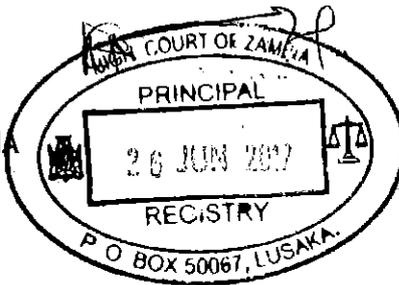


IN THE HIGH COURT FOR ZAMBIA  
AT THE PRINCIPAL REGISTRY  
AT LUSAKA  
(Constitutional Jurisdiction)



2017/ HP/ 204

IN THE MATTER OF: THE PROTECTION OF FUNDAMENTAL RIGHTS REGULATIONS, 1969  
AND

IN THE MATTER OF: ARTICLE 28 OF THE CONSTITUTION OF ZAMBIA

AND

IN THE MATTER OF: ARTICLES 8, 13, 15, 16, 18, 23, AND 266 OF THE CONSTITUTION OF  
ZAMBIA

AND

IN THE MATTER OF: THE MENTAL DISORDERS ACT, CHAPTER 305 OF THE LAWS OF  
ZAMBIA

AND

IN THE MATTER OF: THE PERSONS WITH DISABILITIES ACT, NO. 6 OF 2012

AND

IN THE MATTER BETWEEN:

GORDON MADDOX MWEWA

1<sup>ST</sup> PETITIONER

MULIMA SANTA KASOTE

2<sup>ND</sup> PETITIONER

SYLVESTER KATONTOKA

3<sup>RD</sup> PETITIONER

(Suing on his own behalf and as Executive Director of the  
Mental Health Users Network)

AND

ATTORNEY GENERAL

1<sup>ST</sup> RESPONDER

ZAMBIA AGENCY FOR PERSONS WITH DISABILITIES

2<sup>ND</sup> RESPONDER

DISABILITY RIGHTS WATCH

AMICUS CURIAE

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AMICUS CURIAE'S SUBMISSIONS

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**Statutes**

1. Persons with Disabilities Act, No. 6 of 2012.
2. Mental Disorders Act, Chapter 305 of the Laws of Zambia.

### **International Instruments**

1. United Nations Convention on the Rights of Persons with Disabilities.

### **Foreign Statutes**

1. Vulnerable Persons Living with Disability Act (Manitoba CCSM c V90).

### **Foreign Case Law**

1. *Fose v Minister of Safety and Security* [1997] ZACC 6; 1997 (7) BCLR 851; 1997 (3) SA 786.

### **Decisions of International Bodies**

1. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21. (
2. UN Committee on the Rights of Persons with Disabilities (CRPD), *General Comment No. 1: Equal Recognition before the law* (Art. 12 of the Convention), 11 April 2014, CRPD/C/GC/1.
3. Report by the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment punishment, HRC 66th Session, 5th August 2011.
4. End of Mission Statement by the United Nations Special Rapporteur on the rights of persons with disabilities, Ms. Catalina Devandas-Aguilar, on her visit to Zambia, Lusaka, 28 April 2016

### **Authored Books and Publications**

1. Theresia Degener (2014) *A Human Rights Model of Disability*. (
2. Jillian K Peterson and Others, "How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?", *Law and Human Behavior*, vol. 38, No. 5 (April 2014).

