



## **Developing and adopting a mental health Law: Lessons from Zambia**

The purpose of the Mental Health and Poverty Project (MHaPP) is to develop, implement and evaluate mental health policy in poor countries, in order to provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health. In the second phase of the MHaPP project, Zambia embarked on two projects which are: (i) putting in place mental health district interventions for Zambia and (ii) putting in place mental health legislation for Zambia.

### **What is the current state of mental health Law in Zambia?**

- Zambia's Mental Health Disorders Act of 1951, which was inherited from the colonial era, is outdated.
- The law is inadequate and does not promote the dignity, respect and autonomy of people who have a mental or intellectual disability. The law also fails to safeguard against abuses related to involuntary admission and treatment, seclusion and restraints, special treatments or clinical and experimental research amongst people with mental disorders.
- The law uses derogatory and stigmatizing language such as "imbecile," "idiot," to describe those with mental disorders.
- The law neglects the critical need to promote community based care. It thus perpetuates an outdated model of care often associated with human rights violations and poor quality of care.
- It is essential that this mental health law is repealed or reformed according to national and the international human rights frameworks, such as the newly adopted the UN Convention on the Rights of Persons with Disabilities (2007), which supports the rights of people with mental health disorders on an equal basis with others in all aspects of life.

### **What did we do?**

Using participatory approaches, a number of steps were taken to develop a draft mental health bill that is in line with international human rights standards:

- a. Seventy-six pre-draft consultative meetings were held with key stakeholders, including health professionals, policy-makers, two government ministries, NGOs and service users.
- b. A 2000 Mental Health Draft Bill version was circulated to stakeholders.
- c. Two consensus-building meetings were held with key stakeholders, to help develop the contents of the Mental Health Draft Bill and identify weaknesses, obtain varying opinions and receive ongoing support for the drafting and adopting processes.
- d. Four expert group meetings were held which made amendments and modifications to the drafted Mental Health Draft Bill, based on objections and suggestions raised at consultative and consensus-building meetings mostly from practitioners and mental health users.
- e. The key findings were:
  - The Mental Health Draft Bill did not have a preamble but an object only.
  - The Mental Health Draft Bill's contents lacked depth in most sections.
  - Most of the key terms were not used consistently throughout the legislation (i.e. interchanged with other terms with similar meanings). Terms such as involuntary and emergency were defined differently and they lacked detail. No one would know to what extent they are used in the body of the legislation. Some terms appeared only in the definition e.g. psychotherapist.
  - Not all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation have been defined.
  - The Mental Health Draft Bill did not provide a framework for its application.
  - The Mental Health Draft Bill did not explicitly specify the rights to respect, dignity and to be treated in a humane way. It just mentions the sanctions in a broad context.
  - The Mental Health Draft Bill gave a blanket cover against discrimination on the grounds of mental illness. It fails to prohibit discriminations in all critical areas.
  - The Mental Health Draft Bill did not deal with matters of informed consent and confidentiality.
  - The Mental Health Draft Bill failed to explicitly address issues of seclusion and restraint.
  - The Mental Health Draft Bill failed to explicitly address the issues of mentally ill people when they are offenders.
- f. These meetings and consultations led to the drafting of the current Mental Health Draft Bill that embraces the essentials of a mental health law using tenets promulgated by the International Covenant on Civil and Political Rights, Principles for the protection of persons with mental illness and the improvement of mental health care, and the Declaration on the Rights of Disabled Persons.
- g. The Mental Health Draft Bill is pending submission to parliament to be enacted into law. Mental Health Draft Bill is now in line with latest international human rights standards, highlighting key values such as human rights protection and promotion, deinstitutionalization, integration of mental health care and community care, quality and safety, social inclusion, and intersectoral collaboration.

### **Key obstacles faced**

- a. Delays by most stakeholders in making written contributions and competing conflicting interests among stakeholders.
- b. Difficulties in implementing the interventions even when the activities were integrated in the Ministry of Health annual plans because of unanticipated withdrawals of health sector financing from Zambia's cooperating partners.

### **What lessons can we learn from these examples for developing and adopting a mental health law?**

- a. Lobbying is critical for the Mental Health Draft Bill to be enacted into law.
- b. Given the historical and ongoing trauma experienced by people living with mental disorders, their main concerns and particularly social and economic and political rights which could not be wholly addressed in the draft Mental Health Bill, other legislation needs to capture what the current Draft Mental Health Bill has not covered. This is because the drafters opted to use the separate legislation approach than the integrated approach.
- c. When there is wider stakeholder involvement from the beginning, (in agenda setting and resource mobilisation and pooling) we could mitigate against longer times to get results and the huge financial costs that are normally required in Participatory Action Research approaches.

### **Where can I read more about this issue?**

Mwanza, J., Cooper, S., Kapungwe, A., Sikwese, A., Mwape, L. and the MHaPP Research Programme Consortium. (In press). Stakeholders' perceptions of the main challenges facing Zambia's mental health care system: A qualitative analysis. *International Journal of Culture and Mental Health*.

**MHaPP website:** [www.psychiatry.uct.ac.za/mhapp](http://www.psychiatry.uct.ac.za/mhapp)

The Mental Health and Poverty Project is led by the University of Cape Town, South Africa and the partners include the Kintampo Health Research Centre, Ghana; Makerere University, Uganda; the University of Zambia; the Human Sciences Research Council, South Africa; the University of KwaZulu-Natal, South Africa; the University of Leeds, UK; and the World Health Organization. The MHaPP is funded by the Department for International Development (DFID), UK for the benefit of developing countries. The views expressed are those of the authors and not necessarily those of DFID.