FINAL REPORT BOTSWANA
December 2016

REFORMING MENTAL HEALTH LEGISLATION ACROSS THE COMMONWEALTH

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

Commonwealth Foundation

Commonwealth Nurses and Midwives Federation

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EXECUTIVE SUMMARY

In September 2014, the Commonwealth Nurses and Midwives Federation (CNMF) was funded by the Commonwealth Foundation to work with two Commonwealth countries to review their mental health and other related legislation and assess compliance with the United Nations Convention on the Rights of Persons with Disability (CRPD), the 'gold standard' for mental health legislation, and make recommendations to bring the legislation in line with the CRPD.

The two Commonwealth countries who expressed an interest in participating in the project were the Seychelles and Botswana. Agreement was reached at the Ministry of Health level with both countries on the project aim, objectives, and methodology, the most critical of which was the establishment of a National Mental Health Advisory Committee to oversee the project in-country.

The research partner in the project was the Indian Centre for Mental Health Law and Policy, and the principal researcher and consultant was Dr Soumitra Pathare.

Existing mental health and other related legislation was assessed in both countries against the CRPD. The report of the assessment by the consultant led to a unanimous decision by the NMHAC and other stakeholders, supported by the Minister for Health in both countries, that existing legislation could not be amended and new mental health legislation was required.

This report outlines the process adopted together with achievements and lessons learned during that process as they were experienced in Botswana. The assessment of the legislation is attached as well as the drafting instructions for a new mental health Bill.

The success of the project is attributable to three factors: firstly the support of the Botswana Ministry of Health and Minister for Health; secondly the commitment of members of the Botswana National Mental Health Advisory Committee; and thirdly the experience and expertise of the consultant, Dr Soumitra Pathare.

The CNMF is indebted to the Commonwealth Foundation for their vision in funding the project, and their encouragement, and support throughout the project.

Comments on the report are welcome and should be addressed to the CNMF Project Manager, Jill Iliffe (jill@commonwealthnurses.org).

1. BACKGROUND TO THE PROJECT

Mental ill health affects one in four people worldwide at some time in their lifetime according to the World Health Organisation (WHO). Human rights violations of psychiatric patients, they say, are routinely reported in most countries, including physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders and only 59% of WHO member states have dedicated mental health legislation.[1]

The WHO argues that mental health legislation is equally as important as mental health policy. Legislation, they say, provides the legal framework for protecting individuals against human rights violations and also for providing mental health services that promote access to care. Reform of mental health legislation is urgent and essential because of the unique vulnerabilities of people with mental disorders who face stigma, discrimination, and marginalization which inhibit them from seeking care.[2] Policy and practice needs to be based on a sound legal framework to protect people in need of care and the practitioners who provide that care.

Mental health legislation, when formulated according to human rights principles, provides a legal framework to address important mental health issues such as access to care, rehabilitation, integration of people with mental disorders into the community, the prevention of discrimination, upholding the full human rights of people with mental disorders, and the promotion of mental health.[3]

Mental ill health is the third leading cause of disease burden in the world, predicted to be the leading disease burden by 2030. In 2010, the global economic impact of mental ill health was approximately US$ 2.5 trillion and this cost is estimated to increase to US$ 6 trillion by 2030. While mental ill health is typically left off the list of top NCDs, it alone accounts for over US$ 16 trillion or one third of the overall US$ 47 trillion anticipated spend on NCDs over the next 20 years. Mental disorders are common co-morbidities of NCDs, infectious diseases, and poverty.[4]

The World Health Organisation report that:

- About half of mental disorders begin before the age of 14. Around 20% of the world's children and adolescents, regardless of culture, are estimated to have mental disorders. Regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources.
- Mental health issues are frequently hidden, ignored or stigmatised. Mental disorders are a major risk factor for communicable and non-communicable disease. They can also contribute to unintentional and intentional injury.

[1] World Health Organisation 2011 *Mental Health Atlas 2011.* Available from: http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/index.html p.11
[2] World Health Organisation 2009 *Improving health systems and services for mental health.* Available from: http://whqlibdoc.who.int/publications/2009/9789241598774_eng.pdf
[3] World Health Organisation 2009 *Improving health systems and services for mental health.* Available from: http://whqlibdoc.who.int/publications/2009/9789241598774_eng.pdf
[4] World Economic Forum 2011 *The Global Economic Burden of Non-communicable Diseases.* Available from: http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf

- There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are one of the main barriers to providing treatment and care in low and middle income countries. Low income countries have 0.05 psychiatrists and 0.42 mental health nurses per 100,000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.
- Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care.
- On average about 800,000 people commit suicide every year, 86% of them in low and middle income countries. Mental disorders are one of the most prominent and treatable causes of suicide.
- War and other major disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.
- Few countries have a legal framework that adequately protects the rights of people with mental disorders.[5]

At the 66th World Health Assembly (WHA) held in Geneva Switzerland 20-25 May 2013, member states endorsed a Mental Health Action Plans 2013-2020 (WHA Resolution 66.8).[6,7] The resolution for a mental health action plan followed an earlier resolution at the 65th World Health Assembly (WHA 65.4)[8] which encouraged WHO member states to pay urgent attention to mental health services and adopt a 'rights based' approach to care and treatment.

The WHA Mental Health Action Plan defines mental health as: *a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.* In relation to mental health legislation, the WHA Mental Health Action Plan notes that: *mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community (p.8).*

The Mental Health Action Plan 2013-2020 proposes that member states: *develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions (p.8).*

In 2013, the 25th Commonwealth Health Ministers meeting (CHMM), which is held the day prior to the opening of the World Health Assembly, took mental health as its theme. In preparation for the CHMM, research into mental health legislation in Commonwealth countries was commissioned by the

[5] World Health Organisation 2013 *Ten Facts on Mental Health.* Available from: http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index9.html
[6] World Health Organisation 2013 *Draft comprehensive mental health action plan 2013-2020.* Available from: http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_8-en.pdf
[7] World Health Organisation 2013 *Comprehensive mental health action plan 2013-2020.* Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf
[8] World Health Organisation 2012 *The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country leve.l* Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf p.7

Commonwealth Health Professions Alliance and funded by the Commonwealth Foundation. The research was conducted by a team from the Indian Centre for Mental Health Law and Policy (ICMHLP) led by Dr Soumitra Pathare.

Mental health legislation in Commonwealth member states was reviewed to obtain an insight as to how mental health legislation in the Commonwealth complies with the United Nations Convention on Rights of Persons with Disabilities (CRPD), the 'gold standard' for mental health legislation. The provisions of the United Nations Convention on the Rights of People with Disabilities (CRPD), was used to enable systematic comparison of legislation from different countries. Analysis was restricted to dedicated mental health legislation. Mental health legislation was sought from 53 of the 54 countries of the Commonwealth (the exception being Fiji).

Few countries across the Commonwealth had ratified or signed the United National Convention on the Rights of Persons with Disabilities (CRPD).

Table 1: CRPD status Commonwealth countries.

	Low	Low to middle	Upper middle	High	Total
Ratified	5	11	6	6	28
Signed	0	5	2	3	10
Neither	2	2	2	1	7

Mental health legislation was unable to be obtained from three countries (St Lucia, St Kitts and Nevis, and St Vincent's and the Grenadines) and an official English translation for the mental health law of Cyprus was also not available. Therefore these four countries were not included in the analysis. An extensive online search and correspondence with relevant partners suggested there was no dedicated mental health legislation in four countries namely Cameroon, Maldives, Mozambique and Rwanda. Thus mental health legislation was obtained from 45 countries and included in the analysis.

2.1 Research findings

1. Mental health legislation in 20 per cent of Commonwealth member states was enacted prior to 1960 before modern medical treatments became available and before many of the international human rights instruments came into force.
2. Mental health legislation in only 11 per cent of Commonwealth member states specifically include provisions that state mental health care should be provided on an equal basis with physical health care.
3. Mental health legislation in only 9 per cent of Commonwealth member states promotes voluntary admission and treatment as the preferred alternative for treatment of mental disorders.
4. Mental health legislation in only 29 per cent of Commonwealth member states gives persons with mental disorders the right to be informed of their rights when receiving mental health care or treatment.
5. While laws in 24 per cent of member states had some provisions promoting community care, no legislation met all the criteria to be rated as promoting community care and deinstitutionalisation.
6. Mental health legislation in only four Commonwealth member states had provisions for supported decision making including the provision of Advance Directives in their mental health legislation.

7. Mental health laws in all Commonwealth member states allow involuntary admission to a mental health facility. Only half (51 per cent) of country mental health laws require the person to be discharged as soon as they do not meet the criteria for involuntary admission. 80 per cent of mental health legislation in Commonwealth countries does not apply the principle of least restrictive alternative to involuntary admission.
8. More than two-thirds of the mental health laws do not have a judicial/quasi-judicial body to review involuntary admissions and treatment.
9. Provisions for protection from cruel, inhuman and degrading treatment are included in the legislation in only 23 (51 per cent) countries.
10. The informed consent of persons with mental disorders for participating in clinical and experimental research is specifically mandated in mental health legislation in only five (11 per cent) countries.
11. Mental health laws in only nine (20 per cent) countries include a provision on the protection of confidentiality and only eight (18 per cent) countries include a provision on privacy for persons with mental disorders.
12. Legislation in only three (7 per cent) countries specifically outlaws forced or inadequately remunerated labour within mental health facilities.
13. Very few laws have specific provisions for the involvement of families and care-givers. Legislation in 12 (27 per cent) countries provides for information to be given to families and caregivers; in 10 (22 per cent) countries families and care-givers are encouraged to participate in the formulation of treatment plans.
14. Mental health laws in most Commonwealth countries provide very little protection to minors and children. Laws in only two (4 per cent) countries restrict involuntary admission of minors with mental health problems, and laws in only three (7 per cent) countries ban any irreversible treatments on children with mental health problems.
15. The word “lunatic” is used in the mental health laws of 12 countries; the term “insane” is used in the mental health laws in 11 countries; the term “idiot” is used in the mental health laws in 10 countries; two mental health laws use the term “imbecile”; and two mental health laws use the term “mentally defective”. Overall 21 (47 per cent) laws use one of the above terms.
16. The law in only one Commonwealth country mandates that users of mental health services are involved in mental health policy, legislation development and service planning.

