DISABILITY RIGHTS WATCH

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25th February, 2019


The Clerk,
National Assembly of Zambia,
Parliament Buildings,
P. O. Box 31299,
Lusaka,
Zambia.

**Re: THE MENTAL HEALTH BILL NO. 1 OF 2019**

Reference is made to the above captioned

We here submit a memorandum to the Mental Health Bill No. 1 of 2019 which was presented to the National Assembly on Thursday, 21st February, 2019 and also as a response to your invitation to us to make submissions. In line with our core principles, we have made consultations with both our staff and Board in order to come up with this memorandum. We have also consulted with our key partner, the Mental Health Users Network of Zambia in developing the memorandum.

Firstly, we wish to recommend the Government of the Republic of Zambia for having presented the Bill to the National Assembly after a long process of developing through a consultative process. We also are grateful to the Ministry of Health and the Ministry of Justice for including us in the whole process of developing the Bill. It is gratifying that the Bill is at last in the House after a long period of consultation and hope that the process will come to an end with all stakeholders satisfied with the outcome law.

Please find enclosed 10 copies of the memorandum.

Yours sincerely,

Wamundila Waliuya,

Director

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**MEMORANDUM**

# Submission to the Committee on Health, Community Development and Social Services on the Ramification of the Mental Health Bill No. 1 2019

## 1.0 INTRODUCTION

This memorandum is a response to the invitation extended to Disability Rights Watch (DRW) to make submissions to the Committee on Health, Community Development and Social Services. The memorandum is based on the observations made by DRW on both the positive and negative aspects of the current Bill. The memorandum is also in line with the submissions DRW has been making to the development process of the Bill as one of the key stakeholders who actively participated in its drafting. In making this submission DRW takes into consideration its expertise in international disability rights standards arising from the team of legal, human rights and disability law experts it has.

Therefore, we submit with the hope that the recommendations laid herein will be adopted by the Committee.

## 2.0 DISABILITY RIGHTS WATCH

DRW was incorporated as a company by limited by guarantee under the laws establishing the Patents and Companies Registration Agency (PACRA) and further incorporated as an organisation for persons with disabilities under the laws establishing the Zambia Agency for Persons with Disabilities (ZAPD).

### Vision

The vision of Disability Rights Watch is “persons with disabilities in Southern Africa enjoying and exercising their rights and fundamental freedoms on an equal basis with the rest of society without any form of discrimination on the basis of their disabilities”.

### Mission

The mission statement of the Disability Rights Watch is “to defend, protect and promote the economic, social, cultural, civil and political rights and fundamental freedoms of persons with disabilities and ensure the respect of their inherent dignity on an equal basis with all others”.

### Goal

Persons with disabilities across southern Africa attain real equality and full human rights and dignity.

### Objectives

The objectives of DRW are:

1. To defend and protect persons with disabilities from all forms of discrimination, exploitation, violence and abuse through strategic advocacy including paralegal services and litigation.
2. To establish legal precedents to promote the rights and fundamental freedoms of persons with disabilities and to use these precedents for the purpose of transforming laws across Africa
3. To promote the rights and fundamental freedoms of persons with disabilities outlined in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and other international human rights covenants and national legislation.
4. To monitor the implementation of the UNCRPD at individual country levels.
5. To promote best practice on the domestication of the Convention on the Rights of Persons with Disabilities (CRPD) across Southern Africa.
6. To build the strategic advocacy and organisational management capacity of Disabled People's Organisations and their umbrella federations and bodies in Southern Africa.
7. To undertake individual, joint and collaborative research on disability inclusion, law policies and practices.
8. To provide disability accessibility audit services for institutions and individual clients
9. To be a leading disability rights think tank and consultancy firm.

## 3.0 BRIEF BACKGROUND

DRW has been actively involved in the consultative process which has been going on for a long time now. DRW and many stakeholders have been calling for reforms in the law governing mental health services in Zambia. With this we feel reforms are long-overdue with the primary legislation in place regulating mental health service provision being the Mental Disorders Act, 1949. In finding that the legislation was based on "highly offensive, derogatory and discriminatory" terminology and required a "thorough review", Honourable Mrs Justice M. Mapani-Kawimbe of the High Court at Lusaka found that:

"…it is obvious that in 1949, that the authorities did not have anything in mind as far as the protection of human rights and fundamental freedoms is concerned." (at p. J28)

The inadequacy of the Mental Disorders Act, 1949, is also underlined by widespread human rights violations in Zambia's psychiatric facilities where there is extensive evidence of abusive practices including seclusion and restraints, denial of basic needs and health care, unlawful detention and non-existent complaints and inspection systems. Particularly shocking conditions have been uncovered in Zambia's "mental health settlements" including long-term isolation and starvation. Following a visit to the psychiatric unit of Ndola Hospital, UN Special Rapporteur on the rights of persons with disabilities, Ms. Catalina Devandas-Aguilar said:

"I was appalled by the conditions in the male acute ward, which is not only overcrowded, but has insufficient bedding, and very unhygienic conditions. I was informed about the existing practice of sterilization of women with disabilities without their informed consent… I have also been informed that the conditions in the mental health settlements that fall under the responsibility of the Ministry of Health are

extremely harsh. I would suggest a moratorium on new admissions until these facilitates are permanently closed."

