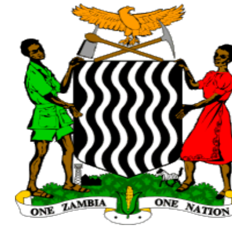

REPUBLIC OF ZAMBIA

REPORT

OF THE

COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES ON THE MENTAL HEALTH BILL, N.A.B. NO. 1 OF 2019

FOR THE

THIRD SESSION OF THE TWELFTH NATIONAL ASSEMBLY

Printed by the National Assembly of Zambia

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REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES ON THE MENTAL HEALTH BILL, N.A.B. NO. 1 OF 2019 FOR THE THIRD SESSION OF THE TWELFTH NATIONAL ASSEMBLY.

1.0 COMPOSITION OF THE COMMITTEE

The Committee consists of Dr C Kalila, MP (Chairperson); Ms P Kasune, MP (Vice Chairperson); Dr C Kambwili, MP; Dr J K Chanda, MP; Mr L N Tembo, MP; Mr J Kabamba, MP; Ms A M Chisangano, MP; Mr L Kintu, MP; Mr M Ndalamei, MP; and Mr A Mandumbwa, MP.

Dr C Kambwili, MP, ceased to be a Member of the Committee following the declaration of the Roan Constituency seat vacant.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir,

The Committee has the honour to present its Report on the Mental Health Bill, N.A.B. No.1 of 2019, for the Third Session of the Twelfth National Assembly, referred to it by the House on Thursday 21st February, 2019.

2.0 FUNCTIONS OF THE COMMITTEE

In addition to any other duties conferred upon it by the Honourable Mr Speaker, or an Order of the House, the Committee is mandated to consider any Bills that may be referred to it by the House.

3.0 MEETINGS OF THE COMMITTEE

The Committee held nine meetings to consider the Mental Health Bill, N.A.B. No.1 of 2019.

4.0 PROCEDURE ADOPTED BY THE COMMITTEE

In order to acquaint itself with the ramifications of the Bill, the Committee sought both written and oral submissions from stakeholders. The stakeholders who appeared before the Committee are listed at Appendix II.

5.0 BACKGROUND

Mental health in Zambia is primarily governed by the *Mental Disorders Act, Chapter 305 of the Laws of Zambia.* This piece of legislation was enacted in 1949, and has since undergone minor amendments, with the last of such amendments having been made in 1994. Under this archaic law, individuals with mental health problems, illnesses and disorders are particularly vulnerable to infringement of their human rights. They are marginalised, stigmatised and discriminated against. Some of the causes of this situation are historical and are reminiscent of the colonial era when mental healthcare was relegated to the periphery of health care

provision. In this regard, the Government views the stigmatisation of mental patients and the marginalisation of mental health services from the mainstream health and welfare services as inappropriate and a past legacy.

It is against this background that the Mental Health Bill, N.A.B No. 1 of 2019 has been introduced.

6.0 OBJECTS OF THE BILL

The objects of the Bill are to:

a) provide for a mechanism for the better management and treatment of persons with mental illness, mental disorder, mental impairment or mental disability;
b) establish the National Mental Health Council and provide for its functions;
c) provide for mental health services in correctional facilities;
d) give effect to certain provisions of the United Nations Convention on the Rights of Persons with Disabilities, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care General Assembly Resolution 46/119 of 17th December, 1991 and other international human rights instruments to which Zambia is a State Party; and
e) repeal the *Mental Disorders Act of 1949* and provide for matters connected with, or incidental to, the foregoing.

7.0 SALIENT PROVISIONS OF THE BILL

The Committee notes the salient features of the Bill as set out below.

7.1 PART I: PRELIMINARY PROVISIONS

Clause 1 – Short Title
This clause provides for the short title of the Bill which shall be cited as the Mental Health Act, 2019.

Clause 2 – Interpretation
This clause provides for definitions of key terms in the Bill. Some of the notable definitions are forensic mental patient, informed consent, mental capacity, mental patient, mental health service user and treatment, to mention few.

Clause 3 – General Principles for Determination of Condition of Mental Patient
The clause provides for the general principles for determination of the condition of a mental patient. Some of the principles outlined, relate to the determination of whether a person is a mental patient, shall not be made on the basis of political, economic nor social status of the person, neither the background of treatment or hospitalisation of a mental patient shall be used as a basis to justify any present or future determination of mental illness.

7.2 PART II: LEGAL CAPACITY AND RIGHTS OF MENTAL PATIENTS

Clause 4 – Legal Capacity
The clause provides for the legal capacity of a mental patient. The clause provides that a mental patient shall enjoy legal capacity. However, where a mental patient lacks legal capacity, a court may appoint a supporter.

Clause 5 – Duty to Respect and Uphold Rights and Dignity of Mental Patients
The clause provides for the duty of every person to respect, uphold and safeguard the rights and dignity of a mental patient.

Clause 6 – Prohibition of Discrimination, Degrading Treatment and use of derogatory names
The clause provides for the prohibition of the use of discriminatory, degrading or derogatory treatment against a mental patient.

Clause 7 – Promotion of Mental Health and Preventive Programmes
The clause places an obligation on the Minister responsible for mental health, in consultation with other relevant ministries, to promulgate policy measures aimed at enhancing awareness about mental health, reducing the stigma associated with mental health and ensuring the provision of adequate mental health services by providing the necessary infrastructure finances and medical supplies.

7.3: PART III: THE NATIONAL MENTAL HEALTH COUNCIL

Clause 8 – Establishment of National Mental Health Council
The clause establishes the National Mental Health Council as a body corporate.

Clause 9 – Seal of Council
The clause provides for the seal of the Council which shall be authenticated either by the Chairperson of the Board or the Vice-Chairperson of the Board and the Secretary.

Clause 10 – Functions of the Council
The functions of the Council are provided for under this clause. Some of the key functions of the Council are to facilitate and promote communication relating to mental health matters, develop guidelines for special and intensive treatment of a mental patient and promote and protect the rights of patients.