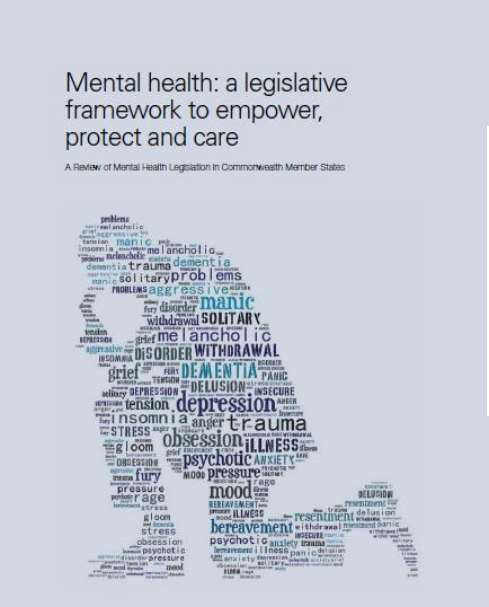
2.2 Research conclusions:

1. Mental health legislation in many Commonwealth member states is out-dated and does not fulfil member states’ international human rights obligations toward persons with mental disorders.
2. Mental health legislation in many Commonwealth member states is not compliant with the Convention on Rights of Persons with Disabilities. Substantive and procedural provisions related to guardianship in mental health laws are particularly problematic in this regard.
3. Many mental health laws reviewed in the report treat persons with mental disorders as needing protection rather than as subjects with rights. As a result, mental health legislation, instead of protecting the rights of persons with mental disorders, is likely to lead to violation of rights.
4. Mental health legislation in many countries is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders and denies the capacity of persons with mental disorders to manage their lives.

5. Provisions in and the language of mental health laws in many instances adds to negative perceptions and further stigmatisation of persons with mental disorders.
6. Most mental health laws pay little attention to protecting the rights of vulnerable groups with mental health problems such as minors, women, and minorities and the special needs of such vulnerable groups.
7. Many mental health laws in Commonwealth countries do not address the issue of (lack of) access to mental health care, in particular, making care and treatment easily available; provided in a manner which enhances the capacities of individuals and protects and promotes their rights; and enables them to live and participate in their communities.
8. There is little participation of persons with mental disorders and their families and care-givers in the development and implementation of legislation.

2.3 Research recommendations:

1. Commonwealth member states should urgently undertake reform of mental health legislation.
2. Member states should ensure that the legislation meets their obligations under international human rights treaties, in particular the Convention on Rights of Persons with Disabilities.
3. Commonwealth member states need to thoroughly review all legislation to comprehensively address all civil, political, economic, social and cultural rights of persons with mental disorders.
4. Commonwealth member states should introduce provisions to promote supported decision making in mental health legislation.
5. Commonwealth member states must involve persons with mental disorders and care-givers, apart from other stakeholders, in the mental health law reform process.



The research report and the executive summary: *Mental health – a legislative framework to empower, protect and care* can be downloaded from the Commonwealth Health Professions Alliance website: http://www.chpa.co. Additional resources available on the CHPA website are the Executive Summary and a power point presentation of key findings.

3. INTRODUCTION TO THE PROJECT

In 2014, the Commonwealth Nurses and Midwives Federation (CNMF) designed a project to build on the 2013 research conducted by the Indian Centre for Mental Health Law and Policy (ICMHLP). The project was based on the premise that mental health legislation, when based on human rights principles, provides a legal framework to address access to care; rehabilitation and integration into the community; prevention of discrimination; and promotion of mental health and wellbeing. The project aimed to work with two Commonwealth countries and facilitate a partnership between civil society and government which would assess the mental health and other relevant legislation of a country against the UN Convention on the Rights of Persons with Disability (CRPD) and make recommendations for amendment to existing legislation or the drafting of new legislation.

The project was enthusiastically endorsed by the CNMF Board and a funding application was submitted to the Commonwealth Foundation as part of their Participatory Governance grants. The funding application was successful and the CNMF received a grant of £51,406.00 over two years. The project commenced in September 2014 and concluded in November 2016.

The overall goal of the project was that the human rights of people with mental ill health are respected within legislation which empowers them, protects them and cares for them. The project aimed to work with two Commonwealth countries using four main strategies:

- Increased awareness and cooperation by government of the need for mental health legislative reform and support for the project;
- The establishment of a national mental health advisory committee (NMHAC) to drive the project in-country and increased communication and dialogue between the NMHAC, Government and other stakeholders around mental health reform issues;
- Assessment of mental health and other relevant legislation against the CRPD and implementation of recommendations for amendments to existing legislation or the drafting of new legislation;
- The provision of education and information on the need for mental health legislative reform to a wide variety of stakeholders, including government, bureaucracy, mental health practitioners, people with mental health disorders and their carers, the media, and the public.

The two Commonwealth countries which, through their Health Department Permanent Secretaries which expressed an interest in participating in the project were Botswana and the Seychelles.

Botswana's Mental Disorders Act was enacted in 1969 and underwent minor review in 1971. A first attempt to review the Act was made 1985 to 1987 however did not proceed to an outcome. Draft amendments were developed in 1996 however once again did not produce an outcome. Botswana recognised that their mental health Act is based on an outdated understanding of mental illness; does not take into account medical advances in the treatment, care and rehabilitation of persons with mental illness; and violates international conventions ratified by Botswana, such as the International Convention on Civil and Political Rights and the Convention against Torture. The Botswana Government welcomed the opportunity to participate in the project and made a formal commitment, by exchange of letters to endorse, participate in, and support the project.

4. PROGRESS OF THE PROJECT: BOTSWANA

4.1: Establishment of the National Mental Health Advisory Committee (NMHAC)

Preparatory correspondence to share the overall aim and objectives of the project was exchanged with representatives from the Botswana Ministry of Health: the Permanent Secretary for Health, Ms Shenaaz El-Halabi; the Director for Public Health, Dr Haruna Jibril; and the Chief Health Officer for Mental Health and Rehabilitation, Ms Gaboelwe Rammekwa.

The Botswana Ministry of Health, through Ms Rammekwa, the in-country focal person for the project, invited potential members of the NMHAC and appointed the Chairperson, Dr Edward Maganu who was Chairperson of the Mental Health Board Botswana (see Attachment 1 for membership). The NMHAC included a user of mental health services and a carer of a person with mental health problems. The Botswana Ministry of Health undertook to provide financial support for meetings and activities of the NMHAC, freeing up project funds for other activities. A list of responsibilities and expectations of each partner in the project was developed and agreed (see Attachment 2), a Terms of Reference was developed for the NMHAC (see Attachment 3); and a Memorandum of Understanding was developed and signed with the Botswana Ministry of Health (see Attachment 4).

4.2: Meetings of the NMHAC

The NMHAC met formally as part of the project on six occasions however met informally to progress activities much more frequently. Additional meetings were also held with the Secretariat for the project from the Botswana Ministry of Health (April and June 2016). Formal project meetings with members of the NMHAC were held:

- 17 February 2015
- 4 May 2015
- 31 August 2015
- 16 November 2015
- 11 and 14 July 2016
- 29 August 2016

First meeting of the NMHAC February 2015

4.3: Endorsement of the project plan and methodology

At the first meeting of the NMHAC which was held on 17 February 2015 the project plan, methodology, and timelines were endorsed. Members of the NMHAC undertook to provide information about the project in their workplaces and to their networks. A power point presentation was developed so that information shared was consistent.

4.4: Assessment of existing mental health and other relevant legislation

The second meeting of the NMHAC was held on 4 May 2015. At this meeting a list of relevant legislation for assessment was developed and the NMHAC committed to obtaining soft copies of the legislation for the research team from the Indian Centre for Mental Health Law and Policy. The NMHAC experienced some difficulties in obtaining soft copies of all the relevant legislation.

NMHAC May 2015

NMHAC August 2015

The third meeting of the NMHAC was held on 31 August 2015. The main purpose of the meeting was to prepare for the visit of the consultant to the project, Dr Soumitra Pathare, in November when the assessment results and recommendations would be shared with the NMHAC. It was recommended that at the same time, a broader stakeholder meeting be organised so the results of the review could be shared with them and their input obtained. Additional legislation was identified to be forwarded to Dr Pathare for inclusion in the analysis. There was a strong recommendation that the process for Cabinet approval for review of the current legislation, and action on the recommendations of the review, was clarified and Cabinet approval obtained as a matter of priority.

4.5: Findings of the assessment

The fourth meeting of the NMHAC was held on 16 November 2015. This meeting was attended by the consultant, Dr Soumitra Pathare, who shared with the NMHAC the result of the assessment of the legislation against the CRPD and his recommendations (see Attachment 5).

Documents which were included in the assessment were:

1. 1. Mental Disorders Act 1971
2. 2. National Policy on Mental Health 2003
3. 3. National Policy on Care of People with Disabilities 1996
4. 4. Constitution of Botswana
5. 5. Penal Code as amended up to 2005
6. 6. Public Health Act 2013
7. Marriage Act 2001

8. Adoption of Children Act as amended up to 2000
9. Prisons Act 1980 as amended up to 2006
10. Wills Act 1957 as amended up to 1977
11. Domestic Violence Act 2008

Botswana has ratified the following International Treaties and Conventions which have relevance to mental health legislation and policies:

(a) International Convention on Civil & Political Rights (ICCPR)
(b) Convention on Elimination of Discrimination against Women (CEDAW)
(c) International Convention on Elimination of all Forms of Racial Discrimination (CERD)
(d) Convention against Torture (CAT)
(e) Convention on the Rights of the Child (CRC) and Optional Protocol
(f) African Charter on Human and People's Rights

Botswana has neither signed nor ratified by the International Convention on Rights of Persons with Disabilities (CRPD) and is consequently not bound by it. Botswana is a dualist state, and international conventions need to be domesticated prior to its application in Botswana. The CRPD has not been domesticated into legislation in Botswana. However the Botswana Court of Appeal has emphasized that international obligations which have not been domesticated should nevertheless, serve as an interpretive source.

The Botswana National Policy on Mental Health in its 'Specific Objectives' lists mental health legislation. Specific Objective 5.3: *Provide a framework for a periodic review of legislation in line with local, regional and international trends in good mental health practices*.

The National Policy on Mental Health also mentions mental health legislation in its 'Strategies' for implementation of the Policy. Strategy 6.8 says that legislation should reflect modern trends and Botswana's obligations under international law and human rights. The specific objectives under the strategy include:

1. The Ministry of Health shall advocate for mental health legislation that is consistent with assuring rights and protection of people with mental disorders and adequate treatment and care of involuntary and voluntary patients.
2. The Ministry of Health shall ensure that legislation in all statutes dealing with mental health is consistent with the principles set out in the National Policy on Mental Health.