Research also uncovered that many people detained at psychiatric facilities were held arbitrarily. This is because mental health practitioners misapply the Mental Disorders Act, 1949, which is widely considered to be unfit for purpose. In practice, many people are detained at psychiatric facilities against their will but are formally regarded as "voluntary patients" when they are brought by family members, the police or others, resulting in arbitrary detention.

The inadequate of investment into voluntary mental health services at the primary health care level leaves a vast section of the population without access to preventive treatments and therapies. There is inadequate data is available regarding the government's total expenditure on mental health. As a result, many people with mental disabilities receive no support at all or are pushed into the hands of unregulated traditional healers. In 2014, the President of the Traditional Health Practitioners' Association of Zambia (THPAZ) stated publicly that the practices used by some traditional healers are deeply worrying and violate human rights, including the absolute prohibition on torture and ill-treatment, noting that "almost half of registered traditional healers were 'quacks'".

It is in view of the above recognition that many stakeholders are calling for the urgent repeal of the Mental Disorders Act of 1949 to replace it with a more human rights based piece of legislation.

## 4.0 OBSERVATIONS

The Mental Health Bill No. 1 2019 is fundamentally flawed in that it fails to conform to Constitutional protections as well as obligations under international human rights law related to persons with disabilities. If passed, the legislation would result in:

i) human rights violations including breaching the principle of informed consent to treatment and discriminatory deprivation of liberty;
ii) failure to ensure access to mental health treatment, including investment in community-based mental health services which are so urgently needed; and
iii) would undermine dignity, social inclusion and equality, adopting derogatory language related to persons with mental disabilities.

The Bill has been substantially changed departing away from almost all the submissions made by different stakeholders who were directly involved in the consultation process of the Bill. Many stakeholders, including persons with disabilities in general, and those with mental disabilities in particular, with other civil society organisations and medical practitioners made submissions, in good faith, which took into consideration provisions of international human rights frameworks and the Constitution of Zambia.

We wish to observe from the onset that in Mwewa, Caste and Katontoka v. the Attorney General and Others [2017/HP/2014], Respondents for the State averred that the Mental

Health Bill would address violations of the Constitution and the Convention on the Rights of Persons with Disabilities (CRPD), to which Zambia is a State Party, sustained by the outdated 1949 Mental Disorders Act. However, to the extent that the Bill falls beneath these Constitutional human rights protections, it brings into question legal undertakings made by representatives for the State in that case.

For the above reasons, the 2019 Bill should not proceed in its current form until the concerns of persons with mental disabilities and wider civil society are fully addressed in the frame of comprehensive, inclusive and transparent process of engagement like this one.

Whereas aspects of the Bill are welcome, notably adoption of a definition for discrimination conforming to that given under the Persons with Disabilities Act 2012, the Bill has fundamental weaknesses which render it incompatible with human rights guarantees provided in international human rights frameworks and the Constitution of Zambia.

(1) The Bill wrongly refers, in the Preamble, to the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care General Assembly Resolution 46/119 of 17th December 1991 which has been superseded by the UN Convention on the Rights of Persons with Disabilities.[1]

(2) The Bill is replete with discriminatory and derogatory language which attacks the dignity of persons with mental disabilities as citizens of Zambia, including the term "mental disorder". The use of derogatory language, including this term, was found to be "highly offensive, derogatory and discriminatory", having "no place in a modern society" by the High Court of Zambia and was banned by the court in Mwewa, Kasote and Katontoka v. the Attorney General and Others [2017/HP/2014].

(3) In its present form, the Bill would legalise abusive practices which breach Constitutional protection and the human rights of persons with mental disabilities including legislating to enable involuntary detention, forced treatment, seclusion, restraint and electro-convulsive therapy (ECT) (which if not modernized cases severe pain).

(4) Despite recognition of the concept of legal capacity of persons with mental disabilities, the Bill retains provisions which allow "supporters" to consent to treatment or hospitalisation of people without the person's consent or even against their will. This is a serious misunderstanding and misconstruction of the concept of "support" which is set out under the UN Convention on the Rights of Persons with Disabilities, Article 12.

(5) The Bill completely ignores the urgent need to set out a legislative framework for the development of community-based mental health and other services for persons with mental illness and mental disabilities, insufficiently addressing the "mental health gap" which is perhaps the most significant feature of the current ailing infrastructure. The World Health Organization's (WHO) Quality Rights Tool Kit on assessing and improving quality and human rights in mental health and social care facilities, points out that

[1] See, for example, Felicity Callard and Others, *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (2012), Chapter 2.

investment in hospitalisation is the incorrect approach: "[Psychiatric and other long-stay inpatient facilities have long been associated with poor-quality care and human rights violations […] For this reason, the World Health Organization (WHO) recommends that countries progressively close down this type of facility and instead establish community-based services and integrate mental health into primary care services and the services offered by general hospitals".

(6) The Bill perpetuates an outdated biomedical model of disability which neglects the fact that persons with mental disabilities are equal members of society and breaching the rights to equality and freedom from discrimination under the Constitution (Article 23).

(7) Many of the clauses of the Bill conflict with Zambia's obligations under international human rights law, notably the Convention on the Rights of Persons with Disabilities (CRPD), and specifically the rights to equality and non-discrimination (Article 5), right to equality before the law (Article 12), liberty and security of the person (Article 14) and the physical and mental integrity of the person (Article 17).