Clause 11 – Board of Council
The Board of the Council is established under this clause. The clause provides that the Board of the Council consists of thirteen part-time members including a representative from the Human Rights Commission and a member from the community with expertise in health matters. The clause additionally provides for disqualification of persons being appointed as a member of the Board.

Clause 12 – Functions of Board
The clause provides for the functions of the Board of the Council. Some of the key functions of the Board are to review the policy and strategic plan of the Council as well as oversee the implementation and successful operation of the policy and functions of the Council.

Clause 13 – Delegation of Functions of Board
The clause provides for the delegation of functions of the Board under the Act to the Executive Director.

Clause 14 – Executive Director and other Staff
The clause empowers the Board to appoint the Executive Director and other staff on terms and conditions that the Emoluments Commission may determine.

7.4 PART IV: MENTAL HEALTH SERVICES

Clause 15 – Access to Mental Health Services
The clause provides for access to mental health services. It places an obligation on a mental health facility to put in place appropriate measures that ensure –

a) 1availability of mental health services at all levels of mental health care;
b) adequate financial and geographical accessibility;
c) provision of services that meet prescribed minimum standards; and
d) access to neuroleptic medication.

Additionally, the clause provides that mental health services shall be provided on an equal basis with physical health services. Clause 15 (4) prohibits the health practitioner who is not a qualified psychiatrist from prescribing psychiatric medication for more than six months without being authorised by designated psychiatrist.

Furthermore, the clause provides that in prescribing the exemption criteria, regard shall be given to certain factors such as the categories of mental patients already receiving free mental health services and the range of free mental health services currently available.

7.5 PART V: RIGHTS AND RESPONSIBILITIES OF MENTAL PATIENTS

Clause 16 – Rights of Mental Patients
The clause provides for the rights of a mental patient. The clause provides for the rights to effective, timely, safe, considerate and respectful care and support, making of decisions about the plan of care before and during treatment, the refusal of a recommended treatment or plan of care to the extent allowed by law, among others. Further, the clause states that a mental patient shall have the right to be protected from 1forced or inadequately remunerated labour within an institution, work place and the community.

Clause 17 – Responsibilities of Mental Patient
The clause provides for the responsibilities of a mental patient. A key responsibility outlined in the clause is that a mental patient should be able to provide information relating to the mental illness including mental health interventions.

Clause 18 – Privacy, Dignity and Confidentiality
The clause provides for the specific rights of privacy, dignity and confidentiality of a mental patient during the subsistence of the therapeutic relationship between a mental patient and a mental health facility or correctional centre.

7.6 PART VI: STANDARD OF CARE AND TREATMENT

Clause 19 – Standards of Care and Treatment
The clause provides for the standards of care and treatment of a mental patient or forensic mental patient.

Additionally, the clause provides that a mental health patient or forensic mental patient shall be treated in the least restricted environment with the least restrictive treatment as appropriate. However, the clause does not absolutely restrict a mental patient from being treated in a more restrictive environment for a fixed period in order to ensure rehabilitation and palliation, as may be necessary.

Clause 20 – Notice of Health Care Standard and Rights
The clause provides for the procedure of informing a mental patient or forensic mental patient on admission of the patient's rights and health care standards. The clause further states that where a mental patient or forensic mental patient is unable to understand the information, the information shall be communicated to a supporter.

Clause 21 – Minimum Standard for Mental Health Facilities
The clause provides for the minimum standards that a mental health facility ought to uphold in the provision of services to a mental patient. Additionally, the clause mandates professional regulatory bodies such as the Health Professions Council of Zambia and the General Nursing Council of Zambia to conduct inspections on the health facilities in ensuring quality control.

7.7 PART VII: CONSENT

Clause 22 – Consent to Admission, Treatment, Care, Rehabilitation and Palliation Services and Admission to Health Facility
The clause places an obligation on a mental health facility to obtain consent before providing treatment, care, support, rehabilitation and palliation services to a mental patient.

Clause 23 – Proxy Consent to Treatment
The clause provides for instances when a mental patient is unable to give consent on their own accord. In such cases, the supporter may on behalf of the mental patient give consent to treatment.

Clause 24 – Advance Decision
The clause provides for advance decisions by a mental patient, in cases where the mental patient understands their right, to decide on an option of treatment. The advance decision being provided for in the clause may be in writing and signed by the mental patient. Additionally, an oral recorded statement of the advance decision may be filed by the mental health facility.

The advance decision given by the mental patient is legally binding where the mental patient is an adult and competent to make an informed decision.

7.8 PART VIII: ADMISSION, TREATMENT, CARE, SUPPORT, REHABILITATON OR PALLIATION

Clause 25 – Admission, Treatment, Care, Support, Rehabilitation or Palliation
The clause provides for the considerations that ought to be taken into account by a mental health facility on admission, treatment, care, support, rehabilitation or palliation of a mental patient. Some of the considerations outlined in the clause relate to voluntary admission and the procedure of admission of a mental patient. However, the clause provides that cases of involuntary admission shall be prescribed by way of a Statutory Instrument.

Clause 26 – Involuntary Admission and Treatment in Emergency
The clause provides for an exception as to when a mental health practitioner is permitted to undertake an involuntary admission in a case of emergency.

7.9 PART IX: SPECIAL TREATMENT

Clause 27 – Special Treatment
The clause outlines the procedures or treatments that are considered to be of a special nature. These include electro-convulsive therapy or psycho-surgery and seclusion or restraint.

Clause 28 – Clinical or Experimental Research and Development of Drugs
The clause provides that due regard of the *National Health Research Act No. 2 of 2013* should be taken into consideration in relation to a clinical or experimental research and the development of drugs during special treatment of persons. For example ethical considerations.

7.10 PART X: CRIMINAL PROCEDURES FOR FORENSIC MENTAL PATIENTS

Clause 29 – Designation of Health Facility for Forensic Mental Patients
The clause mandates the Minister, in consultation with the Minister responsible for correctional services, to designate a health facility for treatment of a forensic mental patient.