The recommendation of the consultant was that it would be very difficult to amend existing legislation to bring it in line with the above international conventions and standards as the Act is premised on a custodial solution and exclusion of persons with mental illness rather than a rights based approach to care and treatment. It will be easier to draft new legislation which complies with these requirements. The Mental Health Act violates international conventions ratified by Botswana, such as the ICCPR and the Convention against Torture.

Although Botswana has not ratified the Convention on Rights of Persons with Disabilities (CRPD), it is important to note that the Mental Health Act will not meet the standards and human rights protections for persons with mental disability (mental illness) under the CRPD. Provisions pertaining to persons with mental illness in other laws such as the Children's Act, the Marriage Act etc. outlined above will also need to be amended to protect rights of persons with mental illness. Although Botswana has not ratified the CRPD, it is important to highlight here that these provisions violate rights protected in the CRPD. The provisions of the Mental Health Act are also contrary to recommendations and standards made by international organizations on mental illness such as the United Nations Principles for the Protection of Persons with Mental Illness[9] and the WHO Resource Book on Mental Health, Human Rights and Legislation.[10]

The consultant noted that it is important that all stakeholders are consulted and part of the drafting process for the new law. In particular, it is important that persons with mental illness and their representative organizations care-givers and their representative organizations and human rights organizations are part of the consultation and law drafting process. It is also important that those drafting the new law take General Comment 1[11] and the Guidelines on Article 14[12] by the Committee on Rights of Persons with Disabilities into account when drafting the new legislation.

The Constitution of Botswana protects the fundamental rights of all citizens such as the right to life, right to personal liberty, protection from inhuman treatment, protection from deprivation of property, protection of law and protection from discrimination. The laws highlighted above including the Mental Health Act, violate these basic fundamental rights of persons with mental illness, which are protected by the Constitution of Botswana.

New legislation will need to incorporate models of supported decision making in the law. For example these could include, advance statements or directives, nominated representatives or enduring power of attorney etc. These are compliant with the CRPD. New legislation also needs to specifically address the mental health needs of children and the elderly.

4.6: Endorsement of the need for a new Mental Health Bill

Following lengthy discussion, the NMHAC acknowledged that the existing mental health legislation was not amenable to amendment and unanimously endorsed the development of a new Mental Health Bill. Consultations were undertaken with the Attorney General's Office to share the outcome of the assessment of the mental health and related legislation. Consultations were also undertaken with staff at the various mental health facilities throughout Botswana. Representatives from the NMHAC and the consultant shared the results of the assessment with the Permanent Secretary for Health and other key people within the Ministry of Health. The recommendations of the consultant, that existing mental health legislation could not be amended and that new mental health legislation was required was endorsed by all parties. The NMHAC was charged with developing a process to move forward the development of new legislation.

[9] United Nations 1991 *The protection of persons with mental illness and the improvement of mental health care.* Available from: http://www.un.org/documents/ga/res/46/a46r119.htm.
[10] World Health Organisation 2005 *Resource book on mental health, human rights, and legislation.* Available from: http://ec.europa.eu/health//sites/health/files/mental_health/docs/who_resource_book_en.pdf.
[11] United Nations 2014 *General Comment No.1 – Article 12: Equal recognition before the law.* Available from: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en.
[12] United Nations 2015 *The right to liberty and security of persons with disabilities.* Available from: http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc.

NMHAC November 2015

NMHAC November 2015

NMHAC November 2015

Meeting with Principal Secretary for Health NMHAC November 2015

4.7: Development of drafting instructions for the new Mental Health Bill

In April 2016, a meeting was held with the Secretariat for the project from the Botswana Ministry of Health to progress drafting new mental health legislation. Difficulties were being experienced within the Ministry on the correct procedure for submitting a memorandum to Cabinet for authorisation to develop new legislation. In discussions with the Chairperson of the NMHAC and the Secretariat from the Ministry of Health it was decided that the consultant would come to Botswana work with the Attorney General's Office to develop a first draft of the Bill. Ministry of Health representatives were confident that the Cabinet Memorandum would be approved by that time.

The consultant visited Botswana between 11-14 July 2016 and spent three days with members of the NMHAC, a representative from the Attorney General's Office and representatives from Botswana mental health facilities to develop drafting instructions for the new mental health legislation. As the Cabinet Memorandum authorising the development of a new Bill had not been finalised, it was not considered appropriate to develop a draft Bill at this time, however comprehensive drafting instructions were considered to be an acceptable outcome. The fifth meeting of the NMHAC was held 14 July 2016 and at this meeting the consultant, Dr Pathare, shared with the NMHAC the first draft of the drafting instructions. The document was discussed in great detail to ensure that it was relevant to the Botswana context and that it met the CRPD standard as far as was possible. Minor amendments to the drafting instructions were made by the NMHAC and the consultant to prepare them for submission to the Attorney General's Office through the Minister of Health (see Attachment 6). An issue which created some concern related to seclusion and restraints. The consultant explained the international position on seclusion and restraints which should be banned in mental health facilities. However the strong feedback from the NMHAC was that Botswana was not ready to ban seclusion and restraints and wanted them retained in the Bill. The consultant argued strongly that the use of seclusion and restraints if included should be restricted with oversight from an

independent body. The consultant emphasised that this was not recommended international best practice. He also reminded the NMHAC that Botswana has ratified the Convention against Torture, and the Special Rapporteur on Torture has stated that seclusion and restraints in mental health facilities may amount to torture. The CRPD also does not support the use of seclusion and restraints.

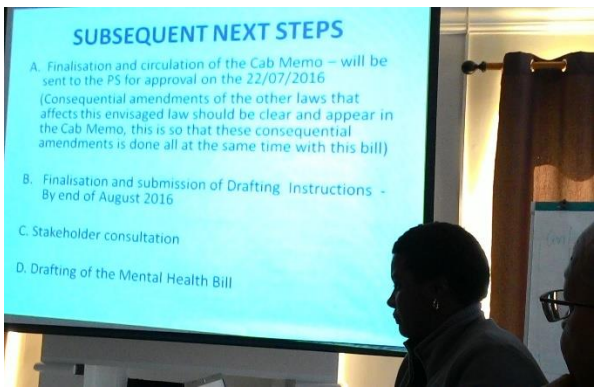

NMHAC July 2016

4.8: Finalisation of phase 1 of the project

The final meeting of the NMHAC was held on 29 August 2016. At this meeting, the NMHAC reviewed the progress of the project. The Chair of the NMHAC confirmed that the drafting instructions for the new Mental Health Bill, will be forwarded to the Attorney General's Office, through the Principal Secretary for Health and the Minister for Health once the Cabinet Memorandum has been approved. A timeline of end of September 2016 was set for this activity however it was noted that the timelines set at the July 2016 meeting had not been met.

The NMHAC reflected on what had been achieved, what was done well, and what could have been done better.

They considered they had achieved their major objective which was to review existing legislation and develop drafting instructions for a new mental health bill. They felt the NMHAC had functioned well, were committed, and provided good input. Dr Pathare's input was unanimously considered invaluable to the process and outcome. They felt they could have done better by having more regular, scheduled meetings with better implementation of the communication strategy and the appointment of a project officer rather than relying on a busy Secretariat within the Ministry of Health and an external project manager.



NMHAC August 2016

5. ACHIEVEMENTS OF THE PROJECT

5.1: Engagement and support of government

The engagement and support of the Botswana Ministry of Health and Minister for Health through the Permanent Secretary for Health was important to the successful establishment and implementation of the project.

5.2: Establishment of a National Mental Health Advisory Committee

The establishment of a representative National Mental Health Advisory Committee to provide in-country oversight of the project was another critical success factor. The members of the NMHAC, including the service user and the carer representatives, remained committed and enthusiastic throughout the project.

5.3: Consensus on the need for a new Mental Health Bill

The recommendations from the consultant following the assessment of the existing mental health and other related legislation of the need for a new Mental Health Bill were unanimously endorsed by the NMHAC and the Ministry of Health.

5.4: Development of drafting instructions for a new Mental Health Bill

The consultant spent four days in Botswana and sat with members of the NMHAC and a representative from the Attorney General's Office to develop drafting instructions for a new Mental Health Bill. This was a very effective strategy. The consultant had the knowledge and expertise of the CRPD and other reformed mental health legislation and the NMHAC members had the knowledge and expertise of the Botswana culture and context. Having a first draft gave a sense of accomplishment for both the consultant and the NMHAC. On reflection, there could have been a much shorter time interval between endorsement of the need for a new Mental Health Bill and development of the drafting instructions.

5.5: Commitment to continuing the project

The members of the NMHAC have made clear their ongoing commitment to the project and to seeing the drafting instructions become a new Mental Health Bill enacted by the Parliament of Botswana. This commitment, among all the other responsibilities of their respective positions, is commendable.

6. LESSONS LEARNED

6.1: Need for a dedicated in-country project manager

The most important lesson is the need for the appointment of a dedicated in-country project manager either full-time or part-time to drive the project forward. The work commitments of members of the NMHAC, particularly the Secretary to the NMHAC from the Ministry of Health, made it very difficult for them to give the project the time required to achieve project timelines and activities and as a consequence timelines and some activities were routinely not met, particularly in relation to implementation of the communication strategy and submission of the Memorandum to Cabinet for the development of a new Mental Health Bill. In-country activities of the NMHAC tended to occur around the time of a scheduled formal meeting called by the external project manager from the CNMF however the interval between formal meetings of the NMHAC were often delayed due to the work commitments of the external project manager. The appointment of a dedicated in-country project manager (either full-time or part-time) would assist in ensuring scheduled activities were undertaken and timelines met. It has been estimated that the appointment of a dedicated in-country project manager would reduce the time required for completion of the project to from 24-30 months to 12 months.

6.2 Size of NMHAC

The Botswana NMHAC although having broad representation, was a large group of 29 people (see Attachment 1). There was not one NMHAC meeting when all 29 people were present and despite a regular core of attendees, the presence of different members of the NMHAC at each meeting was not conducive to effective decision-making or to driving the project forward in a timely manner. A smaller group, meeting more regularly, which reported to the larger group each few months, may have been more effective.

6.3: Need for scheduled and formal regular in-country meetings of the NMHAC

The only formal scheduled meetings of the NMHAC during the project were those organised by the external project manager. While the NMHAC met informally between the formal meetings, these meetings were ad hoc in nature. The committee would have benefitted by scheduling monthly or second monthly meetings between the formal meetings called by the external consultant. It is considered that regular in-country meetings would have assisted in the timely conduct of scheduled activities and conformance to timelines.