## 5.0 IMPORTANT ISSUES TO BE CONSIDERED IN REVIEWING THE BILL

1. Informed consent

Informed consent is defined as the process whereby explicit information is provided to a person which would be relevant for them to decide on whether or not to have a particular treatment or to participate in a particular experiment. The validity of informed consent is premised upon the full disclosure of appropriate information to a person who is permitted to make a voluntary choice.[2] It incorporates five important components; voluntarism, competency, full disclosure, understanding and express authorization by the person.[3]

A recent ruling in Australia further elaborated on informed consent: A person does not lack the capacity to give informed consent simply by making a decision that others consider to be unwise according to their individual values and situation. To impose upon persons with mental illness and mental disabilities a higher threshold of capacity, and to afford them less respect for personal autonomy and individual dignity, than people without disabilities, would be discriminatory.[4]

2. Proxy consent and substituted decision-making

The UNCRPD Article 12 states that all persons are equal before the Law. Further, the General Comment No. 1 on Article 12 issued by the UN Committee on the Rights of Persons with Disabilities is also categorical that support should be provided to the persons to enable them make decisions. Decisions can only be made where there is full

[2] Clinical practice. Assessment of patients' competence to consent to treatment,*AppelbaumPS,N Engl J Med. 2007 Nov 1; 357(18):1834-40.*

[3] Beauchamp TL, Childress JF. Principle of biomedical ethics, 6th edition. New York: Oxford University Press, 2009

[4] **PBU v Mental Health Tribunal (Human Rights) [2017] VCAT 781 (31 May 2017)**

disclosure and access to information by the person concerned. This includes persons with mental illnesses and mental disabilities.

The Bill also conflates the concepts of legal capacity and mental capacity. It must be noted that legal capacity is the right and freedom to hold and exercise said rights. Legal capacity is an inherent right. Mental capacity is the understanding that every individual varies in the way they assess information on a variety of different aspects based on gender, age, societal expectations, etc. Supported decision making therefore becomes the bridge between the two concepts in that a support person guides the persons with mental disability to be able to make a decision but cannot under any circumstance make a decision on their behalf. The rights, will and preference of persons with mental disabilities should always prevail.

The United Nations Special Rapporteur on the Rights of Persons with Disabilities in her 2016 visit to Zambia noted with concern the denial of legal capacity for persons with mental disabilities. Appointments of guardians in Zambia is based on an assumption that a person with a mental disability has no legal capacity due to a lack of "mental capacities". This assumption pervades all aspects of life affecting the exercise of other human rights such as personal liberty, freedom of expression, privacy, education, health, family life and property. For instance, the Constitution of Zambia provides that a person can be deprived of her or his personal liberty if "is, or is reasonably suspected to be, of unsound mind […] for the purpose of his care or treatment or the protection of the community". In addition, it allows limitations in the administration of property of "a person of unsound mind". These provisions do not comply with the Convention on the Rights of Persons with Disabilities.[5]

3. Involuntary and emergency admissions

Involuntary and emergency admission standards have been expanded significantly in the Bill to include circumstances where a patient is "unreasonably withholding or refusing consent". The more detailed procedural aspects covered in the submissions of stakeholders to the development of the Bill have been left out in the current Bill thus, providing the Minister with the power to regulate involuntary admission on the mere basis that it is "necessary for the health and safety of the patient". Involuntary admission is also explicitly referred to as providing for detention. In this situation, there are no procedural safeguards. This is in contravention of Article 14 of the CRPD where one cannot be deprived of their liberty on the basis of disability.

Deprivation of liberty on the grounds of actual or perceived mental illness is and mental disabilities are unjustified, a position which has been authoritatively stated by the UN Special Rapporteur on Torture, Inhuman and Degrading Treatment or Punishment[6], the CRPD Committee[7], and more recently in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities.

[5] End of Mission Statement by the United Nations Special Rapporteur on the rights of persons with disabilities, Ms. Catalina Devandas-Aguilar, on her visit to Zambia, *Lusaka, 28 April 2016*

[6] United Nations, General Assembly, *Report of the Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment, Juan E. Méndez*, A/HRC/22/53 (1 February 2013), available from https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf, para. 69.

4. "Special treatments"

This 2019 Mental Health Bill wrongly advocates in favor of electroconvulsive therapy (ECT), which can be applied without the voluntary consent of the person concerned, a position which represents a grave violation of human rights potentially amounting to torture (that is, when the procedure causes grave pain in a person). The UN Special Rapporteur on Disability in her 2016 visit to Zambia specifically observed that persons with mental illnesses and mental disabilities are hospitalised without their informed consent and subjected to seclusion and forced treatment. She then called for immediate measures to be taken to stop these practices which are inconsistent with international human rights standards. The Provisions in the present Bill on involuntary treatment and admission directly contradict the recommendations of the Special Rapporteur. This is essential to observe because Zambia ratified and domesticated the Convention on the Rights of Persons with Disabilities.

7. The mental Disorders Act of 1949 (MDA) preservation provision/ Savings and Transition Clause

Section 42 preserves all orders made under the Mental Disorders Act. This defeats the purpose of the Bill if the provisions of the Mental Disorders Act, which were highly discriminatory and unconstitutional, will still apply.

In view of the above, it is very important that the Committee takes into consideration all appropriate international human rights frameworks, in particular the UN Convention on the Rights of Persons with Disabilities and the provisions of the Constitution of Zambia.