## ARGUMENTS

IF IT MAY PLEASE this Honourable Court, these are the submissions on behalf of the *Amicus Curiae*:

### 1. INTRODUCTION

- 1.1. The Petitioners seek various declaratory relief and orders from the Court, including a declaration that the Mental Disorders Act, Chapter 305, be declared unconstitutional, contrary to the Persons with Disabilities Act No 6 of 2012 and null and void.
- 1.2. On 28 April 2017, Disability Rights Watch was admitted as *amicus curiae* (friend of the Court). Disability Rights Watch sought leave to be admitted in order to, amongst others, assist the Court with information on international, regional and comparative law and best practice on the rights of persons with disabilities in the light of its expertise on these issues. (See **Affidavit in Support of Notice of Motion by Mr Wamundila Walliuya**).
- 1.3. In these submissions, Disability Rights Watch addresses the following issues:
  - 1) An explanation of the paradigm shift that the Convention on the Rights of Persons with Disabilities (CRPD) introduced towards a social and human-rights model of disability.
  - 2) The violation of human rights that the Mental Disorders Act's approach to people with psychosocial and mental disabilities creates, and how this is harmful to mental health outcomes.
  - 3) The concept of community-based care mandated by the CRPD.
  - 4) The relationship between the right to legal capacity and the right to informed consent to medical treatment and medical admission.
  - 5) The absence of legal and empirical justifications for the human rights violations caused by the Mental Disorders Act.

- 6) The importance of this Court's ruling in the Petition.

## 2. THE PARADIGM SHIFT TO A SOCIAL AND HUMAN-RIGHTS MODEL OF DISABILITY

- 2.1. The Convention on the Rights of Persons with Disabilities (CRPD) (which Zambia has ratified and domesticated under the Persons with Disabilities Act) does not create any new rights but clarifies how established human rights obligations apply to people with disabilities. By doing this, the CRPD has introduced a radical paradigm shift in how disability is conceptualised.
- 2.2. The CRPD and Persons with Disabilities Act mandate a move from a medical and charity-based model of disability to a human rights and social model of disability. This paradigm shift demands a move from viewing persons with disabilities as "objects" of charity needing medical treatment and requiring institutionalised rehabilitation, towards viewing persons with disabilities as being "subjects" with rights who have the agency to claim these rights and to make meaningful decisions for their lives as active members of society.
- 2.3. Medical models of disability focus on a person's impairment, viewing the person as needing to be treated, cured, or fixed. Under the medical model, people with disabilities are excluded from society because of their impairment.  
(See **Theresia Degener (2014) A Human Rights Model of Disability, p 3-4.**)
- 2.4. The charity model of disability is closely related to the medical model. It sees people with disabilities as passive objects that need care and welfare as opposed to empowered and autonomous individuals with rights to participate in all areas of life.
- 2.5. In contrast to these understandings, the CRPD endorses a social and human rights-based model of disability:
  - 1) Endorsing a social model, the CRPD interprets disability as resulting from the interaction between persons with impairment and the barriers that hinder their full and active participation in society on an equal basis. This model focuses on society as opposed to the individual. The CRPD does not define disability, but

recognises an evolving understanding of disability. This is seen in the purpose of the Convention set out in Article 1, which states the following:

"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

- 2) The definition of "disability" in section 2 of the Persons with Disabilities Act similarly understands a disability as state in which a person's impairment, in "combination with social and environmental barriers hinders the ability of a person to fully or effectively participate in society on an equal basis with others."
- 3) This sociological account of disability is accompanied by guidance through a human rights framework in the CRPD that seeks "to promote, protect and ensure the full and equal enjoyment of human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." (**Article 1, CRPD**). This language is repeated in the long title of the Persons with Disabilities Act.
- 4) By tailoring human rights to the context of disability, the CRPD's approach affirms the universality and fundamental nature of the rights of people with disabilities. Because every person is a subject of human rights, the enjoyment of rights does not require the absence of physical or psychosocial impairment for their enjoyment.
- 5) In this way, the human rights model defies the presumption that a person's impairment can hinder their human rights capacity, while the social model acknowledges the role of social factors in sustaining disability, including the denial of fundamental rights.

(See **Theresia Degener (2014) *A Human Rights Model of Disability*, p 5-8.**)

- 2.6. We submit that in the past, the archaic charity-based and medical approaches to disability have informed Zambia's legal responses to mental and psychosocial disability as provided

for in Zambia's Mental Disorders Act. As stated by the United Nations Special Rapporteur on the Right to Health:

"For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities, persons with autism and those who deviate from prevailing cultural, social and political norms."