Clause 30 – Admission of Forensic Mental Patient to Designated Health Facility
The clause provides for the admission procedure of a forensic mental patient to a designated health facility. The procedure outlines that the Registrar or Clerk of the Court shall send a court order to a designated facility which shall be followed by examination of a forensic mental patient within fourteen days of receipt of the order.

Clause 31 – Referral of Forensic Mental Patient between Designated Health Facilities
The clause provides for the referral of a forensic mental patient, where a mental health practitioner considers that it is in the best interest that the forensic mental patient be transferred to another designated health facility.

Clause 32 – Forensic Patient who Absconds
The clause provides for the need to notify the police where a forensic mental patient has absconded treatment from a designated health facility.

Clause 33 – Periodic Review of Mental Health Status of Forensic Mental Patients
The clause places an obligation on the in-charge of a designated health facility to review a forensic mental patient every six months and submit the report to the Minister responsible for correctional services.

7.11 PART XI: MENTALY-ILL INMATES AND UNCONVICTED INMATES

Clause 34 – Assessment of Mental Health Status of Inmate
The clause places an obligation on an officer in charge of a correctional centre to cause the examination of the mental status of an inmate within forty-eight hours where there is information that an inmate may be mentally ill.

Clause 35 – Treatment, Care, Rehabilitation and Palliation of Inmates with Mental Illness
The clause provides for the procedure to be undertaken once an inmate has undergone examination under Clause 34 and it is determined that the inmate is suffering from a mental illness.

Clause 36 – Referral of Forensic Mentally Ill Inmate or Unconvicted Inmate to Designated Health Facility
The clause makes provision for instances when an inmate or unconvicted inmate is required to be referred to a designated health facility to undergo treatment or rehabilitation. The officer-in-charge shall cause this referral to be made within forty-eight hours.

Clause 37 – Review of Mental Health Status of Mentally Ill Inmate
The clause places an obligation on a mental health facility to review the mentally ill inmate and prepare a report for submission to the officer-in- charge of the relevant correctional centre.

Clause 38 – Discharge Procedure of Mentally Ill Inmate
The clause provides for the procedure to be undertaken on discharge of a mentally ill inmate by preparing a discharge report to the officer-in-charge of the relevant correctional centre.

7.12 PART XII: GENERAL PROVISIONS

Clause 39 – Regulations
The clause empowers the Minister to promulgate legislation in form of a Statutory Instrument to give effect to the provision of the Act.

The Minister is empowered to create regulations relating to forms and certificates to be used, exemption criterion for categories of mental patients eligible for free health services or de-institutionalisation of mental patients.

Clause 40 – General Penalty
The clause provides for the general penalty where a person commits an offence under this Act for which a specific penalty is not provided.

Clause 41 – Repeal of Mental Disorders Act, No. 21 of 1949
The clause provides for the repeal of the existing *Mental Disorders Act No. 21 of 1949.*

Clause 42 – Savings and Transitional Provisions
The clause provides for savings and transitional provisions relating to the enactment of this Bill.

The clause makes provision for transitional provisions relating to institutions already existing or established under the current law or orders such as court orders made under the current law that the orders shall continue to be in force should this Bill be enacted as an Act of Parliament.

The clause additionally provides for a change in the use of words such as mental disability or unsound mind in the laws. The proposed wording is “legally disqualified” which is considered to be less derogatory.

8.0 CONCERNS RAISED BY STAKEHOLDERS

Most of the stakeholders who appeared before the Committee welcomed the Mental Health Bill N.A.B No 1 of 2019, pointing out that the need for a robust mental health legal framework was critical if the mental health burden in the country was to reduce. However, some stakeholders lamented that due to the lengthy consultative process on the Bill, which begun as far back as 2010, the spirit of inclusiveness that was intended was not reflected in the proposed Bill particularly on the aspect of human rights. They contended that while the Bill was progressive, the absence of a human rights based approach to disability in certain provisions in the Bill would leave gaps in the comprehensive protection of the rights of persons with disabilities. In view of the foregoing, the following observations and recommendations were made:

8.1 Objects of the Bill

- Stakeholders, expressed concern that the use of the terms “mental illness and “mental disorder,” in the Bill was derogatory. They proposed that these terms must be deleted and must be replaced with “persons with mental impairment” in line with Article 1 of the Convention on the Rights of Persons with Disabilities (UNCRPD), which states that “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on equal basis with others.”

  Further and closely connected to this, the stakeholders held the view that the language in the Bill did not meet the current acceptable terminology in the human rights based approach to disability. Instead, the Bill was based on medical model of disability. In this regard, the Bill’s consistent reference to “mental patient” instead of “person with mental disability” reduced the disability to a medical problem that needs to be cured. It therefore, took away the focus on the rights and needs of the person. Stakeholders further argued that the impact of the medical model of focusing on the person as a patient and not a rights holder led to involuntary treatment, detention in medical centres and other treatment based approaches to the person.

- Some stakeholders also observed that the objects of the Bill appeared to have omitted other important human rights instruments that Zambia is a State Party to. In this regard, they proposed that the objects of the Bill must include other key international human rights instruments that Zambia had ratified such as the UN Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment, the UN Convention on Economic, Social and Cultural Rights (CESCR), the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) among others.

- Other stakeholders lamented that the Bill wrongly referred, 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 had since been superseded by the UNCRPD. They contended that the MI principles were not binding in law and were not grounded on a human rights- based approach to psychosocial disability, and were in contrast with the UNCRPD. They recommended that all the references made in the Bill 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, should be removed and, the connected provisions in the Bill, amended in full alignment with the UNCRPD.

- A concern was further raised that the proposed Bill significantly illustrated the World Health Organisation's (WHO) Resource Book on Mental Health, Human Rights and Legislation, particularly in the following parts:

    - Part II: Legal Capacity and Rights of Mental Patients;
    - Part VII: Consent; and
    - Part VIII: Admission, Treatment, Care, Rehabilitation or Palliation.