## 6.0 RECOMMENDATIONS

In view of all the above observations, we therefore call for the following:

(i) the redrafting of the current Bill to comply with international human rights standards, in particular the Convention on the Rights of Persons with Disabilities and also the Constitution of Zambia.

(ii) The adoption, by the Committee on Health, Community Development and Social Services, of our clause to clause analysis of the Mental Health Bill of 2019 as appended in Annex 1.

## 7.0 CONCLUSION

The Government of the Republic of Zambia ratified the UN Convention on the Rights of Persons with Disabilities and thereafter domesticated it through the enactment of the Persons with Disabilities Act of 2012. This action demonstrates the commitment the State has towards the promotion and protection the rights and fundamental freedoms of persons with disabilities including the rights and fundamental freedoms of persons with mental illnesses or disabilities. This on its own has raised the human rights index

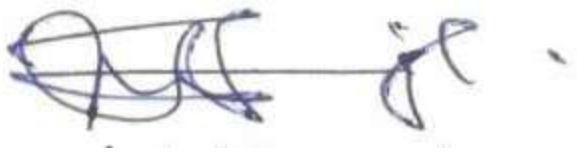
[7] United Nations, Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities* (September 2015), available from https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc, '*Chapter III: The absolute prohibition of detention on the basis of impairment'*.

of Zambia. It is in this spirit that the Committee should seriously consider redrafting the current Bill to conform with the submissions we have made.

We thank the Speaker of the National Assembly and the Chairperson of this Committee for inviting us to submit what we have submitted today. We also thank the office of the Clerk to the National Assembly for recognizing us as a key stakeholder in matters that affect persons with mental illnesses or disabilities.

All queries concerning this memorandum should be directed to Mr. Wamundila Waliuya, Director, Disability Rights Watch on +260977459925 or wamundila@disabilityrightswatch.net.

Signed



Joseph S. Munsanje,
Board Chairperson,
Disability Rights Watch.

Dated: 25th February, 2019

## ANNEX 1: MENTAL HEALTH BILL No. 1 2019 ANALYSIS AND PROPOSALS

1. OBJECTS OF THE BILL

i) The first object uses derogatory language with regard to persons with mental disabilities, including the use of the word "*mental disorder.*" The term "Mental Disorder" should be deleted.
We propose that the terminology mental illness and mental disability be maintained.

ii) The fourth Object correctly refers to the UN Convention on the Rights of Persons with Disabilities (CRPD) which has the status of binding international human rights law; but incorrectly references the Principles for the protection of persons with mental illness (UN General Assembly Resolution 46/119, "MI Principles") which has now been superseded – a position which has been emphasised by the UN High Commissioner for Human Rights.[8]
We recommend that all references to the MI Principles are removed and that connected provisions in the Bill are amended in full alignment with the UN Convention on the Rights of Persons with Disabilities.

iii) The Bill also draws significantly on the World Health Organization's *Resource Book on Mental Health, Human Rights and Legislation*,[9] in particular Part II ('*Legal Capacity and Rights of Mental Patients*'), Part VII ('*Consent*'), and Part VIII ('*Admission, Treatment, Care, Rehabilitation or Palliation*'). However, the WHO has formally withdrawn the *Resource Book* and that the CRPD is now the authoritative basis for reform of mental health systems globally:
"*The work of the WHO is informed by the Convention on the Rights of Persons with Disabilities. The WHO Resource Book on Mental Health, human Rights and Legislation has been withdrawn because it was drafted prior to the coming into force of the UN Convention on the Rights of Persons with Disabilities and is therefore not compliant with the latest human rights norms and standards. In 2008 the UN Convention on the Rights of Persons with Disabilities (CRPD) came into force. The Convention sets out a wide range of rights including, among others, civil and political rights, the right to live in the community, participation and inclusion, education, health, employment and social protection. Its coming into force marks a major milestone in efforts to promote, protect and ensure the*

[8] United Nations, Human Rights Council, *Report of the United Nations High Commissioner for Human Rights: Mental health and human rights*, A/HRC/34/32, Thirty-fourth session, 21 January 2017, para. 22, available online at http://www.un.org/disabilities/documents/reports/ohchr/a_hrc_34_32_mental_health_and_human_rights_2017.docx.
[9] World Health Organization, *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: WHO, 2005).s

*full and equal enjoyment of all human rights of persons with disabilities."*[10]

In alignment with the position of the World Health Organization, it follows that any proposals based on outdated standards such as the Resource Book must be removed. Any legislative proposals targeting persons with mental disabilities must be based on and fully aligned with the CRPD which is the most relevant, authoritative, comprehensive and modern expression of international human rights law.

2. MISSING OR INSUFFICIENTLY DEVELOPED ELEMENTS IN THE BILL

We made comprehensive submissions on certain important elements which needed to be included in the Bill but are missing or insufficiently addressed in the Bill. We here present them.

**i)** Community-Based Services: A more comprehensive framework for the creation of community-based services with the purpose of aiding dignity, equality and social inclusion should be developed. These should include, but not be limited to, the integration of mental health services into the general health care system at all levels, but also enable the provision of individualised, preventive, rehabilitative and auxiliary services.

ii) Elimination Of Restrictive Practices: Part IX of the Bill would allow for seclusion, restraints and potentially other human rights-violating practices against persons with mental disabilities. Such practices have no place in modern mental health care and should be abolished. The proposed National Mental Health Council could have a role in developing and enforcing standards to eliminate these practices in line with human rights guarantees.

iii) Protection Of Vulnerable Groups: While we recognise the provision of the Bill in Section 15 sub section 7 (d) where it stipulates that women, children and elderly persons shall be exempted from fees, the Bill fails to address the enhanced vulnerabilities of particular groups who frequently experience multiple forms of discrimination and abuse, including:

**Women with mental disabilities** who frequently face higher levels of forced treatment, involuntary institutionalisation, violence and rape, including in psychiatric health facilities.