6.4 Significant delay in submitting for Cabinet approval for new Mental Health Bill

Discussion began at the first meeting of the NMHAC in February 2015 regarding the need to submit a memorandum to Cabinet for approval to review existing mental health legislation and if necessary, draft a new mental health law. There appeared to be a lack of clarity about the process and at each subsequent meeting, questions were asked about the status of the Cabinet Memorandum. A draft of the Memorandum was confidentially provided to the consultant to the project for input which was provided by July 2016. At the 14 July 2016 meeting, a commitment was given for the Memorandum to be sent to Cabinet by 22 July. The delay in obtaining Cabinet approval means that the drafting instructions which were finalised and endorsed by the NMHAC at the 29 August 2016 meeting could not be transformed into a new Mental Health Bill despite the willingness of the Attorney General's Office to do so. At the completion of Phase 1 of the project, 30 November 2016, the Memorandum for new Mental Health legislation had still not been submitted to Cabinet. This is very disappointing and an inexplicable delay.

6.5: More effective implementation of communication strategy

The NMHAC endorsed a communication strategy which had a number of elements, none of which worked as effectively as they were envisaged by the project, if at all. The process for distribution of communiqués after each NMHAC meeting was never satisfactorily established. The same applied to educational material developed as part of the project. The project communication strategy recommended briefing 'champions' for the project, however 'champions' were never identified or approached. A data base was developed as part of the project for dissemination of communiqués and educational material however, despite requests to the NMHAC for names to be included on the data base, this facility was underused and could have been more effective. A website was also developed for the project with a secure section for the NMHAC, however website statistics demonstrated that it not as effectively used as it could be or was intended by the NMHAC.

6.6: Lack of broader stakeholder input

The Botswana NMHAC has very broad representation however formal consultation with a wider group of stakeholders did not occur as part of the project. The NMHAC considered that the most appropriate time for this consultation was when a draft Mental Health Bill were available however without stakeholders being informed of and educated about the reasons for the review and being given an opportunity for input into the drafting instructions for the new Bill their support for a new Bill cannot be assumed. Input received at the drafting instruction stage could have been incorporated into the new Bill.

6.7: Potential for streamlining the process

The experience of undertaking the project in Botswana demonstrated a number of ways in which the process could be streamlined. The first is the appointment of a dedicated in-country project manager to drive the project forward and ensure activities and timelines were met. The second is a formal agreement at the Ministry of Health level prior to the commencement of the project regarding communication strategies which could then be implemented by the in-country project manager. The identification and collection of the soft copies of existing mental health and other relevant legislation could be undertaken as one of the first activities of the project, saving several months in the delivery of the assessment report and adoption of recommendations for reform. The time between receipt of the assessment report and the development of drafting instructions could also have been considerably shortened. There is no reason not to move quickly from one to the other.

6.8: Potential for replication in other countries

The NMHAC and the external project manager agree that the overall project strategy lends itself well to replication in other countries, particularly the establishment of an in-country National Mental Health Advisory Committee. The recommendations for streamlining the project so the time taken is reduced should also be strongly considered.

7. NEXT STEPS

The Botswana Permanent Secretary for Health and the National Mental Health Advisory Committee are committed to seeing the project to its logical conclusion: development of a new Mental Health Bill and submission to Parliament for enactment however the delay in gaining Cabinet approval for the development of a new Mental Health Bill is impacting on the achievement of this objective. The Commonwealth Nurses and Midwives Federation has submitted to the Commonwealth Foundation for funding for an extension to the project to facilitate the development of the new Bill and its submission to Parliament including extensive stakeholder consultation for input and support and is quietly confident of the continued support of the Commonwealth Foundation to follow the project to a successful conclusion. The project cannot proceed however with the Botswana Ministry of Health making obtaining Cabinet approval for the development of a new Mental Health Bill a priority.

ATTACHMENT 1

BOTSWANA NATIONAL MENTAL HEALTH ADVISORY COMMITTEE

No	Name	Designation	Organisation
1	Dr Edward Maganu	Chairperson-Mental Health Board	Mental Health Board
2	Dr Mpho Thula	DPS (Psychiatrist)	Clinical Services Department - Ministry of Health
3	Ms Malebogo Pilane	Clinical Psychologist	S'brana Psychiatric Hospital
4	Mr Lameck Balapi Gabakgorwe	Psychiatric Nurse	Botswana Police Clinic
5	Mr Patrick Zibochwa	Programme Coordinator-Mental Health	Rehabilitation & Mental Health Division – Ministry of Health
6	Dr Philip Opondo	Psychiatrist	University Of Botswana
7	Ms Malebogo Motsokono	Community Mental Health nurse	Serowe DHMT
8	Mr Clark Kebaitse	Lecturer-Psychiatric Mental Health Nursing	Institute Of Health Sciences-Lobatse
9	Ms Motlalepula Vakalisa	Prisoners Rehabilitation	Botswana Prisons Department
10	Mr Gilbert Gangata	Specialist Teacher	Botswana Council for the Disabled
11	Mr Samuel Almasi Zoka	Occupational Therapist	S'brana Psychiatric Hospital
12	Ms Violet Losike	District AIDS Coordinator	District Commissioner's Office
13	Mr Abednigo Bigboy Mafhoko	Hospital Manager	Scottish Livingstone Hospital
14	Mr Moagi Gaborone	Health Promotion Officer	World Health Organisation
15	Ms Motlalepula Segopolo	Legal Advisor	Ministry of Health
16	Ms Keaneilwe Ralekgobo	Social Worker	Ministry of Local Government and Rural Development (Social Protection Department)
17	Mr Moagi Gaborone	Health Promotion Officer	World Health Organisation
18	Ms Ruth Madiba	Care giver	Personal capacity
19	Mr Ookame Charles	SHO	RMHD – MOH
20	Obopilwe Mosimane	Student	RMHD – MOH
21	Ms Julia Selebaleng Mathagkong	Administration Officer	Kweneng DHMT (Scottish)
22	Ms Inez G Kenosi	Coordinator	Special Education BCD
23	Mrs Otsetswe Lefhoko	Service user	Personal capacity
24	Dr Bechedza Frank Hatitchki	Psychiatrist	S'Brana Psychiatric Hospital
25	Dr Paul Sidandi	Psychiatrist	Jubilee Psychiatric Unit
26	Ms Gaboelwe Rammekwa	Chief Health Officer	Rehabilitation & Mental Health Division – Ministry of Health
27	Ms Jill Iliffe	Project Manager	Commonwealth Nurses and Midwives Federation
28	Dr Soumitra Pathare	Psychiatrist / Consultant	Indian Centre for Mental Health Law and Policy

ATTACHMENT 2

PROJECT RESPONSIBILITIES AND EXPECTATIONS

Commonwealth Foundation	Funding for project
Commonwealth Nurses and Midwives Federation	Manage project and project budget Ensure all project deliverables Liaison with researcher and Chairperson of NMHAC Secretariat support to NMHAC
Botswana Ministry of Health	Nominating members of NMHAC and appointing Chairperson Providing venue and sustenance for anticipated meetings x 6 Identifying and facilitating access to soft copies of mental health and other relevant legislation
Researcher	Analysing Botswana mental health and other relevant legislation against UN Convention on Rights of Persons with Disabilities Preparing draft report with recommendations Preparing technical drafting instructions to NMHAC instructions
NMHAC	Endorsing project plan and communication strategy Endorsing communication materials Assisting with identification and obtaining soft copies of mental health and other relevant legislation Participating in implementation of communication strategy Providing comment on report of researcher and recommendations Providing researcher with Bill drafting instructions for Botswana context Endorsing technical instructions and submitting to Ministry of Health Lobbying for passage of Bill through Parliament Lobbying for implementation of Bill and subsequent translation to policy and practice.

ATTACHMENT 3

NMHAC TERMS OF REFERENCE

1. **INTRODUCTION**

1.1 The ultimate aim of the project is a new Mental Health Act for Botswana which meets the obligations of Botswana under the United Nations Convention on the Rights of Persons with Disability for the human rights of people with mental ill health to be respected within legislation which empowers them, protects them, and cares for them.

1.2 The project will review the mental health and other relevant legislation of Botswana against the United Nations Convention on the Rights of Persons with Disability and develop technical recommendations for submission to government for amendments to existing legislation or the drafting of a new mental health Bill.

1.3 The project is a partnership between the Botswana Ministry of Health, the Commonwealth Nurses and Midwives Federation, the Commonwealth Foundation, and the Indian Centre for Mental Health Law and Policy.

2. **SCOPE**

2.1 The National Mental Health Advisory Committee (NMHAC) has been established by the Botswana Ministry of Health to support the implementation of the project titled: *Mental health legislative reform across the Commonwealth.*

2.2 The project is managed by the Commonwealth Nurses and Midwives Federation through funding from the Commonwealth Foundation.

2.3 The proposed period for the implementation of the project is from 1 January 2015 to 30 June 2016 unless an extension is agreed with the Botswana Ministry of Health.

3. **MEMBERSHIP**

3.1 Membership is through appointment by the Botswana Ministry of Health. Membership should be as broad as is necessary to meet the requirements of the project and include a person who is a user of mental health services and a carer of a person with mental health issues.

4. **PROJECT OBJECTIVES**

4.1 Submission to the Parliament of Botswana of reformed mental health legislation in the form of amendments to existing legislation or a draft Bill which predominantly meets the UN Convention on the Rights of Persons with Disability.

4.2 The establishment of a National Mental Health Advisory Committee of Botswana which is educated, empowered, and engaged with the bureaucracy and government around ongoing reform of mental health legislation, policy and service provision.

5. ROLES AND RESPONSIBILITIES

5.1 The Ministry of Health Botswana is responsible for:

5.1.1 Nominating members of the NMHAC and appointing the Chairperson.

5.1.2 Providing venue and sustenance for a minimum of four and a maximum of six meetings unless otherwise agreed.

5.1.3 Providing secretariat services in partnership with the project manager.

5.2 The National Mental Health Advisory Committee is responsible for:

5.2.1 Attending and participating in meetings of the NMHAC.

5.2.2 Identifying and facilitating access to soft copies of mental health and other relevant legislation.

5.2.3 Providing guidance to the project manager in relation to project management.

5.2.4 Providing guidance to the project manager in relation to the communication strategy and educational materials for media and the general public.

5.2.5 Participating actively in the implementation of the communication strategy by identifying media contacts and other stakeholders to highlight the project and mental health.

5.2.6 Providing guidance to the researcher in relation to the report of the researcher on the assessment of the legislation.

5.2.7 Providing guidance to the researcher on the development of technical drafting recommendations.

5.2.8 Support wider consultation on technical drafting recommendations and consider consultation input and finalise technical advice for government for amendments to existing legislation or the drafting of a new Bill.