However, the WHO had formally withdrawn the Resource Book and the UNCRPD was currently the authoritative basis for reform of mental health systems globally. The Committee was informed that the WHO Resource Book on Mental Health, human Rights and Legislation had been withdrawn because it was drafted prior to the coming into force of the UNCRPD and was, therefore, not compliant with the latest human rights norms and standards. The Convention set 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 marked a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights of persons with disabilities. In view of the foregoing, the concerned stakeholders submitted that any reference to the outdated standards of the Resource Book must be removed from the Bill and aligned with the UNCRPD which is the most relevant, authoritative, comprehensive and modern expression of international human rights law.

8.2 PART I: PRELIMINARY PROVISIONS

The stakeholders proposed to make amendments to the following definitions in the Bill:

- "Community leader" had been defined but did not appear anywhere in the text of the Bill. Stakeholders proposed that the term must be deleted;

- "forensic mental patient" should be recast to read as "forensic person with mental illness"

- the definition of "informed decision" in the Bill was a source of concern. Stakeholders explained that informed decisions arose from informed consent. Therefore, the definition of "informed consent" adequately defined "informed decision". In this regard, they proposed that the definition of "informed decision" should be deleted in the Bill. In addition, It was unclear how the values and goals under (a) of the current definition would be ascertained. They further proposed that this provision in the definition must be revisited to remove ambiguities.

- "health practitioner" was not defined in the Mental Health Bill and that the definition assigned to it was that in section 2(1) of *the Health Professions Act No. 24 of 2009* which provided that "Health Practitioner means a person registered as a health practitioner under section eight," which did not include nurses.

  In this regard, "Health Practitioner" should be replaced with "Mental Health Practitioner" considering that the title, "Mental Health Practitioner," was already provided for and defined in the Bill.

- Under the definition of "mental health practitioner" other stakeholders submitted that it was important to clarify that the social worker must be a "mental health social worker".

- the concept of "community mental health service" was important in addressing mental health at community level. However, "community mental health service" only appeared in the interpretation clause and not in the main text of the Bill. Therefore, "community mental health service" should be included in the substantive provisions of the Bill.

- "correctional centre" as defined in the Bill "means an institution where a mental patient who commits an offence is held in custody for treatment and rehabilitation". However, stakeholders argued that the term "mental patient" was derogatory. They further contended that using the words 'who commits an offence' was inappropriate as it potentially violated Article 18(2) (a) on presumption of innocence. In view of the foregoing, they proposed that the definition must be recast to read: "correctional centre" means an institution where a person with a mental impairment is held in custody for treatment and rehabilitation.

- The definition of the "mental health facility" should have a similar meaning with that of "public mental health facility" or should be combined to read, "an establishment or unity of an establishment, government run site, health post, clinic, hospital, fixed or mobile providing mental health services for the promotion, prevention, diagnosis, treatment, rehabilitation or palliation of a mental patient."

- other stakeholders held the view that the word 'primary function' in the definition of "mental health facility" should be avoided because it restricted other health facilities from addressing mental health services especially that currently, only Chainama Hospital had the primary function in the provision of mental health services in Zambia.

- A concern was further raised on the principles set out under Clause 3 of the Bill. Some stakeholders were of the view that these principles were based on the medical model of disability and were more of guidelines for medical diagnosis rather than human rights principles. They, therefore, proposed that the principles be recast to reflect the preamble of the UNCRPD.

8.3 PART II: LEGAL CAPACITY AND RIGHTS OF MENTAL PATIENTS

- Under Clause 4, stakeholders observed that despite the recognition of the concept of legal capacity of persons with mental disabilities, the Bill retained the provisions that allowed "supporters" to consent to treatment or hospitalisation of mental health patients without the person's consent or even against their will. They submitted that this was a serious misunderstanding of the concept of "support" which was set out under Article 12 of the UNCRPD.

- Under Clause 4 (2), some stakeholders raised consternation on the restriction of a mentally impaired person having the legal capacity on the basis of "mental illness", "mental disorder" or "mental disability". They felt that the Bill combined the concepts of legal capacity and mental capacity and contended that legal capacity was the right and freedom to hold and exercise the said rights, which was an inherent right. Mental capacity, on the other hand was the understanding that every individual varied in the way they assessed information on a variety of different aspects based on gender, age and societal expectations to name a few. In this regard, supported decision making, therefore, was the bridge between the two concepts in that a support person guided a person with a mental disability to be able to make a decision but could not under any circumstance make a decision on their behalf. The rights, will and preference of persons with mental disabilities should always prevail. The Bill should ensure that this is provided for.

- Under Clause 7 (2) (d) (i) which provides for the promotion of mental health and preventive programmes, some stakeholders submitted that the training in mental health services should include training in human rights standards. Therefore, Clause 7 (2) (d) (i) should be recast to add the words "and training in human rights standards."

8.4 PART III: THE NATIONAL MENTAL HEALTH COUNCIL

- While welcoming the establishment of the Council under Clause 8, other stakeholders were of the view that the National Mental Health Council was unnecessary as its functions could easily be performed by already existing statutory bodies such as the Zambia Agency for Persons with Disabilities (ZAPD) and the Human Rights Commission (HRC). Further, such a dedicated administrative structure would reinforce the stigma against mental health when the objective should be to mainstream mental health in the existing institutions. The stakeholders, therefore, recommended that the body should not be created and the Government should utilise already existing bodies and institutions to handle mental health and disability.

- Under Clause 10, stakeholders proposed that "the promotion of community mental health services" should be added as functions of the Council. This was because when a mental patient was discharged from hospital, that person would be integrated in the established community mental health support system for continuous care and support.

- Clause 10 (g) provides for the Council to, "liaise with the body responsible for the health profession on the professional conduct and inspections of mental health facilities and correctional centres in accordance with accepted national and international standards." Some stakeholders observed that although the body responsible for the professional conduct of health care workers and inspections of the

mental health facilities was the Health Professions Council of Zambia (HPCZ), its jurisdiction did not stretch to correctional facilities. They, therefore, recommended a breakdown in the provision to carter for the separate institutions.