The Bill must include a specific clause on the protection of women with disabilities from any form of violence, abuse and exploitation within the community and in psychiatry facilities.

**Children with mental disabilities**, who are at an enhanced risk of experiencing violence compared to other children and who, in institutional

[10] World Health Organization, 'Mental health, human rights & legislation: A global human rights emergency in mental health', webpage, available at https://www.who.int/mental_health/policy/legislation/en/.

settings, often experience higher rates of restraint, seclusion, immobilisation and punishment as well as harmful practices such as placement with adults.

The Bill must include a clause that will ensure that children with mental disabilities are placed in specialised and separate mental health wards or institutions with specific measures for gender and age appropriate treatment, rehabilitation and protection.

**Older persons with mental disabilities**, who often experience higher rates of isolation, neglect, abandonment, restrictive practices and heightened vulnerability to abuse and exploitation within their families and communities.[11]

The Bill should include, under the proposed provision in proposal 2 (i) on community based services, a clause on community based health services specifically directed to elderly persons who usually suffer from dementia.

3. SECTION 2: INTERPRETATIONS

We propose that the following interpretations be changed:

i) "Community leader" is provided for in the interpretations but does not appear anywhere in the text. It should be deleted from the interpretations.

ii) "correctional centre" is defined as an institution where a mental patient who commits an offence is held in custody for treatment and rehabilitation;" This whole definition must be deleted and changed to defining "correctional facility" means … "as defined by the Zambia Correctional Services"

iii) "forensic mental patient" should read "forensic person with mental illness" Interpretations provide for 'health care provider' and "health practitioner". We propose that health practitioner be defined as is but include the definitions of the HPCZ and GNC. This will cater for both categories of service providers

iv) The Bill defines "informed decision". We observe that informed decision is vaguely defined. Informed decisions usually arise from informed consent. Therefore, the definition of "informed consent" is adequately defined to cover "informed decision". "Informed decision should be deleted"

v) The Bill defines 'involuntary admission" as means the detention and provision of mental health services to a mental patient who—
*(a)* is incapable of making an informed decision due to their mental health status; or
*(b)* unreasonably withholds or refuses to give informed consent but requires those services for that person's own protection or for the protection of others;"

[11] See, for example, Office of the High Commissioner for Human Rights (OHCHR) and the Centre of Old Age and Aging Studies, Pontificia Universidad Católica de Chile, *International Conference on Human Rights of older persons and non-discrimination*, conference report, 3-4 October 2017, Santiago (Chile), available online at https://www.ohchr.org/Documents/Issues/OlderPersons/ConferenceSantiagoReport.pdf.

The definition presumes that persons with mental disabilities should be detained and is premised on the incapacitation to make decisions and choices in access to health. This diminishes the concept of legal capacity. Therefore involuntary admission should be defined, close to admission of a person with a mental illness in circumstances in which his mental capacity is compromised, allowing the medical practitioner to institute admission into a health facility with the protection of all the rights of the persons with mental illness. The definition should not include the element of detention.

vi) We recommend that a definition of legal capacity be included with the guidance of the UN Committee on the Rights of Persons with Disabilities, General Comment No. 1 on Article 12 of the CRPD.

4. PART II – 'LEGAL CAPACITY AND RIGHTS OF MENTAL PATIENTS'

The term Mental Patients should be deleted and replaced with persons with mental illness.

The recognition that all persons shall enjoy legal capacity (Clause 4(1)) is welcome, notwithstanding the use of derogatory language which should be amended.

This Part, however, allows for restriction of legal capacity on the basis of "*mental illness*", "*mental disorder*" or "*mental disability*" (Clause 4(2)). The provisions of Clauses 4 and 5 wrongly conflate the concepts of "*mental capacity*" and "*legal capacity*", where the first relates to legal agency and personality and the second is used to refer to cognitive and neurological processes. The CRPD Committee has authoritatively and consistently stated that restriction or removal of legal capacity on the basis of disability **can never be justified** and violates the right to equality before the law under CRPD Article 12.[12] Guardianship and substitute decision-making, including legal processes which authorise third parties to make decisions without or against the consent of the person concerned, must be abolished.

The proposal to empower the Minister to take policy measures on awareness-raising and capacity-building are welcome but insufficient. Indeed, the use of derogatory language in these Clauses undermines the noble purpose of improving respect for the human rights of persons with mental disabilities

***We recommend that the right to legal capacity is guaranteed for all without exception. Under no circumstances should legal capacity be restricted or denied on the basis of disability – or erroneous grounds such as lack of 'mental capacity', 'mental illness' or 'mental disorder'.***

We further recommend that new, human rights-compliant provisions are included in this Part to enable persons with mental disabilities to exercise their legal capacity. In line with the CRPD, these should include:

[12] United Nations, Committee on the Rights of Persons with Disabilities, *General Comment No. 1 – Article 12: Equal recognition before the law*, CRPD/C/GC/1, Eleventh session, adopted 19 May 2014, available online at https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement.