5.2.9 Identifying and briefing potential champions for the project.

5.2.10 Submitting the final technical advice to the Ministry of Health for the development of amendments to existing legislation or the drafting of a new Bill.

5.2.11 Developing a lobbying strategy to support the passage of the amendments or draft Bill through Parliament and the subsequent translation of the Bill into policy and practice.

5.2.10 Providing input into the case study of the project and the project report.

5.3 **The Commonwealth Nurses and Midwives Federation is responsible for:**

5.3.1 Managing the project, including arranging meetings of the National Mental Health Advisory Committee (NMHAC), development of agendas, minutes, and action lists.

5.3.2 Managing the project funds provided by the Commonwealth Foundation.

5.3.3 Providing secretariat services to the NMHAC in partnership with and through the Mental Health Unit of the Botswana Ministry of Health.

5.3.4 Liaison with the Chairperson of the NMHAC, the Ministry of Health, the researcher, and the members of the NMHAC.

5.3.5 Maintaining project timelines.

5.3.4 Contracting the researcher to assess the mental health and related legislation.

5.3.5 Developing and maintaining a website for the project.

5.3.6 Developing and maintaining a data base of stakeholders to keep informed about the project.

5.3.7 Producing project deliverables including communication and education materials.

5.3.8 Developing with the NMHAC a case study about the project for publication in an appropriate journal.

5.3.9 Writing the report of the project.

6. ACCOUNTABILITIES

6.1 The NMHAC is accountable to the Botswana Ministry of Health through the Mental Health Unit.

6.2 The project manager is accountable to the NMHAC and the Mental Health Unit of the Botswana Ministry of Health, as well as to the Commonwealth Nurses and Midwives Federation for the management of the project and to the Commonwealth Foundation for management of the project funds.

7. PRINCIPLES

7.1 The principles within which the NMHAC will function include commitment, cooperation, active participation, respect, collegiality, and transparency.

7.2 All decisions of the NMHAC will be made by consensus. If a consensus decision is not able to be achieved, the decision of the majority will prevail with the Chair of the NMHAC having a casting vote.

7.3 All communication from the project manager to the NMHAC will first be approved by the Chair of the NMHAC and the Mental Health Unit of the Botswana Ministry of Health.

_____

ATTACHMENT 4

MEMORANDUM OF UNDERSTANDING

TELEPHONE: 363 2500
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

HPDME 13/42 IX (93)

11th February 2016

Executive Secretary
Commonwealth Nurses and Midwives Federation
C/o Royal College of Nursing, 20 Cavendish Square
W1G 0RN London
United Kingdom

Dear Madam,

RE: FINAL MEMORANDUM OF UNDERSTANDING BETWEEN THE GOVERNMENT OF THE REPUBLIC OF BOTSWANA REPRESENTED BY THE MINISTRY OF HEALTH AND THE COMMONWEALTH NURSES AND MIDWIVES FEDERATION

The above subject matter refers.

This serves to inform you that the Memorandum of Understanding between the Ministry of Health and the Commonwealth Nurses and Midwives Federation is complete and it has been signed by our Permanent Secretary.

Please find attached two (2) original copies of the MoU for your signature. You are requested to send one (1) back to the Ministry of Health once the MoU has been signed.

Thank you for your continued support.

Yours sincerely,

G. M. Baikepi
For/Permanent Secretary

REPUBLIC OF BOTSWANA

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE GOVERNMENT OF THE REPUBLIC OF BOTSWANA

REPRESENTED BY THE MINISTRY OF HEALTH

AND

THE COMMONWEALTH NURSES AND MIDWIVES FEDERATION

FOR COOPERATING IN MENTAL HEALTH LEGISLATIVE REFORM IN BOTSWANA.

SEL

REPUBLIC OF BOTSWANA

INTRODUCTION

The Government of the Republic of Botswana represented by the Ministry of Health (herein referred to as the "MOH") and the Commonwealth Nurses and Midwives Federation (herein referred to as the "Federation"), hereinafter jointly referred to as the "Participants" and singularly as the "Participant";

ACKNOWLEDGING that mental health legislation is of paramount importance to a country as it promotes, protects and empowers the human rights of people with mental ill health;

REALISING that there is a need to look into Botswana's mental health legislation and cover the gaps that have been created by mental health developments;

REALISING that MOH has been desirous of facilitating and creating better mental health legislation;

RECOGNISING that the Federation has the capacity to facilitate in the development of better mental health legislation;

DESIROUS that the Participants work together in order to recommend legislation that overcomes new developments that have come along through the passage of time and that the current laws did not envisage; and

REALISING that enhanced and deepened relation would be of mutual benefit to the Participants;

HAVE REACHED THE FOLLOWING UNDERSTANDING:

REPUBLIC OF BOTSWANA

PARAGRAPH 1
PURPOSE AND OBJECTIVES

1.1 The purpose of this Memorandum of Understanding (MOU) is to bring Botswana mental health and relevant legislation in line with the United Nations Convention on the Rights of Persons with Disability and support the implementation of the project titled: "*Mental health legislative reform across the Commonwealth*".

1.2 **Project Objectives**

The Participants aim to achieve the following:

a) establish a National Mental Health Advisory Committee to oversee the project;

b) review of the Mental Disorders Act and related legislation of Botswana against the United Nations Convention on the Rights of Persons with Disability;

c) develop technical recommendations for possible amendment or drafting to the Legislative Drafting Division of the Attorney General Chambers;

d) highlight the project by developing and implementing a communications strategy targeted to health professionals, people with mental health issues and their carers, the general public and the media.

PARAGRAPH 2
COMMITMMENTS OF THE PARTICIPANTS

2.1 **The MOH will:**

a) establish the National Mental Health Advisory Committee (NMHAC);

b) nominate members of the NMHAC including the Chairperson;

c) provide a venue and sustenance for meetings of the NMHAC (at least four (4) and no more than six (6) meetings);

d) obtain copies of mental health and relevant legislation for assessment against the United Nations Convention on the Rights of Persons with Disability;

e) provide guidance to the project manager and the researcher in relation to the development of technical drafting instructions, communication materials, project case study and the project report;

f) actively participate in the implementation of the communications strategy; and

g) adhere to project timelines as reflected in attachment 1.

2.2 **The Federation will:**

a. manage the project and arrange meetings of the NMHAC;

b. manage the project funds provided by the Commonwealth Foundation;

c. contract the researcher to assess the mental health and related legislation;

d. produce all project deliverables including communication materials, a case study about the project for publication, and the report of the project;

e. liaise with the Chairperson of the NMHAC, the Ministry of Health, the researcher and the members of the NMHAC; and

f. maintain project timelines according to attachment 1.

Other responsibilities and expectations of the Participants are further outlined in attachment 1

REPUBLIC OF BOTSWANA

PARAGRAPH 3
CONCURRENT MOU

This MOU will not derogate from the provisions of any other agreement to which the Participants are bound and will accordingly not detract from any rights obtained there from or obligations assumed by virtue thereof.

PARAGRAPH 4
CONFIDENTIALITY

4.1 All information obtained by the Participants in the implementation of this MOU will be held in strict confidence. However, the foregoing obligations will not apply to any information that was in the Participants possession prior to commencement of the programmes and activities under this MOU, or which is trivial or obvious.

4.2 The obligations of this paragraph will continue following the expiry or termination of this MOU.

PARAGRAPH 5
FUNDING

This Project will be funded by the Commonwealth Foundation and will be managed by the Federation. MOH shall only fund the provision of the venue and sustenance for the meetings of the NMHAC.

PARAGRAPH 6
APPLICABLE LAW

This MOU will be governed and construed in accordance with the laws of Botswana. All communication, correspondence, and reports pertaining to the MOU will be in English.

PARAGRAPH 7
SETTLEMENT OF DISPUTES

Any dispute arising from the interpretation or implementation of this MOU will be amicably resolved.

REPUBLIC OF BOTSWANA

PARAGRAPH 8
AMENDMENTS

8.1 This MOU may be amended or revised at any time by the mutual written consent of the Participants. No amendments or revisions will have effect unless signed for by all Participants.

8.2 The Responsible Authority of the Participants will sign any amendments to this MOU.

8.3 An amendment to the MOU will take effect immediately after signature by the last Participant, unless otherwise agreed by the Participants.

PARAGRAPH 9
FORCE MAJEURE

9.1 Neither Participant will be required to perform under this MOU if such failure to perform is as a result of a *Force Majeure*. For the purposes of this MOU, a *Force Majeure* means an event which is beyond the reasonable control of a Participant and which event makes a Participant's performance under this MOU impossible or so impractical as reasonably to be considered impossible under the circumstances.

9.2 A Force *Majeure* will not include:

a) any event which is caused by the negligence or intentional action of the Participant claiming a *Force Majeure* or such Participant's, nor

b) any event which a diligent Participant could reasonably have been expected to :
   (i) take into account at the time of the execution of this MOU; and
   (ii) avoid or overcome in the carrying out of its obligations hereunder.

9.3 During the period of such *Force Majeure*, the provisions of this MOU may be suspended and neither Participant will have any claim against the other by virtue of such a *Force Majeure*. If an event of a *Force Majeure* arises in respect of the project, then the Participant affected by such an event on its own or upon request by the other Participant, will prescribe reasonable alternative measures for the continuation of the project.

REPUBLIC OF BOTSWANA

9.4 The time schedules for the performance of the programmes or activities interrupted by such suspension will be revised by mutual agreement when those programmes or activities are resumed.

PARAGRAPH 10
COMMENCEMENT AND DURATION

10.1 This MOU will be deemed to have come into effect on 1 February 2015 and will remain in effect for a period of sixteen (16) months (up to 30 June 2016) unless earlier terminated by either Participant in accordance with its terms.

10.2 In the event that there are outstanding activities upon the expiry of this MOU, the Participants will consult to determine how those matters will be dealt with.

PARAGRAPH 11
TERMINATION OF THE MOU

11.1 Either Participant may at any time give written notice to the other Participant of its intention to terminate this MOU. In such event, the MOU will terminate ninety (90) days after the notice of termination is received by the other Participant.

11.2 The termination of this MOU by either Participant will not affect the project established in terms of this MOU. This project will continue until the Participants have completely executed unless otherwise agreed by the Participants.

PARAGRAPH 14
RESPONSIBLE AUTHORITIES

The following entities shall oversee the implementation of this MOU:

a) The MOH represented by the Permanent Secretary; and
b) The Federation represented by the Executive Secretary.

REPUBLIC OF BOTSWANA

PARAGRAPH 15
RECOMMENDATIONS

The Participants agree that while the aim of the project is to bring Botswana mental health and related relevant legislation in line with the United Nations Convention on the Rights of Persons with Disability, MOH is under no obligation to accept the technical drafting instructions recommended by either the researcher or the NMHAC.