- Stakeholders were further concerned that the use of "liaise" under Clause 10 (g), made this provision ambiguous and weak. It was, therefore, proposed that the Mental Health Council should rely on the provisions of the Health Profession's Act and General Nursing Council Act to govern the conduct of health practitioners in mental health. Additionally, the Council should rely on inspection reports from HPCZ and General Nursing Council with respect to health facilities to avoid the duplication of functions.

- Under Clause 10 (i), which provides for the Council to "develop guidelines for special and instructive treatment of mental patients", stakeholders proposed that the guidelines must conform to the National Health Care Standards.

- Under Clause 11 (1), stakeholders observed with concern the lack of representation on the Council by the Zambia Agency for Persons with Disabilities. They submitted that this was against the provisions of the *Persons with Disabilities Act* particularly Section 14(1) (j) which empowered the Agency to make representation on behalf of persons with disabilities before any state or institution. Section 14 (1) (p) of the Act further mandated the Agency to advise relevant State organs and institutions on the provision of equal opportunities, empowerment programmes and facilities to persons with disabilities. They, therefore, proposed that the Zambia Agency for Persons with Disabilities be represented on the Board of the Council.

- Other stakeholders were of the view that there be representation from the Zambia Police Service, the Judiciary and a Counsellor on the Board of the Council, considering the role that they played in handling persons with mental impairments.

8.5 PART IV: MENTAL HEALTH SERVICES

- Stakeholders observed that mental health services should be integrated in all healthcare facilities and not just mental health facilities as provided for under Clause 15(1). They contended that there was no justification for limiting the mainstreaming of mental health services to situations "where possible" as stated by Clause 15(2) of the Bill. According to the stakeholders, these provisions encouraged the discriminatory regime that a modern mental health law should seek to transform in order to address situations where people have to travel far and wide to access treatment.

- Other stakeholders observed that, the emphasis on community and family which does not centre on the person as an agent for their healing, as contained in Clause 15(5) was problematic. They argued that any reference to the provision of mental health services must also be aligned to the practice of psychiatry with other areas of medicine that adhere to the principles contained in the Code of Ethics for medical practitioners as contained in the Health Professionals Act. In view of the foregoing, the stakeholders recommended that these provisions be dispensed with as they did not promote health rights and other rights of persons with mental disabilities.

- Under Clause 15 (1) (d), stakeholders proposed to replace ‘neuroleptic’ medication with ‘psychiatric medications’ as neuroleptic medication referred to only one small group of drugs used in psychiatry.

- To harmonise (a) and (b) under Clause 15(3) and increase access to mental health services, some stakeholders proposed that mental health services should be an accredited health service as provided for under Sections 54 to 59 in the *Health Professions Act No. 24 of 2009* so that the services may be provided by any health facility that meets the accreditation requirements.

- Clause 15 (5) provides that a health practitioner ‘shall’ provide mental services in a manner that facilitates the involvement of the community, family members and support persons. Some stakeholders observed that this provision was cast in mandatory terms and which may cause delay in the treatment of patients in the event that the community or family did not wish to get involved. They, therefore, proposed that the term “may” be used instead of “shall.”

8.6 PART V: RIGHTS AND RESPONSIBILITIES OF MENTAL PATIENTS

- Stakeholders observed a typographical error on the heading of this Part. The word “and” had been misspelled as “adn”. They, therefore, recommended that it be amended to read “Rights and Responsibilities” of Mental health patients.

- There were stakeholders who submitted that the rights of mental health patients stated in Part V of the Bill did not comprehensively cover the rights as stated in the UNCRPD. They, therefore, recommended that Part V should be aligned with the rights in the UNCRPD.

8.7 PART VIII: ADMISSION, TREATMENT, CARE, SUPPORT, REHABILITATON OR PALLIATION

- Some stakeholders contended that Clause 25 (c) allowed for involuntary admission and treatment on the basis of the “health and safety of the mental patient”. They argued that in practice, this provided extraordinarily wide discretion to personnel in health care facilities to detain and forcibly treat persons against their will, therefore, violating, their rights to equality and non-discrimination as provided for under Articles 5, 12, 14, 15 to 19 and 25 in the UNCRPD. Stakeholders therefore, submitted that this Part should be revised in conformity with the required standards in the Convention.

- Other stakeholders were of the view that Clause 26 was vague on who should initiate the involuntary admission. They proposed that the involuntary admission should be initiated by either a community health worker or the police. They contended that the use of a community health worker or police within the community would help curb abuse in situations where the community or family forced a diagnosis on someone for various reasons not related to mental health.

- A recommendation was further made on the need for a clause allowing for an appeal in cases of involuntary admission. Stakeholders contended that an appeal against emergency treatment and admission under the proposed clause may be lodged with the

Board by a spouse, a parent or guardian or a supporter of the person with the mental impairment.

8.8 PART IX: SPECIAL TREATMENTS

- Under Clause 27, **s**ome stakeholders were unhappy that the Bill provided and advocated for the use of electro-convulsive therapy (ECT), which could be applied without the voluntary consent of the person concerned, which they contended, was a grave violation of human rights, and potentially amounting to torture. They, therefore, recommended that this treatment be removed from the Bill.

- Other stakeholders expressed the view that in its present form, the Bill would legalise abusive practices such as involuntary detention, forced treatment, seclusion and restraint, therefore, breaching the Constitutional protection and the human rights of persons with mental disabilities. They, therefore, recommended that Clause 27 in its entirety should be removed from the Bill.

8.9 PART X: CRIMINAL PROCEDURES FOR FORENSIC MENTAL PATIENTS

- Some stakeholders observed that the provision relating to a forensic mental patient under Clause 29 did not distinguish whether forensic mental patients were those detained under remand or those in correctional centres at His Excellency's Pleasure (HEP). They observed that this ambiguity may raise challenges in the management of the two categories of patients. In this regard, they recommended that the Bill must clearly differentiate the two categories of inmates. They further argued that a definition of patients and inmates who are in correctional centres at His Excellency's Pleasure (HEP) should be included in the Bill.