The right to request and receive reasonable accommodations when accessing public services, in line with the definition contained in CRPD Article 2 and the Persons with Disabilities Act No 6 2012 enacted by this house.

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The right to receive support in exercising legal capacity in conformity with CRPD Article 12, and Section 8 of the Persons with Disabilities Act giving full effect to the will and preferences of the person concerned and protecting against abuse, exploitation and substituted decision-making.

The redrafting of the Minister's powers to issue human rights-compliant policies concerning the rights of persons with mental disabilities including the initiation of awareness-raising and capacity-building initiatives targeting the general public, media and state officials is necessary.

5. PART III – 'THE NATIONAL MENTAL HEALTH COUNCIL'

Establishment: The establishment of a central national authority on mental health is welcome as a way of focusing government efforts to improve the lives of persons with mental disabilities and improving the overall mental health of the nation.

Functions: However, the functions of the new Council require careful consideration and should be strengthened through explicit reference to and alignment with relevant human rights norms and standards. For example, the functions of the Council under Clause 10 could be amended as follows:

*(a)* The Council should promote and protect the rights of all persons to attain the highest attainable standard of mental health.

*(b)* The Council should collaborate with relevant local and international actors on promoting mental health as a human right.

*(d)* The Council should lead and support anti-stigma campaigns – but should not use derogatory language such as "mental disorder" itself!

*(g)* The Council should be explicitly required to use standards set out under the CRPD when assessing professional conduct and undertaking inspections of health facilities and services, with reference to those obligations contained under CRPD Article 16(3) (*preventing exploitation, violence and abuse in all facilities and programmes designed to service persons with disabilities*) and Article 33 (*national implementation and monitoring of compliance with the CRPD*).

*(h)* There should be an explicit obligation on the Council to liaise with persons with mental disabilities and their representative organisations, who should also be properly represented on the Council, in compliance with recommendations set out by the CRPD Committee.[13]

[13] Specifically: United Nations, Committee on the Rights of Persons with Disabilities, *General Comment No. 7 on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention*, CRPD/C/GC/7, 9 November 2018,

*(m)* The development of community-based services should be one of the highest priorities of the Council with an explicit obligation to focus government resources on strengthening access to mental health care at the primary health care level.

*(n)* The focus on deinstitutionalisation is highly welcome and could be strengthened through requiring the Council to provide guidance and standards on reducing and avoiding long-term care in in-patient facilities.

Composition: At present, persons with mental disabilities have a minimal role. Clause 14(2)(3) says that the Executive Director of the Council must be a psychiatrist. This will enshrine a medical approach within the Council to the exclusion of other non-medical forms of support and services that are important to aid the inclusion of persons with mental disabilities in society; and will side-line the views of persons with mental disabilities themselves.

*We recommend, instead, that the role of persons with mental disabilities and their representative organisations should be enhanced. The Human Rights Commission should also be represented on the body.*

## 6. PART IV – 'MENTAL HEALTH SERVICES'

The commitment to introduce mental health care services at all levels is welcome, but the provision of such services should not be restricted to psychiatric facilities.

We recommend, instead, that mental health services are integrated at all levels of the general health care system including the role of community health workers.

Clause 15(2) proposes that mental health services should be provided on an equal basis with physical health care services *"where possible*". This limitation is vague and should be removed.

The derogatory terminology ("*mental patients*", "*forensic mental patients*") used in this Part should be removed.

Persons with mental disabilities accessing care should be at the centre of decision-making related to their care.

We recommend that Clause 15(5) should be amended according to provide primacy to the decisions, will and preferences of persons concerned.

## 7. PART V – 'RIGHTS AND RESPONSIBILITIES OF MENTAL PATIENTS'

available online at http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsnbHatvuFkZ%2bt93Y3D%2baa2pjFYzWLBu0vA%2bBr7QovZhbuyqzjDN0plweYI46WXrJJ6aB3Mx4y%2fspT%2bQrY5K2mKse5zjo%2bfvBDVu%2b42R9iK1p.

Section 16 contains various rights of persons accessing mental health services however, similarly to other Parts of the Bill, contains derogatory terminology including "*mental patients*", which should be removed.

We recommend that derogatory language is removed.

- We further recommend that the concept of supported decision-making mentioned under paragraph (i) ot section 16 requires detailed rules which should be developed in line with General Comment 1 of the CRPD Committee.[14] The law must state that these will be in regulations to be prescribed.
- We also recommend that additional rights should be integrated into Section 16 including:

    - the right to freedom from torture, ill-treatment, exploitation, violence or abuse (in line with CRPD Articles 15, 16 and 17);
    - the rights to equality and freedom from discrimination on the basis of disability (in line with CRPD Article 5);
    - the right to request and be provided with reasonable accommodations (as defined CRPD Article 2), and that failure to provide reasonable accommodations amounts to discrimination on the basis of disabilities; and
    - the independent right to complaint and access justice (in line with CRPD Article 13), including the provision of independent advice and advocacy services.

Section 18 paragraph (c) appears to allow for the sharing of information related to the health status of persons accessing services without the need for prior and informed consent of the person concerned. This should be amended accordingly.

We recommend that Section 18 paragraph (c) is redrafted to state that a person has the right to provide or withhold consent to be passed on to any third party, and is notified in all cases.