The foregoing represents the understanding reached between the Participants on the matters referred to in this MOU.

IN WITNESS WHEREOF the Participants hereto have caused this MOU to be signed by their Responsible Authorities.

SIGNED at Gaborone on the _____ day of_____ 2016, in two (2) original copies, both texts being equally authentic.

PERMANENT SECRETARY
FOR AND ON BEHALF OF THE
GOVERNMENT OF BOTSWANA
MINISTRY OF HEALTH

EXECUTIVE SECRETARY
FOR AND ON BEHALF OF THE
THE COMMONWEALTH NURSES
AND MIDWIVES FEDERATION

ATTACHMENT 5

REPORT OF THE REVIEW OF BOTSWANA MENTAL HEALTH AND RELATED LEGISLATION

Review of Mental Disorders Act, 1971 and other related legislation
Prepared by: Dr Soumitra Pathare, Consultant to the Project
November 2015

The purpose of the review was to identify areas of legislation which need to be amended/repealed/replaced to comply with the Constitution of Botswana and Botswana's obligations under international law and human rights, to implement the strategies contained in Botswana's National Policy on Mental Health and to protect the rights of persons with mental illness in Botswana.

I. INTRODUCTION

The following documents were reviewed for preparing this report:

- Mental Disorders Act 1971
- National Policy on Mental Health 2003
- National Policy on Care of People with Disabilities 1996
- Constitution of Botswana
- Penal Code as amended up to 2005
- Public Health Act 2013
- Marriage Act 2001
- Adoption of Children Act as amended up to 2000
- Prisons Act 1980 as amended up to 2006
- Wills Act 1957 as amended up to 1977
- Domestic Violence Act 2008

Botswana has ratified the following International Treaties and Conventions which have relevance to mental health legislation and policies:

(a) International Convention on Civil & Political Rights (ICCPR)
(b) Convention on Elimination of Discrimination against Women (CEDAW)
(c) International Convention on Elimination of all Forms of Racial Discrimination (CERD)
(d) Convention against Torture (CAT)
(e) Convention on the Rights of the Child (CRC) and Optional Protocol
(f) African Charter on Human and People's Rights

Botswana has neither signed nor ratified by the International Convention on Rights of Persons with Disabilities (CRPD) and is consequently not bound by it. Botswana is a dualist state, and international conventions need to be domesticated prior to its application in Botswana. The CRPD has not been domesticated into legislation in Botswana.

However Botswana Court of Appeal has emphasized that international obligations which have not been domesticated should nevertheless, serve as an interpretive source.

The National Policy on Mental Health in its 'Specific Objectives' lists mental health legislation. Specific Objective 5.3: *Provide a framework for a periodic review of legislation in line with local, regional and international trends in good mental health practices*.

The National Policy on Mental Health also mentions mental health legislation in its Strategies for implementation of the Policy (Strategy 6.8). It says that legislation should reflect modern trends and Botswana's obligations under international law and human rights. The specific objectives under the strategy include:

1. The Ministry of Health shall advocate for mental health legislation that is consistent with assuring rights and protection of people with mental disorders and adequate treatment and care of involuntary and voluntary patients
2. The Ministry of Health shall ensure that legislation in all statutes dealing with mental health is consistent with the principles set out in the National Policy on Mental Health.

2. ANALYSIS OF KEY LEGISLATION RELEVANT TO RIGHTS OF PERSONS WITH MENTAL ILLNESS

2.1 Mental Disorders Act

Section 2: Interpretation

The definition of "mentally disordered or defective person" has serious problems, apart from the use of outdated terminology ('defective'). The definition of mental illness includes mental incapacity and/or dangerousness and also includes intellectual disability.

The term 'patient' is a presumption that the person has an illness while the definition seems to imply that a determination of illness is necessary.

The term 'place of detention' as it is defined may include a police lock-up with the consent of the Commissioner of Police.

Section 3: Classification

This classification is not based on any medical logic and appears to be irrational and arbitrary.

Section 5: Application for Reception Order read with Section 6, 7, 8, 9

These sections relating to Reception order (and subsequent sections eg: Section 16) violate international human rights principles such as equality before the law, access to justice and due process and most importantly, are open to potential abuse by individuals as well as institutions. Any relative (and in some instances, any person) can make an allegation about mental illness of a person, and if the person refuses to voluntarily present himself/herself, the District Commissioner can authorise a police officer to apprehend the person and bring him before a medical practitioner for the purpose of obtaining a certificate (Section 7), then hold a hearing private (Section 8, District Commissioner's discretion) and if satisfied that the person has a mental illness, authorize his/her detention in an institution. During this entire process, there is no provision for person who is alleged to have a mental illness to be heard or represented in the proceedings against himself/herself. There is no provision of judicial review or appeal against the order of the District Commissioner.

Section 11: Duty of the District Commissioner in respect of property

Once a reception order is issued for detention of the person by the District Commissioner, the person also loses control over his property and in the name of protection, the District Commissioner can take into his possession any property belonging to the person. Thus the finding of mental illness results in a complete loss of legal capacity. Once again, there is no provision for judicial review or appeal against this decision by the District Commissioner.

Section 16: Other reception orders

Under Section 14, the period of the detention under a Reception Order is restricted to 30 days, however provisions of Section 16 allow for detention up to 60 days and can be renewed indefinitely by the District Commissioner on the recommendation of a medical practitioner. Once again there is no provision either for a judicial review of this detention, nor is there a provision for appeal against the renewal of the order of detention by the District Commissioner.

Section 17: Urgent application

Provisions of Section 17 allow for Reception order to be bypassed in 'cases of urgency' where it is 'expedient either for the welfare of the patient or in public interest' that the person is immediately admitted to an institution for 'care, supervision, or treatment' based on an urgent application made by a relative and accompanied by a medical certificate from a medical practitioner. Under an urgent application, a person may be detained in an 'institution, hospital, prison or cell'. A person can be detained for a period of 14 days under an urgent order.

As before, there is no provision for appeal or a judicial review of this decision by an administrative officer.

Section 19: Apprehension without warrant in certain cases

This section allows a Police officer/headman/tribal messenger/member of a city, town, or district council "who has reason to believe that a person apparently mentally disordered or defective is dangerous to himself or to others and that it is necessary for the public safety or for the welfare of such person that before proceedings are taken under this Act he should be placed under care and control, may forthwith, **without warrant or order**, apprehend and convey such person to an institution or any suitable **hospital, prison or cell** and the person in immediate control thereof may, **notwithstanding the absence of warrant or order, receive and detain such person**. (Emphasis mine)

The provisions of Section 19 are very wide and potential open to abuse by persons in position of authority.

Section 27: Powers of Master on consideration of Reception Order and documents

The provisions of this section give authority to the Master to

(a) Allow indefinite detention of a person alleged to have mental illness

(b) Appoint a guardian

(c) Can order discharge if so recommended by a medical practitioner; it appears that this is the only way for a person under a Reception Order to be discharged from detention.

(d) There is no mandatory review of the detention order at periodic intervals; there is also no provision for appeal against the order of the Master with regard to detention or the appointment of a guardian.

Section 29: Where no remuneration is paid for maintenance and care

The provisions of this section allow a relative of a person who is alleged to have a mental illness to detain and restrain the person in the home dwelling and only needs to inform the District Commissioner of the same along with a copy of a medical certificate as to the physical and mental condition of the 'patient' and the District Commissioner is supposed to forward the documents to the Director, who is supposed to forward the documents to the Master, who will make an order that the person may be detained in the home or order the relative to take steps to have a Reception Order issued. The Master also has the authority to appoint a guardian (to manage property) for such a person. There is no requirement for the Master to hold a hearing or for the person to be present or represented when such an order is made. There is also no provision for appeal or periodic review of such orders.

Section 32: Reports on patients

The Superintendent of the hospital where the person is detained has to make an annual report to the Director. However there is no provision for review of the detention or a provision for appeal by the patient against the detention.

Section 34: Termination of Detention

Under the provisions of this section, a termination of the reception order for detention has to be ordered by the Master and requires **two** medical certificates. Furthermore, since the person has no legal representative, the termination is essential dependent on two medical practitioners getting together, writing the necessary certificates and requesting the Director for termination of detention of the person concerned. This entire process means that the process of detention is made much more difficult as compared to the process of admission. This is unlike legislation in most other countries – where the process of discharge is easier as compared to the process of admission. Surprisingly, there is provision to appeal to the High Court against a termination of the detention, whereas there was no provision of appeal to the High Court in the previous sections.

Section 36: Voluntary patients

The Act is written in such a manner that Voluntary care and treatment seems to be the exception while Reception Order for detention seems to be the norm. This is quite contrary to the trends in mental health legislation internationally and also as recommended by international human rights conventions and practice. It is also unclear whether Voluntary patients have to give their consent to treatment or whether they will be treated forcibly. There is no provision in Section 36 that their consent should be obtained prior to any treatment.

Furthermore, voluntary patients also have to give 1 weeks' notice to be discharged from the hospital. This is quite against the principle of voluntary admission and treatment – a person who is admitted voluntarily should have the right to discharge himself/herself at any time.

Section 50: Mechanical means of restraint

This section permits application of mechanical means of restraints which are approved by the Minister and also permits the Superintendent of hospitals to authorize seclusion. This section also has an unusual definition of seclusion: a person is not regarded as being in seclusion if "he is isolated in a room in which the lower half of the door is so fastened or held but the upper half left open." It is

necessary to highlight that the Special Rapporteur on Prevention of Torture has said that seclusion and restraint of persons with mental illness may amount to torture, and Botswana has ratified the Convention against Torture (CAT). International best practice in mental health (eg: WHO) recommends removal of provisions for restraint and seclusion from mental health legislation.

Section 52: Minister may authorize removal of patients from Botswana

This section gives the Minister the power to remove from the country any person who has been declared to be 'mentally disordered or defective', if, in the Minister's opinion, removal is likely to be for his benefit and proper care and treatment arrangements have been made.

There is no provision for appeal against the Minister's decision in this regard. This provision violates international human rights conventions protecting citizenship rights and freedom of movement of all citizens, including those with mental illness.

2.2 Marriage Act 2001

Section 14: Insane persons and persons below age

This section prohibits marriage of an 'insane person' who is 'incapable of giving consent'. However the term 'insane person' is not defined in the Act, and is quite likely to be interpreted as a person with mental illness. A plain reading of the text also means that marriage is prohibited only if the 'insane person' is incapable of giving consent; so presumably, an 'insane person' who is capable of giving consent can still marry. However this provision, is highly discriminatory to persons with mental illness for two reasons: the lack of definition of insane person will result in it being interpreted as a person with mental illness and second, mental illness is no barrier to marriage.