  For the same reason, Clause 30(2) should relate to forensic mental patients who are held on remand while Clause 33(1) which makes provision for review of every six months should relate to inmates who are detained at the President's Pleasure.

- Stakeholders contended that the Bill does not distinguish between health facilities and correctional centres with regard to treatment of forensic patients. As a result, there is likely to be confusion about which minister; between the Minister of Home Affairs and the Minister of Health has jurisdiction in a facility such as Chainama East, for instance, which is both a correctional and health centre. In this regard, it was recommended that the Bill should make the distinction.

- Some stakeholders contended that since some mental health problems could be equated to a terminal illness, the Minister of Home Affairs should be accorded express powers to recommend for discharge of such inmates as provided for in Section 111 (a) of the *Prison Amendment Act No.16 of 2004* that; "*The Commissioner (Commissioner General) may, with the approval of the Minister, order the discharge from prison of any terminally ill prisoner on the recommendation of the Regional Commanding Officer and the medical officer responsible for the health care of the prisoner............*"

8.10 PART XI: MENTALLY ILL INMATES AND UNCONVICTED INMATES

- Some stakeholders stressed the need to emphasise that the officer-in-charge of the correctional centre shall facilitate for the assessment of the inmate, regardless of the arresting institution. They explained that it had been observed that currently, an inmate would not be sent for assessment as the correctional centre would await for the arresting institution to come and facilitate this. In the process, patients would become severely unwell and even die.

- Other stakeholders observed that Parts X and XI of the Bill were at variance with Sections 164 and 165 of the Criminal Procedure Code, which provided for the holding of a mentally ill patient at the President's pleasure, who had committed a criminal offence if that person could not take plea and defend himself in the criminal matter or proceedings. If, therefore, the mentally ill patient was incapable of defending himself in criminal proceedings, then it appeared that Parts X and XI of the mental health patient was at the President's Pleasure, therefore, there was need to reconcile the two provisions.

- Schedule: Clause 11 (1) provides that after the end of the financial year, the Mental Health Council shall submit to the President, a report concerning its activities during the financial year. Stakeholders wondered whether it was the intention of the Bill that the Council's report should be submitted to the President rather than the Minister of Health.

  They, therefore, proposed that the clause be amended to provide for the report being submitted to the Minister of Heath as opposed to the President.

9.0 MISSING OR INSUFFICIENTLY DEVELOPED ELEMENTS IN THE BILL

Stakeholders submitted the following concerns as having been omitted or insufficiently provided for in the Bill.

- A more comprehensive provision for the creation of community-based services should have been addressed in the Bill. The provision should have catered for but not limited to; the integration of mental health services into the general health care system at all levels, and also enable the provision of individualised, preventive, rehabilitative and auxiliary services.

- The Bill was silent on relatives who gave false information about a patient's mental disability and its severity, relatives who refused to accept their relative, a mental patient following discharge from a mental health facility and non forensic mentally ill patients who absconded from a mental hospital. Stakeholders submitted that specific penalties should have been provided for in the Bill for such offences.

- Some stakeholders held the view that the Bill should have provided for a grievance mechanism for persons with psychosocial disabilities that had a grievance or were not satisfied with a process or decision. They proposed that the Bill should have provided for such a person to appeal to the Board Chairperson of the Mental Health Council and if he or she was not satisfied with the outcome, they could appeal to the office of the Minister of Health within 14 days.

- The Bill should have had a standalone provision for quality residential treatment programmes for children and adolescents with mental health and substance abuse conditions respectively, as an essential component of quality of care. Stakeholders observed that adolescents required residential treatment when available community based alternatives had been explored and had not successfully addressed the persons needs, when the complexity of his or her needs confound community based care and hence, required a treatment environment in order to keep the person safe and prepare them to be responsive to community based care.

10.0 COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

The Committee welcomes the introduction of the Mental Health Bill N.A.B No 1 of 2019, which is long overdue considering that there is need for a robust mental health legal framework to guide the management of mental health in the country. The Committee notes that mental health in Zambia has been managed under the *Mental Disorders Act of 1949*, a piece of legislation that was passed in the colonial era and is therefore, replete with numerous derogatory terminologies which are inconsistent with the modern era and age.

The Committee notes that due to the lengthy consultative process on the Bill, which begun as far back as 2010, the spirit of inclusiveness that was originally intended has been lost. Of the four approaches possible in the consideration of a piece of legislation, namely; the medical approach, the social approach, the human rights approach and the environmental approach, the Bill seems to lean more on the medical approach, to the exclusion of the social and human rights approach.

The Committee agrees with the stakeholders who contended that persons with mental disabilities should first and foremost be seen as human beings with inalienable rights before they are seen as patients. The absence of a human rights based approach to the management of mental health has left gaps in the comprehensive protection of the rights of persons with mental disabilities.

In view of the foregoing, the Committee makes the observations and recommendations set out below.

Objects of the Bill

i) The Committee is concerned with the use of derogatory terms such as "mental illness and "mental disorder," which have been used in the Bill. The Committee, therefore, recommends that these terms must be amended and replaced with "persons with mental impairment" in line with Article 1 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) which states that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on equal basis with others."

ii) The Committee observes that the objects of the Bill appear to have omitted other important human rights instruments that Zambia is a State Party to, such as the UN Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment, the UN Convention on Economic, Social and Cultural Rights (CESCR), the UN Convention on the Rights of the Child (CRC) and the UN Convention on the

Elimination of all Forms of Discrimination Against Women (CEDAW) among others.

In this regard, the Committee recommends that the objects of the Bill should include other key international human rights instruments that Zambia has ratified.

iii) The Committee notes that the Bill refers 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 since been superseded by the UN Convention on the Rights of Persons with Disabilities. The Committee notes that the MI Principles are not binding in law and are not grounded on a human rights based approach to psychosocial disability and are in contrast with the UNCRPD. The Committee is alive to the provision in the objects of the Bill which provides thus"...and other international human rights instruments to which Zambia is a State Party."