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 8.)**

- 2.7. By ratifying the CRPD and enacting the Persons with Disabilities Act, we submit that Zambia's legal response to psychosocial disability is mandated to undergo a paradigm shift towards a social understanding of disability that is grounded in human rights.
- 2.8. In addition to ratification, a comprehensive harmonization of the normative and policy frameworks in Zambia should be undertaken, to ensure their compliance with the Convention. Several statutory instruments, such as in the areas of education, health, accessibility and employment, need to be adopted in order to speed up implementation of the Persons with Disabilities Act and other relevant policies.

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

- 2.9. The CRPD explicitly frames this approach as requiring respect for the following general principles in Article 3:

- "(a) *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
- (b) *Non-discrimination;*

- (c) *Full and effective participation and inclusion in society;*
- (d) *Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
- (e) *Equality of opportunity;*
- (f) *Accessibility;*
- (g) *Equality between men and women;*
- (h) *Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities."*

2.10. Section 4 of the Persons with Disabilities Act repeats these principles, adding emphasis on the following additional principles:

- "(c) recognition as persons before the law;*
- (d) respect for physical and mental integrity;*
- (e) independent living".*

2.11. In specifying State obligations under the CRPD, it is specifically envisioned that States are obliged to adopt "appropriate legislative" measures and "abolish existing laws, regulations, customs and practices that constitute discrimination against people with disabilities".

**(Article 4(a) and (b) of the CRPD)**

### **3. DETENTION, COERCED TREATMENT AND ISOLATION**

3.1. We wish to illustrate that not only is the detention, coerced treatment and isolation practices envisioned and sustained by the Mental Disorders Act a violation of human rights, it is also harmful to mental health.

3.2. The Mental Disorders Act provides for the detention of persons with mental disabilities on suspicion of their mental disabilities. The Act designates places of detention(including prisons) where persons with mental and psychosocial disabilities are detained.

- 3.3. Furthermore, the Act gives extensive powers to the Police and members of the community to arrest and detain persons with mental disabilities without due regard to their right to liberty, legal capacity, and respect to constitutional protection of law.
- 3.4. The Petitioners' evidence illustrates that as a result of these provisions, persons with mental disabilities continue to suffer chaining, being restrained physically and chemically, isolation, deprivation, and abuse.
- 3.5. In particular isolation and seclusion has been identified as a means of torture under the UNCAT and under no circumstances should isolation be used on minors and person with mental disabilities:

*"Persons with disabilities are held in solitary confinement in some jurisdictions as a substitute for proper medical or psychiatric care or owing to the lack of other institutional housing options. These individuals may not necessarily pose danger to others or to themselves, but they are vulnerable to abuse and often regarded as a disturbance to other prisoners and prison staff.*

*68. Research has shown that with respect to mental disabilities, solitary confinement often results in severe exacerbation of a previously existing mental condition. Prisoners with mental health issues deteriorate dramatically in isolation. The adverse effects of solitary confinement are especially significant for persons with serious mental health problems which are usually characterized by psychotic symptoms and/or significant functional impairments. Some engage in extreme acts of self-mutilation and even suicide."*

***(Report by the Special rapporteur on torture, Torture and other cruel, inhuman or degrading treatment punishment, HRC 66th Session, 5th August 2011 par. 67 and 68)***

- 3.6. The Petitioners have argued that these aspects of the Mental Disorders Act, in purpose and in application, violate their human rights under the Zambian Constitution, including their rights to dignity, equality, freedom from discrimination, to liberty, and equal protection of the law. We do not repeat those submissions here but to affirm the incompatibility of the Mental Disorders Act with a human-rights based approach to disability.
- 3.7. Furthermore, coercive approaches that are disproportionately focussed on biomedical interventions, as are entrenched by the Mental Disorders Act, are harmful. As described by the Special Rapporteur on Health:

“A growing research base has produced evidence indicating that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health.

Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives.”

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 10 and 13)**

- 3.8. The Special Rapporteur has further stated that laws that establish detention regimes and non-consensual treatment disempower people with psychosocial and mental disabilities and lead to abuses of power:

“That asymmetry disempowers [mental healthcare] users and undermines their right to make decisions about their health, creating an environment where human rights violations can and do occur. Laws allowing the psychiatric profession to treat and confine by force legitimize that power and its misuse. That misuse of power asymmetries thrives, in part, because legal statutes often compel the profession and obligate the State to take coercive action.

(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health HRC 35th 28/03/2017 A/HRC/35/21, at para 22.)

#### 4. COMMUNITY-BASED CARE

4.1. In adopting a social and human rights approach to psychosocial and mental disability, the CRPD and Persons with Disabilities Act affirm that rehabilitative and healthcare services should be offered in a non-discriminatory manner that respects and protects the rights of people with disabilities. This vision of mental healthcare services explicitly rejects coercive, non-consensual treatment and admission into healthcare facilities, detention regimes, and the centralisation of services away from communities. This approach is endorsed in the following provisions:

- 1) Article 9 of the CRPD which acknowledges that in order to enable people with disabilities to live independently, appropriate measures must be taken to ensure people with disabilities in both urban and rural settings are able to access all facilities and services.
- 2) Article 14 of the CRPD that affirms the right not to be deprived of one's liberty and that the existence of liberty "shall in no case justify deprivation of liberty".
- 3) The explicit prohibition on non-consensual medical treatment under the prohibition on torture and other cruel, inhuman or degrading treatment in article 15 of the CRPD.
- 4) The protection of physical and mental integrity in Article 17 of the CRPD.
- 5) The right to liberty of movement that includes the right to choose one's residence and the right to enter one's own country in article 18 of the CRPD.
- 6) Article 19 of the CRPD is explicit in affirming the "equal right of all persons with disabilities to live in the community, with choices equal to others" and mandates States to take appropriate measures to ensure people with disabilities' "full

inclusion and participation in the community". State obligations are specified to include ensuring that persons with disabilities "have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community." Further obligations include to ensure that "community services and facilities are available on an equal basis to persons with disabilities".

Similar provisions are repeated in section 40, 41, 42 and 43 of the Persons with Disabilities Act.

- 7) Respect for privacy under article 22 of the CRPD.
- 8) Respect for the right to enjoy one's home, family, and relationships on an equal basis with others under article 23 of the CRPD.
- 9) Article 25 of the CRPD affirms that persons with disabilities should enjoy the "same range, quality and standard of free or affordable health care and programmes as provided to other persons" as well as health services specific to people's disabilities. Similar obligations are stated in section 27(a)-(b) of the Persons with Disabilities Act.

Article 25(c) of the CRPD and section 27(c) of the Persons with Disabilities Act obliges States and the relevant Ministers respectively to provide "these health services as close as possible to people's own communities, including in rural areas."

Article 25(d) of the CRPD and section 27(d) of the Persons with Disabilities Act requires that health professionals provide healthcare to persons with disabilities on an equal basis with others "including on the basis of free and informed consent".

- 10) Article 26 of the CRPD obliges states to take measures to enable persons with disabilities to enjoy maximum independence and "full inclusion and participation in all aspects of life" by providing comprehensive habilitation and rehabilitation

services. The relevant government ministries have similarly framed duties under sections 28, 32 and 33 of the Persons with Disabilities Act. Section 34 of the Act explicitly states that the "Ministry shall ensure that persons with disabilities are rehabilitated in their communities to foster their integration."

- 11) The CRPD stresses integration of people with disabilities in work and employment (article 27), in the provision of social services (article 28), in political and social life (article 29), in cultural life, recreation, leisure and sport (article 30), and in education (article 24).