8. PART VI – 'STANDARDS OF CARE AND TREATMENT'

There are multiple issues with this Part which draw heavily on outdated guidance set out by the World Health Organization which has subsequently been withdrawn (see also para. 1.1.ii) above).

For example, the principle of least restriction contained in Clauses 19(3) and (4) operate on the now outdated MI Principles referred to in paragraph 11.b above which have been superseded by the UN Convention on the Rights of Persons with Disabilities. In Zambia it conflicts with the Persons with Disabilities Act.

The reliance on conflicting standards in this Part is further evidenced with the erroneous proposition that "*supporters*" can act as proxies for persons deemed

[14] Ibid.

"*unable to understand the information communicated*" (Clause 20(2)). The CRPD Committee has made clear that **support is a concept linked to the exercise of legal capacity** and must never be construed in such a manner as to substitute the will, preferences or decisions of persons with disabilities, including persons with mental disabilities:

"*16. […] States parties must refrain from denying persons with disabilities their legal capacity and must, rather, provide persons with disabilities access to the support necessary to enable them to make decisions that have legal effect.*

*"17. Support in the exercise of legal capacity must respect the rights, will and preference of persons with disabilities and should never amount to substitute decision-making. 'Support' is a broad term that encompasses both informal and formal support arrangements, of varying types and intensity. For example, persons with disabilities may choose one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy (including self-advocacy support), or assistance with communication."*[15]

Beyond this, Part VI disproportionately privileges clinical psychiatric service provision to the detriment of other forms of individualised social, ancillary and supportive services to persons with mental disabilities, reducing the quality and types of support they may access.

*Given that Part VI is fatally flawed, we recommend it is removed. Any revised Part should be developed carefully in line with the standards of the CRPD and in close consultation with persons with mental disabilities and their representative organisations. Key considerations include that any future proposals should:*

*i) Clearly state that the right to legal capacity can never be restricted on the basis of disability, including mental disability;*
*ii) Set out a framework for the provision of support for persons to exercise their legal capacity when making decisions about their health care or treatment, with safeguards against exploitation, violence, abuse and substitute decision-making;*
*iii) Provide a framework for the provision of a diverse range of high quality medical and non-medical services to persons with mental disabilities; and*
*iv) Specify that the goal of such services should be to promote and protect the human rights of all persons, including persons with mental disabilities; to enable citizens to achieve the highest attainable standard of health and mental health; give full respect to the principle of free and informed consent to all care, treatment and services, at all times; and support the autonomy and inclusion of people into their communities.*

[15] Ibid.

9. PART VII – 'CONSENT'

The principle of free and informed consent must guide all health care and other services provided to persons with mental disabilities, in full conformity with the right to health as set out under CRPD Article 25, guarding against arbitrary or discriminatory deprivations of liberty (CRPD Article 14), and preventing all forms of abuse (CRPD Articles 15, 16 and 17).

The current drafting of Sections 22(1)(b)-(c), (2)-(4) advance the proposition that persons with disabilities may be involuntarily detained or subjected to non-consensual treatment or other interventions with reference to the principle of "*least restriction*". This approach to mental health care directly contradicts the standards set out in the preceding paragraph and will result in profound and widespread human rights violations against persons with mental disabilities.

Once again, this Part puts forward the untenable proposition that supporters may be able to provide proxy consent to treatment (Clause 23), in complete opposition to the definition and purpose of "*support*" specified above in para. 0.

It remains that this Part provides for the possibility of persons to make "*advance decisions*" although the rules set down are imprecise and provide for the possibility of vitiating such a decision should the person be deemed to lack competence to make such informed decisions.

*This Part is poorly drafted and will result in grave and widespread human rights violations. It must be withdrawn in its current form. Future proposals should be built on the standards set out in the CRPD (and not the outdated MI Principles), must be subjected to extensive consultation with persons with mental disabilities and their representative organsiations, and must ensure that:*

- *i) the will, preferences and decisions of persons with mental disabilities are given primacy in all matters concerning their care and treatment;*
- *ii) supporters, where they are appointed by the person concerned, must at all times support persons concerned with expressing their will, preferences and decisions; but that they must never make decisions for the person concerned;*
- *iii) free and informed consent is gained in relation to all care, treatment and placement decisions;*
- *iv) persons have the right to conclude advance decision-making agreements related to their health care or other service provision; that persons have the right to comprehensive support in the drafting of such agreements; that agreements clearly specify the conditions that should be met before the terms of such agreements are acted upon; that there are mechanisms in place to prevent abuse; and that persons making agreements can also amend them as and when they wish.*

10. PART VIII – 'ADMISSION. TREATMENT, CARE, REHABILITATION OR PALLIATION'

Continuing the reliance upon the MI Principles which have now been superseded by the CRPD, this Part continues to allow involuntary admission and treatment on the basis of the "*health and safety of the mental patient*". In practice, this provides extraordinarily wide discretion to personnel in health care facilities to detain and forcibly treat persons against their will, again violating, *inter alia*, the rights to equality and non-discrimination (CRPD Article 5), legal capacity (CRPD Article 12), liberty (CRPD Article 14), freedom from torture, ill-treatment, exploitation, violence and abuse (CRPD Articles 15 to 19), and the right to health on the basis of free and informed consent (CRPD Article 25).