The Committee, therefore, recommends that the Bill should make specific reference to the UNCRPD and that consequentially, provisions in the Bill, connected to the MI Principles should be amended to bring the Bill in full alignment with the UNCRPD.

iv) The Committee observes that the proposed Bill significantly reflects the World Health Organisation's (WHO) Resource Book on Mental Health, Human Rights and Legislation, particularly in the following parts: Part II: Legal Capacity and Rights of Mental Patients; Part VII: Consent; and Part VIII: Admission, Treatment, Care, Rehabilitation or Palliation. However, the Committee notes that the WHO has formally withdrawn the Resource Book because it was drafted prior to the coming into force of the UNCRPD and was, therefore, not compliant with the latest human rights norms and standards.

The Committee, therefore, recommends that any reference to the outdated Resource Book must be removed from the Bill and that reference should, instead, be made to the UNCRPD, which is the most relevant, authoritative, comprehensive and modern expression of international human rights law.

Part II: Legal Capacity and Rights of Mental Patients

v) The Committee observes that Clause 6, seeks to promote the prohibition of the use of derogatory words against people with mental disabilities. However, derogatory words such as 'idiot', 'imbecile' and 'feeble-minded' have been used in other pieces of legislation such as the *Penal Code Act*. In this regard, the Committee recommends that in order to ensure consistency, the Government should ensure that other laws are reviewed and amended to remove derogatory terms following the enactment of the Bill.

vi) The Committee notes that Clause 7 (2) (d) (i) provides for the training in mental health services but is concerned that training in human rights standards is conspicuously missing.

The Committee, therefore, recommends that Clause 7 (2) (d) (i) should be recast to add the *words "and tr*aining in human rights standards."

Part III: The National Mental Health Council

vii) The Committee expresses concern that the composition of the Council, under Clause 11 (1), does not include representation from the Zambia Agency for Persons with Disabilities, contrary to the provisions of the *Persons with Disabilities Act,* particularly Section 14(1) (j), which empowers the Agency to make representation on behalf of person with disabilities before any state or institution. Section 14 (1) (p) of the Act further mandates the Agency to advise relevant State organs and institutions on the provision of equal opportunities, empowerment programmes and facilities to persons with disabilities.

The Committee, in this vein, recommends the inclusion of the Zambia Agency for Persons with Disabilities on the Board of the Council.

Part IV: Mental Health Services

viii) The Committee observes that Clause 15(1), restricts the provision of mental health services to mental health facilities, which has been a recipe for stigma and that the Bill only advocates for the mainstreaming of mental health services to situations "where possible" as provided at Clause 15(2) of the Bill.

The Committee, in this regard, recommends that in order to fight stigmatisation, reduce distances to be covered to access mental health services and promote community based care; these services should be integrated in all healthcare facilities.

ix) The Committee observes that Clause 15(1) (d) refers to 'neuroleptic' medication which is only one small group of drugs used in psychiatry.

The Committee, therefore, recommends that 'neuroleptic medication' be replaced with 'psychiatric medications' as this is more encompassing.

x) While commending the proviso at Clause 15 (3) (b) that mental health care shall be provided in specialised public and private health facilities, the Committee is concerned that the provision does not provide for how private health facilities will undertake this exercise.

The Committee, therefore, recommends that in order to include private health institutions in the provision of mental health care, mental health services should be provided on an accreditation basis, as provided for under Sections 54 to 59 in the *Health Professions Act No. 24 of 2009* so that the services may be provided by any health facility that meets the accreditation requirements.

xi) The Committee observes that Clause 15 (4) provides that "a health practitioner who is not a psychiatrist shall not cause a mental patient to receive prescribed psychiatric medication for more than six months without being authorised by a psychiatrist who is designated to provide medication and review psychiatric treatment". The Committee is of the view that this may not be practical at the moment, given the low numbers of trained psychiatrists in the Country. Currently, Zambia only has eight trained psychiatrists.

In view of the foregoing, the Committee recommends that the clause should be amended to allow health practitioners who have studied psychiatry but are not yet specialists, to treat patients while they consult trained psychiatrists. This will bring the provision in tandem with the push that mental health services should be mainstreamed and made available in all health institutions.

Part X: Criminal Procedures for Forensic Mental Patients

xii) The Committee notes that the provision relating to a forensic mental patients under Clause 29, does not distinguish whether forensic mental patients are those detained under remand or those in correctional centres at His Excellency's Pleasure (HEP). This ambiguity may raise challenges in the management of the two categories of patients.

In this regard, the Committee recommends that the Bill be amended to clearly differentiate the two categories of inmates. Further, a definition of patients and inmates who are in correctional centres at His Excellency's Pleasure (HEP), should be included in the Bill. For the same reason, Clause 30(2) should relate to forensic mental patients who are held on remand, while Clause 33(1), which makes provision for review of every six months, should relate to inmates who are detained at the President's Pleasure.

xiii) The Committee observes that the Bill does not distinguish between health facilities and correctional centres with regard to treatment of forensic patients. This is likely to create confusion about which minister between the Minister of Home Affairs and the Minister of Health, has jurisdiction over a facility such as Chainama East, for instance, which is both a correctional and health centre.

The Committee in this regard, recommends that the Bill should be amended to provide for the distinction.

Schedule

xiv) The Committee observes that Clause 11 (1) provides that after the end of the financial year, the National Mental Health Council shall submit to the President, a report concerning its activities during the financial year. The Committee is of the view that this is erroneous and therefore, recommends that the clause be amended to provide for the report being submitted to the Minister of Heath as opposed to the President.

xv) The Committee observes that the Bill under Clause 40 provides for the general penalty for offences committed under the Act. However, the Bill does not highlight specific offences. The Committee in this regard, recommends that specific offences and penalties must be highlighted in the Bill to warrant enforcement.

xvi) The Committee observes that the Bill sets out a community based approach to mental health provision, which is commendable. However, the Bill is silent on what should be done when community or family members refuse to accept a mentally impaired person, following discharge from a mental health facility. The Committee, therefore, recommends that in addition to providing a penalty in the Bill, a subsequent

responsive law must be put in place to compel community or family members to accommodate mentally impaired persons.