The Persons with Disabilities Act similarly requires respect for persons with disabilities' family life and enjoyment of social activities in section 7 by requiring that people with disabilities will not be deprived of their right to choose their place of residence, live with their family, or participate in social, political, economic, creative or recreational activities. The Act advances integration of people with disabilities in employment (section 35), cultural life, recreation, leisure and sport (section 48), political and public life (section 51), and education (sections 22-26).

None of this participation in life is possible if people with psychosocial disabilities are physically and socially isolated and forced to access mental health services through centralised, detention-centric facilities.

4.2. The Special Rapporteur on Health has stated in this regard:

"Mental health services must be geographically and financially accessible on the basis of non-discrimination. In many low- and middle-income countries they are concentrated in major cities and inaccessible to a large part of the population. The problem is acute in countries where there is inappropriate overreliance on segregated residential and in-patient psychiatric institutions, such as in Central and Eastern Europe, and a failure to develop rights-based models of care in the community. Integrating mental health into general hospitals, primary care, and social care services and rights-compliant use of mobile technologies can support accessibility and enhance the enjoyment of the right to live and participate in the community. Accurate information on mental health must be made accessible to the

public and evidence-based information on treatments, including side effects, must also be accessible, which requires the routine, complete and timely disclosure of all pharmacological information from clinical trials. A contextual understanding of the experiences of suffering and distress is critical for ensuring accessibility within systems of mental health care and support."

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 57).**

- 4.3. The Special Rapporteur on Health further describes how the integration of mental health services at primary healthcare level not only enhances accessibility to services for people with mental health needs on an equal basis with others, but also supports people with psychosocial disabilities' socio-economic wellbeing:

"The right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically. It not only integrates mental health services into mainstream health care so they can be accessible for everyone, it ensures that entire groups of people who are traditionally isolated from mainstream health care, including persons with disabilities, receive care and support on an equal basis with others. Inclusion also comes with socioeconomic advantages. Mental health concerns everyone and when needed, services should be accessible and available to all at the primary and specialized care levels."

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 78).**

- 4.4. We submit that the Mental Disorders Act is firmly rooted in a paradigm that does not support community-based, human-rights affirming mental health services being provided to people with mental health needs. This perpetuates mental and psychosocial disability and denies people with disabilities their human rights.

- 4.5. In contrast, the CRPD and Persons with Disabilities Act has committed Zambia to a vastly more progressive paradigm that envisions the inclusion of mental healthcare services in an environment conducive to mental health, integrated into society, and respectful of the equality and dignity of people with disabilities.

## 5. LEGAL CAPACITY AND THE RIGHT TO INFORMED CONSENT

- 5.1. Article 12 of the CRPD, and the correlating section 8(1) of the Persons with Disabilities Act, recognise the right of persons with disabilities to enjoy legal capacity on an equal basis with others.

These provisions are central to the paradigm shift that the Convention and Persons with Disabilities Act introduces.

- 5.2. The Committee recognizes that legal capacity consists of two strands. The first, "legal standing", allows one to hold rights and to be recognized as a person before the law. The second, "legal agency", allows one to act on those rights and to have these actions recognised before the law. The Committee has further explained that the concepts of "mental capacity" and "legal capacity" are distinct and should not be conflated.

**(UN Committee on the Rights of Persons with Disabilities (CRPD), General Comment No. 1: Equal Recognition before the law (Art. 12 of the Convention), 11 April 2014, CRPD/C/GC/1, at para 13 and 15.)**

- 5.3. The Committee on the Rights of Persons with Disabilities has stated that the right to legal capacity, which is provided for under other international human rights treaties, is non-derogable.