*This Part must be thoroughly revised in conformity with the abovementioned standards. Admission to health care facilities should only be allowed on the basis of the free and informed consent of the person concerned and this includes supported decision making.*

11. PART IX – 'SPECIAL TREATMENT'

The provisions of this Part are deeply concerning in that they provide a legislative basis extremely dangerous and abusive practices which, in themselves, are highly likely to fall foul of the absolute prohibition on torture and ill-treatment which is a peremptory norm of international law.

Most recently, former United Nations High Commissioner for Human Rights, Zeid Ra'ad Al Hussein called for the "elimination of practices such as forced treatment, including forced medication, forced electroconvulsive treatment, forced institutionalization and segregation".[16]

According to the UN Special Rapporteur on Torture,

"*there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-28, 78). Moreover, any restraint on people with mental disabilities even for a short period of time may constitute torture and ill-treatment [fn: See CAT/C/CAN/CO/6, para. 19 (d); ECHR, Bures v. Czech Republic, Application No. 37679/08 (2012), para. 132].*"[17]

[16] United Nations, Human Rights Council, *Mental Health and human rights – Report of the United Nations High Commissioner for Human Rights*, A/HRC/39/36, Thirty-ninth session, 24 July 2018, available online at https://www.ohchr.org/Documents/Issues/MentalHealth/A_HRC_39_36_EN.pdf.

[17] United Nations, Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, A/HRC/22/53, Twenty-second session, 11 February 2013,

Article 15 of the CRPD (freedom from torture or cruel, inhuman or degrading treatment or punishment) states: "*In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.*" Clause 28, however, allows for "clinical or experimental research and development of drugs" with reference to the relevant rules under the National Health Research Act, 2013. Yet, it is deeply worrying that the consent of persons with "mental disability" is not compulsory when undertaking health research in the case that person is deemed not to be "capable of understanding" (Section 45(7)(c)). Such practices would undoubtedly amount to torture or ill-treatment under international human rights law.

*We recommend that this entire Part be removed.*

12. PART X – 'CRIMINAL PROCEDURES FOR FORENSIC MENTAL PATIENTS
PART XI – 'MENTAL ILL [SIC] INMATES AND UNCONVICTED INMATES

There are numerous and serious problems with these Parts too, not to mention the fundamental problems with the concept of forensic psychiatric detention and treatment under the CRPD. It is a highly complex area where standards are less well-developed internationally.

These Parts raise issues including forensic detention on the basis of mental disability which is discriminatory pursuant to the guidance of the CRPD Committee on Article 14 CRPD;[18] the possibility that abusive "special treatments" may be used with little oversight pursuant to Clause 31(1); that reviews of detention will take place on a six-monthly basis but without there being any clarity as to the criteria which will be used in determinations under Clause 33, which is highly likely to result in situations of prolonged and arbitrary detention; and the problematic continuation of the need to secure Ministerial Orders permitting release, a system which has been shown to leave persons languishing in the criminal justice system for years or even decades.

*Consideration should be given to removing these Parts, which should receive greater scrutiny under a separate Bill. In the case that this is not accepted, it is recommended to specialist technical support is formally requested by the Government from the UN Committee on the Rights of Persons with Disabilities pursuant to CRPD Article 35.*

13. PART XII – 'GENERAL PROVISIONS'

The powers of the Minister to issue Regulations are unnecessarily limited in focusing mainly on mental health facilities rather than the integration of mental health services throughout the health system and ensuring accessibility and availability for the entire population. Further, Regulations on de-institutionalisation (Section

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para. 63, available online at https://www.ohchr.org/documents/hrbodies/hrcouncil/regularsession/session22/a.hrc.22.53_english.pdf.

[18] United Nations, Committee on the Rights of Persons with Disabilities, *Guidelines on article 14 o the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities*, Fourteenth session, September 2015, available online at https://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc.

39(2)(g)) should not be focused on "*mental patients*" but rather "*residential mental health facilities*".

*We recommend that the powers of the Minister under Clause 39 are amended in line with these observations.*

The perpetuation of orders made under the Mental Disorders Act under Section 42 is unjust given the high numbers of persons currently experiencing involuntary and/or legally tenuous detention and treatment at Zambia's mental health facilities.

*(a)* This provision should be removed. All orders made under previous legislation should be reviewed within [3 months] of the provisions of the new legislation coming into force or lapse automatically.

*(c)* The same.
All mental health facilities should undergo compulsory inspection with a view to conforming with relevant Regulations made under new legislation, within a period of 1 year.

*(d)* All terms used here, including "mental patient", are derogatory and must be removed from the law in conformity with the judgment in *Mwewa, Kasote and Katontoka v. Attorney General*.

*(f)* This term will keep in place institutions which restrict or deny the legal capacity of persons with mental disabilities in conflict with the universal nature of the concept under CRPD Article 12. The Clause should be deleted.

*We recommend that Section 42 (savings and transitional provisions) are amended in line with these observations.*

SCHEDULE – PART I: 'THE BOARD OF THE COUNCIL'

1. This regulates the tenure and appointments of Council members at the newly established National Mental Health Council (See Part III of the main Bill). Detailed analysis has not been completed but it is clear that the provision of reasonable accommodations to ensure the direct involvement of persons with mental disabilities are not provided.

   *Detailed consultations on the composition of the Board of the National Mental Health Council are required, with a particular focus on the role of persons with mental disabilities and their representative organisations, and the need to ensure that reasonable accommodations are provided to enable participation in the official business of the Council.*