However, were

Uganda to have a provision similar to section 78(1)(*b*), those charged would stand a better chance of benefiting from the defence of insanity. The empirical research already alluded to suggests that the mental state of persons who attempt suicide often renders them incapable of acting in accordance with the appreciation of the wrongfulness of suicidal behaviour. This is as a result of their inability to control or guide their behaviour in consonance with the wrongfulness of suicide. A provision similar to that of South Africa's arguably creates room for manoeuvre in addressing the mental health needs of persons who attempt suicide. It would render them eligible for the insanity defence and, accordingly, pave the way for them to receive mental treatment and help.

An approach to the insanity defence that encompasses the two versions elaborated upon above makes room for the mental state of a person who attempts suicide to be given due consideration. Where persons who attempt suicide fall within the ambit of the insanity defence, it would follow that the criminal justice system is mandated to deal with such accused persons in terms of section 48(1) of the TIA. However, if the crime of attempting suicide were to be decriminalised, the defence of insanity would no longer be needed.

## CONCLUSION

Debates about whether attempting suicide should be decriminalised have been ongoing. In states such as India, these debates have led to the penal provision on attempted suicide being struck off the statute book. In Uganda, despite the continued advocacy for decriminalisation, the authorities have not been persuaded to decriminalise this offence. Although much has been written on this subject in the context of Uganda and beyond, two issues have hardly been the focus of research. The first pertains to the issue whether the offence of attempting suicide finds justification in the principles of criminal law and the second questions whether the defence of insanity under Ugandan law can found a basis for the acquittal of those charged with this offence. On the first issue, the analysis has revealed that the crime of attempting suicide under Uganda's Penal Code Act is at odds with the principles of criminal law pertaining to attempts to commit crimes generally. This, therefore, is a new perspective from which to challenge this crime.

On the second issue, it has been established that the defence of insanity creates an entry point via which those accused of this offence can be acquitted by reason of suffering from a disease of the mind. The discussion has, however, highlighted the reality that the narrow nature of the defence of insanity in Uganda limits the extent to which an accused in cases of attempted suicide can benefit from this defence. Reference was therefore made to South Africa's defence of insanity for an example of good practice in the context of the observence of human rights. Worthy of note, however, is that the success of this defence in dealing with cases of attempted suicide will depend on the extent to which defence attorneys will be prepared to make use of expert evidence, a territory that seems to have been largely uncharted to date.

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