**(UN Committee on the Rights of Persons with Disabilities (CRPD), General Comment No. 1: Equal Recognition before the law (Art. 12 of the Convention), 11 April 2014, CRPD/C/GC/1, at para 3.)**

- 5.4. The Draft protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa (adopted on 25th February 2016) under Article 8 recognises the rights of person with disability to legal capacity and equal protection before

the law. In particular Article 8 (3 ) (d) provides that state parties shall take all appropriate measure to review and repeal all policies and laws which have the purpose or effect of limiting or restricting the enjoyment of legal capacity by person with disabilities.

- 5.5. The issue of legal capacity is echoed in the special rapporteur end of mission statement to Zambia where she highlighted legal provisions that discriminate against persons with psychosocial disabilities, such as those contained in the Mental Disorder Act, the Penal Code, the Criminal Procedure Code, the Prisons Act, the Citizens of Zambia Act, and the Electoral Commission Act.
- 5.6. The Mental Disorders Act conflates legal capacity and mental capacity contrary to the CRPD and the Draft Protocol. Once a person is deemed "mentally disordered or deficient" under the Act, the will of that person is deemed to be legally irrelevant: their participation in judicial proceedings determining their fate, their consent to being admitted into psychiatric institutions, their autonomy to choose whether they wish to receive invasive medical treatments, and even their ability to exercise ownership over their property is nullified.
- 5.7. Furthermore, the Mental Disorders Act provides for no safeguards to ensure that will and preferences of people with mental and psychosocial disabilities are considered, for procedures to protect people under detention and control orders from decisions unduly influenced by conflicts of interest, for measures to be tailored to a person's individual circumstances, or for practically operational measures that ensure restrictive measures meet the minimum impairment test under human rights law – that they are restrictive for as short a period of time as possible and as minimally as possible.
- 5.8. The Mental Disorders Act does not have any specific provision that excludes the right to informed consent to medical treatment. However the operative effect of the removal of informed consent is a necessary consequence to placing persons under the absolute and non-consensual control of detaining authorities and the Act's preclusion of people with mental disabilities from the enjoyment of their legal capacity. That the practice of the denial of informed consent to treatment is a practice occurring as a result of the Mental Disorders Act is attested to by the Petitioners.

- 5.9. The Special Rapporteur on the Right to Health has described how the right to legal capacity is a prerequisite for the enjoyment of the right to informed consent for mental health treatment:

"The evolving normative context around mental health involves the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one's own health and body. That is also linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity. While informed consent is needed to receive treatment that is compliant with the right to health, legal capacity is needed to provide consent and must be distinguished from mental capacity. The right to health also includes a right to integration and treatment in the community with appropriate support to both live independently and to exercise legal capacity (see, for example, E/CN.4/2005/51, paras. 83-86, and A/64/272, para. 10). The denial of legal capacity frequently leads to deprivation of liberty and forced medical interventions, which raises questions not only about the prohibition of arbitrary detention and cruel, inhuman or degrading treatment, but also the right to health.

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 31.)**

- 5.10. Informed consent in medical care requires knowledge of consequences and risks of treatment, appreciation of those facts, and free and voluntary agreement to the intervention.

**(Castell v Greef 1994(4) SA 408 (C) at para 426).**

- 5.11. That persons with mental and psychosocial disabilities may require reasonable accommodations and support to enjoy their right to informed consent in a particular context is provided for in the CRPD and Persons with Disabilities Act. The Act and CRPD require that in refraining from discrimination against people with disabilities, reasonable accommodations are made. This may require, for example, that a person be **supported** in making a decision in their healthcare, but not that their will is **substituted** by a third party.

**(UN Committee on the Rights of Persons with Disabilities (CRPD), General Comment No. 1: Equal Recognition before the law (Art. 12 of the Convention), 11 April 2014, CRPD/C/GC/1.)**

- 5.12. Supported decision making is a concept that has been embodied by the Draft Protocol to the African Charter on Human and People's Rights on Persons with Disabilities. Article 8 (3) (c) states that all States shall ensure: Persons with disabilities are provided with the support they may require in enjoying their legal capacity, and that such support respects the rights, will and preferences of persons with disabilities and does not amount to substituted decision-making;
- 5.13. Supported decision making has been provided for in other jurisdictions. In Canada, section 6(1) of the **Vulnerable Persons Living with Disability Act (Manitoba CCSM c V90)** defines supported decision making as:

“the process whereby a vulnerable person is enabled to make and communicate decisions with respect to personal care or his or her property and in which advice, support or assistance is provided to the vulnerable person by members of his or her support network.”