2.3 Adoption of Children Act 1952 as amended up to 2000

Section 5: Appointment of guardian for the purposes of adoption

While the Adoption Act requires that a guardian should consent for adoption, under this section, the Minister may appoint a guardian for a child whose parent is incapable by reason of a 'mental disorder or defect' of consenting to the adoption. This section effectively means that a person with mental illness cannot either consent or object to adoption of their own child. This provision adversely affects the parental rights of a person with mental illness and violates international human rights conventions which protect the rights of all persons to found a family.

Section 8: Rescission of an order of adoption

This section [1(c)(iv)] permits the adoptee parents to request and obtain and order rescinding the adoption if they prove that the child they adopted had a 'mental disorder' at the time of adoption and the adoptive parents were unaware of the same at the time of adoption. This section is discriminatory to children with mental health problems and also promotes stigma against persons with mental disorders. It also violates international human rights conventions and is contrary to international best practice in the field.

2.4 Domestic Violence Act 2008

Section 7: Application for an order

This section provides for a person who is subject to domestic violence to apply to the Court for an interim order, restraining order, tenancy order and occupation order. However a person who is 'mentally challenged' is not permitted to make such application.

However the term 'mentally challenged' is NOT defined in the Act, and is therefore open to arbitrary interpretation. It could either be interpreted as a person with mental illness and/or a person with intellectual disability or who is regarded to have a mental illness and/or intellectual disability.

This section violates the rights of persons with mental illness/intellectual disability to access justice on an equal basis with others.

2.5 Public Health Act 2013

Section 22 (2) (c) directs the health officer to "take all lawful, necessary and reasonably practicable measures to ensure equal access and equity to health care services for all including those with mental illness." This provision is in line with international best practice and is a very useful provision for advocating for increased quantity and better quality mental health services and for funding of such better quality services.

3. RECOMMENDATIONS

1. The Mental Health Act, 1971 is based on an outdated understanding of mental illness and does not take into account medical advances in the treatment, care and rehabilitation of persons with mental illness. The Mental Health Act also violates international conventions ratified by Botswana, such as the ICCPR and the Convention against Torture. Although Botswana has not ratified the Convention on Rights of Persons with Disabilities (CRPD), it is important to note that the Mental Health Act will not meet the standards and human rights protections for persons with mental disability (mental illness) under the CRPD. The provisions of the Mental Health Act are also contrary to recommendations and standards made by international organizations on mental illness such as the United Nations MI Principles, the WHO Handbook on Mental Health, Human Rights and Legislation. It will be extremely difficult to amend the Mental Health Act to bring it in line with above international conventions and standards as the Act is premised on a custodial solution and exclusion of persons with mental illness rather than a rights based approach to care and treatment. It will be easier to draft new legislation which complies with these requirements.

2. It is important that all stakeholders are consulted and part of the drafting process for the new law. In particular, it is important that persons with mental illness and their representative organizations care-givers and their representative organizations and human rights organizations are part of the consultation and law drafting process.

3. It is important that those drafting the new law take General Comment 1 and the Guidelines on Article 14 by the Committee on Rights of Persons with Disabilities into account when drafting new legislation.

4. Provisions pertaining to persons with mental illness in other laws such as the Children's Act, the Marriage Act etc. outlined above will also need to be amended to protect rights of persons with mental illness. Although Botswana has not ratified the CRPD, it is important to highlight here that these provisions violate rights protected in the CRPD.

5. The Constitution of Botswana protects fundamental rights of all citizens such as the right to life, right to personal liberty, protection from inhuman treatment, protection from deprivation of property, protection of law and protection from discrimination. The laws highlighted above including the Mental Health Act, violate these basic fundamental rights of persons with mental illness, which are protected by the Constitution of Botswana.

6. New legislation will need to incorporate models of supported decision making in the law. For example these could include, advance statements or directives, nominated representatives or enduring power of attorney etc. These are compliant with the CRPD.

7. New legislation also needs to specifically address the mental health needs of children and the elderly.

ATTACHMENT 6

DRAFTING INSTRUCTIONS FOR A NEW MENTAL HEALTH LAW BOTSWANA
14 July 2016

CONTENT OF LEGISLATION

1. Definition of Mental Illness

a) "Mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life
b) Personality disorders should be excluded because it is contentious and not stable diagnosis
c) Intellectual disability is excluded except when the behaviour arising out of intellectual disability is focus of treatment. Use Intellectual Disability rather than Learning Disabilities because Intellectual Disability is a diagnosis of mental illness and it is also broad. For clarity, an **intellectual disability** describes below-average IQ and a lack of skills needed for daily living. This condition used to be called "mental retardation." A **learning disability** refers to weaknesses in certain academic skills.
d) Alcohol and substance abuse per se is excluded except when there may be mental illness arising out of alcohol and substance abuse.

2. Determination of Mental Illness

a) It should be made on the basis of nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease (ICD) of the World Health Organization.
b) Mental Illness should not be determined on the basis of political, economic, social status or membership of a cultural, racial, religious group, or non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community.
c) Past treatment or hospitalization shall NOT **by itself** be grounds for present or future determination of mental illness.

3. Capacity

a) There is a presumption of capacity – that is persons with mental illness have capacity to make decisions unless proved otherwise.
b) Capacity is task specific – so a loss of capacity in one area of life should not lead to loss of capacity in other areas of life.
c) Any loss of capacity is regarded as temporary and time limited and fresh assessment should be done at intervals of time. In the event that a person is presumed to have incapacity in a particular area, their right to make decisions in that area of life should be regarded as temporarily suspended and not to permanently take away the person's right to make decisions.
d) Different procedures for determining lack of capacity for different tasks eg: for making mental health treatment decisions, property, and testamentary capacity.
For all areas other than mental health treatment decisions, the determination of loss of capacity should be done by a court.

For the purpose of mental health treatment decisions, the initial determination of loss of capacity (for a short time period) can be made by mental health professionals and a judicial or quasi-judicial procedure should follow later (see later). This is done so that there is delay in providing necessary medical and mental health treatment.

e) Provide an opportunity for the person to be able to appeal the mental health professionals or court's decision on the incapacity to make decisions.
f) The capacity or incapacity to make a decision can only be made based on the assessment confirmation of the person's ability or inability to make decisions. This means the person should be subjected to some tests that will verify if indeed the person has or does not have the capacity to can make a decision. The assessment procedures should be different for different areas.
g) The suspension of the capacity in one area should not be regarded as incapacity in other areas
h) Since there is a presumption of capacity for persons with mental illness, the onus of proving lack of capacity is on the person alleging the lack of capacity of a person with mental illness.

4. Advance Directives and Enduring Power of Attorney

a) These are provisions to enable persons with mental illness to exercise their will and preferences even when they have loss of capacity to make decisions.
b) Advance Directives – this provision is only applicable to mental health care decisions. Any person can write an advance directive specifying the kind of treatment they wish to receive if they have a mental illness in the future. They can also specify in the Advance Directive if they wish to nominate a person to make decisions on their behalf when they have loss of capacity to make decisions and are unable to make decisions for themselves.
   Advance directives cannot be contrary to the provisions of Constitution of Botswana.
   Advance directives shall not apply to emergency treatment
   Advance directives can be revoked, amended or cancelled by the person who made the Advance Directive
   Procedure for making the advance directive should be outlined in the Act and should be similar to how a power of attorney is made in Botswana
c) Enduring Power of Attorney – this provision can be used by persons with mental illness for decisions affecting all areas of life, including property, health care etc. The existing provisions for power of attorney in Botswana shall apply. Persons with mental illness shall also have the right to execute a power of attorney unless it is shown that they lack to capacity to make such decisions.

5. Rights

a) It is noted that persons with mental illness enjoy all the rights guaranteed to citizens under the Constitution of Botswana.
b) Mental illness patients are a vulnerable and disadvantaged population and hence there is a need to create an environment which enables them to enjoy and exercise their rights
c) The mental health law is meant to correct the historical wrong treatment that mental illness patients endured in the past (restorative justice)

d) Language – needs changing from the derogatory statements and terms referring to mental illness. The law must uniformly use the term "persons with mental illness" so that the illness is separate from their identity as persons like everyone else.

e) Apart from the rights guaranteed under the Constitution of Botswana, the following rights need to be included in mental health legislation
Right to Privacy
Right to get quality mental health services
Right to live in the community: persons with mental illness have a right to live in, be part of, and not segregated from the community

f) Parity
Every person with mental illness shall be treated as equal to persons with physical illness in the provision of all health care
Persons with mental illness being treated in mental health facilities enjoy the same rights as patients receiving treatment any other health facility.

g) Right to information about one's own mental illness and treatment

h) Right to access medical records of one's own mental illness and treatment

i) Right to employment – provision has already been made in the Employment Act and Public Service Act however there is a need to check whether this provision adequately protects persons with mental illness.