The Committee further urges the Executive to ensure that quality community rehabilitation centres are provided in different districts and provinces as close to the community as possible, as an essential component of quality of care.

11.0 CONCLUSION

The Committee commends the Government for introducing such a progressive piece of legislation and hopes that its recommendations will be taken into consideration in order for the piece of law to be in tandem with modern trends in providing mental health care.

The Committee wishes to express its gratitude to all stakeholders who appeared before it and tendered both oral and written submissions; and to thank you, Mr Speaker, for affording it an opportunity to scrutinise the Bill. The Committee also appreciates the services rendered by the Office of the Clerk of the National Assembly and the permanent witness from the Ministry of Justice.

We have the Honour to be, Sir, the Committee on Health, Community Development and Social Services mandated to consider the Mental Health Bill, N.A.B. No.1 of 2019 for the Third Session of the Twelfth National Assembly.

Dr C Kalila, MP
(Chairperson)

Ms P Kasune MP
(Vice Chairperson)

Dr J K Chanda, MP
(Member)

Mr M Ndalamei, MP
(Member)

Mr A Mandumbwa, MP
(Member)

Mr L Kintu, MP
(Member)

Ms A M Chisangano, MP
(Member)

Mr J Kabamba, MP
(Member)

Mr L N Tembo, MP
(Member)

March 2019
LUSAKA

APPENDIX I – NATIONAL ASSEMBLY OFFICIALS

Ms C Musonda, Principal Clerk of Committees
Mr F Nabulyato, Deputy Principal Clerk of Committees (SC)
Mr S Chiwota, Senior Committee Clerk (SC)
Mr C Chishimba, Committee Clerk
Ms C T Malowa, Committee Clerk
Ms S Sakala, Legal Counsel
Ms A Maluwa, Stenographer
Mr M Kantumoya, Parliamentary Messenger

APPENDIX II – THE WITNESSES

MINISTRY OF JUSTICE
Ms M K Bwalya, Acting Chief Parliamentary Counsel

DISABILITY RIGHTS WATCH
Mr W Waliuya, Director
Mr J Musanje, Chairman
Mr B Chooma, Programme Coordinator
Ms T Mkandawire, Finance and Administration Officer
Mr A Nyirenda, Senior Adviser
Mr R Musuma, Programme and Administration Assistant

CHAINAMA HOSPITAL
Dr N Besa, Acting Senior Medical Superintendent
Mr G Tafuna, Head – Psychiatric Social Services
Mr B Bwalya, Psychologist

ZAMBIA AGENCY FOR PERSONS WITH DISABILITIES
Ms J Mwape, Acting Director General
Mr F Mambwe, Senior Rehabilitation Officer
Ms I Mutenekwa, Senior Planner
Mr L Chola, Personal Assistant

HUMAN RIGHTS COMMISSION
Ms F Chibwesha, Director
Mr K Banda, Chief Investigations and Legal Services Officer

ZAMBIA CORRECTIONAL SERVICES
Dr C Chisela, Commissioner General
Mr Y Lungu, Special Assistant to the Commissioner General
Mr M M Musonda, Correctional Secretary
Ms C Bwalya, Head – Legal

HEALTH PROFESSIONS COUNCIL OF ZAMBIA
Mr B B Bwalya, Acting Registrar
Mr I M Kolala, Chief Operations Officer
Ms C S Kachomba, Senior Training Officer
Mr F Daka, Senior Inspections Officer
Ms M Namfukwe, Public Relations Officer

ZAMBIA MEDICAL ASSOCIATION
Dr A Chansa, President
Dr C Siwo, Psychiatrist
Dr M Akani, Psychiatrist

MENTAL HEALTH USERS OF ZAMBIA
Mr Katontoka, Director
Mr M Chipu, Programmes Officer

MINISTRY OF COMMUNITY DEVELOPMENT AND SOCIAL SERVICES
Ms P C Kabamba, Permanent Secretary
Mr E Mwakalombe, Director - Planning
Ms M C Tembo, Chief Planner – Policy
Mr S Chiwele, Chief Social Welfare Officer
Ms N Soko, Parliamentary Liaison Officer

GENERAL NURSING COUNCIL OF ZAMBIA
Dr A Banda, Chief Executive Officer/Registrar
Mr G Banda, Manager - Human Capital and Administration
Mr A Tembo, Finance Manager
Mr T D Yungana, Manager - Regulation and Compliance
Mrs B Zimba, Monitoring and Evaluation Specialist
Mrs E Daka, Education and Examination Specialist

UNIVERSITY OF ZAMBIA SCHOOL OF LAW
Mr L Banda, Special Research Person

UNIVERSITY OF ZAMBIA, SCHOOL OF MEDICINE
Dr R Paul, Head of Department of Psychiatry
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TRADITIONAL HEALTH PRACTITIONERS ASSOCIATION OF ZAMBIA (THPAZ)
Mr K Solo, Secretary General
Ms F Tembo, Provincial Chair Lady
Mr S W K Nyoni, Director of Information and Publicity

MINISTRY OF HEALTH
Hon Dr C Chilufya, MP, Minister
Dr K Malama, Permanent Secretary – Technical
Dr C Siwo, Psychiatrist/Acting Mental Health Coordinator
Mr A Silumesii, Director – Public Health
Mr F Mwila, Director – Human Resource Administration
Mr J Mayeya, Chief Mental Health Officer
Ms N Mayowe, Principal State Advocate
Ms M Nsakashalo, Assistant Director Health Promotion – Non Communicable Diseases
Ms S Kapambwe, Assistant Director, Health Promotion – Environment Social Determinants
Mr E Malikana, Assistant Head – Health Policy