- 5.14. Supported decision-making for people with mental and psychosocial disabilities may also be enabled through the use of Advanced Health Directives, which provide a mechanism for recording the will and preferences of a person in the event of future crisis.
- 5.15. The Committee on the Rights of Persons with Disabilities has repeatedly urged States to repeal laws that subject people with mental and psychosocial disabilities from being subjected to treatment without their free and informed consent, and from involuntary commission to institutions.
- (See, for example, Committee on the Rights of Persons with Disabilities (2011) Consideration of the reports submitted by States parties under article 35 of the Convention: Tunisia, CRPD/C/TUN/CO/1).**

6. **THERE IS NO JUSTIFICATION FOR THE OUTDATED APPROACH TO PSYCHOSOCIAL DISABILITY**

6.1. In assisting the Court, we wish to debunk some of the justifications that are often cited by proponents of detention and coercive treatment legal regimes for people with mental and psychosocial disabilities.

6.2. Once justification is that regimes like the established by the Mental Disorders Act are required to "protect" society. These justifications view people with mental disabilities as dangerous.

However, research indicates that people with psychosocial disabilities are more frequently victims of violence than perpetrators of violence. While perpetrators with mental and psychosocial disabilities are overrepresented in the criminal justice system, symptoms of mental ill-health relate weakly to the likelihood of criminal behaviour.

**(See Jillian K Peterson and Others, "How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?" ,*Law and Human Behavior*, vol. 38, No. 5 (April 2014).)**

6.3. As discussed above, justifications on "medical necessity" for coercive treatment and detention are similarly not supported by evidence, as these measures are harmful to mental health and wellbeing. By socially isolating and coercing people with mental and psychosocial disabilities to endure forced treatment in inhumane conditions, the Mental Disorders Act also disables the ability of people like the Petitioners to access the social determinants of mental health that includes a supportive social environment, education, leisure, and the enjoyment of social and public services:

"Justification for using coercion is generally based on "medical necessity" and "dangerousness". These subjective principles are not supported by research and their application is open to broad interpretation, raising questions of arbitrariness that has come under increasing legal scrutiny. "Dangerousness" is often based on inappropriate prejudice, rather than evidence. There also exist compelling arguments that forced treatment, including with psychotropic medications, is not

effective, despite its widespread use. Decisions to use coercion are exclusive to psychiatrists, who work in systems that lack the clinical tools to try non-coercive options. The reality in many countries is that alternatives do not exist and reliance on the use of coercion is the result of a systemic failure to protect the rights of individuals."

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, at para 64.)**

- 6.4. Finally, it is important to affirm that the adoption of a social and human-rights based approach to psychosocial disability does not purport to claim to bring an end to suffering from mental health problems. The approach mandated by the CRPD and Persons with Disabilities Act instead seeks to ensure that suffering is minimised and that the legal response to mental health retains respect for individual human dignity:

"While the paradigm shift in mental health requires a move towards integrated and population-based services, mental distress will still occur and rights-based treatment responses are required. The interventions used to address serious cases are perhaps the biggest indictment of the biomedical tradition. Coercion, medicalization and exclusion, which are vestiges of traditional psychiatric care relationships, must be replaced with a modern understanding of recovery and evidence-based services that restore dignity and return rights holders to their families and communities. People can and do recover from even the most severe mental health conditions and go on to live full and rich lives.