6. Admission and Treatment of Persons with Mental Illness

a) As far as possible, persons with mental illness should be treated in their community near to their home.

b) If persons with mental illness need admission to a hospital, then it should be independent (equivalent to a voluntary admission) admission, as far as possible. This should be the norm while supported admission should be the exception and restricted to situations when the person lacks capacity to make decisions for their mental health care.

c) All persons with mental illness who are admitted to hospital as independent patients should be treated with their informed consent.

d) Independent admission

i. All persons with mental illness desiring of taking treatment as independent patients in a mental health facility shall apply to the mental health facility for admission. They will be examined by a mental health professional who will certify that they have a mental illness and will benefit from admission to a mental health facility.

ii. Persons who are admitted as independent patients have the right to discharge themselves from the mental health facility when they wish to do so. However if the mental health professional in charge of the mental health facility is of the opinion that they meet criteria for a supported admission (see below), they may be prevented from leaving the facility by a change of their status from independent to supported admission.

e) Supported Admission

i. If a person lacks capacity to make mental health care decisions, they may be admitted to a hospital as a supported admission

ii. An application for a supported admission has to be made by:
   - The Power of Attorney holder, if any, or;
   - A person nominated under an Advance Directive, if any, or
   - A nearest adult Relative, if any, or
   - A Social Worker in public service.

iii. Once the application is made, the person should be examined by two health professionals and certify the following:
   - The person lacks capacity to make mental health decisions and;
   - The person has a mental illness as defined under the Act and;
   - The person has one of the following:
     - They have recently threatened or attempted or threatening or attempting to cause bodily harm to himself/herself or
     - Has recently behaved violently or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him/her
     - Has recently shown or is showing an inability to care for himself/herself to such a degree that places the individual at risk of harm to himself/herself.

iv. Of the two health professionals, one has to be a psychiatrist, and the other health professional can be a mental health professional or a registered medical practitioner. The above professionals should have examined the alleged person with mental illness in a period not exceeding 7 days preceding the day when they certify (iii) above.

v. The admission of a person with mental illness as a supported patient shall be limited to a period of 30 days.

vi. The head of the mental health facility has the right to discharge the persons before the end of the 30 day period if they believe that the person no longer meets the conditions for supported admission and may discharge the person with mental illness from this section.

vii. Any person who is admitted as a supported admission shall receive treatment as prescribed by the mental health professional, either with or without their consent to the said treatment.

viii. At the end of the 30 day period, the following may happen:
   a. If the conditions for a supported admission continue to be met, the mental health professional in charge of the mental health facility shall apply to the Local Tribunal for an order to continue the admission
   b. If the conditions for a supported admission are no longer met, the person with mental illness may either continue to remain admitted as an independent patient if necessary or may be discharged from the facility.

ix. All persons admitted under a supported admission order have the right to appeal to the Local Tribunal against this order at any time during their admission.

x. It shall be an offence to make a false declaration for the purposes of this supported admission.

xi. The Social Worker or the mental health professionals should not have a conflict of interest or be a relative of the person being examined for a supported admission.

xii. When an application is made to the Local Tribunal for continuation of the supported admission:
   a. The Tribunal shall hold a hearing.
   b. The person shall be represented at the hearing.
   c. The Tribunal shall also hear evidence from the mental health professionals.
   d. The Tribunal may decide to either discharge the patient or extend the supported admission.
      - All extensions in the first instance shall be limited to a maximum of 60 days, while subsequent extensions shall be limited to a maximum of 120 days.
      - Doctors should have the right to discharge earlier if the conditions are no longer met. No need to go back to the Tribunal to ask for a discharge.
   e. Person with mental illness shall have the right to appeal to the Local Tribunal at any time during the extension of their supported admission and if dissatisfied with the findings of the Local Tribunal to appeal to the National Tribunal.

f) Admission of Minors

All admissions of minors shall be treated as supported admission, as they lack capacity to make decisions for themselves.

The difference is that the application in this instance shall be made by a parent or a guardian.

Another difference from supported admission is that minors will only be treated with the consent of the parent or legal guardian

g) Persons with mental illness who **are at their home** and unwilling to attend for an assessment

A care-giver or relative, of a person who is at home and who in the opinion of the care-giver or the relative is suffering from mental illness of such a degree as to warrant their admission in a hospital, but the person in unwilling to go for assessment or treatment of their mental illness, may:

xiii. Request assistance at the nearest health facility.

xiv. A health care worker from the said health facility shall visit the alleged person with mental illness and make an assessment.

xv. If after assessment, the health care worker is satisfied that the person appears to have a mental illness of a degree that the person is a risk to their own safety or the safety of others or are neglecting themselves to an extent which put their own lives at risk, the health worker has the right to request assistance from the Police, and the Police the duty to provide necessary assistance, to have the person moved to the nearest health facility.

h) Persons with mental illness found wandering on the street

If any Police Officer is informed by any member of the public that they have seen a person who appears to have a mental illness wandering on the streets, or if the Police find a person wandering on the street who they suspect has a mental illness, the Police shall have a duty to convey such a person immediately to a nearest health facility for assessment.

i) A person with mental illness at any health facility

Any person at a health facility, who has come either through (g) or (h) above or has voluntarily attended the health facility and after examination, the health care staff at the facility are satisfied the person has a mental illness which requires assessment at a mental health facility, they shall arrange for the said person to be transported to the mental health facility. If necessary, the health workers shall be entitled to ask Police to provide assistance in such a transfer if the patient is violent or at risk of harming themselves or others and to also seek assistance of Police to keep the person in a place of safety while transport is being arranged. This transfer shall take place within a period of 48 hours and the Police can hold the persons in a place of safety up to a period of 48 hours until transfer to the mental health facility.

j) Leave of Absence for persons in a mental health facility
The mental health professional in charge of a mental health facility may grant leave to a persons with mental illness for a period not exceeding 7 days at a time. The leave of absence is for the person to go home and live with their relative. The mental health professional has the right to revoke the leave at any time if the mental health professional is satisfied that it is necessary for improvement or prevent deterioration of the mental health of the person concerned.
If the person refuses to come back to the mental health facility, the mental health professional shall inform the nearest health facility of the same and the subsequent process shall be similar to (g) above.

k) Absence without leave from a mental health facility
Any persons who has been admitted as a supported admission and goes missing from the mental health facility, the mental health professional in charge of the mental health facility shall inform the Police of the same.

7. Emergency Treatment

Any medical practitioner shall provide urgent medical treatment to a person with mental illness either in the community, home or in a mental health facility without waiting for consent from the person with mental illness if it is immediately necessary to prevent:

- death or irreversible harm to the health of the person or
- person inflicting serious harm to self or others or

Emergency treatment includes transportation of the person to the nearest mental health facility for assessment

Emergency treatment shall be limited to a period of 72 hours

No special treatments can be done under this emergency treatment provision.

8. Regulation of Special Treatments

a) Electro-convulsive therapy (ECT): ECT may only be given to a person with mental illness subject to the following conditions:
    i. Informed consent from the person
    ii. 2nd opinion from a mental health professional

iii. When the person lacks capacity to give informed consent, then with the consent of the person named in an Advance Directive or the POA holder or the Social Worker
iv. Information has been provided to the person with mental illness or persons named in (iii) above of the treatment plan and the risk and consequences of such a treatment.
v. Not to be done on a child below age of 18 years

b) Psycho-surgery for mental illness can only be performed with the approval of the National Tribunal AND the informed consent of the person with mental illness.

c) Seclusion and Restraint should only be:
i. done as a matter of last resort, in exceptional cases to prevent immediate or imminent harm to self or others
ii. they should be regulated by having standards decided by the Board,
iii. can only be done in an accredited mental health facility
iv. should be authorised by a mental health professional.
v. that the reasons and duration of each incident be recorded in a database and made available to the Board
vi. should never be used and a means of punishment or for the convenience of staff
vii. specify a restricted maximum time period for which seclusion and restraints can be used
viii. family members/cares and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint
ix. encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities.

9. Prisoners with mental illness

If it appears to a prison officer that a prisoner is likely to be having a mental illness, the officer in charge of the prison shall make an application to the mental health facility to transfer the prisoner to the mental health facility for assessment and admission to the mental health facility if necessary.
On assessment, the mental health professional may recommend either:

i. Outpatient treatment and send the prisoner back to the prison or
ii. Recommend admission to the mental health facility either as an independent patient or supported admission depending on the criteria being met.
iii. On discharge from the mental health facility the prisoner shall be sent back to the prison.
iv. Time spent at the mental health facility will count towards the prison's duration of sentence.

10. Rights of Care-givers and Families

a) Caregivers and families have the right to information:
i. information about the treatment and care being provided to the person, and
ii. the grounds for a supported admission, and
iii. treatment and care being proposed to be given, and

iv. if any seclusion or restraint was done.

b) They have the right to be involved in treatment planning and discharge planning
c) They have the right to visit their person in the mental health facility
d) They have the right to complain about deficiency in services

e) They have the right to provided support by health services to be able to perform their care-giving role
f) In case of independent patients, information will be shared with the care-giver and families only with the consent of the person concerned.

11. Bodies to be created under the Act

A National Mental Health Co-ordinating (NMHC) Body shall be established within the Ministry of Health

The NMHC shall exercise its functions through the following bodies:

- Tribunal
- Mental Health Board

A) Mental Health Tribunal

The Mental Health Tribunal shall consist of a National Mental Health Tribunal and Local Mental Health Tribunals.

The National Mental Health Tribunal shall be appointed by the President. It will be chaired by a Judge of the High Court and shall consist of a consultant psychiatrist with at least 10 years' experience, a representative from the Attorney General's office, a representative from the Law Society and a representative from the Ministry of Health.

Functions of the National Tribunal include (i) hearing all appeals against the orders of the Local Tribunals (ii) any issues related to violation of rights of persons with mental illness in mental health facilities and (iii) decision on discharge or otherwise of all persons who have be detained as Special Presidential detainees after conviction as Guilty but Insane verdicts of the Courts.

The **Local Mental Health Tribunals** shall be appointed in different parts of country and number of such local tribunals shall be decided based on quantum of work and need for such tribunals.
The Local Tribunal will consist of 7 members be appointed by the Minister of Health. It will be chaired by a Principal Magistrate and shall consist of psychiatrist, psychologist, psychiatric nurse, 1 person who is care-giver or a family member of person with mental illness, and 2 civil society representatives. The Tribunal will have a quorum of 4.

Functions of the Local Tribunals include (i) hearing appeals by persons with mental illness against supported admission and (ii) Deciding on renewal/extension of supported admission after 30 days.

B) Mental Health Board

The Board shall consist of 7-9 members and include mental health professionals (psychiatrists, psychologists, psychiatric nurses, psychiatric social workers), a public health administrator,

representatives of users of mental health services (i.e. person with current or past mental illness) and representatives of care-givers/families of persons with mental illness.

Functions of the Board include (i) setting standards for accreditation of mental health facilities (ii) regulating mental health facilities (iii) Setting criteria and standards for specific mental health services, interventions, treatments as necessary (iv) setting standards for use of seclusion and restraints in mental health facilities (v) visiting and inspecting mental health facilities (vi) review use of seclusion and restraints in mental health facilities.

Non-official members of the Board will be paid a sitting fee and expenses for attending meetings of the Board.

The NMHC will be the Secretariat for National Mental Health Tribunal, Local Mental Health Tribunal and the Mental Health Board.

12. Offences and Penalties

The following offences need to be included:

a) Making false declarations for any actions under the Act
b) Neglect and/or abuse of persons with mental illness
c) Obstructing professionals/others from performing their duties under the Act
d) Breach of confidentiality
e) Failure to declare conflict of interest
f) Performing procedures and/or treatments not in conformity with the procedures laid down in the Act

	Penalty for 1st offence (minimum, maximum)	Penalty for 2nd or subsequent offence (minimum, ,maximum)
Making false declarations for any actions under the Act		
Neglect and/or abuse of persons with mental illness		
Obstructing professionals/others from performing their duties under the Act		
Breach of confidentiality		
Failure to declare conflict of interest		
Performing procedures and/or treatments not in conformity with the procedures laid down in the Act		
General offences		