**(Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, HRC 35th 28/03/2017 A/HRC/35/21, para81.)**

## **7. THE IMPORTANCE OF THE COURT'S INTERVENTION**

- 7.1. The practical effect of the orders sought by the Petitioners is of profound importance to the lives and wellbeing of people with mental and psychosocial disabilities in Zambia. Their

orders include declarations to affirm the right of all people with mental and psychosocial disabilities to the enjoyment of informed consent to admission and medical treatment and to freedom from detention on the basis of their disability.

- 7.2. The practical effect of the orders sought by the Petitioners is of profound importance to the lives and wellbeing of people with mental and psychosocial disabilities in Zambia. Their orders include declarations to affirm the right of all people with mental and psychosocial disabilities to the enjoyment of informed consent to admission and medical treatment and to freedom from detention on the basis of their disability.
- 7.3. Further to the orders sought, a binding precedent, to affirm the legal paradigm shift that the CRPD and Persons with Disabilities Act mandates, will secure the assurance that future legal developments will be guided by respect for the human rights of people with psychosocial disabilities.
- 7.4. That an "effective remedy" is required for a breach of constitutional rights is trite law, a consideration that, in our humble submission, should also include cognisance of Zambia's social context, in which most people with psychosocial disabilities will be unlikely to enjoy the means to access the courts to enforce their rights:

"Given the historical context in which the interim Constitution was adopted and the extensive violation of fundamental rights which had preceded it, I have no doubt that this Court has a particular duty to ensure that, within the bounds of the Constitution, effective relief be granted for the infringement of any of the rights entrenched in it. In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced. Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovative remedies, if needs be, to achieve this goal."

**(Fose v Minister of Safety and Security [1997] ZACC 6; 1997 (7) BCLR 851; 1997 (3) SA 786, at para 69.)**

7.5. We note further that section 65 of the Persons with Disabilities Act creates a general offence for contravention of the Act which may include imprisonment for up to three years and a fine. This Court's guidance on compliance with the Persons with Disabilities Act in the context of persons with psychosocial disabilities will further provide important support for service providers to ensure they are not in breach of the law in the face of outdated legislation.

Dated this ----- day of ----- 2017.

Settled by Counsel of:

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LUSAKA  
**The Second Respondent**

**IN THE HIGH COURT FOR ZAMBIA  
AT THE PRINCIPAL REGISTRY  
AT LUSAKA**  
*(Constitutional Jurisdiction)*

**2017/ HP/ 204**

**IN THE MATTER OF:                    THE PROTECTION OF FUNDAMENTAL RIGHTS REGULATIONS, 1969  
AND**

**IN THE MATTER OF:                    ARTICLE 28 OF THE CONSTITUTION OF ZAMBIA**

**AND**

**IN THE MATTER OF:                    ARTICLES 8, 13, 15, 16, 18, 23, AND 266 OF THE CONSTITUTION OF  
ZAMBIA**

**AND**

**IN THE MATTER OF:                    THE MENTAL DISORDERS ACT, CHAPTER 305 OF THE LAWS OF  
ZAMBIA**

**AND**

**IN THE MATTER OF:                    THE PERSONS WITH DISABILITIES ACT, NO. 6 OF 2012**

**AND**

**IN THE MATTER BETWEEN:**

**GORDON MADDOX MWEWA  
MULIMA SANTA KASOTE  
SYLVESTER KATONTOKA**  
*(Suing on his own behalf and as Executive Director of the  
Mental Health Users Network)*

**1<sup>ST</sup> PETITIONER  
2<sup>ND</sup> PETITIONER  
3<sup>RD</sup> PETITIONER**

**AND**

**ATTORNEY GENERAL  
ZAMBIA AGENCY FOR PERSONS WITH DISABILITIES  
DISABILITY RIGHTS WATCH**

**1<sup>ST</sup> RESPONDENT  
2<sup>ND</sup> RESPONDENT  
AMICUS CURIAE**

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**AMICUS CURIAE'S SUBMISSIONS**

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